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CANADA

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Original Communications.

CANCER OF THE BREAST IN ITS RELATION TO PAGET'S DISEASE OF THE BREAST.

By J. A. GRANT, M.D., M.R.C.S., Ottawa.

(Read before the Canada Medical Association, at Toronto, September, 1882.)

Mrs. M. C., aged 39 years, mother of three living, healthy children, the youngest of whom is aged 1 year and 5 months, of short stature and regular conformation, rather pale complexion, and temperate habits, was admitted by Dr. St. Jean into the Ottawa General Hospital, August 5th, 1882, owing to the existence of a tumour in the right breast, of considerable size and hardness, and having a nodulated and irregular feel; glands in the axilla and same side of the neck implicated, and possessing considerable hardness. On the surface of the breast, towards the subclavicular region, several small and well-defined superficial nodular growths exist, having a slightly discoloured condition of the skin, hard and sensitive to moderate pressure. Family history good, and menstruation always regular. The first trouble experienced in the breast was an eczematous eruption covering the greater part of the areola, to which little attention was paid until after a lapse of several months, the exact period not being known. A sense of uneasiness in the gland, associated with a hardness about the parts, then, for the first time, attracted particular attention, having to earn a living, in a rough country district, by vigorous manual labour. At this stage, operative interference was decidedly objectionable.

The fact of chronic eczema of the nipple being closely connected with mammary cancer was first observed by Sir Jas. Paget in 1874. In the London *Lancet* of January 27th, 1877, he most cautiously expressed the opinion that he could only speak of the clinical character of these cases. He had no doubt of the frequency with which chronic eczema, or any chronic irritative disease of the breast or nipple, was followed by cancer. Fifteen or twenty cases had come under his observation, from which he was led to believe "that if any irritative condition were present in the skin of the areola and nipple for a period of three or four years (the patient being of an age favourable to cancer), cancer of the breast would ensue." The clinical value of this fact was so important that in December, 1879, at a meeting of the Royal Medico-Chirurgical Society, Mr. Erichsen stated "he could not but think that this condition of nipple, when associated with cancer, was something different from any known form of cutaneous disease," and attention being first called to it by Sir Jas. Paget, he termed it "Paget's Disease of the Nipple." At a meeting of the Royal Medico-Chirurgical Society, January 23, 1877, Dr. Thin maintained that the supervention of cancer upon eczema of the nipple was unknown, except in London. It is true that, as far as Ottawa is concerned, during a period of 28 years work in two General Hospitals, the present is the first opportunity which has presented of recording this peculiarly interesting clinical fact.

Dr. Thin, in examining carefully the histology of this disease, has come to the conclusion that the breast-tumour in Paget's Disease is actually duct cancer, developed from the epithelium of the lactiferous ducts, and never true scirrhus or parenchymatous cancer, which he considers is developed from the secreting epithelium of the acini: so, from the origin of the disease, which spreads downwards to the gland and promotes at the same time, superficially, this type of eczema, termed *papillary dermatitis*. In examining into the clinical history of this subject, we find that Walshe, "on the Nature of Cancer, 1846, p. 473," has recorded, in reference to cancer of the breast, that the skin sometimes undergoes cancerous infiltration coevally with, and,

as it were, independently of, the subjacent structure," or the disease actually commences in the cutaneous surface. Thus we observe that the attention of pathologists has long been directed to the cutaneous importance of cancerous disease, a few histologists like Mr. Butlin holding that all varieties of cancer have an epithelial origin. Gross (Vol. II, p. 272) writes: "Although scirrhus generally commences in the glandular structure of the mamma, yet occasionally its primitive seat is in the common integuments, &c."; thus we observe here a recognized principle. The great majority of pathological productions contain cells analogous to epithelial cells, or to the corpuscles of the connective tissue. (Virchow's Cellular Pathology, p. 63.) That we may have eczema of the breast, independent of cancer, is undoubted; hence the importance of discriminating between the purely simple and the *malignant papillary dermatitis*. The age of the individual, the duration of the disease, the intractable character, associated with the well defined margin of malignant dermatitis, and the evidence, when the tissue is grasped between the fingers, of infiltration in the papillary layer, doubtless point to the true character of the diseased condition. The demonstration within the past few years, of a local cause of several cutaneous diseases, formerly classed as expressions of blood states, is undoubtedly an advance beyond the old basis of an undefined *materies morbi*. Still, error would arise out of a general acceptance of such local power. From the microscopic character of eczema, Dr. Bulkley is disposed to consider it more decidedly constitutional than local. (Virchow's Cellular Pathology, p. 61.) "In the micrographical school of the west, a certain number of observers have come to the conclusion that in the series of new formations there is only one particular structure which is specifically different from natural formations—namely, *cancer*." Under such circumstances, traced up diversity becomes doubly interesting. The nature of eczema, as described by Dr. Tilbury Fox in London *Lancet*, in 1870, is not supposed to arise from mere capillary excitement; that capillary congestion is a sequence of cell activity, and that the abnormal state of the cells may be the result of perverted

nutrition, as defined by Hebra. Dr. Bulkley of New York (Report on Eczema and Psoriasis, International Med. Congress, Phl.,) expresses his opinion "that there is no proof that this cell change is really primary in eczema, and independent of constitutional conditions, and that it exists as a local affair." From such deductions, the physiological importance of the skin, in its relation to subjacent parts, cannot be over-estimated. At every stage of life, in rugged health as well as in diseased conditions, we trace the outcome of nature's efforts on the cutaneous surface. Thus the apparently healthy skin of markedly eczematous subjects becomes, both before and after local disease, an interesting field of observation. The most important point, however, is the part the diseased tissues take in eczema, as to primary or secondary significance. Thus far the question is in doubt. It is an interesting analogy to observe how, on the one hand, lingual and buccal psoriasis become transformed into true epithelioma, and, on the other, eczema of the nipple into cancer of the breast. Here, again, we trace analagous pathological bearings between surface and interior. In the unsettled state of the subject, the question of treatment becomes difficult. Practical experience, the outcome of patient and careful observation, will, fortunately, as a general rule, guide and direct the most prudent action under such rare circumstances.

A CASE OF TUMOUR OF THE BONES OF THE SKULL PRESSING ON THE BRAIN.

By Dr. PREVOST, Ottawa, Ont.

(Read before the Canada Medical Association, at Toronto, September, 1882.)

On the 12th of May, 1882, M. C., aged 58 years, raftsman, came to consult me with regard to a tumour situated in the forehead. The patient, to all appearance, was a strong, robust man, complaining only of this growth that he wished to rid himself of. I could discover no hereditary taint of any kind; he never had syphilis, and always enjoyed perfect health, notwithstanding the twenty years hardship of a shantyman's life. However, within the last seven or eight years, every autumn, he has been subject to neuralgic pains in the course of the right trifacial

nerve. His sufferings, although very acute, were always of short duration, never preventing him attending his work. During the fall of 1881 this neuralgia did not reappear. Towards the end of January, 1882, passing, by chance, his hand over his forehead, he discovered a small opening in the frontal bone, covered by the skin. This he at once communicated to his friends. They found there really was a hole in the bone, and, moreover, a slight tumefaction, a lump on the side of this little opening which had then the size of a 25 cent piece. The patient feeling in perfect health, and experiencing no pain whatever, this discovery caused him no anxiety. Nevertheless, the lump augmented gradually, until at last it bulged under the skin. At the beginning of the spring the patient, becoming anxious about the development of the tumour, came to Pembroke, where he consulted several physicians. One of them plunged an exploratory needle into the lump and withdrew pure blood. They told him to return home and avoid falling or any kind of hard work, that he was affected with an aneurism, and no surgical intervention was possible. He then came to me.

To the right of the median line of the forehead there projects a lump about the size of a large orange, almost regularly spherical, except on the external side, where it seems to be elongated, decreasing in bulk. There is no discoloration of the skin, which is moveable over the tumour. The latter is elastic, moderately tense, boggy, offering to the hand the sensation of a false fluctuation. It pulsates synchronously with the heart's action. This character, although very slight, is perfectly distinct. Respiration has no effect whatever upon the tumour. By a steady and continued pressure of the hand the tumour is almost obliterated, and we perceive that a large portion of the frontal bone has disappeared, leaving an aperture of two or three inches in diameter. Through the skin the edges of this perforation appear to be serrated, irregular, and tender to the touch. The compression of the tumour and the reduction of the latter caused no feeling of uneasiness to the patient, neither any appreciable physiological phenomena. This growth, according to the patient's own observation, does not always present the same volume, but

ordinarily bulges more in the afternoon, decreases in the morning and during the forenoon. Within the last few weeks, he complains also of weakness of vision in the right eye. The general health is good. The heart and lungs present nothing abnormal, and the digestive functions are properly performed. There is absolutely no trouble of motility or sensibility.

Owing to the situation and character of the tumour, my attention was attracted towards the intellectual functions, and I looked for some signs of cerebral compression, but, strange to say, there, also, the symptoms remained almost entirely negative. There was, it is true, a certain appearance of dullness and stupidity in his face, but, for all I knew, that state might have been innate and habitual. Although he supplied the elements of the present observation, I must confess that it was hard work to me to gather the facts, owing to the lack of lucidity of his mind and the slowness of his answers. Quietly sitting in his chair, he seemed silent and drowsy. I asked him to accompany me to the medical meeting taking place that evening; he readily consented. It was growing late. I said to him: "We must hurry; being a shanty-man, you must be a good walker; can you follow me?" He replied in the affirmative, and I started ahead. But I soon noticed that he was astray in his calculations concerning his capacities, for I had to wait for him two or three times. I even had to return to meet him, and found him walking slowly, head bent, and looking distracted. On speaking to him, he, each time, suddenly quickened his step, as if he had forgotten that he was coming with me, and would soon fall back into his old gait. The assembled physicians examined him. His answers were laconic, but clear, and with no disturbance of speech. On leaving the meeting, I asked him if he could reach his boarding-house alone; he said "yes," and I left him. But the next day I learned that he had lost his way, with which he was, however, familiar, and had not come in until five o'clock in the morning. Two days after he entered the hospital, and soon fell into a state of total indifference, passing his time in bed, not asking for food or anything whatever. I then noticed a well-marked degree of exophthalmos of the right eye, the volume of which kept the

lids apart. The eye-ball also appeared to be somewhat softened. The skin covering the tumour presented a reddish colouration, and was traversed with dilated veins. On the 16th of May, at noon, I found him in a state of coma, the pulse beating 140, with high respiration. In this state he remained until death, which ensued at six o'clock in the evening.

At the autopsy, made eighteen hours after death, I found the tumour partly sunk in. The skin covering it had resumed the colour of the skin of the rest of the face, and was furrowed with wrinkles. I dissected two flaps that I drew back to expose the tumour, which appeared bulging through the perforation of the bone, and presenting a smooth aspect and a bluish hue. Incised in its horizontal diameter, it appeared composed, in the most external portion, of a soft, reddish-brown tissue, extremely vascular, and contained in a very thin web. Gradually, and especially under the level of the frontal bone, the consistency changed and presented the aspect of a greyish pulp, similar to the cerebral substance, although a little softer, which I scooped out with a spoon. This substance filled a cavity of the size of a hen's egg, situated between the bone and the dura mater. This latter membrane was depressed backwards, driving before it the right cerebral hemisphere, which it compressed almost on a level with the temporal bone. The dura mater was perfectly sound, without any vascular injection, and, after the evacuation of the cavity, it kept up the rounded depressed form impressed upon it by the neoplasm. The posterior part of the orbit appeared also to have been invaded by the morbid growth, which accounts for the exophthalmos noticed during life.

This patient, gentlemen, was affected with an encephaloid medullary cancer of the frontal bone, and the vascularity of its texture ranges it in the class of these morbid products to which Hey has given the name of *fungus hæmatodes*. This disease has long been, and is still by some writers, designated exclusively under the improper term of fungus of the dura mater. In fact, Louis, and all the surgeons preceding him, claimed that all the cancerous tumours of the vault of the skull constantly originated on the external face of the dura mater, and then proceeded to

wards the integument, after having perforated the cranial box. In 1785, Sandiford and Siebold were the first to renounce these exclusive theories demonstrating that these tumours originated in the diploë. A few years afterwards, Lassus, in his Treatise of Surgical Pathology, and Waltier and Chelius, proved by indisputable observations the multiple origin of the cancerous growths of the skull; and to-day almost all surgeons admit that these tumours may have their origin in the integuments, the bones, the dura mater, and even in the brain itself.

In the case which I have the honour to submit for your consideration, it is evident that the morbid process originated anywhere else than in the dura mater, which, at the autopsy, appeared free from all alterations, presenting all the characters of the normal membrane. The clinical history of the case demonstrates, besides, that the bone must have been the primary seat of the growth, which, after having perforated the frontal, bulged beneath the integuments on the one hand, and pressed back the dura mater on the other, and also the cerebral hemisphere. Cancer of the bones of the skull ordinarily shows itself in adults, and appears sometimes solitary, and at others as a manifestation of generalized cancerous diathesis. The morbid product begins sometimes between the bone and the periosteum, and then develops itself externally by propagation to the integuments. But, generally, the process begins within the diploë, separates the internal table from the external, which, being absorbed, disappear, producing a perforation of a more or less extensive size, with rough, bristling, serrated edges, indicating a rarifying osteitis, ending in partial necrosis. The symptoms vary according as the tumour begins on the external surface of the bone or within the diploë. In the first case, we may feel a more or less soft lump, giving the sensation of false fluctuation, and liable to present the character of a real liquid tumour. When it originates within the diploë, it might remain a long time without showing any external manifestation; but, little by little, the external table gets thinner and thinner, owing to absorption, and the growth allows itself to be depressed by the finger, which experiences the sensation of a parchment-like

crepitation. When the bone is entirely perforated, the fungus raises the skin and appears as a rounded, elastic tumour, beating synchronously with the pulse, and more rarely with the movements of respiration. If the internal table has been absorbed, the tumour is totally or partially reducible, and the osseous perforation can then be felt. Sometimes this reduction of the tumour induces cerebral disturbances, such as syncope, convulsions, epileptic seizure; at other times it takes place without any accidents, as in the present case. These cerebral symptoms often appear spontaneously, and, consequent upon the progress of the disease, the patient experiences then numbness of the limbs, syncopes, paralysis, coma—in short, all the signs of cerebral compression. Death, then, is not far off. Sometimes the tumour ulcerates, and the patient dies from hemorrhage or exhaustion. The duration of the disease may be pretty long, but, when once the bone is perforated, it is seldom prolonged beyond one or two years. Death might occur a great deal sooner, as is shown by the present case, which went through all its stages in five months.

