

Technical and Bibliographic Notes / Notes techniques et bibliographiques

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

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

- | | | | |
|-------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | Coloured covers /
Couverture de couleur | <input type="checkbox"/> | Coloured pages / Pages de couleur |
| <input type="checkbox"/> | Covers damaged /
Couverture endommagée | <input type="checkbox"/> | Pages damaged / Pages endommagées |
| <input type="checkbox"/> | Covers restored and/or laminated /
Couverture restaurée et/ou pelliculée | <input type="checkbox"/> | Pages restored and/or laminated /
Pages restaurées et/ou pelliculées |
| <input type="checkbox"/> | Cover title missing /
Le titre de couverture manque | <input checked="" type="checkbox"/> | Pages discoloured, stained or foxed/
Pages décolorées, tachetées ou piquées |
| <input type="checkbox"/> | Coloured maps /
Cartes géographiques en couleur | <input type="checkbox"/> | Pages detached / Pages détachées |
| <input type="checkbox"/> | Coloured ink (i.e. other than blue or black) /
Encre de couleur (i.e. autre que bleue ou noire) | <input checked="" type="checkbox"/> | Showthrough / Transparence |
| <input type="checkbox"/> | Coloured plates and/or illustrations /
Planches et/ou illustrations en couleur | <input checked="" type="checkbox"/> | Quality of print varies /
Qualité inégale de l'impression |
| <input checked="" type="checkbox"/> | Bound with other material /
Relié avec d'autres documents | <input type="checkbox"/> | Includes supplementary materials /
Comprend du matériel supplémentaire |
| <input type="checkbox"/> | Only edition available /
Seule édition disponible | <input type="checkbox"/> | Blank leaves added during restorations may
appear within the text. Whenever possible, these
have been omitted from scanning / Il se peut que
certaines pages blanches ajoutées lors d'une
restauration apparaissent dans le texte, mais,
lorsque cela était possible, ces pages n'ont pas
été numérisées. |
| <input checked="" type="checkbox"/> | Tight binding may cause shadows or distortion
along interior margin / La reliure serrée peut
causer de l'ombre ou de la distorsion le long de la
marge intérieure. | | |
| <input checked="" type="checkbox"/> | Additional comments /
Commentaires supplémentaires: | | Continuous pagination. |

THE
Canadian Journal of Medical Science.

A MONTHLY JOURNAL OF BRITISH AND FOREIGN MEDICAL SCIENCE, CRITICISM, AND NEWS.

U. OGDEN, M.D.,
EDITOR.

R. ZIMMERMAN, M.D., L.R.C.P., London,
171 Church Street Toronto, Corresponding Editor.

SUBSCRIPTION, \$3 PER ANNUM.

All Communications, Letters and Exchanges must be addressed to the Corresponding Editor.

TORONTO, JUNE, 1879.

Selections: Medicine.

ACUTE EXACERBATION OF CIRRHOTIC KIDNEY, WITH PERITONITIS AND PLEURISY, SIMULATING TYPHOID FEVER.

BY J. M. D'ACOSTA, M.D.

This is a case in which there is an element of doubt as to whether it belongs in the series ; but let us consider it further. The boy was admitted in a state of collapse. He was taken sick in the ship six weeks ago, and he has been on shore for four weeks. He had diarrhoea, which continued until a few days before admission, lasting, therefore, at least six weeks. It was persistent, and has since returned. Scybala and mucus, but no blood, were noticed in the discharges. Three weeks ago he had epistaxis ; he never had delirium, but he had fever, and was confined to bed ever since leaving his ship. Therefore, for weeks, even prior to his admission to the hospital, he was confined to bed. He had headache almost all the time. Three weeks before admission great prostration began, with swelling of the abdomen, and the parts were tender. When he entered the ward the pulse was 120, respiration 128, and temperature 100. He was so collapsed after being brought here that an accurate physical examination was impossible. But we recognized peritonitis ; also right-sided pleuritic effusion, with partial consolidation of the lung. We tested the urine, and found it contained albumen to a moderate amount (about one-twelfth). But under the microscope it showed a large number of granular casts ; some of them were fatty.

This, then, is the record prior to your seeing him this morning. But you find him here in very much better condition than when I first saw him. He is now quite over his collapse. This was accomplished by steady stimulation and a moderate use of opium. Although the temperature was as high as 106°, it has now declined to 101° this morning. He has still the fever-pulse, but it is of much better volume. His abdomen is still somewhat tender and large, but nothing like what it was, nor so distended ; the peritonitis is clearly passing away. The heart sounds are feeble, or, to speak more correctly, the first sound is short and sharp, like the second sound, but no murmur exists. Examining the back of the right lung, which I told you had been so congested, we find it is somewhat dull on percussion, but the respiratory murmur is heard tolerably low down ; it is evident that the lung is still somewhat congested, but the effusion has largely disappeared.

What is the matter with this patient ? Two things might be supposed ; two perfectly tenable views might be advanced. And in the absence of a distinct history, which it was impossible to get here, we must choose between these two ; either the patient has had typhoid fever, with peritonitis, and the lung complication of typhoid fever, and the kidney complication of typhoid fever, or he has not had anything of this kind, but has had a kidney disease of long standing, with pleuritic and abdominal effusion as a consequence. Between these it is difficult to decide. And I will discuss them, premising that the difficulty is so great that we may chance to be wrong in our conclusion. This doubt will arise in any case,

however simple, where we do not know the early history. I believe that it is not a case of typhoid fever. I believe that the view that it is a case which had its root in the kidney disease, with peritonitis and pleurisy super-added, is the correct one. You will say, there is the epistaxis, headache, fever, and the age of the patient. These are all strong points in favour of typhoid fever. You may even say that the congestion of the lung was in favour of typhoid fever, but I still think that the balance of evidence is in favour of the other view.

Let us take these points up for discussion. First, the epistaxis. This we find did not happen till he had been ill three weeks. Please mark this. This is not the kind of epistaxis we have in typhoid fever; it is an early symptom in typhoid, not a late one. Therefore, the time of the occurrence is very important. But epistaxis is also a symptom of Bright's disease. It appears in Bright's disease when the kidney disorder is chronic, and when an exacerbation occurs in the course of the chronic malady. The epistaxis, in the present case, then, admits of this explanation.

Now, for the peritonitis. Does this happen in typhoid? Yes. In Bright's disease? Yes; not unfrequently. But when does it happen? Peritonitis in typhoid occurs with the acute symptoms; peritonitis without perforation is so rare that its possibility has been denied. I will not say so, but will state that, as a rule, it happens after perforation, coming on directly. It was not so here. In typhoid fever it is very unusual to see a case of peritonitis of gradual development. Then the course which the peritonitis has taken is against this view.

Let us turn to the other side of the question. Does peritonitis happen in Bright's disease? It does, at times, and in a very chronic form, and is part of the influence upon serous membranes peculiar to Bright's disease. That such an influence exists in the present case is shown by the co-existing pleuritic effusion. So you see that the case can be explained on the supposition that it is Bright's disease, as well as that it is typhoid fever, and rather better by the former than the latter.

Now, the kidney. You will say that the examination of the urine settles the question.

The casts show that it is a case of Bright's disease, and not typhoid fever. But kidney disease may happen as a consequence of typhoid fever. You will not, therefore, be able to lay much stress upon it in the diagnosis. This is the least valuable point in the argument, although we must admit that it is a point. But when I look at the urine report, I find the amount of the albumen moderate, and the tube casts are granular and fatty. Now, a moderate amount of albumen happens in a kidney complication of typhoid fever, but it also happens in some of the chronic forms of disease of the kidney, just as in one of the preceding cases I have shown you, where there was granular contracting kidney. I lay particular stress upon the microscopic appearances, the granular and fatty tube casts. These microscopic appearances are in favour of old kidney trouble, rather than the acute kidney complications, such as would occur in typhoid fever. This is the one point in the case that shows the existence of old kidney disease. In typhoid there are small amounts of albumen and few epithelial casts. The granular and fatty casts belong to old Bright's disease.

I have endeavoured to show you that this may, after all, belong in my series. He has been taking five drops of laudanum ever hour, with reference to the peritonitis, turpentine stupes and subsequent blistering, and he had enough stimulant to sustain him, half an ounce every two hours, which was found to be absolutely necessary.