As you may have noticed, at the reading of this observation, the tumour was the occasion of an error of diagnosis, and was mistaken for an aneurism. Instances are not uncommon in the records of science, where a similar mistake has been committed, and the diagnosis of encephaloid of the bones of the skull is certainly surrounded with certain difficulties, which, however, are not insurmountable, as can be demonstrated by the following considerations:

The reducibility by pressure, the pulsations synchronous with the beatings of the pulse, allowed us at once, in this case, to range the tumour in the class of tumours communicating with the cranial cavity, and to eliminate from the diagnosis all the morbid growths situated at the surface of the vault of the skull. Amongst the former, encephalocele, aneurisms of the middle meningeal artery, and fungus of the dura mater, were the only ones which might have induced a mistake. But encephalocele is a congenital disease, or produced by a blow, a fall, with fracture of the skull, besides having its seat generally at the

posterior part of the head. Nothing in the history of the case showed that any of these different characters were present.

Aneurism of the middle meningeal artery has, on the skull, a seat different from the one occupied by the fungus in this case. It shows itself naturally in the course of the artery, that is, on the lateral parts of the head. The pulsations, in aneurism, are besides a great deal more energetic than those noticed in the cancers of the bones, whatever may be the vascularity of the latter. Under the influence of pressure, the aneurism is reducible, it is true, but as soon as pressure is removed the tumour resumes its primitive volume almost suddenly, after two or three cardiac pulsations, whereas, in encephaloid, it is not until after a larger number of these pulsations, and slowly, that the neoplasm comes back to its primitive form. Blowing is absent in the fungus, and the compression of the carotid, which suppresses the pulsations in aneurism, has no influence upon the beatings with which the fungus is agitated. As far as the differential signs are concerned between encephaloid of the bones of the skull and fungus of the dura-mater, I must confess that they are very often wanting, especially at the last period of the disease. Perhaps, in the fungus of the dura-mater the cerebral symptoms are of a more frequent occurrence, as well as certain functional symptoms, such as neuralgias, deafness, and so on; the error, however, would be of little importance, the prognosis being similar in both cases, and also the indications of treatment, which are total abstention of all surgical interference. In fact, the nature of the morbid product and its situation amply suffice to restrain the hand of the surgeon. Nevertheless, it has been advised to largely lay bare the fungus, circumscribing it by a sufficient number of crowns of trephine, and to make a complete extirpation of the growth. Grossman, Peccholi and Nelaton seem to have obtained real success by this means. But these cases are not numerous enough to justify the surgeon in resorting to such a grave operation, especially when one has to deal with a disease the nature of which is, sooner or later, certain of reproduction. Upon the whole, every time we have to deal with a tumour, dense, elastic, semi-fluctuant, situated on the

vault of the skull, especially in the frontal region, beating synchonously with the heart's action or with the movements of respiration, reducible under pressure, through a perforation of the skull, slowly resuming afterwards its former state, being neither the seat of blowing nor influenced by the compression of the large vessels, let this tumour be accompanied or not with symptoms of cerebral compression, we may, without fear, pronounce it to be a cancerous tumour having originated either on the surface of the dura-mater, or, rather, within the diploë of the skull—an affection certainly fatal, and giving rise but to indications of a mere palliative treatment.

Gentlemen, I thought this observation interesting, for several reasons, but among the facts that I cited there is one which, in my humble opinion, surpasses all the others. It is the considerable degree of compression which the morbid growth produced upon the brain, at the same time with an almost total absence of the physiological phenomena that we had reason to expect. This fact, although not uncommon, is none the less remarkable, owing to the group of symptoms which classical authors generally attribute to the compression of the encephalon. This relative integrity of the cerebral functions, noticed in our patient, may seem extraordinary at first sight; however, we find a satisfactory explanation in the recent ideas of science, by means of numerous and judicious observations. We can comprehend the physiological phenomena due to cerebral compression, either by an attrition of the elements of the substance of the brain, either by the changing of the parts constituting it, or by the impaired circulation resulting from the external pressure. The absence of one or more of these elements suffices to present the exterior manifestations liable to be determined by the compression. Without going so far as Gama, Deseault and Malgaigne, who almost completely annuled the influence of compression, attributing the disturbances to an inflammation of the brain or its membranes, it is nevertheless true that the functional disorder is subject to many circumstances, such as the situation, the extent and the nature of the compressing agent, as well as the more or less rapidity of its formation. For instance,

compression of the base of the skull is almost always followed by appreciable symptoms, whereas a similar lesion at the convexity of the hemisphere is often devoid of any. This fact is in conformity with the ideas given by experimentation, which teaches that the periphery of the brain is insensible to physical and chemical irritants, whilst the irritation of the protuberance, the peduncles and the bulb give rise to troubles of motility and sensibility. The nature of the compressing element plays also an important part in the more or less frequency of the physiological disturbances, and these latter, which are rarely wanting in abscess of the brain, are due to the inflammation of the parts in contact with the pus rather than to the compression produced by the purulent collection. So much so, that examples are very rare in science where the evacuations of a cerebral abscess has produced the cessation of the symptoms, which, on the contrary, persisted with almost the same intensity. Lastly, a sudden compression would more surely produce cerebral symptoms than that due to a lesion gradually developing itself, and permitting, as it were, the brain to become accustomed to the presence of this foreign body. In this case the tumour was situated on a level with the convexity of the hemispheres, though subjacent parts were the seat of no organic alterations, the growth gradually increased, so we must not wonder if the signs ordinarily attributed to compression of the encephalon were almost completely wanting.

CASE OF ECHINOCOCCUS DISEASE OF THE LUNG.

By DR. BLACK, Uxbridge, Ont.

(Read before the Canada Medical Association, at Toronto, September, 1882.)

I was consulted in the latter part of November, 1878, by Mr. R., Primitive Methodist minister, native of Essex, England, and a resident of Canada for about six years, whose health had been gradually failing for about four years. In 1876 he had been under the treatment of Dr. Aikins, of Toronto, who had punctured and removed the contents of a hydatid tumour of the liver; after which, for a time, the patient's health had improved,

but the improvement was not lasting. During a year and a half previous to consulting me, he had steadily been becoming less fit for attending to the duties of his profession.

The patient was very much emaciated; sallow complexion, nostrils dilated; countenance had a pinched and somewhat cachectic appearance, appetite had largely failed, a good deal of gas in the abdomen, bowels constipated, and there was some dyspnœa, with a dry cough, particularly when in the recumbent position. The epigastrium and right hypochondrium were tense, and somewhat painful when subjected to pressure; the lower intercostal spaces on the right side were enlarged and tense; the upper part of the right lung was in its normal condition, as was also the whole of the left lung. There was, however, very marked dullness over the lower part of the right lung, the highest point of dullness being in the region of the nipple, in the axilla, and close to the sternum; at the vertebral column the points of dullness were about an inch lower. The heart's position and sounds were normal, though it was greatly deficient in force. The spleen was very little in excess of its natural condition. The right lobe of the liver was large, hard and smooth, particularly along the lower margin of the dull space; and the diaphragm, on the right side, had little or no action. From these signs I inferred that a tumour of some kind, situated in or on the upper part of the liver, was projecting into the thorax. Had the pain been more acute and persistent, the cachectic appearance of the patient, combined with the fact that the tumour did not present any traceable fluctuation, would certainly not have led me to the diagnosis of *echinococcus*. The fact, however, that the patient had been afflicted with that disease two years before, coupled with the long duration of the tumour and the absence of acute pain, induced me to favour the opinion that the existing trouble was an offshoot from the former, or, perhaps, more correctly, a continuation of it.

My faith that the results of treatment would prove in any degree satisfactory not being of the character that was calculated to remove mountains, I advised that the opinion of some one possessed of more skill and experience in the management of

such cases should be sought, and suggested that the gentleman, Dr. Aikins, who had had charge of the case in 1876 should be consulted. My advice was followed, and the patient brought back a very unfavourable prognosis. So far as treatment was concerned, there was not the smallest suggestion thrown out. I inferred that the doctor did not look upon treatment as being of any service, further than the treatment of symptoms for the relief of the patient, as they occurred. Fl. Ext. Rhei and Taraxaci were prescribed to counteract the constipation, and a cinchona bark tonic, with a little Spt. Amm. Arom., for the purpose of helping to raise the gas from the stomach.

Dec. 10th.—Little or no change in the condition of the patient.

Dec. 24th.—Acute persistent pain in the upper hepatic region, with repeated rigors, followed by heat and perspiration; obstinate constipation of the bowels; pulse 125; temperature 103½°. Calomel, opium and quinine, with counter irritation, followed by warm cataplasms over the seat of pain, were prescribed.

From this time until the beginning of January the patient had repeated attacks of rigors, and the pain, though not so acute as on the 24th, was very severe, the pulse varying between 105 and 120, and the temperature between 100° and 103°. Specific gravity of urine, which was scant and high-coloured, was 1010. It gave considerable bile-pigment reaction.

Jan. 4th.—No rigors; great tenderness over the liver; the dullness in the lung has pushed its way up in the axilla and close to the spine about an inch and a half further than it was previous to the attack of December 24th; spleen increasing in size rapidly; dyspnœa more marked; some œdema of the feet; and great unrest, the patient not being able to assume any other than the sitting posture. The same medicines were again prescribed that were used before the attack of the 24th ult., sulphuric ether taking the place of the spt. amm. arom. Urine, 1008.

Jan. 27th.—Up to this time there has been no change, except increased emaciation, with general aggravation of all the features of the case. I now fancy I detect some slight tubercular indications in the upper part of the right lung. On enquiry I find that several of his relations have died of phthisis. I add stimulants to the other treatment.

Feb. 10*th.*—Patient very much exhausted; dyspnœa and cough greatly increased, the rapid growth of the spleen interfering with the action of the left lung. The dullness in the upper part of the right lung is much increased, and the patient has hectic fever, with exhaustive night sweats. The impulses of the heart indicate its position to be nearly on a level with the left nipple. The lower limbs are very much swollen. Pulse 110; temperature 101°.

From this time during two weeks there is no new feature in the case.

Feb. 25*th.*—After a coughing fit of a most distressing character, the patient raised nearly two pints of purulent fluid, in which floated a large number of small cysts, the largest of which, in their collapsed condition, would, in their longest diameter, measure two or three inches, while the smallest specimens were barely perceptible. This was followed by complete prostration, from which, under the influence of stimulants, the patient rallied towards night.

Feb. 26*th.*—Patient had secured more sleep than had fallen to his lot in one night since the 24th December. Dyspnœa was not so great as it had been for some time, and the patient was actually cheerful, and entertaining hopes of recovery. The heart impulses were not so much to the left as they had been previous to the discharge through the bronchi on the 25th.

From this time until the day of his death the patient continued hopeful of recovery. Appetite was better, bowels more regular, and breathing less difficult. With the exception of the œdema of the lower extremities, the symptoms were all less distressing. He daily raised less or more purulent matter and some cysts.

March 10*th.*—He had succeeded in raising a cyst of larger dimensions than any of its predecessors, and was exhibiting it and saying, "Here is a fine fellow I must keep for the doctor," when, giving a sudden cough, purulent matter began to boil out of his mouth and nostrils, and he was strangled instantly.

Autopsy 16 *hours after death.*—Did not examine the cranium. In the thoracic cavity found indications of the existence of an

abscess in the lower part of the right lung, which had been distinct from that of the liver. The purulent matter and cysts discharged on Feb. 25th, and from that time until the 1th of March, I believe to have been the contents of this abscess. The cavity was flooded by a greenish-yellow purulent fluid, and floating cysts discharged from the hepatic abscess. The heart was lying with its apex directed to the left, nearly beneath the left sterno-clavicular articulation. The upper part of the right lung was studded with tubercle. The left lung was in its normal condition. The diaphragm was pushed far up into the thorax; the liver was adhering to the diaphragm, and through the diaphragm was a large opening, which communicated with an immense cavity in the liver. The rupture of the diaphragm, and the consequent discharge of the contents of the hepatic abscess, I believe to have been the immediate cause of death. The cavity in the liver was about 9½ inches in depth and 6 inches across; in the cavity was still a large quantity of greenish-yellow fluid like that found in the chest. The liver was of immense size, and studded with tubercle of a yellowish colour, many of which were about the size of a pea. The spleen, which we have here, had imbedded in it this large cyst, filled with a clear fluid, in which I could detect no scolex. The intestines were anæmic; kidneys normal; bladder normal and empty.

ABSTRACT OF PAPER ON OPERATION FOR CLOSURE OF THE HARD PALATE AND HARE-LIP IMMEDIATELY AFTER BIRTH.

By D. H. GOODWILLIE, M.D., New York City.

(Read before the Canada Medical Association, at Toronto, September, 1882.)

In many cases there is tissue enough developed, but there is a failure to unite, and the maxillary bones are separated, making the diameter from side to side greater in proportion to other parts of the face. What is of special importance in this method is to restore the bones to the normal position without any loss of hard or soft tissue, except so much as would be required to freshen the edges of opposing parts. The cleft of the hard palate and lip, if any exist, should be done soon after birth, and

before the child is two months old, to avoid injuring the developing teeth. The closure of the soft palate, if it is to be by a surgical operation, should be done, if possible, before the child begins to speak, at about 2 or 3 years of age.

My method I will illustrate by a case represented in the wax model that I pass around, and which was taken from a cast of a child one week old, and also by diagrams. By its examination you will see presented a cleft of the lip on the left side, and also a cleft through the left of the intermaxillary, extending through hard and soft palate. Bone development has been sufficient in amount, but there being a failure to unite the two sides in the process of growth, the bones became separated, and the intermaxillary attached to the right maxillary leaves the normal anatomical form of the anterior alveolus and becomes more or less straight, the end of the intermaxillary protrudes forward into the cleft of the lip. By this straightening process the nose is carried to the right side, as the anterior part of the nasal septum rests on the intermaxillary, while the left ala is very much stretched to the left. The usual practice is to only close the lip in infancy; but in order to do so it is necessary to have the protruding end of the intermaxillary removed either by cutting it away or crushing it, both of which means is bad surgery. In the former, the bone is removed with all the teeth germs; and in the latter, the germs are destroyed and the parts misshapen. And also to dissect the lips from the bone to allow them to approximate.

The operation for the relief of the deformity the model represents in this case was made in the following manner: The child was placed under an anæsthetic, and by means of a small revolving knife and the surgical engine a small V-shaped section was removed inside of the alveolar process of the intermaxillary, also running up into the septum a very little, and at the same time the edges of cleft of the hard palate were freshened by the revolving knife. Holes were also cut on either side of the hard palate for the purpose of passing suture pin clamps to hold the maxillæ together. Just enough was taken away by the V-shaped section to allow the alveolus of the intermaxillary to resume its

normal position. Now, by means of a properly-constructed forceps the maxillary bones were forced together so as to close the cleft in the hard palate. Then a nasal forcep was passed into the nostrils, grasping the septum, and the nose drawn into perpendicular position, and, at the same time, the intermaxillary was forced into its normal place, closing up the V-shape section made by the revolving knife. The alveolar ridge of the intermaxillary now connects with the maxillary of the opposite side. They are now held together by the suture pin clamps which I have devised for the purpose, and made of the very best steel and gold plated. The cleft in the lip is now closed by first carefully applying the compression lip clamp on each side of the cleft lip to prevent hemorrhage. After the edges are pared, then carefully approximate both skin and mucous membrane by passing the first suture in the vestibule of the nostril and ending with the vermilion border, and then complete the operation by passing the suture pin clamps to take the stress off the sutures.

In all simple or double clefts, all bone tissue should be preserved to prevent deformity in adult life.

The advantages of this method are: 1st, The cleft in the hard palate is closed in all cases where there is the normal amount of bone developed. 2nd, The alveolar ridge with the tooth germs are saved and brought into place, securing, as near as possible, the normal outline of the mouth and subsequent development of the teeth. 3rd, The nose is brought into normal position and over-distended nostril restored. 4th, The external normal appearance of the face is reclaimed.

BI-MONTHLY RETROSPECT OF OBSTETRICS AND GYNÆCOLOGY.

PREPARED BY WM. GARDNER, M.D.,

Prof. Medical Jurisprudence and Hygiene, McGill University; Attending Physician to the University Dispensary for Diseases of Women; Physician to the Out-Patient Department, Montreal General Hospital.

A New Method of Rendering Sponge Tents Aseptic.—Since the introduction of laminaria and tupelo tents and the method of rapid dilatation, sponge tents have been used much less fre-

quently than formerly. The profession gladly welcomed any means of dilating the uterus unattended with the putrefaction and its attendant dangers which so frequently follows the use of sponge. Experience, however, has shown that for certain purposes we possess in sponge, used as a dilator, a therapeutical agent which cannot be replaced by any of the other methods of dilatation. Such conditions are chronic inflammation of the uterus, body or cervix, and the soft, flabby condition of subinvolution. In such conditions the hyperæmia, softening and serous infiltration of the uterine tissues induced by the dilating sponge-tent, are followed by a stimulation of the absorption process to such an extent as greatly to reduce the size of the organ. No method hitherto employed to render sponge aseptic, such as by the use of carbolic acid, has succeeded in preventing the frightful stink of the sponge-tent when removed. This, however, was attained to some extent by Dr. Albert Smith of Philadelphia, by greasing slightly the sponge-tent and then coating it with finely-powered salicylic acid. This experience of Dr. Smith suggested a similar employment of iodoform to Dr. Ernest Frænkel, private docent at Breslau. He took the ordinary cerated sponge-tents, rubbed them well with salicylated cotton, and then coated them from base to apex by rolling them in iodoform. He then filled the vagina with tampons of iodoform-gauze made by Kahnemann and Krause of Vienna. When the tents were removed 18 or 20 hours later, there was absolutely no offensive odour, and particles of the iodoform were still to be seen in the cervical canal and adhering to the sponge tents. The method can be used just as well with laminaria and tupelo tents as sponge and preliminary anointing of the tents with carbolated or borated vaseline will probably be better than with simple cerate. I can testify from recent personal experience how completely free from putrefactive odour a sponge-tent thus treated is, when removed from the cervix, where it has lain for 24 hours. In a recent case, with a view of rendering asepticism more certain, I passed a few grains of iodoform into the uterine cavity before inserting the tent.—(*Centralblatt fur Gynäkologie*, No. 32, 1882.)

The Irrigating Curette and Spoon.—Dr. M. B. Freund of

Breslau describes this instrument in the *Centralblatt fur Gynakologie*, No. 35, 1882. It is formed exactly like the ordinary curette or spoon, but hollow. At the lower end of the handle is an olive-shaped knob, over which the thin-walled rubber irrigation-tube is slipped. The principal use of this instrument is, of course, to secure prophylactic antisepsis, and further, if necessary, to arrest hemorrhage during the operation of curetting, inasmuch as, during and after the operation, the morbid surface is bathed with antiseptic or styptic solutions. In all cavities (uterus, rectum, nose, or a fistula), by the use of the ordinary curette, a simultaneous irrigation cannot be attained from the want of necessary space for another instrument. The importance of antiseptic irrigation during the operation of curetting such surfaces is obvious, seeing that they usually contain putrid secretions or fragments of tissue, which, under the pressure of the instrument, may easily gain access through the numerous freshly opened portals to the general circulation.

The Etiology of Uterine Displacements and Distortions (Flexions.)—This is the title of an article by Dr. Graily Hewitt of London in the July number of the *American Journal of Obstetrics* for this year. For some years Dr. Hewitt has taken particular pains to ascertain the cause of the cases of displacement coming under his care. He has found it possible, in a good many cases, to trace in the previous history particular causes to explain the occurrence. He has been struck with the fact of how frequently the particular cause of displacement or distortion proved to be some external mechanical, physical injury. From the history of cases sent to me for treatment by physicians, I have formed the opinion that the frequency of operation of such causes is not as generally appreciated by the profession as it deserves to be, and it is with a view of drawing the attention of our readers to this subject that I have embodied the substance of Dr. Hewitt's paper in my report for this month. The author found that of 340 cases of sterile married or single patients, 43 per cent. were distinctly traceable to some mechanical exciting cause. Strains from efforts in lifting or nursing sick relatives were common causes—62 out of 149 cases. They most com-

monly produce the effect in persons who undertake such exertions without proper training or strength. Lifting, or occupations involving much standing, are responsible in many cases. "Stretching up to a cord," "drawing the cork of a bottle," "carrying a child," "strain at archery," "moving furniture," "rowing," "use of sewing machine, "lifting a patient from the ground," "lifting wash-stand," were the causes traced in other instances. Unnecessary gymnastic feats, excessive standing at croquet, one or two cases traceable to excessive swimming, may also be mentioned. "Falls" or other accidents include many cases in the tabular list above given. "A complete somersault down a flight of steps," "thrown from a carriage," "thrown from a horse," "fall from a horse," "falls on the back on the ground, down stairs," etc. Under the foregoing heads I find cases of retroflexion recorded. "Jump from a carriage," "slipped down stairs," "fall down steps," "jump from a horse," "fall from a horse," and "horse rolled over her,"—under these heads cases of anteflexion could be quoted. Horse exercise was clearly traced as a cause in several cases. In one case it indirectly led to displacement, owing to prolonged retention of urine. In weakly young women, imperfectly trained to it, horse exercise appears decidedly injurious. Over-walking includes several cases. "Long mountain walks," "daily long walks," and "long walks to catch a train," are causes traced in some retroflexion cases. "Long walks up hill," "very fatiguing walk," "walk during menstrual period," etc., in certain cases of anteflexion. Organ or harmonium playing was found injurious in a few cases. Retention of urine during long railway journey, fright, etc.,—these cases require no particular mention. There were fourteen cases in which the cause assigned is measles, scarlet fever, or typhoid fever. The reason for introducing these causes is, that the cases on investigation proved that the uterine affection had occurred from ordinary walking during convalescence from fever. The conclusion formed was, that the uterus, enfeebled in common with the other organs of the body, gave way under ordinary exertion, and the preceding fever was thus really responsible for the resulting uterine affection.

The author draws attention specially to some of these causes. He has notes of a considerable number of cases of severe injury to the uterus from strains, falls, and railway or carriage accidents. At the time of the accident the injury is not usually made out, but later, inquiry and examination reveal the distortion or displacement. Horse exercise may cause flexion of the uterus. It may be produced suddenly and at once, or more gradually. It is not so liable to happen if the individual be strong and properly trained to it; but evidence that could be adduced seems to show that it is a kind of exercise not free from danger of producing serious uterine mischief, even when judiciously managed. The evidence shows that the uterus is liable to be pushed downwards on the floor of the pelvis, and generally very decidedly flexed backwards or forwards. If there be no particular predisposition to flexion, horse exercise may do no harm, but it is never certain that it will not. Severe flexions of the uterus, as well as other injurious results, often ensue from standing a long time, as in the case of shop-women. Laundry work also very frequently produces similar results.

Marriage, also, Dr. Hewitt asserts, must be mentioned among the causes of flexion. In cases where there is a predisposition to flexion, and where the uterus is soft and weak, intercourse has often a very prejudicial effect, and marriage in such cases may lead to troublesome disease of the uterus in consequence of mechanical disturbing influence thereby brought to bear on the organ.

Eucalyptus Globulus in Gynæcological Practice.—Dr. A. F. Currier of New York, in a short paper in the *American Journal of the Med. Sciences* for the present month, gives the results of a trial of this drug at the New York State Woman's Hospital. The trial was made in the service of Dr. Jas. B. Hunter at the time that Dr. Currier was house surgeon. The preparation used was a mixture of equal parts of fluid extract of eucalyptus and glycerine. Dr. Hunter has, however, used the undiluted and unmixed oil in private practice, and with satisfactory results. It has long been known that this drug on mucous membranes in general, is stimulant, astringent, and antiseptic. Hence a wide

variety of uses was suggested, as in diphtheria, lung affections, gonorrhœa, and in inflammations of the mucous membranes of bladder, vagina and rectum. The cases in which it was used under Dr. Hunter at the Woman's Hospital were cellulitis, prolapsed, painful, and congested ovaries, and displacements with adhesions. It was applied on cotton-wool pledgets, with which the vagina was lightly tamponed. This was repeated daily, or nearly so, for weeks; half an ounce of the preparation being used at each time. The results in the five cases reported were very decided in relief to the pain and other symptoms. In no case could it be claimed that cure was effected, but the remedy was proved to be a most valuable anodyne in a class of affections in which we have a very small number of remedies that are of value.

Retention of the Head of a Mature Child, together with remains of the Placenta, in the Uterine Cavity for Forty Days without Symptoms.—A contribution to the subject of the tolerance of the uterus to traumatic and septic influences, by Alois Valenta of Laibach. (*Archiv f. Gyn.*, Band XVIII, Heft 3.) This was the case of a healthy, well-developed woman, aged 35, the mother of four children, who was brought to the Laibach Obstetrical Clinic. The child presented by the shoulder, a physician was sent for, he turned, and, after great difficulty, delivered the body of the child; and as he did not succeed in delivering the head, he cut it off, leaving it in the uterine cavity. Two other physicians were called, but neither did they succeed in delivering the head. No vaginal injections were used till the eighth day, when a midwife was employed to inject warm water two or three times a day for several days subsequently. Notwithstanding this neglect, she had no rigors or abdominal pain; the functions of bowels and bladder were healthily performed; appetite and sleep were normal. The only symptoms complained of were weakness and an offensive vaginal discharge. After admission to the clinic, vaginal injections of carbolized water were administered. There were no evidences of uterine contractions. The uterine tissue was represented by a thin layer stretched over the head. The local and general conditions indi-

cated that involution of the body of the uterus had proceeded as far as possible under the circumstances, while that of the cervix appeared to be complete—a condition quite unfavourable for the extraction of the retained fœtal head. The cervix was dilated with sponge and tupelo tents, ergot was given in large doses, and by means of a polypus forceps the head was broken up and extracted piecemeal, after the patient had been chloroformed. It was, however, necessary to incise the external os on both sides before the parietal bones could be extracted, as a laceration was imminent. During the process of extraction of the cranial bones, portions of tolerably fresh-looking placenta came away, and when the uterus was otherwise empty, a piece of the size of the palm of the hand was discovered and removed. During the operation, three per cent. carbolized intra-uterine injections were repeatedly employed, and at its close a subcutaneous ergotine injection. The subsequent course of this case, the patient's second puerperium of one pregnancy, was entirely favourable. There were absolutely no unfavourable symptoms.

In his remarks upon the case, the author justly claims that it is very extraordinary in two respects: 1st, The tolerance of the uterus of a foreign body (as the head must be considered to have become) without any tendency to expel it; and 2nd, The absence of any septicæmia under such circumstances. With reference to the tolerance of the uterus of substances of this description, it is to be remarked that there are a few cases on record. Liebmann has industriously collected a few cases, which he has published in the *Beitrage zur Geburtshülfe und Gynakologie*, Berlin, 1874, Bd. III, s. 47. Freund also (*Deutsche Klinik*, 1869, Nr. 33) reports the case of a woman in whom the head of a child was retained within the uterus for ten years. As regards the second remarkable fact, the absence of septicæmia in these cases, the fact is pertinent to the question of the value of antiseptic intra-uterine injections when the lochia are offensive. When we reflect on the fact of how often a dirty finger or instrument is sufficient to carry the death-warrant to a woman in labour and after delivery, and compare these cases with those of the nature just related, we are forced to the con-

clusion that there are other conditions necessary to the setting up of septicæmia besides the presence of septic material. Dr. Valenta accounts for the remarkable immunity of his patient by the original tetanic contraction and progressive involution of the uterus. The uterus was thus so firmly and tetannically contracted over the head that no air or gas could be accumulated between it and the skull of the child; and, further, the occipital foramen of the child was applied near or directly over the os uteri, so that the putrid diffluent brain matter escaped without any opportunity for contact with the interior of the uterus.