Now, what change shall be made in his treatment. You see him better as regards the peritonitis; the pleurisy I have already referred to as having disappeared. Shall we go on with the opium treatment, though, perhaps, not pushing it as actively as before? On account of the Bright's disease my opinion would lead me to discontinue it, as we run a risk of checking the secretions of the kidneys and of producing uræmic convulsion. You remember that I told you that in kidney disease opium must be given with great care. As he is getting so much better, I will reduce it to five drops every third hour, and discontinue it as soon as possible. A blister shall be applied to the right side, followed by poultices. We will

also give him ten drops tincture digitalis every three hours, partly to control the circulation and partly to act on the secretions. As he still has diarrhoea, we will give him a suppository of five grains tannic acid and one grain opium, morning and evening.—*Medical and Surgical Reporter.*

DIFFERENTIAL SYMPTOMS OF MULTIPLE CEREBRO-SPINAL SCLEROSIS AND PARALYSIS AGITANS :

MULTIPLE CEREBRO-SPINAL SCLEROSIS.	PARALYSIS AGITANS.
First appearance at the age of 20-45 years.	Always after 55 years.
Commences with vertigo, uncertainty of gait, psychical disorders, headache.	No brain symptoms.
This is followed by paresis and paralysis, to which later the shaking is added.	Begins with fine tremor, after whose existence for some time gradual impairment of motion sets in.
Impairment of sight, nystagmus and impairment of speech.	No such symptoms.
Rarely ever, and then very mild, sensory disturbances.	Always disturbances of general sensation.
Apoplectic attacks, gastric crises.	No such symptoms.
Tremor consists of long oscillations, real shaking.	Tremor resembling very small, fine oscillations.
Shaking only on motion.	Trembling constant, not specially influenced by motion.
Disappears in recumbent position totally.	Does not change by position.
Head always affected.	Head never affected.
Bulbar symptoms.	None.
Badder and rectum always implicated.	Never affected.
Occasional sudden disappearance of all the symptoms for greater or lesser time.	Continuous to death from other cause.
Always fatal.	Does not seem to influence duration of life very much.

—*Medical and Surgical Reporter.*

JABORANDI IN PUERPERAL CONVULSIONS.—In a report and analysis of six cases of puerperal convulsions treated by jaborandi, Dr. Fordyce Barker concludes that its utility in the treatment of puerperal albuminuria is more than doubtful, and that after puerperal convulsions its depressing influence and action, which is continuous and exhausting, prevents sleep and the repose of the nervous system, and thus renders it in these cases an unsafe and dangerous remedy.

Surgery.

TREATMENT OF ANGULAR CURVATURE OF THE SPINE BY A PLASTER-OF-PARIS JACKET APPLIED IN THE RECUMBENT POSTURE.

BY THOMAS JAMES WALKER, M.D., LOND.

Surgeon to the Peterborough Infirmary.

* * * * *

I will now proceed to demonstrate the manner in which I apply it in the recumbent posture; a proceeding for which I claim these advantages. The diseased bones are, at least, as perfectly relieved from pressure, the muscles are as completely relaxed, and the deformity is as much diminished when the patient lies flat on a bed as when he is suspended. These conditions are obtained without risk of injury, without terror, distress, danger of syncope, or any inconvenience to the patient; and a perfect jacket fixing the spine in the proper position for cure can be applied by the surgeon in his own consulting-room or in the patient's house, be it ever so small a cottage, without the help of any skilled assistant, and without a splash of plaster on his clothes, or even on the floor.

As I have elsewhere described, I formerly moulded the gutta-percha jackets by using a modification of the many-tailed bandage, and it is only on the same principle that a plaster-of-Paris jacket can be applied with the patient in a recumbent posture.

The best lining for the jacket is this closely fitting under-shirt recommended by Sayre. I have used occasionally a flannel bandage applied round the patient, or a sheet of cotton-wadding tacked like a shirt round the trunk, both of them being very imperfect substitutes for the vest. The bandage should be of muslin; those I generally use are torn from a piece of Victoria lawn, nine yards long; the width must vary from two to four inches, according to the size of the patient. Plaster-of-Paris mixed with water alone, sets too quickly to admit of the necessary proceedings, and we must, therefore, add some material to retard the process of setting; the best, I believe is the ordinary gum, and the materials

must be used in the exact proportions of one pound of freshly baked plaster, one ounce of mucilage of gum acacia (*B.P.*),* and eight ounces of water; with plaster mixed in these proportions, there is sufficient time to go through the details necessary to apply the jacket, and it will set firmly in from ten to fifteen minutes after it is applied. I now employ the bandages rolled with dry plaster as recommended by Sayre, placing them in the water and mucilage until they are sufficiently soaked. (Slips of bandage previously torn to the proper length may be steeped in the plaster mixed as directed above, then taken out, and with the help of an assistant, smoothed and laid in position on the bed.) The bandage thus charged with wet plaster has now to be cut into slips of the length necessary to wrap round the patient's back, meet in front, and fold over for a few inches, and these slips have to be placed in proper position on the bed and in suitable layers for folding round the trunk of the patient so as to form a jacket reaching from below the crest of the ilium to the axilla. I, therefore, measure round the patient's chest, and take the depth of the jacket from the axilla to half an inch below the anterior spine of the ilium, and mark these dimensions on the bed, which I have protected by laying a few sheets of paper upon it. My assistant taking the end of the bandage, I rapidly unroll it across the bed, and with scissors divide it at the appropriate length, leaving the slip lying across the bed; the nurse again taking the end, places it so that the bandage as again unrolled shall overlap two-thirds of the slip previously laid down; I again cut it off at proper length, and we repeat the process until a layer of slips of bandage, each overlapping the other two-thirds of its width, is laid across the bed, of sufficient size to reach from the hip to the axilla. This will only give a jacket of the thickness of three layers of muslin, which is not sufficient; I therefore begin again at the bottom with the fresh bandages, first placing a narrow slip of paper across the bottom layer

at each side, so as to prevent my confusing the ends of the bandages in the two layers during the next stage of the application. If I wanted a specially strong jacket for an active adult, I could repeat the process again, so as to form a third layer; but usually, if the bandage be well saturated with plaster, a thickness of six folds is sufficient, and, as each slip of bandage overlaps two-thirds of the one below it, this is obtained with two such sets of overlapping bandage.

The patient, who is stripped and clothed in the vest which is to form the lining of the jacket, will now lie down on the bed. I place him carefully, so that the edge of the jacket may come well below the crest of ilium and not rest upon the bone; he raises his arms and lays them in such a position that the elbows shall just clear the top of the jacket (in the case of a female, the breasts must be held up, and pads of cotton-wool placed so as to mould the plaster in a proper form to receive the breasts when the pads are removed), and lies down on the strips of bandage; I now take one end of the last slip laid down, while my assistant takes the other, and bringing them smoothly round the side we cross them tightly over the chest; we repeat this with each slip until we come to the bottom of the first layer; then, lifting the slips of paper placed to distinguish the two layers, we commence again with the bottom stratum, smoothing the whole over with what wet plaster remains. I have never found it necessary to use what Dr. Sayre calls the dinner-pad. The patient may now put his arms down, that I may, if I find it necessary before the plaster has set, cut away or fold over the edge under the arms; in the same way, I fold up the ends of the lower slips of the bandage, and cut away the lower edge of the jacket if I find that it is so low that it will catch the thigh of the patient when he sits down. From the folding over of the slips in front, the jacket is at this point twice as thick as at any other; it has a strong wide rib down the front, which is the point at which it should be strongest to resist the tendency of the spine to curve forward; should it be thought desirable, it is easy to strengthen the back by placing a few strips of well-charged bandage vertically

* Some surgeons who saw this demonstration complain that the plaster sets too quickly. This is owing to there being insufficient gum, the mucilage not being thick enough.

down the middle of the jacket before the patient lies down upon it, or by pouring in a little wet plaster between the layers of bandage.

You will observe that the addition of the mucilage has given me ample time to complete the jacket, but all must be done with a certain degree of rapidity, or the plaster on the first slips laid down, which are, of course, the last to be folded round, will be found to have set. In a few minutes, the lad will be able to get up, the jacket being completely hardened, and you will see that the spine is fixed in its straightened condition as completely as it would have been if the boy had been suspended by his head instead of resting easily on his back.

I do not propose to detain you by entering into any account of the cases to which the method I have demonstrated is applicable; but I may state that I believe it to be adapted to every case in which Sayre recommends suspension; the jury-mast can be fixed as well in this way as by suspension; and the direction in which the slips of bandage are laid and folded may be modified according to the situation of the disease. Even in lateral curvature, the spine is much straightened, and the twisting remedied when the patient is laid either supine or prone; and what is gained in straightness, and consequently in height, may be retained by such an application of the plaster-shell as I have shown.

Although my demonstration is intended only to illustrate the application of the apparatus in spinal cases, the practical surgeon will see at once that the method of applying by a many-tailed bandage plaster-of-Paris, the setting of which has been delayed by the addition of mucilage, may be available in many other cases where a solid immovable retentive apparatus is required.

In conclusion, I would thus summarise the points which I wish to impress upon you by my demonstration, and the remarks with which I have accompanied it.

1. The main object of the treatment of angular curvature of the spine should be the maintenance of the affected bones and joints in a state of absolute rest, and that in the posi-

tion most favourable for the cure of the disease without deformity.

2. This position is found when the patient is placed comfortably in a recumbent posture.

3. By the application of a plaster-of-Paris jacket, as recommended by Sayre, the bones may be fixed in this position, so as to retain it when the patient rises and moves about.

4. The only way in which such a jacket can be applied with the patient recumbent, is by the method which I have demonstrated.

5. This method depends for its practical facility on the application of the many-tailed bandage and the use of plaster-of-Paris mixed as I have directed.

6. The adoption of the recumbent posture dispenses with the inconvenience and serious risks of suspension, while all the advantages of Sayre's method are secured for the patient at a minimum of trouble to the surgeon.—
British Medical Journal.

AMPUTATION AT THE HIP-JOINT BY A MODIFIED METHOD.

(Under the care of MR. FURNEAUX JORDAN.)

A youth of sixteen years had had acute and extensive periostitis of the left femur. Several attempts had been made at various times to remove the dead bone, but the results had not been satisfactory. A few sinuses had refused to close, the limb remained useless, the hip-joint was involved (the thigh was quite immovable, and no tendons could be made tense under anæsthesia), and the general health was reduced to the lowest ebb. It was clear the patient, left to himself, had not long to live. After much consideration it was deemed desirable to amputate at the hip-joint, and to use every precaution against shock and hæmorrhage. A tourniquet was put over the external iliac artery, the limb having been exsanguined as completely as possible by Esmarch's elastic bandage and by position. A straight incision was made, and the trochanters and upper part of the shaft were freed from their muscular attachments, after which the capsule was opened, and some early, but unmistakable, bony union was broken through. Next the shaft was cleared downwards from all its attachments (which are here mostly loose and

cellular) for a considerable distance, and then a few free sawing movements, with a long-bladed knife, through the thigh from which the bone had been removed, ended the operation. The integuments were simply drawn upwards, and the soft parts were cut straight through. No bone being left, the muscles quickly retracted, and were easily covered by the skin. Very little blood was lost. The larger trunks were tied with catgut. It was so important to save every drop of blood, that some oozing between the acetabulum and the gluteal region was instantly checked by putting a sponge, soaked in terebene, on the parts, and leaving it within the wound. Adjustment was effected by deep silver sutures. The stump was then dressed by two large sponges (subsequently kept moist with terebene and water), firmly and evenly held in place by broad long strips of plaster, one strip being so carried over the opposite shoulder that the two ends overlapped the stump. The improvement was so sudden and marked that the next day he said he was "very well." There had been neither shock nor hæmorrhage. The "interior" sponge was left for three days. When the dressing was undone the whole stump had united, even over the sponge, the united parts requiring to be partially broken through for its removal. The later steps of progress were as favourable as the earlier.

Remarks.—Mr. Furneaux Jordan said that the principle of the operation which he had done now, and on previous occasions, might be thus described :—First enucleate the bone, then cut through the limb at any desired spot—the middle of the thigh, or below, or even near the knee. Compared with the ordinary operation of two large flaps, the wound was less severe, the cut surfaces were less extensive, and, in a manner, further removed from the trunk; it was followed by less shock, less hæmorrhage, less opportunity for septic infection. The vessels were more easily dealt with. The thigh might be simply cut through with a circular sweep or a few free sawing movements. The boneless thigh should be firmly held, and somewhat flattened if cut across. The muscles may be cut on the same level as the skin; the bone being absent they retract

so strongly that the skin readily covers them, its vitality is less endangered, and a great cellular plane is not opened. The bulk of the soft parts of the thigh, especially near the pelvis, lies at the inner side of the femur. Why put a knife through these parts? It is better to enucleate the femur where it is most thinly covered, and cut across the limb where it is smaller and further removed from the trunk. In removing the thigh very low down, the area of the wound is no doubt increased, but even then it would be a much less dangerous wound in character and locality. The operation was of course more suitable for those cases in which the soft parts could be freely left than for malignant and other exceptional cases. The surgeon may, if he choose, make the circular sweep, before the shaft of the bone is turned out, if precaution against hæmorrhage have been very complete. There ought to be no hurry; the patient is in a deep sleep, no large vessels are near, and the femur may be patiently turned out of a bed that need neither be scored nor stabbed. If the thigh were to remain a soft, pendulous mass, it would be a small price to pay for greater safety, but it is a remarkable circumstance that the muscles do not rest until the longest thigh has become a short one. In hip-disease, with much acetabular mischief, the wound gives safe access and free drainage for any length of time. The principle of the operation might be adopted in amputation below the trochanters (a chainsaw being used), and indeed in amputations in other localities. The cut surfaces being moistened with terebene, the large sponges were kept constantly moist with the same antiseptic liquid. These kept up deep adjustment, gentle elastic pressure, cleanliness, antisepticity, and rest. When the sponges were removed the stump was as clean as a newly washed face. It seems a paradox, perhaps, but the moist, antiseptic sponge is constantly washing and cleaning at the same time that it is constantly maintaining perfect rest and immobility.

London Lancet.

A case is reported in the *Journal of the Sociedade das Sciéncias Medicas*, at Lisbon, of a successful distal ligature of the common carotid for aneurism of that artery.

FRACTURE OF THE FOREARM IN CHILDREN.

DR. DE SAINT GERMAIN.

Translated for the Canadian Journal of Medical Science.

* * * * *

We come now to the most frequent form of fracture in early life: fracture of the forearm. It presents in the child the following peculiarities:—1st. Both bones are almost always broken, and fracture of the radius alone may be considered as absolutely exceptional until we approach the age of fifteen years. 2nd. Fractures by penetration are much rarer than in the adult. 3rd. Incomplete fractures are rather frequent, and for proof of this I only need that characteristic crepitus which is perceived when a fracture of the forearm in a child is reduced, and when you thus render complete the "green-stick" fracture of the English. From these observations it may be deduced that the typical characteristic signs of the classic fracture of the radius (the back of the fork, the equalization of the styloid apophyses, the Z line of the radial border of the forearm) are almost constantly wanting here. On the other hand, the most convincing sign is that which you have always seen me invoke. It consists in a manœuvre analogous to that we have described for the recognition of fracture of the radius at its upper part, and consisting in the exaggeration of the curve which the fracture has impressed upon both bones of the forearm which are most frequently broken on the same level. This method of proceeding leaves no doubt, and it is unnecessary to insist upon seeking for crepitus which is almost never found. The fracture which now engages our attention is rarely complicated with sufficient swelling to prevent the immediate application of retaining apparatus. This is how I invariably proceed:—The patient having been chloroformed, although this is scarcely necessary here, an assistant draws the arm from the body and holds it solidly by the elbow. Putting the forearm in pronation, I seize with the left hand the middle part of the forearm; my right hand embraces the wrist in such a way that my two thumbs are placed on a line with the fracture, and are ready to interfere if the coaptation proving rebellious to traction

require a direct pressure. A vigorous and progressive traction is then practised, as if I were going to pull the arm in two; and soon a rectification of the axis of the forearm, the disappearance of the tumour on its anterior face, and sometimes the characteristic crepitation mentioned above, inform me that the reduction is accomplished. I then apply two graduated compresses upon the anterior face of the forearm from the bend of the elbow to the ends of the fingers. A wooden splint the same length as the compresses is placed over them. Two other graduated compresses, likewise supported by a splint, are also placed on the back of the forearm, and extend far enough downwards to cover about half the dorsal surface of the hand. It is imprudent to, as is often done, allow the compresses and splints to end opposite the radio-carpal articulation. The continuous pressure exercised upon this region very often in the child produces sloughs which are very obstinate to cure. The apparatus then formed, is fixed by means of long strips of diachylon plaster, three in number, the first for the middle, the second for the upper end, and the last for the wrist. It is indispensable not to draw these bands too tight. Their simple application is sufficient. You thus have an apparatus open to inspection, which enables you to watch the condition of the integuments, the coloration and any phlyctenulae which may occur, and to interfere as soon as may be deemed necessary. A roller bandage designed to keep the adhesive strips in place, and obviate soiling of the apparatus, is afterwards applied and covered with a thin layer of paste. The apparatus must be removed every four days at least, and if any irregularity in the consolidation be perceived it must be rectified at once. Nothing is more frequent in fact, than fractures of the forearm viciously consolidated. * * * * * When the apparatus we have above described, is removed at the end of twenty days, it is necessary to practise movements of pronation and supination, for the superior and inferior radial articulations having been subjected to a prolonged immobility have become stiff, and it is on their account that forced movements become necessary. A sling only will be required for two or three days after removal of the splints.—*La France Médicale.*

EXCISION OF THE INITIAL LESION OF SYPHILIS.