Acceleration of Labour: A Contribution to our Knowledge of Eclampsia.—This is the title of a paper by Dr. F. Schauta in a recent number of the *Archiv fur Gynakologie*. Dr. Schauta is assistant at the clinic of Professor Späth of Vienna. The paper gives statistics based upon the large number of 134,345 labours, among which 344 cases of convulsions occurred. Figures are furnished bearing upon many points in the natural history of this disease, which are of much value, and deserve the attention of specialists. *Convulsions* coming on *during* pregnancy quite as often, according to Dr. Schauta, persist during labour, *as cease before* that process begins. The commonly received opinion that convulsions first attacking the patient during labour commonly cease when delivery is complete, Dr. Schauta finds to a great extent negatived by the facts he has collected. The practical point, says Dr. Schauta, which springs out of these results seems to be this: that in labour complicated with convulsions, the accoucheur should not allow himself to be persuaded into operative delivery unless the clearest indications exist and the necessary conditions are present, and that the *accouchement forcé*, now on other grounds rightly abandoned, should, looking at the prognosis of puerperal eclampsia, be unconditionally condemned. The author tests this conclusion by analyzing the cases according to whether labour was artificially induced or not. Of the 42 cases of convulsions occurring during pregnancy, 20 were delivered spontaneously, and 21 by the help of the accoucheur; the remaining one passed from observation undelivered. Of the former, two

died, or 10 per cent.; of the latter, 19, or 90.4 per cent. These 19, however, include five who were delivered by Cæsarean section after the death of the mother. The subtraction of these reduces the mortality to 87.5 per cent. It will, of course, be obvious that the cases in which interference to effect delivery was resorted to were in all probability the worst cases, and the enormous difference in the result between those left to nature and those delivered artificially is probably for the most part to be accounted for in this way. But admitting this, it is also evident that the acceleration of labour did not do very much for the patients. The result shown by cases of convulsions coming on during labour is much the same. There are, however, two good reasons for hastening delivery—if we can do so without doing harm. The first is, that by emptying the uterus, the intra-abdominal pressure which, in the large majority of cases, is a main cause of the kidney changes which produce eclampsia is reduced, and therefore the earlier the delivery takes place the earlier the recovery may be expected to begin. The second is, that the sooner the delivery is effected the better chance the child has of survival. The risk to the child, as well as to the mother, Dr. Schauta shows, is in proportion to the number of the fits. The prognosis for the child is, as, perhaps, might be expected, worse when the fits come on before, than when they commence during, labour. The infantile mortality among the cases of the former class which Dr. Schauta tabulates was 41.8 per cent.; among those of the latter, 20.5 per cent. In considering, in the light of these figures, whether in eclampsia delivery ought to be hastened, the question naturally occurs, whether the bad results enumerated may not have been the result of an aggravation of the nervous condition by the operation necessary to effect delivery, *i.e.*, whether operative delivery *per se* has any influence in producing convulsions. Dr. Schauta has, with this point in mind, analyzed the cases in which eclampsia appeared after labour. He finds that 74 of these had been naturally delivered, of whom 19 died, or 25.6 per cent.; 8 had been delivered by operative aid, of whom 2 died, or 25 per cent., a proportion nearly the same. These figures seem to

us of considerable practical moment. It would be going too far to regard the high mortality among those who were delivered by art as due solely to the mere fact of interference. It seems to us largely explained by the consideration that the cases in which this treatment was resorted to were probably the worst; and it may also have been sometimes the case that the state of the patient led the medical attendant to hurry delivery more than he would have done had death seemed less imminent, and in doing so, to inflict damage which might have been avoided had less haste been used. If pregnancy has anything to do with the causation of the disease in question—and that it has, we think, there cannot be a doubt—we might expect that the removal of so powerful a cause would favour recovery. But Dr. Schauta's cases show this: that there is no such immediate advantage as to justify us in running any risk of other dangers for the sake of speedily ending the pregnancy. If labour has begun, or if it has been induced, it is best left to take its course with the minimum of interference. It seem to us still an open question whether labour may not be induced with advantage, provided the process be conducted in a manner as closely as possible approximating to that of nature; but whether induced or at the natural term, such interference as would be called for if there were no convulsions is alone that which is required. Everything further is submitting the patient to unnecessary risk without any compensating advantage.—*Med. Times and Gazette*, Sept. 2, 1882.

Hospital Reports.

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

CASES UNDER THE CARE OF DR. RODDICK.

(*Clinical Clerks*—Messrs. J. B Howard and Scott.)

CASE I.—*Enlarged Bursa Patellæ treated by Antiseptic Puncture.*

J. E., æt. 38, was admitted June 10th, 1882, complaining of enlargement over the right knee cap, and which was readily diagnosed as *bursitis*. It appears that about two months pre-

vious to admission he was thrown forcibly against an iron post, striking the right patella. Effusion followed very slowly until it reached its present dimensions, namely, the size of a goose's egg. The enlargement is slightly tender on deep pressure, but there is about it neither heat nor redness; it is distinctly fluctuating. Immediately on admission the patient was placed under the influence of ether, and (under the spray) a puncture made into the sac on the outer side. Over an ounce of clear bursal fluid, containing a few flocculi, was withdrawn. About a dozen threads of the coarser catgut were then introduced into the cavity and made to protrude through the wound. The whole was dressed antiseptically, and the limb placed on a back splint.

June 16th.—The dressings were removed to-day, and the wound found perfectly closed, the catgut having been absorbed at the line of the skin. There was no sign of the bursal enlargement. The antiseptic dressings are ordered to be discontinued, and a flannel bandage, with pad over the patella, substituted. He was discharged cured on the twelfth day after admission.

Remarks.—This method of treating housemaid's knee and bursal enlargements generally, will be found invariably satisfactory. Care should be taken to introduce the catgut well into the cavity of the bursa, otherwise the cure may only be temporary. I would suggest that, if the spray be not available, the incision be made either under water charged with carbolic acid, or that a stream of one to forty solution be projected on the part during the operation. This will prevent the ingress of impure air and subsequent pus formation.

CASE II.—*Lupus Exedens of the Face treated with Volkmann's Spoon and the Gas Cautery.*

M. P., aged 20; married; comes of a healthy family, and knows of no similar case among her relations; has had three children at full term; last confinement one month before admission (Jan. 31st, 1882.) Had eczema when a child.

The present attack began eighteen months ago as a small "button," just in front of the tragus of the right ear. This was

round, hard, of a dull red colour, and when scratched bled a little. It enlarged considerably, then gradually healed, and as it healed other spots appeared around it, and went through similar stages. Lately, however, due probably to the puerperal condition, the ulcerating process has far outstripped the healing, and we now find the whole of the right cheek and temple involved. In places, within the zone, are to be seen evidences of cicatrization, with here and there tubercular nodules, which have not yet broken down. There is no tenderness, pain or itching about the eruption, nor can any enlarged glands be felt about the face or neck.

Feb. 2nd.—Ether was administered and Volkmann's spoon used to scrape away any tissue that could be thus removed. Paquelin's thermo-cautère was then freely applied to the scraped surfaces. Lead lotion ordered for 24 hours, and subsequently poultices of linseed meal.

Feb. 6th.—Patient has had a considerable amount of pain, but the temperature has not been affected, and her general condition is excellent. The sore looks well, the sloughs having nearly all separated. Water dressing is to be substituted for the poultices.

Feb. 10th.—She insisted on leaving the hospital, and is given a mixture containing five minims of Fowler's solution in each dose, and an ointment of iodoform to be applied to the sores.

This patient returned subsequently under Dr. Fenwick's care, who repeated the scraping and cauterizing operation to some small spots of a suspicious nature, but at present (Aug., 1882), there is no evidence of disease remaining, the affected area being covered with a firm and apparently healthy scar.

Remarks.—Lupus of this form is now invariably treated in the Montreal General Hospital, after the method just described, and when the operation is performed with care and thoroughness a cure is certain to follow. Arsenic and cod liver oil are indicated in some cases, but the local treatment is most to be depended upon. For the scraping process to be effectual, the spoon must be used freely, especially about the edges of the ulcerated spots, removing all tissue soft enough to be broken

down by it. The cauterizing is intended to complete the work of destruction, and is probably, in many cases, an unnecessary procedure.

Reviews and Notices of Books.

De la Lithotritie Rapide.—Par le Dr. RELIQUET, Laureat de l'Institut, Vice-Président de la Societé de Médecine de Paris, &c. Paris: Adrien Delahaye. 1882.

La Lithotritie Sans Traumatisme.—By the same author.

Dr. Reliquet is no mean authority on the subject of genito-urinary diseases; in fact, we understand he is almost as favourably known in this connection among French surgeons as Sir Henry Thompson is in England: hence anything from the pen of Dr. Reliquet is usually hailed with delight by the profession. In the papers before us, however, we fail to find any hint or suggestion on the subject of rapid lithotrity of very practical importance. In fact, though Bigelow's original instruments are figured and described, the author does not appear ever to have used them, and nothing is said of their more recent improvements. The author has a theory regarding the relative position of the stone and body of the patient during lithotrity, which he is evidently anxious to develop. He maintains that the patient should be so placed that the instrument shall at once seize the stone on entering the bladder, and, to that end, advises the use of a special apparatus, which, placed under the patient's buttocks, can be made to raise the pelvis to any desired height and to rotate it. Dr. Reliquet figures a lithotrite of his own invention —*brise-pierre à pignon*—for which it is claimed that it cannot possibly become clogged with *débris*, on account of the projecting character of the male blade. The author is opposed to "aspiration" in many cases, preferring to rely on large and repeated injections of carbolized water for the removal of fragments through a large-eyed catheter. He thinks that this water does good, besides, in soothing the mucous membrane of the bladder and cauterizing slightly bruised points. When the expulsive power of the bladder is deficient, however, he uses an

aspirator, preferring Thompson's to Bigelow's. After each operation Dr Reliquet throws a solution of boracic acid into the bladder, to be left there.

The papers are carefully written, full of excellent woodcuts, and altogether well worthy of perusal.

On Diet and Regimen in Sickness and Health, and on the Interdependence and Prevention of Diseases and the diminution of their fatality.—By HORACE DOBELL, M.D., Consulting Physician to the Royal Hospital for Diseases of the Chest, Consulting Physician to the Royal Albert Orphan Asylum, &c. Seventh edition, revised and enlarged. London: H. K. Lewis.

This excellent book of Dr. Dobell, which has passed already through several editions, is one which deserves to be better known in this country. The supreme importance of dietary and regimen both in health and in sickness is becoming daily more fully recognized. The author is one who is best known by his writings upon physiological subjects connected with the digestive system and upon pulmonary consumption. After considering what should constitute a normal diet in a healthy adult person, he goes on to formulate the principles which should guide us in arranging a dietary for sick persons. A great many useful recipes are given, sanctioned by his own experience. This leads to the second division of the work—the interdependence and prevention of diseases and the diminution of their fatality. In connection with the matter of diet, the subjects of anæmia and fatty degeneration, &c., are very well and philosophically treated.

The Illustrated Quarterly Journal of Medicine and Surgery.—Edited by GEO. HENRY FOX and FREDERICK R. STURGIS. No. III. July, 1882. New York: E. B. Treat.

This number maintains the high standard of the previous ones, both in the character of the illustrations and the quantity of the subject matter. The first paper, by Dr. F. W. Campbell of Montreal, is on a case of duodenal ulcer, which is accompanied

by a beautifully-executed plate from a coloured drawing by our well-known artist, Mr. Wm. Raphael. Dr. McBurney describes and figures a new method of closing urethral fistula. Three coloured figures illustrate Congenital Keratoma, Papilloma of the Pharynx, and Gummous Iritis. Dr. Chamberlain writes on the therapeutic uses of rubber tubing, and numerous cuts are given illustrating the mode of application to different parts. Dr. M. J. Roberts advocates the use of elastic tension in the treatment of Potts' disease.

The Transactions of the American Medical Association. Vol. XXXII.

We have received the above volume, which contains the report of all the proceedings of the meeting held in Richmond in May, 1881. Many of the papers have, of course, appeared in the medical journals shortly after their delivery, but, at the same time, it is extremely useful to have in library form the complete collection. This volume is quite equal to any of its predecessors in the variety and value of the articles it contains.

Books and Pamphlets Received.

THE DISEASES OF THE RECTUM. By William Allingham, M.D., F.R.C.S. Fourth edition. Philadelphia: P. Blakiston & Co.

A PRACTICAL LABORATORY COURSE IN MEDICAL CHEMISTRY. By John C. Draper, M.D., LL.D. New York: Wm. Wood & Co.

NITRO-GLYCERINE AS A REMEDY FOR ANGINA PECTORIS. By Wm. Murrell, M.D., M.R.C.P. Detroit: Geo. S. Davis.

TRANSACTIONS OF THE MICHIGAN STATE MEDICAL SOCIETY FOR THE YEAR 1882. No. 2. Vol. VII. Lansing: W. A. George & Co.

THE MULTUM IN PARVO REFERENCE AND NOTE BOOK. By C. Henri Leonard, M.A., M.D. 14th thousand. Price 30c.

ESSENTIALS OF VACCINATION AND ON SMALLPOX. By W. A. Hardaway, M.D. Chicago: Jansen, McClurg & Co.

THE PHYSICIAN HIMSELF AND WHAT HE SHOULD ADD TO HIS SCIENTIFIC ACQUIREMENTS. By D. W. Cathell, M.D. Second edition. Baltimore: Cushings & Bailey.

Extracts from British and Foreign Journals.