Dr. Otis writes that in nine cases in his practice early excision modified the intensity of the general infection. Auspitz records twenty-three cases, in fourteen of which there were no subsequent manifestations. Kölliker records eight cases in thirty of which there were no secondary symptoms, and in the remaining five the secondary symptoms were mild. Dr. Otis lays down the following rules for this operation: First cleanse the parts thoroughly by gentle bathing in warm water; in all open lesions apply a solution of carbolic acid of a strength of one part to forty of water, after which raise the mass of induration between the forefinger and thumb, and encircle it firmly at the base with a bit of fine silver, or malleable iron wire. The indurated part may be separated from the normal tissue in the same way by compression between the arms of a bent probe, being careful to include the entire induration. Now, with a narrow sharp-pointed bistoury, pierce the tissues at the centre beneath the compression wire or probe, and cut well under and out, including all the indurated and a little of the sound tissue of that side. This effected, from the place of beginning, cut out in the same way on the opposite side. Be assured, by careful examination, that every portion of the neoplasm is removed; then introduce uninterrupted sutures of silk or silver wire at intervals of $\frac{1}{4}$ of an inch. The patient should be kept in the recumbent posture, the parts constantly wet with carbolated water, until the third day, when, on removal of the sutures, union by first intention will, as a rule, have taken place. The resulting cicatrix may indurate to a greater or less degree, but rarely, if ever, to the extent of inducing a solution of continuity. In no case does this procedure lessen the necessity for constitutional treatment.

COLOUR-BLINDNESS.—M. Jouval recommends interposing between two glasses a thin layer of gelatine tinted with fuchsine. By regarding objects through such a medium, all the difficulties of colour-blindness are said to be corrected.

Midwifery.

THE TREATMENT OF HÆMORRHAGE IN ABORTION.

BY W. T. LUSK, M.D.,

Professor of Obstetrics, and Diseases of Women and Children in the Bellevue Hospital Medical College.

As it is practically desirable to make some distinction between interruptions of pregnancy taking place in the earlier and later months previous to the time when the child becomes viable, I shall use the term abortion to designate the discharge of the ovum in the first three months, and apply the expression "immature delivery" to the completion of labour from the fourth to seventh month inclusive.

THE TREATMENT OF INEVITABLE ABORTION.

In the first two months little treatment besides rest in bed for a few days is ordinarily required. In the exceptional cases the treatment does not differ from that in the hæmorrhages of the non-pregnant uterus.* In the third month we distinguish:

I. Cases in which the ovum is thrown off entire.

II. Cases in which the sac ruptures, and the embryo escapes with the discharged fluid.

1st. When in the third month the ovum is thrown off without rupture of the fetal membranes, the hæmorrhage rarely assumes dangerous proportions. The uterine contractions press the ovum into the cervix, which dilates and, in primiparæ, becomes somewhat elongated. As the ovum descends, the body of the partially emptied uterus retracts. The effused blood coagulates in thin layers between the ovum and the uterine walls. The ovum forms a tampon which fills the cervix and restrains the hæmorrhage.

No active treatment is therefore demanded. A vaginal douche, consisting of a pint of tepid water, may be used twice a day as a measure of cleanliness. All attempts to disengage the ovum with the finger should be avoided, as endangering its integrity. The vaginal tampon is unnecessary. It should only be used as a

* In the discussion following the reading of this paper Dr. Barker drew my attention to the occasional severity of hæmorrhages in the first two months of pregnancy.

safeguard, where patients live at a distance from medical assistance, and can only be visited at long intervals. As it is never certain that the rupture of the ovum may not take place during the course of its expulsion the tampon may in such cases be employed in anticipation of a possible increase of hæmorrhage from sudden collapse of the membranes. In multiparæ the ovum seldom remains long in the cervix. In primiparæ, on the other hand, the tardy dilatation of the os externum may lead to a retention of the ovum in the cervix lasting for days. As this condition is extremely painful, it is allowable to dilate the os externum with the index finger, or even by incisions through the ring of circular fibres which furnish the cause of delay.

Small portions of the decidua vera sometimes remain after abortion, attached to the uterine walls. They commonly do no harm, but are discharged later with the lochial secretion.

2. When the sac ruptures, and the *liquor amnii* escapes, the removal of the pressure exerted upon the uterine wall by the intact ovum is followed by profuse hæmorrhage from the utero-placental vessels.

The diagnosis of rupture may be made either from finding the embryo in the clots, or in the case of a dilated cervical canal by the direct examination of the uterine cavity. Although after rupture portions of the ovum may still be felt, we miss the smooth surface of the fluctuating amniotic sac. When the embryo cannot be found, and the cervix is closed, profuse hæmorrhage alone would render the occurrence of rupture extremely probable.

The principles of treatment in these cases are very simple. The indications are to check the hæmorrhage, and to empty the uterus. As to the best methods of attaining these results opinions widely differ.

When cases are treated with rest in bed,* the internal administration of ergot, and cold cloths applied to the abdomen and vulva, the loss of blood is usually considerable, but the most of them terminate favourably. In some, however, the hæmorrhage may prove so severe as even to threaten life. Now, it is in every way desirable, for the future welfare of the patients, to restrain the hæmorrhage within the

narrowest limits. The most effectual means of arresting the hæmorrhage, is to clean out the uterus. If, therefore, the physician finds at the time of his visit the cervix sufficiently dilated to allow him to introduce his finger into the uterus, he should not hesitate at once to remove the retained portions of ovum. The operation does not require any considerable amount of technical skill, while the immediate results are in the highest degree satisfactory. The patient should be placed cross-wise in bed, with the hips drawn well over the edge. The legs should be flexed, and the thighs held, where assistants can be obtained, at right angles to the body, to secure the greatest degree of relaxation to the perineum and abdominal walls. The right index finger should be then passed into the vagina and through the cervical canal, while the left hand placed upon the abdomen gradually presses the uterus down into the pelvic cavity, so as to bring it within reach of the examining finger.* This portion of the act should be performed slowly, while every effort is made to divert the attention of the patient. Hasty manipulations invariably excite, in the most willing of patients, the full resistance of the abdominal walls. When the point of the finger reaches the os internum it is sometimes necessary to pause for a minute or two, to await a sufficient degree of dilation to allow the finger to pass beyond the insertion of the nail. When the right finger is used, it should be made to pass upward with its dorsal surface along the left side of the uterus to the opening of the Fallopian tube, thence across the fundus to the right side. As the tip of the finger passes down upon the right side it presses the detached ovum before it toward the os internum. By the time the finger has thus made the circuit of the uterus, the ovum is pressed into the cervical canal, and thence passes easily into the vagina. With the left finger the movement is exactly the reverse. The finger passes first with its dorsal

* Prof. A. R. Simpson (Trans. Edin. Obst. Soc., Vol. IV., page 227) recommends drawing down the uterus by means of volsellum forceps attached to the anterior lip of the cervix. I have once seen extreme hæmorrhage follow this manœuvre (seventh month of pregnancy), and now feel some hesitation about its employment, at least in the later months.

surface directed to the right side, from the right Fallopian tube across the fundus, and downward along the left side of the uterus. The only resistance the finger meets is at the placental insertion, where a certain amount of manipulation is required to complete the detachment.

When the uterus cannot be pressed down within reach of the index finger by force exerted above the symphysis pubis, it is permissible to introduce the hand into the vagina; but, in such a case the fingers are apt to become cramped, and all freedom of manipulation to be destroyed. A better means of overcoming the difficulty consists in the administration of an anæsthetic. In cases of extreme anæmia, chloroform should be discarded as too dangerous. Ether, however, has often seemed to me, on the contrary, to possess a stimulating action, and its use to be followed by increase in the volume and force of the pulse. The relaxation produced by the anæsthetic makes it easy to depress the uterus down to the pelvic floor, where it can be reached with comparative ease.

After the removal of the ovum, the cavity of the uterus should be washed out with a stream of tepid carbolized water, in order to bring away any small detached portions of the ovum.

In the manual extraction of the ovum, deliberation and perseverance are the main elements of success.

If, when the patient is first seen by the physician, the cervix is not sufficiently dilated to allow the finger to pass without force, the vaginal tampon should be employed.

The tampon restrains the hæmorrhage, stimulates the uterus to contraction, and allows time for the employment of measures to rally a patient exhausted by profuse losses of blood. The material of which a tampon is made is a matter of indifference, provided only it fills the vagina to its utmost capacity. In cases of urgent need, a soft towel, handkerchiefs, strips of cotton cloths, dampened cotton, wool and the like, may be seized upon to meet a temporary emergency. The time-honoured sponge, on account of its porosity, is least deserving of favour. When, however, the physician proposes to leave his patient for a number of

hours, the mere hasty filling of the vagina through the vulva will not suffice. On the contrary, the highest degree of safety can only be secured by the closest observance of the rules of art.

The first essential of a good tampon is, that it be carefully packed around the cervix uteri, and fill out the more dilatable upper portion of the vagina. This can be accomplished only by the aid of a speculum. The method I usually employ is one, the credit of which, so far as the general features are concerned, I believe belongs to Dr. Marion Sims. It consists in soaking cotton-wool in carbolized water, and then, after pressing out any excess of fluid, in forming from the carbolized cotton a number of flattened disks about the size of the trade dollar. The patient is then placed in the latero-prone position, and the perineum retracted by a Sims' speculum. The dampened cotton disks are introduced by dressing-forceps and under the guidance of the eye are packed first around the vaginal portion, then over the os, and thence the vagina is filled in from above downward, until the narrow portion above the vestibule is reached. No other plan of tampon with which I am acquainted can compare in solidity and effectiveness with this. Its removal is accomplished by the detachment with two fingers of a portion at a time. This part of the procedure is moderately painful. Many methods have been suggested to overcome, in the removal, the necessity of introducing the fingers into the vagina. A very ingenious one consists in attaching the cotton to a piece of twine, so as to form a kite-tail, which can be withdrawn by simply making tractions upon the extremity of the string left hanging outside the vulva. Prof. I. E. Taylor uses a roller bandage. It is efficient, and, like the kite-tail described, can be easily removed.

Before the introduction of the tampon the vagina should be thoroughly washed out. No tampon should be allowed to remain in the vagina much over twelve hours. Immediately after withdrawing the tampon, before proceeding to the examination of the uterus, the vagina should be cleansed by an injection of tepid carbolized water (gr. xxx. ad. Oj.). Often, after the removal of the tampon, the ovum

is found in the upper portion of the vagina, or filling up the cervix. If this is not the case, and the cervix is not dilated, so that manual extraction may easily be performed, the tampon should be re-introduced.

It is customary from the outset to sustain the action of the tampon by the administration of ergot, either in the form of the fluid extract (thirty drops every three to four hours), or of a solution of ergotine given hypodermically. (Ergotine, gr. xij., glycerine, ʒi., ten minims twice in the twenty-four hours.) In women with abundant adipose tissue, the injection should be made into the subcutaneous tissues of the lower abdomen. In others, the outer surface of the thigh should be selected.

If the patient is collapsed from loss of blood, after tamponing, opiates, tea, and alcoholic stimulants should be administered; the latter in small, but frequently repeated quantities, until the cerebral anæmia is relieved, and the capillary circulation restored.

If after its removal the cervix is found not to be dilated, the tampon may be reintroduced and left *in situ* for another period of twelve hours. The employment of the tampon is not, however, to be recommended for a period much exceeding twenty-four hours. Its continued use is apt to irritate the vagina. In spite of carbolic acid it acquires an offensive odour. It generates septic matters which, in the long run, creep upward through the cervix into the uterine cavity, and produce decomposition of the ovum. I prefer, therefore, in cases of undilated cervix, after twenty-four hours of vaginal tamponing, to resort to sponge-tents. The tent should be long enough to pass well up through the os internum. After six to twelve hours the tent should be removed, and, after a preliminary vaginal douche, manual extraction be proceeded with in accordance with the rules already given.

In manual delivery it is desirable to remove the decidua as well as the ovum. When the cervix is patent this is easy, as the decidua is then detached from the uterine walls. When the cervix is unchanged the detachment is usually incomplete. In such cases it is advisable, therefore, to try first the tampon before the sponge-tent, as the former stimulates the

uterus to contract, and promotes the separation of the decidua, even when it fails to secure the discharge of the ovum.

Inside the uterine cavity ovum-forceps should be used with great caution. I have discarded them altogether. In the first place they are dangerous. In the second place they are unnecessary. When, however, the retained portions of ovum have left for the most part the uterine cavity, and occupy the cervical canal, the delivery may at times be advantageously hastened by placing the patient upon her side, and, with the cervix well brought into view by a Sims' speculum, applying the ovum-forceps, under the guidance of the eye, within the cervix to the sides of the placenta (Skene). But great care requires to be exercised not to break away the fragile structures, and leave material portions behind.

Under like circumstances Hoening recommended a modification of Crede's method for expression of the placenta. With the patient lying upon the back, the operator, according to Hoening, should seek to compress the body of the uterus between the left hand, laid above the symphysis pubis, and two fingers of the right hand, introduced into the vagina. The measure is only practicable when the ovum has, to a great extent, passed from the uterine cavity. As it is somewhat painful, and requires, for success, lax abdominal parietes, it possesses a limited range of applicability.

Treatment of Neglected Abortion.—When, following abortion, the uterus has once been completely evacuated, hæmorrhage ceases. A slight lochial discharge persists for a few days during the period in which the uterine portion of the decidua vera completes its period of repair. If, therefore, a patient comes to us two to three weeks after the supposed conclusion of an abortion, with the story of recurrent hæmorrhages taking place as a rule whenever she leaves her bed and assumes the upright position, it may be assumed, with an approach to certainty, that portions of the ovum still remain within the uterus. Oftentimes a fetid discharge points to the fact that decomposition has been set up. The absorption of septic materials may furthermore become the source of chills, of fever, and of great uterine tender-

ness. In most cases, with rest in bed, the contents are discharged by suppuration, and recovery ultimately takes place, but only after a slow, protracted convalescence, during which pelvic cellulitis and pelvic peritonitis occur as not uncommon complications. Hæmorrhage, peritonitis, and septicæmia may, however, bring the case to a fatal issue. The removal of the retained placenta and membranes is therefore indicated not only as a measure calculated to promote recovery, but to avert possible danger to life.

With regard to the operation for removal, the rules already given are applicable. The following peculiarities should, however, be borne in mind. In case the retained portions are undecomposed the cervix is usually found closed, and requires preliminary dilatation with the sponge-tent. When decomposition has once set in, the os internum will, as a rule, allow the finger to pass into the uterus.* When a decomposed ovum is removed by the finger, a chill and a septic fever, which rapidly exhausts itself, however, is apt to follow in the course of a few hours. This chill and fever result from the slight traumatic injuries inflicted by the finger upon the uterine walls, whereby the capillaries and lymphatics become opened up to the action of the septic poisons. The fever ends in a short time because the reservoir of supply is removed with the *debris* of the ovum. If the uterine cavity, after the operation, is carefully washed out with carbolized water, the septic fever is often averted. The beneficial results following the complete emptying of the uterus in these cases are so decided, that of late years I have not allowed myself to be deterred from proceeding actively, even when perimetritis and parametritis in not too acute a form already existed. In practice, multitudes of examples show that the products of inflammation situated in the pelvis, do not absorb so long as putrid materials are generated in the uterine cavity.

The removal of a fibrinous polypus, owing to its smoothness and the small size of the pedicle,

* HUTER: *Compendium der Geb. Operationen*. Leipzig, 1874, S. 32. To this excellent work I acknowledge my indebtedness for many hints and suggestions of extreme practical value.

is often a Sisyphus task. The separation can only be successfully accomplished when the palmar surface of the index finger presses from above upon the point of attachment. This necessitates a choice of hands. Thus, when the polypus is situated to the left, the right index finger should be employed; and the left index finger when the polypus is situated to the right. After the detachment is complete it is necessary to press the polypoid body firmly against the uterine walls and proceed with its withdrawal slowly. If, as sometimes happens, the polypus slips from under the finger, it is necessary to pass the finger again to the fundus of the uterus, and repeat the attempt. Small portions, not larger than a pea, can be washed out by the uterine douche. When the polypus is attached near the os internum, the latter will be found patulous, but, when it is well up in the body of the uterus, dilatation with sponge-tents is a frequent prerequisite to removal.

A good deal of testimony has been offered of late, by Skene, Spiegelberg, Mundé, Boeters, and others, in favour of the use of the curette for the removal of retained portions of ovum. To whom, exactly, the honour of this method belongs it is difficult to say. Accidentally, I read in a record book of Bellevue Hospital, a few days ago, an account of the operation performed by Dr. Fordyce Barker in 1870. With the curette the dangers from dilating the os and manipulating the uterine cavity are avoided. For myself, however, I confess I never feel quite safe until my index finger has made the complete tour of the uterine cavity. Still, the method has its advantages in cases where the removal of bodies retained within the uterus is complicated by the existence of extensive peri- and parametritis.

The Treatment of Immature Deliveries (fourth to seventh month).—Distinctive of immature deliveries are: painful periodic uterine contractions, which can be recognized by the hand applied above the symphysis pubis; rupture of the membranes, and discharge of the fœtus; the complete formation of the placenta and umbilical cord; while in abortion the uterine contractions are obscure, the placenta rudimentary, and the ovum is frequently expelled

entire. In the treatment of immature delivery the tampon may usually be discarded. After rupture of the membranes and expulsion of the fetus, the hæmorrhage should be controlled by grasping the fundus of the uterus in the hand through the abdomen and compressing the uterine walls firmly together.