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

Effect of Bleeding on Inflammation.—The effect of local abstraction of blood in relieving local inflammation is one of the ancient doctrines of therapeutics which is still unrefuted. and still unexplained. It was formerly held that the result was produced by a perfectly simple *modus operandi*. By the removal of blood from the surface the vessels of the deeper inflamed parts were partly emptied; but it was later recognized that this explanation is incompatible with the known conditions of the circulation. The local removal of blood never produces a lasting effect on the circulation in the part. At the present time it is generally assumed that the effect of local depletion is to remove the inflammatory stasis, although such an effect has never been demonstrated experimentally; and, moreover, the idea of a derivatory action still haunts the theory of the subject, while the effect is sometimes ascribed to the influence of the depletion on the whole mass of blood. The question has been lately subjected to experimental investigation by Genzmer and Nikolas, of Halle, and the results obtained have been described by the former in the *Centralblatt für Med. Wiss.* In the web of the foot of curarized frogs foci of inflammation were excited by punctiform cauterization, either by nitrate of silver or a red-hot needle; and the process was watched with the microscope. When well-known phenomena of inflammation made their appearance, the aggregation and exit of the white corpuscles, retardation of the blood current, and, finally, the formation of stasis, a leech was applied to the leg. As soon as the leech began to suck, a striking change occurred in the inflammatory process in the foot; the blood current became quickened, and carried on the corpuscles which were adherent to the wall. The stasis passed away, and in a few minutes the inflamed capillaries were cleared, and presented to the end of the experiment a normal and even accelerated circulation. Whether the corpuscles which had already wandered out of the vessels were influenced by the abstraction of blood could not be determined with certainty. In some experiments

scarification was employed after the focus of inflammation had been excited. The effect was less conspicuous, since the loss of blood did not occur with the same vehemence as with a leech, although the amount of blood abstracted was nearly the same. The effect of abstraction of blood from the general circulation, by opening an abdominal vein, was still slighter, although the amount of blood taken was considerable. The conclusion drawn from these experiments is that the antiphlogistic action of local abstraction of blood is produced by a purely mechanical agency. A temporary augmentation of the circulation occurs, by which the capillaries are cleared; and the stasis, which is the first step in a local necrosis, is removed. Not only is no local anæmia produced, but there is actually an arterial hyperæmia; there is an increased supply of arterial blood to the focus of inflammation, which, besides its effect on the blood vessels, may reasonably be supposed to improve the nutrition of the tissues, and so to counteract the tendencies of inflammation. The antiphlogistic action is clearly proportioned to both the amount of blood withdrawn and to the rapidity of its withdrawal, and its action is notably greater when blood can be withdrawn from the circulation between the region of the inflammation and the right side of the heart.—*Lancet.*

Dry Gangrene from Local Application of Carbolic Acid.—(J. B. Garrison, M.D., Garretson's Landing, Ark.)—About the middle of February last, a daughter of Dr. Childress, of Williamette, Ark., consulted her father as to an onychia in process of development on her right index finger. She was directed to "apply carbolic acid," but instead of applying a few drops to the affected part, she wrapped the entire finger as far as the second joint with several folds of linen and poured on it to saturation pure carbolic acid, liquified, and allowed it to remain in *statu quo* all night. Next morning the bandage was removed, and on the third day after the occurrence, when I first saw it, the finger as far as the second joint was as black as jet, cold, perfectly anæsthetic, wrinkled and shrivelled, with sulci apparently clinging to the bone; hard as wood; in a

word, actually mummified, with a line of demarkation entirely around the finger, indicating a complete separation of the dead from the living tissue. Although there seemed no possibility of saving the finger, as it had actually lost every vestige of vitality, yet I directed a small rubber band to be tied around the finger, near the metacarpo-phalangeal articulation, sufficiently tight to obstsuct the reflux of venous blood without repressing the arterial supply. This was applied for five or ten minutes every hour and kept up continuously for more than two months. The tissues of the finger gradually yielded to the mechanical pressure of the blood, and the digit resumed its shape and functions, except that it was entirely denuded of integument. The old skin was allowed to remain as a protective, and warm, moist poultices, with oil and glycerine, were constantly applied to soften the tissues. The fortunate result of this case is an additional argument in favour of the principle of conservatism in surgery which should obtain in all similar cases.—*Western Med. Reporter.* [Several cases similar to the above have been recorded during the past two years, in which carbolic acid locally used has produced a condition closely resembling dry gangrene. In none of these cases, however, was any attempt made, if we remember correctly, to save the parts. Dr. Garrison's success in his case will lead to a more active line of treatment in the future.—B.]

On Cases showing the Utility of a Laminated Plaster Splint.—We have now in the wards, and always have had during the last few years, several cases showing the use of a simple splint—a splint so simple, that I think we may not inaptly call it the universal splint. I will tell you in a few words what it is, and go more into details afterwards. Take a few sheets of muslin, put them one over another, spread plaster-of-Paris between them, roll or fold up this "layered" sheet in any convenient form, dip it in water a few moments, lift it out of the water and very gently squeeze it, spread it out neatly and smoothly, and you have a soft sheet of splintage ready for any purpose which splints can secure. This

sheet may be little or big; it may envelope a finger or a limb, or the trunk, or the trunk and the head, or the trunk and the lower limb. It is simply drawn under the part, and folded over it. The drawing under, the folding over, and the trimming by means of scissors, are the work of a time measured by seconds. The part is kept in one unaltered position by intelligent force until the sheet sets—a time measured by minutes. A firm, durable and perfectly fitting splint is thus obtained, which may be left on for weeks or months.

Here is a woman who came in with a tucked knee, the result of joint-disease of some standing. The knee was flexed at a right angle, and the head of the tibia was slightly displaced backwards. Under ether, and by a contrivance to which I shall refer again, we straightened the knee. A prepared laminated plaster splint, having been dipped in water and unfolded, was drawn under the limb, folded over it, and allowed to set before the extending forces were relaxed. In another ward, we shall see a fractured femur treated by a similar method; the pelvis, thigh and upper part of the leg being enveloped in a layered plaster splint. All our broken thigh-bones are treated in this way, with this signal advantage—we get them up on crutches in a fortnight. Our broken tibiæ we got up in a few days. Some of you have recently seen a case of osteitis of the wrist enveloped in a laminated splint, a hole in which let the thumb pass through. This layered plaster splint is, in principle, the exact opposite of the plaster roller. For the lower limb, especially for the lower limb and pelvis, the unrolling of plaster bandages is a slow and tedious proceedings, and necessitates many movements and many positions. The principle of lamination or stratification in the construction of plastic splintage may, with suitable change of detail, be extended to other materials; but I have hitherto found the checked muslin and thinly spread plaster in superimposed layers the most generally useful—useful in fractures, joint-diseases, spinal diseases; useful, in short, wherever rest, immobility and support are needed. The laminated plaster splint is quickly and easily made. The surgeon first determines how much of the limb or trunk it is well to

cover. A pattern is then cut. One of the layers of checked muslin does very well for this purpose, as it is stiff enough to keep its shape, and is easily marked with a pencil. Afterwards, other pieces of muslin are cut of the same size and shape. Six or seven layers make a good average splint; three or four will do for a child; eight or nine may be needed for a heavy, restless or delirious patient. The first layer is laid flat on the table, and sprinkled with a stratum of good dry powdered plaster, which is smoothed over with a spatula or paper-knife; on this, with its margins corresponding, is placed the next layer of muslin, which in its turn is sprinkled with plaster. The process is repeated until all the layers are in place. The splint is then slowly and carefully folded or rolled up and kept dry, ready to be dipped in water when wanted. The water—let this be well understood—immediately passes through any number of layers of muslin and plaster, thoroughly drenching them both in less than sixty seconds. The part to be encased is drawn into position, and held so until the plaster partially sets. If the fingers of the extending hand be in the way, as when the foot is included in the splint, a temporary sling of webbing or plaster over the instep and heel may be used, which can be drawn out or relaxed afterwards. A flannel bandage, or layer of wadding or jersey, is next applied without traction. The splint is now dipped in hot water (hot for comfort and for more rapid setting) for a minute or so. When taken out, it is very gently squeezed, being quite sloppy and limp. When the water is pressed out too freely the sheet will be sandy, friable and difficult to apply. The splint is then unfolded, and drawn out in a perfectly smooth and soft sheet; it is next put under the ailing part, and simply folded over. The overlapping margins instantly and firmly adhere to each other. Traction should be most carefully avoided; perfect neatness is enough. The layered plaster splint is applied with as much ease, as regards limpness and adjustability, as is a fomentation; but it is a fomentation which sets, and, with rock-like firmness, lastingly holds the part in any given position. In the upper limb, the laminated limb sheet should be large enough to overlap two or

three inches; in the lower limb, the overlapping should extend to three or four inches; in the trunk, to five or six. A pair of strong, sharp scissors easily trims the splint while it is still wet. Redundance may be now curtailed, or windows made. To get a neat fit opposite joints, especially flexed joints, as the elbow and ankle, the margins of the splint may be notched at each side, or V-shaped bits may be cut out. The corners of a paper box suggest methods of dealing with the elbow. Windows may also be made. and redundancies curtailed very readily, by means of a sharp scalpel, when the plaster is partially set. When the splint is quite dry, a Hey's saw may be used. When it is wished that a sixth or fourth of a whole limb shall be visible, a longitudinal strip is easily removed with a knife in the early setting stage—a stage which lasts long enough for any desired degree of carving. Windows, scollops or openings of any kind do not weaken a splint; and it is better to make them opposite bony prominences, breasts and other compressed parts, as well as opposite abscesses, wounds and compound fractures. If it be desired, a sheet splint may be put on at first, so as to leave a longitudinal strip uncovered. If so, a separate outer layer of muslin must be large enough to overlap, and be fixed with a row of pins for a few minutes. I have adopted this method several times; but I much prefer the overlapping method for ease of application and for efficiency. If, in rare cases, an exposed strip be desired, the carving method in the setting stage is preferable. In the upper limb, a gaping longitudinal splint may be conveniently held in place by a few turns of bandage until the setting is firm. It is convenient, in making a very large splint, to envelop, say, the trunk, or the pelvis and the lower limb, to put it on in two or three pieces made to overlap each other. Where the layered pieces overlap, they amalgate and form a perfectly homogeneous and continuous splint. I will now describe the method of putting on the laminated splint in a few of its more simple but most useful applications. I begin with a simple method of applying a plaster jacket. It may be put on under the tripod—an advantage when the tripod is needed. I usually adopt the horizontal posture, as

advocated by Dr. Walker. Three layered pieces, averaging about thirty-six inches by seven or eight inches, are prepared. These three rolls are easily packed, and may be carried any distance. If any suspicion of dampness exists, hold them over a fire a few minutes in a frying-pan lined with a newspaper. Marks having been previously made on the mattress opposite the axilla and the trochanter, the pieces, when taken out of water, are so arranged that the patient, sitting in readiness, lies down upon them. The middle piece is neatly and leisurely folded over the trunk (encased in a jersey) first; next, the lower and upper pieces are folded over, their margins freely overlapping the central piece. The upper and lower pieces are so applied as to make a waist—the overlapping ends of the upper piece tending upwards, the ends of the lower piece tending downwards. It might be naturally feared that the margins of the pieces would be sudden or prominent. On the contrary, the margins are graduated; and, if the water have not been pressed out too freely, the continuity of the splint is so complete that they cannot be found. The armpit and groin portions should be quite freely cut out when the plaster is partially set. The plaster sheet-splint for fractured femur and for hip-disease is also put on in three pieces, and, when applied, forms one continuous splint, embracing the pelvis, the thigh, the knee and the upper part of the leg. The piece first put on embraces the upper part of the thigh and the pelvis spica-wise, the ends crossing over the trochanter. Overlapping this, and fixing the ends, is the pelvic piece, which in size and position is similar to the lower piece of a spinal jacket. A third large and long piece overwraps the "spica" piece, and covers the thigh, knee, and half the leg. All these pieces are drawn under the patient, and put in place before any one of them is folded over. Moreover, the needed position is also obtained before the folding over begins. The margins of the third piece may need a cut here and there, to avoid wrinkling. The fixity is so complete that, as a rule, it is unnecessary to enclose the ankle and foot. In hip-disease, pulley extension (put on after the position is improved under ether, if needful), with a splint on the sound side, should restore

a good position before the plaster splint is put on. In due time, crutches and a patten on the sound foot may be used. This splint is cheap, durable and simple, and, to my mind, superior to Thomas's splint. Diffused pressure is better than the pressure of stems and bands. Perhaps the greatest utility of the laminated plint is seen in the treatment of knee-disease, especially in that state where chronic and persistent flexion exists. I straighten the tucked knee by a peculiar but simple method. Ether being given, extension is made from the ankle; but, what is much more efficient, direct pressure is made on the knee by means of a long, broad strap of adhesive plaster thrown over the knee, the ends being passed through a hole in the table underneath the knee. As you see, I have here a table full of round holes, each little more than an inch in diameter; but one or two apertures in an ordinary table will do. In keeping up good positions while sheet splints are setting, a peg or two stuck in suitable holes help to steady the extending hands. To return to the knee; when the limb is enveloped in flannel, one assistant takes charge of the ankle, another has the strip of plaster (already fixed on the knee) in his care. A layered plaster splint, of sufficient size to embrace two-thirds of the thigh and two-thirds of the leg, is dipped in water, unfolded and smoothed, and drawn under the limb, the knee of which lies over the opening; a slit is cut with sharp-pointed scissors in the sheet; the adhesive strap is passed through the slit and the hole; the limb is now gently but firmly drawn into position; the knee-strap, with traction made under the table, doing the greater part of the work. The best possible position being obtained, the sheet is lastly folded neatly over the limb, and the position maintained until the plaster is sufficiently set. The assistant in charge of the knee-strap fixes it in a given position by drawing it tightly against the edge of the aperture. This knee-splint should be worn several months, and renewed from time to time until the knee is practically well. A slit in a plaster sheet in no way weakens it, and the principle may be usefully adopted in applying plaster splints elsewhere. In fracture of the elbow, a band thrown temporarily across the bend of the elbow, and

carried through a slit opposite the olecranon, readily keeps the parts in place until the sheet sets.—*Clinical Lecture by Mr. F. Jordan in the British Medical Journal.*