The passage of the fetus opens the uterus so as to allow, in the fourth and fifth month, the introduction of two fingers; in the sixth and seventh month, that of the half-hand. In case compression of the uterus does not arrest the hæmorrhage and expel the placenta, the cord should be carefully followed to its insertion, to determine the side upon which the implantation exists. If the placenta is implanted upon the right side, two or four fingers of the right hand, according to the degree of cervical dilatation, should be passed up along the left side of the uterus, across the fundus to the placental site. The detachment should be effected with the tips of the fingers, and the placenta pressed downward as the fingers descend along the right side of the uterus. The left hand should be employed, in the reverse direction, when the placenta is situated to the right.

In conclusion, the following summary of the views which have been expressed is respectfully offered :

1. In the first two months an abortion needs no special treatment. The hæmorrhages of early date are amenable to the same principles of treatment as those from the non-pregnant uterus.

2. In the third month no treatment is required when the ovum is expelled with intact membranes.

When the membranes rupture previous to expulsion, and hæmorrhage takes place, immediate removal should be attempted, provided the cervix be sufficiently dilated to admit the index-finger. When the cervix is closed, the tampon should be tried for twenty-four hours. If the tampon proves ineffective, the cervix should then be dilated with a sponge-tent, and the ovum removed with the finger. The finger should pass up along the side of the uterus, across the fundus, and complete the circuit of the uterine cavity.

3. In cases of neglected abortion, retained

portions should be removed by the finger or the curette. When the ovum is decomposed, no dilatation of the os is usually necessary. When the ovum is fresh, the preliminary use of sponge-tents is usually demanded if manual delivery is resorted to.

4. Fibrinous polypi, when situated near the os internum—a rare occurrence, indeed—arrest the involution of the lower portion of the uterus. The os is therefore open, as a rule, and permits the passage of the finger. When the polypus is attached to the fundus, the cervix is usually closed. Small, smooth, slippery bodies, like fibrinous polypi, are rarely to be detached, unless the finger operates from above, so that the choice of hands depends on the side to which the polypus is attached.

5. In immature deliveries hæmorrhage can usually be controlled without the tampon, by compression of the uterus, and, in cases of delay, by the manual extraction of the placenta.—*New York Record.*

MECHANICAL SUPPORT OF THE UTERUS.

DR. THOMAS ADDIS EMMET.

* * * * *

"We will now consider briefly the mechanical means to be resorted to for the relief of displacements. I am ignorant of any instrumental means, safe or reliable, for correcting the position of an anteverted uterus. Great relief may sometimes be obtained, on increasing the degree of anteversion, by the use of a pessary with a long enough curve in the posterior *cul-de-sac* to lift the neck of the organ from the floor of the pelvis. On thus slinging the organ, as it were, with the fundus resting against the pubis and the cervix elevated, the circulation will be improved, and the irritability of the bladder lessened. We gain time by this means, and enable the patient to take more exercise, since we break the force or jar which would be otherwise transmitted to the organ so long as the cervix rested on the floor of the pelvis. The various devices for forcing the uterus into an upright position to a point which the organ likely never occupied even when in a healthy state, are faulty in theory

and wrong in practice. If we can lift, by any appliance, the uterus to a point where the obstructed venous circulation can be relieved through the neighbouring tissues, which have been put on the stretch by the sagging organ, it is all that can be accomplished by such means, and the mere anteversion is of no consequence. Any instrument making direct pressure on the anterior wall, the chief seat of disease and the point of greatest tenderness, must prove a source of irritation. I deprecate even more the intra uterine stem-pessary, for, had this instrument been the device of the Evil One himself, its use could not be productive of more danger. Its use in a flexure seems as rational as would be the introduction of a straight steel sound into the urethra for the relief of an existing chordee; the penis might be straightened by force, but the cause of difficulty would certainly not be removed. The treatment of retroversion of the uterus is more satisfactory, mechanical means can be better applied, and the good resulting from relieving the obstructed circulation is well marked on restoring the organ to its natural position. A recent case of retroversion can be reduced with comparative ease, and an instrument can readily be adjusted which will keep the organ so far anteverted as to render it difficult for it to return to its former position. If, however, the displacement has been of long duration and the uterus has become flexed, the condition will, in all probability, have acted as a source of irritation in causing cellulitis to a greater or lesser extent. Even should adhesions not have formed, a degree of congestion will have been kept up so as to require but a slight provocation to establish a fresh attack of inflammation. It is, therefore, wise to proceed with the greatest caution in any attempt at reduction until we have fully appreciated the condition. Should we find the uterus firmly bound down by adhesions, it can be replaced in time, for with care, patience, and good judgment, in not attempting too much in a single effort, these bands will gradually become so stretched and attenuated as to offer no longer any resistance. The utero-sacral ligaments, in a state of health, are scarcely worthy of note, being formed but of a reduplication of the peritoneum and a

little cellular tissue. These, however, become frequently thickened, and having closed partially over an enlarged and retroverted uterus, can be readily mistaken for adhesions, in consequence of the obstacle they sometimes present in an attempt to restore this organ to its normal position. I have long accustomed myself to rely on the index-finger for the reduction of this displacement, and with a little practice it becomes the most reliable means we can employ. It is one certainly attended with the least risk, as we are able to appreciate at once the point and extent of resistance. When we have once ascertained the fact that there are no adhesions nor lurking inflammation in the neighbouring cellular tissue, an experienced operator may, with comparative safety, use the sound or any other means to which he has been accustomed. But the method which I will describe is attended with less pain, and I believe with the least danger, under all circumstances. The patient is to be placed on the back, with the knees flexed, and the hips drawn down to the edge of the operating table or chair. Introduce then the index-finger into the vagina, and direct the point of a tenaculum, which is to be hooked into the posterior lip, just within the os. This instrument is to be used for the purpose of gently drawing forward the organ, sufficiently toward the vaginal outlet, that we may be satisfied the fundus is distant enough from the hollow of the sacrum to pass the promontory when elevated. At the first attempt this must be done with care, and if a point is reached at which great pain is caused, we must then desist. By this manœuvre the uterus has, of course, become more retroverted than before. To correct this, the perineum should be pressed firmly back, that the finger in the vagina may be passed as far up behind the uterus as possible, and made at the same time to lift up the organ. When the uterus has been thus elevated, and while it is being held up by the finger, the cervix is suddenly carried in an arc of a circle, downward and backward, by means of the tenaculum held in the other hand. By aid of the finger in the vagina, the fundus has been pressed up against the utero-sacral ligaments. These ligaments, having been put slightly on the stretch, gap

as the tension is suddenly relaxed by carrying the cervix backward, and the fundus slips between them. The finger must be then placed against the anterior lip, the tenaculum withdrawn, and the organ anteverted by passing the finger repeatedly down the anterior face of the uterus, so as to press the cervix downward and backward into the hollow of the sacrum. If an unusual degree of pain is experienced at any point, we must use our judgment as to how far it may be safe to proceed, or desist entirely for the time being, until all active symptoms have subsided under the proper treatment. When successful, I frequently make no attempt, by mechanical means, to hold the uterus in position, until I have again replaced it and satisfied myself that no tenderness on pressure exists at any point which would come in contact with the pessary to be used. The form of the instrument should be adapted to carry the cervix well back, and with a sufficient curve in the posterior *cul-de-sac* to keep it elevated, so that the organ must remain anteverted. I have been consulted, more than on any other point, as to the best form of pessary to be used in practice. A difficult question to answer, as there is some individual peculiarity about nearly every case, on the appreciation of which to a great extent success will depend. Some modification of Hodge's closed lever pessary, however, will be found applicable to the largest number of cases, as it conforms more than any other to the natural shape of the vagina. A pessary, to do no harm, should be small enough to admit of the passage of the finger between it and the vaginal wall at every point, while the patient lies on the back.