Oleoresin of Male Fern: Increasing its Efficacy against Tapeworm.—According to E. Dieterich, the frequent failure of oleoresin of male fern as a remedy against tapeworm is to be ascribed to its irrational administration. It has become known that the popular "worm doctors," who use almost exclusively the oleoresin of male fern, and who hardly ever meet with a failure, administer the remedy in conjunction with castor oil, instead of following it by the oil after one or two hours, as is usually done by practitioners. The object is to bring the extract, in an unaltered or undigested condition, in contact with the worm. The experiments which have been made by mixing one part of the oleoresin with two parts of castor oil have been very successful, and this mode of administration deserves therefore the preference. Oleoresin of male fern is apt to derange the stomach, and when enveloped partly in the oil is likely to pass it more rapidly, which constitutes another advantage. The mixture has, it is true, an unpleasant taste. This may, however, be disguised by filling it in capsules of about three grams (forty-five grains) each. The dose may be regulated from six capsules (equal to six grams or ninety grains of the oleoresin and twelve grams of castor oil) to seven or eight more, according to circumstances. It is advisable to empty the bowels on the preceding day by a mild purgative, best by castor oil.—*New Remedies.*

Questionable Surgery: Oophorectomy.—The operation introduced by Dr. Battey is, unfortunately, being widely performed in this country. It is perfectly safe to assert that on no organ of the body are more doubtful operations performed than on the uterus and its appendages, and that in no department of medicine is the intellectual crippling of specialism more signally demonstrated than in that of obstetrics. Greed and the predilection engendered by special and limited study are apt to compel men to unravel all forms of disease,

from the standpoint of the particular department of which they may happen to have taken parental charge. This is daily illustrated in the experience of every practitioner who chooses to have his eyes and his mind open to conviction. Quite recently, at the Obstetrical Society of London, Dr. Braithwaite, of Leeds, read a paper "On Two Cases of Unilateral Oophorectomy," the first of which was performed for a *cardiac affection*, associated with dpspnœa! and the other for pain in the left ovarian region. We thoroughly endorse the remarks of the President—Dr. Matthews Duncan—on these cases, that "to remove one ovary as a treatment of cardiac dyspnœa he regarded as a wild proceeding; nor could he imagine that it ever could come within the range of rational medicine." Surely the unfortunate women thus operated on do not properly apprehend the nature of the operation to which they are subjected. It is not so long ago since obloquy and contumely were showered on an unquestionably able surgeon—the late Mr. Baker Brown—for the operation of clitoridectomy; we seem to have made rapid strides since then; yet, we have no hesitation in saying that in the cases indicated by Baker Brown, clitoridectomy was an infinitely more justifiable operation than oophorectomy. We hope to hear less of this barbarous operation in future. At the same time we would protest against the indiscriminate examination of women at public institutions before crowds of students as demoralizing to all concerned. At a certain *clinique* for women, in Scotland, we understand that the vast majority of women who present themselves are examined with the speculum in the presence of the students, and the *os* daubed with "iodized thymol" for all conceivable diseases. This disgusting and degrading practice should be circumscribed, not less in public than in private. It is saddening to reflect on the amount of mischief which is fairly chargeable to meddlesome surgery in the course of one single year.—*Med. Press.*

The Danger of Iodoform Dressings.—The search for an antiseptic body which shall be a powerful germicide, and yet not injurious when absorbed by the human

organism, still continues. Not long ago, Mikulicz, and many other surgeons in Germany, enthusiastically extolled the merits of iodoform; and it has been widely used both in that country and, though to a less degree, in this. For a time all seemed to promise well with the new drug, but gradually we began to learn its demerits; and recent experience seems to show that its use, under certain conditions, as yet not fully explained, may give rise to most serious, perhaps even to fatal results. Iodoform was introduced into England some years ago, as a local application which was of great use in the treatment of spreading ulceration, and especially of the local contagious ulcer. Gradually its use extended; it gained much favour with gynecologists, especially for the purpose of correcting the fœtor of ulcerating cancer of the womb; it was blown into the nose and into the ear, and, made up into a bougie, introduced into the male urethra. About two years ago, Mikulicz recommended it as a dressing after operations, major and minor, on the ground that it was a powerful antiseptic, and yet did not irritate the parts. Its employment was said to be especially advantageous in the treatment of scrofulous joints; and those who adopted this line of treatment did not hesitate to open freely a knee-joint affected with tumor albus, and introduce iodoform in large quantities into the cavity of the joint; in such a case, an outside dressing of cotton-wool, treated with iodoform, was applied, and left undisturbed for a month or more. No great care seems to have been taken to estimate the quantity of the drug used in such a dressing; it was ladled out of a bottle into the joint, and no ill effects appeared to follow. Now, Dr. Ringer pointed out last summer that iodoform was a heart-poison; he found that one-fifth of a grain would almost arrest the frog's heart. Such an experiment as this prepared us for the clinical observations detailed by Dr. Max Schede of Hamburg, who, in an important paper, published recently in the *Centralblatt fur Chirurgie*, drew attention to the toxic action of the drug. He found that, in certain cases, its use is followed by an enormous increase in the frequency of the pulse, which runs up to 180, even in the adult, without any marked rise of temperature, or any general symptoms beyond some disquietude,

malaise, and loss of appetite; in other cases, in addition to the rapid and feeble pulse, there are some fever and headache; in both of these classes of cases, the withdrawal of the drug is immediately followed by a disappearance of the symptoms. In other cases, where the rapidity of the pulse is very great, and the temperature very high (104°F. or more), the danger to the patient, in spite of the absence of marked general symptoms, is also greater—inasmuch as the withdrawal of the drug is not always followed by an immediate cessation of the symptoms. By far the most serious form that iodoform poisoning takes, however, is that in which the sensorium is deeply involved; in children the symptoms closely resemble those of meningitis, and have been frequently rapidly fatal, in spite of the immediate withdrawal of the drug. The child, who may have been in excellent health for some weeks under the use of iodoform dressings, suddenly becomes very ill, the pulse grows rapid, with irregular or perhaps very slight pyrexia, vomiting is severe, consciousness is disturbed or lost, and there are localized paralyses. It has been urged that probably, in Schede's cases, these symptoms did in reality depend upon a rapid meningitis—perhaps of a tubercular nature, for the patients have generally been strumous children; but this we do not believe to be a complete explanation, because, among other reasons, we are acquainted with a case of this kind which recently occurred in a London hospital, where symptoms pointing, as it was thought, most unmistakably to meningitis entirely disappeared when the affected joint was freed from iodoform. In Mr. Stanley Boyd's report of four cases, in the wards of University College Hospital, drowsiness and stupor were observed in two patients, symptoms of meningitis in one, and delirium in a fourth, which ended fatally. Both Schede and Küster say that the drug can cause sudden collapse and death; but of this there does not appear to be sufficient proof.

Iodoform is an iodine-compound, chemically analogous to chloroform; its composition is represented by the formula CHI^3; it contains therefore 96.7 per cent. of iodine. From this fact, it has been argued by some, wise after the event, that its use in large quantities must be injurious; but, what do we know of the

toxic properties of iodine itself? Very little, in fact. Iodine has been injected into the cavity of the pleura without ill effect, and, combined with potassium, enormous doses can be tolerated. Rather does the above account of the symptoms it can produce tend to approximate somewhat to chloroform in its therapeutics; and he would be a bold man who would maintain that the symptoms of chloroform poisoning were due to the chlorine in its composition. A writer in the May number of the *London Medical Record*, to whom we are much indebted, adopts the view of Dr. Mundy of Vienna, who contends that the toxic or fatal symptoms have been due to the reckless manner in which large quantities of the drug have been used. No doubt this is perfectly true; but it does not seem to explain all the phenomena. In the first place, it is comparatively rare to get any symptoms of poisoning at all. There are surgeons in this country who have used the drug in large quantities at a time, and have never met with a single case of poisoning; and in a great proportion of the cases reported, the symptoms did not appear until after the continuous use of the drug for two or three weeks. We are loth to fall back on Dr. Max Schede's theory of a peculiar idiosyncrasy; and, before doing so, we would certainly desire more complete observations, especially with regard to the urine. The supposed cumulative action of other drugs—of digitalis, for instance—has been distinctly traced to renal disturbances. So long as the kidneys perform their functions vigorously, so long is the poisonous substance rapidly eliminated from the blood, and gives rise to no symptoms; but if, from some cause, the urinary excretion is checked, then the poisonous body accumulates in the blood, and gives rise to its characteristic symptoms. For this reason we think that a careful examination of the urine, where iodoform is being used, may not only throw light on the way in which it produces toxic symptoms, but may also furnish a timely warning of their approach.

Lastly, we are informed that Prof. Kocher, of Berne, has been struck by the resemblance between the symptoms of iodoform and of chloroform poisoning, and that he has encountered one case where the onset of the symptoms was marked by signs of acute nephritis.—*Brit. Med. Journal.*

Pneumonia an Infectious Disease.—That acute, lobar, croupous pneumonia is considered by some an infectious fever, with evident tendency to the lungs, or as now better expressed, a zymotic disease, caused by the inhalation of bacilli, which accumulate mostly in a lower lobe of one lung, we have often had occasion to note. The proofs of this statement accumulate daily. Dr. Köhnhorn found that the disease had become endemic in one of the barracks at Wisel. Occasionally it broke out as a local epidemic. The regiment stationed there had suffered frequently from the disease. Not a year passed without many falling a victim to pneumonia. The regiment was then placed in other quarters, and no further case happened in this regiment. The barracks were torn down, the soil disinfected most thoroughly, as also the building material. Since the regiment has been camping in these rebuilt barracks not a solitary case of pneumonia has made its appearance.—*Phil. Med. and Surg. Reporter.*

Ear-ache.—Another way of stating that atropia paralyzes a peripheral sensery nerve is given by Dr. A. D. Williams in Martin's *Chemists' and Druggists' Bulletin.* He says what physician has not been puzzled to know what to do for the constantly recurring ear-aches of children at night? The most effectual treatment, and the one which has stood the test of years, is the local application of a solution of the sulphate of atropia. Not a single case but has yielded at once. The solution is to be simply dropped into the painful ear and allowed to remain there from ten to fifteen minutes. Then it is made to run out by turning the head over, then being wiped with a dry rag. The solution may be warmed to prevent shock. From three to five drops should be used at a time. The strength of the solution must vary according to the age of the child. Under three years, one grain to the ounce, and over ten years four grains to the ounce of water. In growing persons almost any strength may be used. All ages will bear a stronger solution in the ear than in the eye. The application should be repeated as often as may be necessary. Usually a few applications will stop

the pain. In acute suppurative inflammation of the middle ear, and acute inflammation of the external meatus, atropia will only slightly palliate the suffering, but in the recurring nocturnal ear-aches of children it is practically a specific.—*Chicago Med. Review.*

Iodoform in Chronic Pulmonary Affections.—Prof. Chiarmelli (*Giorn. di Clin. e Terapia et Gazz. Med. Ital., Prov. Ven.*, 1882), encouraged by the happy results obtained by Prof. Semmola with iodoform in the treatment of chronic affections of the bronchi, has experimented with this medicine during four consecutive years at the Hospital for Incurables, in many affections of the respiratory passages.

In phthisis, even at an advanced period of the disease with the presence of cavities, iodoform has given the author excellent results. In each case it diminished expectoration, and exercised a favorable influence upon the febrile manifestations. "Iodoform," he says, "diminishes the fever and affects the expectoration, which it not only diminishes in quantity but alters in character, preventing the putrefaction of its albuminoid elements. I am also convinced that the contents of the cavities in the lung exercise a powerful influence upon the production of hectic fever." In recommending iodoform in pulmonary phthisis, the author does not assert it to be a specific, but he claims that it arrests the march of this cruel malady and prolongs the life of the sufferer. He also holds that in cases where caseous pneumonia is commencing, iodoform administered for a time proves efficacious in arresting the progress of the disease. With many individuals affected with chronic bronchitis and emphysema, it renders great service. The formula which is employed is as follows:

Iodoform, - - - - -	grs. iss.
Powdered lycopodium, - - -	grs. viij.
Ext. of gentian, - - - -	q. s.

Make into 10 pilules. Take 3 to 5 in the day. If the dose is increased, gastric disorders supervene, and it is better to continue the above dose for a considerable time.—*Glasgow Med. Jour.*, August, 1882.—*Medical News.*

How to Demonstrate Tubercle Baccilli in the Sputum of Phthisical Patients.—Baumgarten recommends the following method as more convenient than that employed by Koch, and as equally efficacious. A portion of the sputum is dried on a cover-glass, and then treated with potash—one or two drops of a thirty-three per cent. solution of caustic potash added to a watch-glass of distilled water. The tubercle bacilli can then be readily seen with a magnifying power of four or five hundred diameters, from the enclosing detritus of tissue. In order to preclude the possibility of confounding the bacilli of tubercle with those of other species, the cover-glass may be raised and placed aside until the layer of fluid on its under surface is dry, and then passed two or three times through a gas flame, and then on it may be placed a drop of an ordinary watery solution of aniline voilet or any other nucleus-tinting preparation of aniline. All the putrefacation bacilli appear under the microscope as an intense blue or brown (according to the testing agent and its strength), while the tubercle bacilli remain absolutely colorless, and can be seen with the same distinctness as in the ordinary potash preparation. The whole process does not occupy more than ten minutes.

Curable Ascites of Alcoholists.—Ascites occurring among alcoholists is generally regarded as the result of hepatic cirrhosis, and hence incurable. In two patients Dr. Bouveret (*Lyon Medical*) has noticed a perfectly curable ascites. The first case was a man aged 45, who was a clear case of alcoholism. Following certain intestinal and gastric disorders a marked ascites made its appearance to which relief could only be given by tapping. The patient fully recovered after nine months of treatment. Bouveret brings this case and a second similar case which he reports into relation with the ascites which Murchison has reported as accompanying hepatic congestion, and Semmold has found to exist in certain cases of interstitial hepatitis and finally with the ascites found in chronic peritonitis by Leudet and Lancreux. Differential diagnosis is impossible, and only the progress of the affection can throw light on the nature of the ascites.—*American Med. Weekly.*

Should Babies' Milk be Boiled?—A correspondent, who has also contributed a letter upon this subject to the *Cincinnati Lancet and Clinic*, sharply criticises our recommendation given in a recent article, to boil the milk for children during the period when summer diarrhœa prevails, and expresses his unqualified preference for the plain article. As he apparently invites us to state our reasons, we will endeavor to do so, though not in a spirit of controversy, but simply because we are strongly convinced of the importance, if not the necessity, of the proceeding which we have recommended. In the first place, we cannot accept the statement that boiled milk is more difficult to digest than unboiled; on the contrary, as we have long been accustomed to rely upon it as the sole diet in cases of chronic diarrhœa of adults, in typhoid fever and convalescence from acute diseases, as well as for infants' food, experience has taught us that it is not true; we have failed to see it ever cause indigestion; on the contrary, as an article of food, have always found it bland and unirritating. Plain milk often forms large coagula in the stomach, and the masses are sometimes vomited and sometimes discharged from the bowels undigested; this is much less likely to occur with the scalded milk. In preparing the food of young infants, authorities generally agree that it should be raised a little above the temperature of the body. We advise that it should be raised considerably higher, and afterwards reduced to the desired degree, for reasons shortly to be stated. Milk is very complex and uncertain fluid. It easily undergoes a change of reaction, from sweet to sour, owing to the presence of the lactic acid ferment. It rapidly absorbs gases and odors, and, as has been repeatedly shown, it may thus act as a carrier of disease, by becoming tinted with emanations of zymotic affections like typhoid fever (Murchison), scarlatina (Bell), and diarrhœa (Wilson), etc. This danger is by no means slight; it is dwelt upon in many of our text-books upon children's diseases. Dr. Wilson, in his Hand-Book of Hygiene, speaks very pointedly with regard to it (page 53, third edition, Phil., 1877.) He says: "There can be no doubt that much of the infantile diarrhœa which proves

specially fatal during the summer and autumn months is due to milk which either becomes tinted in this way, or becomes tinted by being put into feeding bottles, which are seldom or never properly cleaned. Indeed, there are so many unseen dangers in the use of milk, especially among careless and filthy people, that, to ensure safety, *it should always be boiled* during warm weather." (Italics our own.) Dr. Day, the author of the latest English systematic treatise on diseases of children, also recommends that the milk be boiled. Meigs and Pepper speak in the highest terms of praise of a food for infants which requires the milk to be boiled; they find it to agree best with the children, who thrive upon it better than anything else they had employed. They say: "In several cases it has agreed well with infants who could not, without vomiting, diarrhœa and colic, take plain milk and water." J. L. Smith also speaks favorably of Hawley's and Liebig's Food for Children, which requires the milk likewise to be boiled, and observes that it agrees best with the digestion. It is not our desire to quote a long list of authorities in support of our statement that boiled milk is preferable to plain as an article of diet both for children and adults at the time of year when zymotic disease prevail, but those interested in the subject will find some of them given in detail by Day and Wilson, in the places quoted, as well as in Parke's classical work on Hygiene, and by many others that we need not mention.

When the experiments of Bollinger, of feeding milk from tuberculous cows to healthy calves and inducing tuberculosis, are borne in mind, we have an additional reason for submitting all milk to disinfection by heat, unless we know it to be from a healthy animal. Moreover, in the city, where the milk is from twelve to twenty-four hours old when delivered, and is well advanced towards acid fermentation, there is often nothing but Hobson's choice with regard to scalding it, if it is desired to keep the milk from one day to the next; and many families habitually boil the milk during hot weather, simply as a means of domestic economy.—*The College and Clinical Record.*

The Fillet in Breech Presentations.—Dr. Heinrich v. Weckbecker-Sternfeld, assistant physician to

the lying-in institution at Munich, contributes to a recent number of the *Archiv fur Gynakologie* a paper on the above subject. He points out that there are cases in which some help is required, in which traction by the unaided finger is inefficient, and bringing down a leg difficult and not devoid of danger. The blunt hook cannot be used without much risk of injuring the child; the forceps are apt to slip, and, indeed, can only get a hold by strongly compressing the pelvis. There are, therefore, cases in which traction by the fillet or loop is called for. The object of the paper, and our reason for quoting it, is to describe a new instrument invented and recommended by Professor Hecker, of Munich, for the purpose of getting the loop into position. It consists of a blunt hook having a very obtuse curve, somewhat that of a bladder-sound, and hollow from end to end. In this travels a steel spring, like that of Bellocq's instrument for plugging the nares. The tape (or strip of whatever material is preferred as a means of traction) is provided with a little pocket at one end, into which the extremity of the blunt hook fits. It is thus carried by the hook up on the outer side of the hip-joint, and over the fold of the groin. The spring running inside the hook is then pushed forwards, made to protrude from the end of the hook, and of course carry before it the pocket on the end of the strip of tape. The elasticity of the spring makes it curl round the thigh, and then, of course, the end of the tape can be seized and drawn downwards, and an efficient means of traction is thus secured. The author gives an account of twelve cases in which this means of delivery was used. As the chief objection commonly urged against it is the risk of injury to the fœtus, we quote the results from this point of view. Four times deep pressure-marks were found; twice superficial excoriations. In one case a fracture of the humerus was produced in drawing down the arm, and twice fracture of the femur—in one case made in an unsuccessful attempt to bring down a foot, in the other during extraction by the loop. No maternal bad result was noticed, except in one case rupture of the perineum during extraction of the shoulders.—*Med. Times and Gazette*, September 2nd, 1882.

CANADA

Medical and Surgical Journal.

MONTREAL, OCT., 1882.

SEMI-CENTENNIAL CELEBRATION OF McGILL MEDICAL FACULTY.

The Medical Faculty of McGill College has entered upon its 50th Session. Its opening day was a proud one for those who are to-day carrying on the good work so well begun now half a century ago. It had been decided to mark this event in a manner suitable to the occasion. Invitations were therefore issued to all medical graduates of McGill College, and to numerous representatives of other Universities both in Canada and the neighbouring States, to attend the opening lecture of the session, and to be present at a commemorative dinner in the Windsor Hotel. These invitations were accepted by a great number of guests, and both events have been entirely successful, and have afforded the liveliest satisfaction to all the friends of our University, as showing the love and enthusiastic esteem entertained by the old graduates for their Alma Mater. We may mention that graduates came from great distances, often at considerable personal inconvenience, to do honour to their College. From the West there were representatives from as far away as Chicago and Duluth; from the East, from Campbellton, New Brunswick, and from all intermediate points of Ontario and Quebec. From numerous graduates who were unable to attend came letters of regret conveying the kindest wishes and congratulations.

On the evening of the 4th October, the introductory lecture was delivered by Professor Howard, the newly-appointed Dean of the Medical Faculty, in presence of a large assemblage of graduates and undergraduates, and ladies and gentlemen spe-

cially invited for the occasion. The room chosen was the large lecture-room of the new Peter Redpath Museum. The address dealt with the history of the Faculty, starting from the foundation of the Medical Institution, and tracing the steps by which it had grown to its present strength and usefulness. An outline was given of each of the founders—Stephenson, Robertson, Holmes, and Caldwell. To them was added the name of Dr. G. W. Campbell, the late Dean, whose useful and exemplary life was drawn by a loving hand. Dr. Howard drew attention to the difficulties under which the Faculty labour for want of an Endowment Fund, a great many equipments being necessary to enable them to keep pace with the rapid progress of medical science. After the address, the charming rooms of the Museum were thrown open, and the remainder of the evening was spent by the guests with music and conversation.

On the evening of the 5th October, a dinner was given in the large dining-room of the Windsor Hotel. Two hundred guests sat down. Amongst the invited guests present were: His Honor Dr. Robitaille, Lieut.-Governor of the Province of Quebec, Principal Dawson, Dr. Joseph Workman of Toronto, Dr. Chadwick of Boston, President Buckham of Vermont, Dr. Grant of Ottawa, Dr. Hingston of Montreal, Mr. Andw. Robertson, President Montreal General Hospital, Dr. Rottot, Dr. F. W. Campbell, Mr. D. Morrice, Rev. Dr. Jenkins, Hon. Mr. Chauveau, Dr. Laramee, Mr. Alex. Campbell, Dr. Trudel, Hon. Dr. Church, Dr. Henry Howard, Prof. Prior, Q.C., Prof. Archibald, Prof. Harrington, Prof. Bovey, Mr. Duncan Robertson, Prof. Moyse, Dr. Wilkins, Mr. John Stirling, Mr. Manson, Mr. S. E. Dawson, Dr. Lamarche, Judge Torrance, Mr. John Molson, Rev. Dr. Murray, Mr. Hugh McLennan, Hon. D. A. Smith, Mr. J. H. R. Molson, Dr. Covernton, Prof. Johnson, and many others, representatives of the sister Universities, and friends of the College. The entertainment was everything that could be desired, and the greatest harmony and goodwill prevailed. The great event of the evening was the announcement by the chairman, Dean Howard, that, following upon his remarks of the day previous, he had received a note from a gentleman (whose name

he was not allowed to give) offering that if, before next August, a sum of $50,000 were subscribed to endow the Faculty, he would be ready to add to that an equal amount. This generous offer was received by all with manifestations of the greatest delight.

It is our intention to send to each of our subscribers a copy of Dr. Howard's address and a portrait of the late Dean, Dr. Campbell, together with the speeches at the dinner. We do not at present, therefore, give any more detailed account of these very interesting proceedings.

We congratulate the Faculty upon the success which has attended their efforts at securing a general gathering of their graduates to commemorate this important event, and upon the hearty response which they have met with from all quarters. Apart from the more public proceedings, much private enjoyment was experienced by the meeting of old College friends who had been separated for many years, and who might never have met except for the opportunity here afforded them. It was a pleasant sight to see these frequent meetings during the two days of the festivities, and interesting to watch two former chums, each trying to recognize in the greyish middle-aged man the rollicking student of his recollection; and then the stories and the memories of old times, the old scrapes both had been concerned in, the reminiscences of the old teachers,—all this was very pleasant.

And now McGill begins its second half century—hopeful and confident, not boastful—and we wish it all success and prosperity.

THE CANADA MEDICAL ASSOCIATION AND McGILL COLLEGE.

Our last number contained a full account of the recent successful meeting of this our Dominion Association at Toronto. This journal has always strongly advocated the necessity of maintaining this society in an efficient condition and rendering it thoroughly representative of medical progress throughout all sections of our country, and of the views of the profession generally in the Dominion. It has now held meetings in nearly every

city of any magnitude, and at these gatherings the proceedings have always been harmonious and conducted by all with a spirit of fairness and unanimity which has rendered attendance upon them a pleasure to all. It is, therefore, all the more surprising to find that one of the Toronto journals—the *Canada Lancet*—in its last issue uses expressions equivalent to saying that, up to the present time, the Association has been governed by those belonging to McGill College. It looks forward to a large increase in the membership when, says the *Lancet*, "it can no longer be said to be under the wing of McGill or any other College." This is the first intimation we have ever had that McGill College had taken the society "under its wing," and we are at a loss to conceive what could have led the *Lancet* to make such a atatement. We are happy to know that for several years past Montreal men, and those connected with McGill especially, have been diligent in their attendance, and have taken an active part in the proceedings. Those who wish well to the society would like to say the same thing of every city and every college in the Dominion. And is it because the men from McGill have thus performed what they consider a public duty that they should be subjected to remarks calculated to render them so misunderstood as actually to appear to desire to control the society in any way? Surely, this is not the way to encourage the profession generally to lend their active support to the keeping up of our common Association.

Near the close of the proceedings the next place of meeting had to be decided upon. Kingston was named by the nominating committee. A member from Montreal (and from McGill College) proposed Montreal. The result of a vote was the selection of the former by a considerable majority. There existed, however, according to the *Lancet*, "a feeling that the Association is being manipulated by McGill Professors and their friends," and that *therefore* the proposition to visit Montreal was negatived. We have it on the authority of the same article that the editor "has no sympathy whatever with" this feeling. We leave to any ingenious reader so inclined, the task of reconciling this with the previous remark concerning the rela-

tions between the society and this College. Now we should like to say that we think the *Lancet* has not been well informed when referring to the existence of such a feeling on the part of any considerable number of the members of the Canada Medical Association. That a certain few might feel so is, of course, possible, but at the same time if these would honestly consider the matter they could not but conclude to reverse their previously entertained opinion. That the motion was really defeated for this reason is not in accordance with the facts of the case. It is always competent for any member to move an amendment to a recommendation of the nominating committee, and Dr. Roddick did so in the exercise of his ordinary privileges as a member, and in the interests of what he thought best for the society. But, what completely proves what we wish to show, is the fact that all the other members present connected with McGill College voted *against* coming to Montreal and in favor of Kingston. Does that look like an organized attempt on the part of McGill College to control the action of the society and to influence its movements?

Anything like the introduction of sectional matters into the affairs of the Association is much to be deprecated. Let all work together for the common good on what should always be kept as neutral ground, then all will go well, and the society will prosper; but let sectional differences be introduced, and a good beginning will be made towards weakening the foundations and the structure will soon fall into ruins.

SEMI-ANNUAL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS, PROVINCE OF QUEBEC.

The semi-annual meeting of this College (the Provincial Medical Board) was held in the rooms of the Medical Faculty of Laval University, Quebec, on the 27th September, Dr. Robert Palmer Howard, of Montreal, President, in the chair. The following governors were present; Drs. C. E. Lemieux and E. H. Trudel, Vice-Presidents; Drs. A. G. Belleau and F. W. Campbell, Secretaries; Dr. E. P. Lachapelle, Treasurer; Dr.

Leonidas Larue, Registrar; Drs. Jas. Lanctot, L. D. Lafontaine, E. Gervais, J. B. Gibson, O. Bonin, Alf. Simard, Robert Craik, Thos. Larue, L. T. E. Rousseau, R. A. Kennedy, T. A. Rodger, Jos. Marmette, Chas. Gingras, E. A. De St. George, C. S. Parke, R. F. Rinfret, W. Marsden, Jules Prevost, F. X. Perrault, J. A. Sewell, N. H. Ladouceur, and the Hon. J. J. Ross.