It must be just large enough to give the needed support to the uterus, and be at the same time small enough for the vagina to regain gradually its natural size. The elasticity of the canal is sufficient to admit of a dilatation to the extent of the pelvic excavation; but it will prove an exception to the rule if a pessary, properly curved, need ever be over three inches in length and an inch and a-half in width. Whenever it is possible to avoid making the pubis the chief point of support, I do so. But it is often unavoidable in cases

of long standing retroversion, where the anterior wall of the vagina has become shortened in consequence, and in cases of prolapse of the posterior wall, from laceration of the perineum. But where the vaginal outlet is not too large, and the posterior *cul-de-sac* is of a natural depth, the principle of the lever-pessary is applicable to nearly all cases. The fulcrum of this double lever rests on the posterior wall of the vagina at the bottom of the *cul-de-sac*. It should be so curved in reference to this *cul-de-sac* and posterior wall at one extremity, and at the other end bent with a lesser curve in the opposite direction, so that the instrument may be balanced. As the patient stands on her feet, the weight of the uterus will cause the other end of the instrument to rest against the anterior wall of the vagina, near the neck of the bladder. On assuming the horizontal position, the instrument will present in the axis of the vagina near the outlet. It will thus compensate itself by a change of position, so that it cannot, from continued pressure at one point, cut into the vaginal tissues. A longer curve will be needed in the *cul-de-sac* where retroversion has existed, than with prolapse from hypertrophy, where the object is simply to lift the organ from the floor of the pelvis. In the latter condition, the upper portion of the vagina will be more dilated, as a rule, than the lower part, and the instrument must be made to correspond. The closing in of the vaginal walls around an instrument, made larger above, has the effect of crowding it upwards in the canal. When even the outlet is larger than natural, and dilated from a prolapse of the vaginal walls, we must restore the canal to a natural size and close the laceration through the perineum, by a surgical operation, before an instrument can be worn with advantage for correcting the retroversion. An instrument, under the circumstances, to be used as a temporary means of relief, must be made wider below, with the greater curve also at this point, so as to get the needed support from behind the pubis, and with a depression to guard the neck of the bladder from pressure. We find occasionally a difference in the curve on each side of the symphysis, so that, if an instrument is made symmetrical, it will bury

and cut into the soft parts covering the lesser curve. On the corners of the instrument there should be no sharp angles, but a gradual curve; frequently it is necessary to bend the corners downward, to correspond with the roof of the vagina at this point. In the posterior *cul-de-sac* the instrument should never be so abruptly curved as to make pressure directly against the uterus at its junction with the vagina, but at some little distance beyond. The circulation in the neck is easily obstructed by pressure at this point, so that it will soon cause an erosion about the os; and frequently an intolerance to the presence of any instrument in the *cul-de-sac* becomes established, in consequence of irritation or inflammation of the lymphatic glands found in this neighbourhood.

The shorter the vagina, the straighter must the instrument be made, for if curved too much it will rotate and remain across the axis of the canal. A straight instrument has to be wider in the middle, in proportion to its length, than a curved one. The widest part of the vagina is from one sulcus to the other, while the lateral walls and posterior surface of the canal form a concavity; consequently, a curved instrument should be made rather smaller in the middle, as its support is chiefly derived from the posterior wall. It is a very common occurrence to find an instrument, when too wide, cutting its way along the lateral walls of the vagina, at the bottom of a deep fold formed as the pessary is carried downward from the pressure above. It may be accepted as a rule that, so long as a patient can recognize by her feelings that she is wearing an instrument, it either does not fit, or she is in no condition to wear one; and in either case it will do her harm. So soon as an instrument has been properly adjusted, and there is no tenderness on pressure at any point in the vagina coming in contact with it, the patient will be unconscious of its presence. I prefer at first the use of block tin rings, on account of their greater malleability. After modelling one of a proper size to the case, and having fairly tested its use, I then have the instrument reproduced in aluminium, silver gilt, or hard rubber. These are, in brief, the main points to be observed in adjusting a pessary properly, but in each case there will be a necessity for some modification in consequence of individual peculiarities. Success will depend entirely on an accurate appreciation of these differences, and on the mechanical skill innate to the operator. To a want of both or of either gift, must be attributed the unsatisfactory results so often complained of.—*St. Louis Medical and Surgical Journal.*

Original Communications.

A CASE OF PEMPHIGUS FOLIACEUS.

BY J. E. GRAHAM, M.D.

In the *Archives of Dermatology*, (Jan. number, 1877,) the history of a case of pemphigus foliaceus is given by Dr. Sherwell, which he claimed to be the first recorded case occurring in this country. I have not seen the notice of any similar case since that time, so that the following might be considered the second in the order of publication. I do not think, however, that the disease occurs so rarely as one might be led to believe from the above statement, but am of opinion that some true cases of pemphigus foliaceus have been diagnosed as pemphigus chronicus or eczema.

John F——, æt. 55, farmer, admitted Sept. 1, 1878. He had always been quite healthy until about five years ago, when he suffered from a sore on the lip which appears to have been an epithelioma. The part was removed by the knife after ineffectual attempts had been made to destroy it with caustics. Since that time he has noticed a peculiar numb feeling in the lip, and there is also some scaliness about the margin of the epithelial surface.

About eighteen months ago an eruption of a squamous character appeared on the upper part of the chest, which spread gradually until the whole of the trunk became affected. About the time of the appearance of this eruption he was told by a quack that the cancer on the lip had not been entirely cured. Caustics were again applied to the part, until it became sore and discharged pus. During this time the only application used on the skin was olive oil. In a short time the sore on the lip healed up, but the eruption on the body spread gradually. About a year ago, while working in the harvest field, the perspiration irritated the skin so that the eruption became much more general, and of a more aggravated form. After the harvest was over it remained as it was before, until last spring, when it again increased in severity, and spread to some extent on the extremities.

Family History.—His mother died of consumption when he was nine years of age; one

cousin also died of consumption. No other members of the family suffered from that disease. His father died at eighty. He never knew any of the family to have disease of the skin. He himself has been subject to occasional attacks of colic, had inflammation of the bowels twice, and when about twenty years of age he had a venereal sore on the penis. No secondary symptoms followed. He has a healthy family. He has always been temperate, and has lived well. His wife has been dead some years. He states that he has not exposed himself to venereal disease since his marriage, some thirty years ago.

Present Condition.—The patient is a medium-sized man in moderately good condition. His appetite is poor; bowels constipated; pulse increased in frequency. The greater part of the trunk is covered over with dirty yellow scabs, which can be easily removed, and which leave a base deeply pigmented, similar to that which follows local congestion. The epidermis can be easily rubbed off on all parts of the body, especially in the neighbourhood of the eruption. The head and face present an appearance similar to that of the chest, except that on the face there are several patches of a raw, bleeding surface. On the arms and legs there exist bullæ from the size of a pea to that of a walnut. The smaller ones are filled with a clear, transparent fluid, and the larger ones are flattened, and partly filled with a white opalescent fluid. On account of the irritability of the parts many of the bullæ have been destroyed, leaving a raw congested surface, very similar to that left after a burn. This surface is very sensitive, the least rubbing causing pain.

Some of the red patches are quite fresh and moist, whereas others are dry, and partly covered by coagulated blood. Those bullæ which have dried up without being rubbed, present large dirty yellow scales, which, in some instances, are turned up at the edges. The eruption is most irritable at night, being aggravated by the warmth of the bed. He always notices a burning pain in the part immediately before the vesicles make their appearance.

Treatment.—Alteratives and tonics were given internally. An external application of calamine, zinc oxide, glycerine and water, was

ordered for the sore parts. Ol. lini to be used on the chest, and a bran bath to be given each morning.

Sept. 2nd. The patient feels rather better this morning. He had two or three chills during the morning, but they were not so severe as those of the last few days. A number of the dirty yellow scales have been removed by the nurse and have left a pigmented surface. On the feet there are bullæ from the size of a ten cent piece, to that of a large penny. They are flattened, and are almost identical in appearance with the blisters which follow burns. The bullæ, according to the patient's statement, last three or four days, when they commence to dry up. They sometimes appear on parts previously affected, and sometimes on new places. He states that the bullæ appear in greater numbers after the daily use of the bath. He had been treated by bathing for several months previous to his admission.

To-day I stopped the baths, thinking that they might have an injurious effect on the skin. On the right thigh a number of new bullæ have appeared since yesterday. They are of various sizes. A number of small ones sometimes form separately, and afterwards unite to form a larger bulla.

Sept. 3rd. Examined some of the fluid from several different bullæ to-day. Found in all cases that it was either alkaline or neutral. On adding nitric acid a precipitate was formed. On examining the urine found the "Specific Gravity" to be 1020. There was no albumen; no sugar. It was of a slightly acid reaction. Noticed on the thigh some spots where the exudation had become dried up in the form of scales with turned-up edges.

Sept. 4th. Patient is not so well to-day. He suffered from the perspiration, and shaking in the carriage yesterday. A spot on the thigh, which I noticed yesterday to be moist and raw, is now dried up, and covered by a scab composed of partly dried exudation, and of dried blood.

Examined to-day some of the fluid under the microscope. In that from the fresh vesicles, that is from those of less than twenty-four (24) hours' duration, a number of cells were present; they were about the size of red blood

corpuscles, had a granular appearance, and were of a globular form. In the fluid from the older bullæ the cells were more numerous, and much larger than in that from the fresh vesicles.

Sept. 5th. The patient is to-day altogether better. Some new vesicles and bullæ have appeared on the thigh. Ordered the linseed oil to be more freely used.

Sept. 6th. The patient is slowly improving. There are not so many new bullæ appearing as before. There is one bulla on the right knee, quite large, and raised a quarter of an inch above the knee. It is situated a little to one side of the knee. Its contents are separated into two parts; the lower part is made up of pus, the upper part is clear, and of a slightly yellow colour. Ordered to-day of morrhuae to be given internally.