After the reading and adoption of the May meeting minutes, the President moved, seconded by Dr. C. E. Lemieux, and unanimously resolved:—"That the Board of Governors of the College of Physicians and Surgeons of this Province have heard with much regret of the unexpected death of Dr. George W. Campbell, late Dean of the Medical Faculty of McGill University, and its Professor of Surgery for forty years, one of the original members of this College, for some time one of its Governors, and for about half a century a distinguished practitioner of the medical art; and desire to bear testimony to his talents as a teacher, his eminent abilities as a practitioner, his high character as a colleague, and his honorable career as a citizen."

The reports of the Assessors of Laval University at Quebec and Montreal were read and adopted, providing that the latter will give the names of the graduates to the Montreal Secretary.

The following gentlemen were admitted to the study of medicine:—J. H. Darey, Montreal; Louis V. Benoit, St. Hyacinthe; Alex. Kinloch, Montreal; H. Hervieux, St. Jerome; J. D. Fontaine, Belœil; L. S. P. Normand, Three Rivers; P. Ulric Garneau, St. André de Kamouraska; Alfred Mallette, Montreal; J. Legault, St. Valentine; A. St. Amour, Acton Vale; A. Laval, Yamaska; D. McNamara, Mile End, Montreal; G. B. Tanguay, Quebec.

Mr. Key's, of Georgeville, application for registration was refused on account of being an eclectic.

The following graduates received the license of the College on being sworn on their respective diplomas:—Drs. Arthur Hébert, of Quebec; Elz. Laberge, of St. Roch's, Quebec; Jos. Valere Côté, of St. Raphael de Bellechasse; G. A. Casgrain,

of St. Agapit: T. W. Mills, L.R.C.P., Lond.; Walter de Moulpied, Chas. O. Brown and Levi J. Lennox.

Moved by Dr. J. B. Gibson, seconded by Dr. T. A. Rodger, and unanimously resolved:—"That whereas certain rumours have prevailed whereby it is stated that private examinations are given by professors connected with a Medical School in this Province, and recognized by this College, and that on these examinations certificates are issued, purporting that the bearers are entitled to a diploma, and are in fact medical practitioners; and whereas one Emile de Lorimier, a student of this College, has publicly stated that he was so examined, and paid a large sum therefor, and holds such a certificate; and whereas, in the interests of the profession, it is the duty of this Board to ascertain if such irregular examinations are held by any school in this Province, or if certificates or diplomas are granted upon examinations other than those which take place before the Assessors appointed by this College;—be it therefore resolved that a committee be appointed to make investigation into these statements and report at the next meeting of this Board, and that the committee be composed of Drs. Craik, Hingston, Lachapelle, Robillard and Rodger.

The reports of the Treasurer and of the detective officer of the College and a new tariff were submitted.

North-Western Veterinary College.—The prospectus of the second session of this Institution has been received, and we congratulate Dr. Lyford, the Principal, and Faculty on the excellent arrangements which they have made. Following the example of the Montreal school, of which he is a graduate, Dr. Lyford has wisely insisted from the outset on a high standard, and requires each candidate for the diploma to pass an entrance examination and to spend three winter sessions and one summer session. The College is connected with the Minnesota Medical School, and doubtless the association will be mutually beneficial. Dr. Lyford is an alumnus of McGill University, and is well aware how satisfactory the arrangements are which have existed for many years between the Medical Faculty and the Montreal

Veterinary College. We are glad to see associated with him two other Montreal graduates—H. J. Burwash, M.D. (McGill, '79), and Richard Price, V.S. We sincerely wish the College every success.

DEAN OF MCGILL MEDICAL FACULTY.—Prof. R. P. Howard has been appointed Dean of the Medical Faculty, McGill University, in place of the late lamented Dr. Campbell. We offer the new Dean our sincere congratulations upon his promotion, and trust that the Faculty may more than ever flourish under his skilful management.

MEDICO-CHIRURGICAL SOCIETY OF MONTREAL.—At the annual meeting of this Society, held on the 6th inst., the following were elected officers for the ensuing year: *President*, Dr. R. A. Kennedy; *1st Vice-President*, Dr. T. G. Roddick; *2nd Vice-President*, Dr. T. A. Rodger; *Secretary*, Dr. Andw. Henderson; *Treasurer*, Dr. W. A. Molson; *Librarian*, Dr. D. F. Gurd; *Council*, Drs. F. W. Campbell, Osler and Geo. Ross.

PHARMACEUTICAL ASSOCIATION.—The fifteenth session of the Montreal College of Pharmacy was opened on Tuesday evening, the 3rd inst., at the rooms of the Pharmaceutical Association, corner McGill and Notre Dame Streets. Mr. H. R. Gray delivered the opening lecture on "Pharmaceutical Education" to a very large audience. Dr. Reed, Mr. David Watson, Prof. Bemrose, Mr. Bennett of Philadelphia, and Mr. Ahern, also made a few remarks, after which a large number of students enrolled their names for the lectures, and the prospects are that all the classes will be well filled. Several names have been handed in, and it is probable that a class of practical pharmaceutical chemistry will soon be in operation under Professor Bemrose.

DRUGGISTS AND LIQUOR SELLING.—Several of our leading pharmacists were very much surprised, about three weeks ago, at being summoned to appear at the Police Court for selling spirits of wine. They were entirely ignorant that they had been violating any Act of Parliament. We cannot help thinking

that the action of the License Inspector was hasty and injudicious, as we are satisfied that whatever sins our Montreal pharmacists may have to answer for, liquor-selling is not one of them. However, "all's well that ends well," and the pharmacists are to be congratulated on the sensible view taken of the situation by the Hon. Mr. Wurtele, Provincial Treasurer, who, when the matter was explained to him, ordered the withdrawal of the actions already instituted. It is understood that the pharmacists can now sell spirits of wine for medicinal use in quantities of not more than an imperial pint. A special license will be issued, by an order in council, to those wishing to sell wholesale in quantities of not less than two imperial gallons.

PESSARY ON THE BRAIN.—In a speech at the recent meeting of the British Medical Association, Prof. Playfair speaks of the "over much and injudicious local treatment" of the uterus. He alludes to a case in which "the patient may fairly be said to be suffering from pessary on the brain—so incessantly is she thinking of one or other of the *seventy-nine* different instruments which she has had inserted in the last few years in America and in this country."

THE "POPULAR SCIENCE MONTHLY" FOR OCTOBER, 1882.—This number is one of great excellence. It contains several papers which are of considerable interest to medical readers. The chief one is that by Dr. Douglas Graham, on "Massage: its mode of application and effects." Another, by Mr. W. Mathieu, is very suggestive. Its title is sufficiently odd. It is, "The Utility of Drunkenness." The author treats it from the standpoint of "survival of the fittest," inebriety furnishing a means, supposed to be agreeable to themselves, of clearing the world of the "unfittest." "Delusions of Doubt" is a description of a curious form of mental disease. Dr. Felix Oswald lends the unique charm of his keen humour to the discussion of "Physiognomic Curiostities." The portrait and sketch are of Prof. Virchow, physiologist, anthropologist, and advocate of popular rights.

Personal.

Walter Moffatt. M.D. (McGill, '68) is at Pensacola, Fl.

W. K. Law, M.D. (McGill, '77) is practising at Coleraine, Ireland.

T. J. Pierce O'Brien, M.D. (McGill, '82), is at Kansas City, Mo.

R. F. Rooney, M.D. (McGill, '70) has moved from Colfax to Auburn, Placer Co., Cal.

Clarendon Rutherford, M.A., M.D. (McGill, '82) has begun practice in Chicago.

Wm. Young, M.D. (Bishop's, '78) has moved from Hong Kong (China) to Montreal.

Mr. Knowsley Thornton, the ovariotomist, passed through Montreal on the 5th.

Chas. M. Stevenson, M.D. (McGill, '—), has moved from Barnston, Q., to Coaticook, Q.

The many friends of Dr. Chadwick, of Boston, were rejoiced to see him at the McGill semi-centennial festival.

We were pleased to have a call from an old friend, Henry C. Fielde, M.D. (McGill, '77), of Barbadoes, who is on a visit to friends in Canada.

Thos. Kelly, M.D. (McGill, '73) has been appointed surgeon to the Colonial Hospital, Georgetown, Demerara, W.I.

W. D. Ross, M.D. (McGill, '75), whose address in the last McGill College announcement is given Buckingham, is in Pembina, Da.

Dr. Morrell McKenzie, of London, has been making a six weeks tour of the country. He was in town at the time of the A. A. A. S. meeting.

Dr. J. Collins Warren, of Harvard Medical School, was in town for a few days. He is the worthy representative of the Warren family which has furnished celebrated anatomists and surgeons to Harvard for a century.

It is curious that in the 100 years of the existence of Har-

vard School, only three men have filled the chair of anatomy—John Warren, John Collins Warren, and Oliver Wendell Holmes, the present occupant, who entered on his duties in 1847. *On dit* that this is his last session, and that he is prepared to resign.

Dr. Henry Harkin, lately of Guelph, Ont., has removed to Montreal, where he has commenced practice. Before leaving Guelph he was the recipient of a handsome testimonial from his many friends in that city, and an address expressive of their regret at having to part with him. We are most happy to welcome Dr. Harkin, as an old friend, to this city.

Medical Items.

—Chiari, of Vienna, has been called to the chair of Pathological Anatomy at Prague, as successor to Klebs.

—The class in the Medical Faculty, McGill College, is the largest for several years. Up to the 12th inst. there have been 58 new entries.

—Hæmophilia is said, by the *British Medical Journal*, to be the disorder from which H.R.H. Prince Leopold suffers from time to time. He is just now recovering from some attacks of hæmorrhage.

—A man was killed recently on the Canada & Atlantic Railway. The following was the verdict given: "That death was caused by hemorrhage from the *ephemeral* artery and its branches; said hemorrhage was caused by cars running over him."

—At the time of the plague in London, a noted body-searcher lived whose name was Snacks. His business increased so fast that, finding he could not compass it, he offered to any person who should join him in his burdened practice half the profits; thus those who joined him were said to go with Snacks. Hence going snacks, or dividing the spoil.—(*Morning Herald*, in London *Lancet*, Oct. 6th, 1823.)

—Of the 917 graduates in medicine of McGill University, 192 are known to be dead. Of those whose addresses are known, there are in Ontario, 237; in Quebec, 207; United States, 139;

Great Britain, 34; Manitoba, 25; New Brunswick, 9; Nova Scotia, 6; Prince Edward Island, 8; Newfoundland, 4; British Columbia, 4; India, 2; New Zealand, 3; West Indies, 6; Sandwich Islands, 1. The three oldest living graduates of the University are Roderick Macdonald ('34) of Cornwall, Joseph Workman ('35) of Toronto, and F. W. Hart ('35) of St. Martinville, La.

DENTAL QUALIFICATIONS.—The *Louisville News*, in expressing surprise at the conviction of a dentist in Vienna for want of proper qualifications, thus epitomizes what is required of a tooth extractor in the United States: A hard grip and a strong arm; anything for instruments, from a shoemaker's nippers or a blacksmith's tongs to a monkey wrench; a diagnostic skill (not always possessed) sufficient to ensure the differentiation of the decayed tooth from a sound one standing next to it; and a total indifference to human agony.

DIAGNOSIS OF UTERINE DISEASE BY THE LARYNGOSCOPE.—Dr. Seiler was consulted by a young girl with general relaxation of the mucous membrane of the throat, which he concluded to be due to uterine disease, for which he advised her to put herself under the treatment of her family physician, as local treatment of the throat would be of no use to her. Her reply was: "Doctor, if I had known that you could see all the way down, I would not have come to you."—*Maryland Med. Journal.*

"MORE BABIES"?—Not long since a doctor was attending a case of labour. About the time the baby arrived, an older chick of two years had found its way into the sick room, and watched the operation of tying the cord and separating and handing over to the nurse with marked interest. Doctor supposed little chap was now busy with the nurse, and proceeded to remove the after birth, and just as this was about completed, the little gentleman peeped over the opposite bed-rail and piped out—*more babies, doctor?*

EMBALMING.—In a recent article dealing with the process of embalming, the *Lancet* remarks that the principal Italian professors of this art keep their special processes a secret, although the chief steps are well known. The process of embalming is

stated to consist of five steps. First, cold water is injected through the whole circulatory system until it issues quite clear; this may take as long as five hours. Alcohol is then injected for the purpose of abstracting all the water from the body; this is followed up by the injection of ether to dissolve out the fatty matter; this injection is carried on for several hours—in thin subjects for two, in very fat ones for even as long as ten hours. After this a strong solution of tannin is slowly injected, and time is allowed for its soaking into all the tissues; this takes from two to five hours. Lastly, the body is exposed for from two to five hours to a current of warm air, which is previously dried by passing it over heated choride of calcium. The body can then be preserved for any length of time without undergoing change, and is as hard as stone.—*Student's Journal.*

—To Dr. J. E. Janvrin, of New York City, has been allotted the task of writing the chapter on the "History and Statistics of Ovariotomy," in the "System of Gynæcology by American Authors," now in process of preparation. All who wish their cases published are requested to send to Dr. J., 191 Madison Avenue, N.Y., answers to the following question:—1. Name of operator? 2. Age of patient? 3. Nationality? 4. Married or single? 5. Aspiration or previous tapping? 6. Duration of growth? 7. Laparotomy or vaginal operation? 8. Condition of patient at time of operation? 9. Were antiseptic precautions used? 10. Was the spray used? 11. Long or short incision? 12. Adhesions or other complications? 13. Double or single ovariotomy? 14. Pathological feature of cyst? 15. Treatment of the pedicle? 16. With or without drainage? 17. Duration of operation? 18. Complicated or uncomplicated history after operation? 19. Antipyretics used, if any? 20. Result. Cause of death, if any? 21. Primary or secondary operation?

CONSUMPTION AND TUBERCULOSIS.—Dr. McArthur is a sanguine advocate of the Churchill method. His Syrup of the Hypophosphites is an excellent preparation, and though we do not concede all the virtues claimed for it as a remedy for consumption, yet we can testify to its value from actual trial.—*Prof. Henry Gibbons, M.D., Pacific Med. & Surg. Journal, San Francisco, Cal.*