Sept. 7th. Noticed to-day on the right leg, anterior and posterior surface, three or four large bullæ the size of fifty cent pieces; these have appeared during the night. On the anterior part of the abdomen immediately above the pubes, some large bullæ have appeared, and have been rubbed off, leaving a very moist surface. He feels more comfortable. His appetite is good. He has some fever, but not more than usual. Pulse 94, temperature 100. There is neither thickening nor infiltration of the derma to be found anywhere.

Examined some of the bullæ to-day with the lens, and found that in some cases the fluid exists between the layers of the epidermis, whereas in other cases the whole epidermis is raised. Examined the contents of the vesicles with the microscope again, and found the same appearance as before.

Sept. 8th. He is a little more feverish to-day. Pulse 108. Appetite not so good.

He had some chills this morning. He says he always has chills and fever before the appearance of new bullæ. Noticed a number of new ones to-day. Was able to examine the fluid of bullæ which had only existed for a few hours. I found the fluid in the very fresh ones to be distinctly acid, and containing very few leucocytes. On examining the base of the bullæ with a lens I found that in the more recent ones there was little or no congestion,

whereas in the older ones the base was very much congested. I noticed also that in the more recent ones the epidermis was tense, giving the bullæ a round appearance, whereas in the older ones the surface is flattened. New bullæ are appearing on the thigh and legs, and a few on the feet. None on the hands. The trunk is now almost entirely covered with yellow scabs and scales. To-day I made a great number of trials, and found in every case that the more recent the bulla the more acid were its contents.

Sept. 9th. He feels more uncomfortable, around the abdomen and back. His penis is somewhat swollen. On the trunk there is very little healthy skin remaining. Pulse 105, temperature 101½.

The bullæ come out in groups periodically. There are scarcely any new ones to-day. Ordered to-day quinine, iron, and arsenic.

Sept. 11th. Patient is still troubled with chills and fever. Pulse 104. Notice that the sores on the face are now covered by thick yellow scabs. Here no application has been made. The yellow scabs on the chest are giving place to large dry scales with upturned edges. These scales are coming off in large quantities. There are now very few new bullæ on the legs. Both knees are now covered with large scales. Added liq-hydrarg-perchlor to the tonic mixture.

Sept. 16th. I have not seen the patient for a few days, owing to absence from town. He is not so well as when I last saw him. Pulse 80, temperature 101, appetite poor; he does not sleep well, owing to a burning sensation which exists in his back. His face is almost completely covered with thick yellow crusts. The skin of the forehead presents a number of deep fissures. The conjunctivæ are inflamed, and a slight purulent discharge appears at the inner corner of both eyes. On the front of the chest scales are coming off in large quantities. The surface of the skin beneath the scales is dry, and presents a more healthy appearance than before. Scabbing is now going on over the parts where the bullæ were in the greatest profusion when he came in. On the legs there are large patches of raw bleeding surface, the result of the peeling off of the epidermis.

Sept. 23rd. Pulse 112, temperature 100. The patient is very restless at night. Complains of chills. The exfoliation from the chest and abdomen is very great. In some places there are deep fissures beneath the scales.

Sept. 25th. He feels more comfortable than when I last saw him. Scales large and flaky. There are still a few bullæ on the legs and feet; none on the trunk. His appetite is better. Condition in every way improved. He is now taking a simple tonic.

Sept. 27th. Patient continues to improve. The amount of exfoliation is not so great. His face is improving. Pulse 97, temperature 100.

Sept. 29th. Very few scales on the chest and abdomen, but they still exist in large quantities on the thighs.

Oct. 3rd. Patient is better. He is sitting up. Suffers still from irritation in some places; ordered ointment of Bismuth, and cerat galeni.

Oct. 25th. The patient is very much improved. In many places the skin is quite healthy; there are still scabs and scales in places.

Nov. 15th. He continued to improve until a few days ago, when the bullæ again appeared on the chest and abdomen, preceded by chills and fever. I determined to give the linseed oil treatment of Dr. Sherwell a fair trial. Ordered it to be freely applied externally, and gave it inwardly.

Dec. 15th. The linseed oil treatment has been carried out faithfully for the past month. The surface of the body has been kept saturated in the oil. I do not see that it has produced any beneficial effect.

Dec. 20th. Patient is now recovering from the second attack from which he has suffered since his admission.

Jan. 18th, 1879. Patient is in much the same condition as when the last entry was made. The pulse, during the past week, has ranged between 80 and 90, and the temperature not above 99°. He is taking a tonic of phosphate of iron, quinine, and strychnine. A lotion of tannin, glycerine, spts. vini rect., and water, being applied externally.

May 3rd. The patient is still in the hospital. He is becoming very much emaciated. Has violent attacks of delirium, so that he has to

have an attendant always beside him. During the latter part of the winter, and the early part of spring he has had two or three relapses similar to that mentioned before. The recovery each time becomes less apparent, and is of less duration. He suffers very much from involuntary muscular movements. The twitching is sometimes so great that he can scarcely keep his bed. Two or three times during the winter he has suffered from small sores in the throat and mouth.

The principal features of the disease, as it affected the patient, may be summed up as follows:—

(1) Appearance of bullæ, with flattened surfaces, commencing on the chest and spreading to other parts of the body.

(2) Drying up of the exudation and the formation of larger scales with upturned edges.

(3) The appearance of each successive crop of bullæ was preceded by chills and fever.

(4) Nervous symptoms such as twitching of muscles, delirium, restlessness in sleep, were especially prominent.

(5) Progressive emaciation.

(6) Absolute uselessness of all remedies in producing any permanently beneficial result.

On reading over the history of this case one cannot but be impressed by its typical character. Almost every symptom of the disease, as described in Hebra's treatise on skin diseases, was present in this man's case, and from present appearance the very unfavourable prognosis given will also be verified. The nervous symptoms which were so marked in this case are not mentioned by Hebra.

In attending the case, and watching it throughout its course, I was often struck with the similarity it bore in some of the stages to some forms of eczema. There was, however, no infiltration of the true skin, except that the feet and legs were œdematous when the bullæ were most abundant on these parts.

Since writing the above the patient died. A report of the post-mortem examination will appear next month.

Dr. Isaac Hays died on April 13th, aged 83. He was the editor of the *American Journal of Medical Science* for many years.

Translations.

SULPHATE OF IRON IN CHRONIC ECZEMA.

Dr. Mariani, in the *Revista Medica de Chili*, summarises an article by Prof. Percy in which he highly extols the employment of sulphate of iron dissolved in distilled water in the proportion of 30 grammes (450 grains) to 300 of the solvent, in chronic affections of the skin, and especially in eczema. On applying to the affected portions of the skin compresses wet with this solution the results are rapid and astonishing, and eczematous eruptions, which had long resisted various methods of treatment, promptly disappear. In cases in which the smarting and itching are excessive, the tincture or extract of belladonna may be added to this solution. In ten cases Dr. Percy obtained ten cures.—*Gazzetta Medica Italiana*.

RETENTION CURED BY METALLOTHERAPY.

In the same number of the same journal we observe the report of a case of retention successfully treated by metallothrapy. In this case, which occurred to M. Dupuis, catheterism had been resorted to daily for five months, and all kinds of antispasmodic remedies had been exhausted in the treatment of the hystermism which was the cause of the trouble. The application of gold upon the skin provoked convulsions and spasms of the limbs. Other metals, as steel, copper, and platinum caused them to disappear at once; accordingly, some of Burq's plates were applied over the bladder and the neighbouring muscles. An hour later the urine was voided abundantly and painlessly. After this there was no necessity for the catheter, the armatures always sufficing to provoke micturition.

TREATMENT OF OCULOPALPEBRAL PHELGMASIE BY ERGOTINE.

Dr. Planet says its topical application is attended by no pain. His formula is:—Glycerine 20 grammes (3v), ergotine 1 gramme to $1\frac{1}{2}$, 8 to 10 drops to be used every two hours. In cases of extensive inflammation it is well to place a compress wet with this solution on the eye for some hours. The graver cases get well in two or three days. The superficial position of the vessels explains this result.—*Revista de Medicina y Cirugia Practicas, Madrid*.

THE CANADIAN Journal of Medical Science,

A Monthly Journal of British and Foreign Medical Science, Criticism, and News.

TO CORRESPONDENTS.—*We shall be glad to receive from our friends everywhere, current medical news of general interest. Secretaries of County or Territorial medical associations will oblige by sending reports of the proceedings of their Associations to the corresponding editor.*

TORONTO, JUNE, 1879.

LACTOPEPTINE.

This valuable preparation now so well and favourably known to the profession, contains pepsin, pancreatine, diastase or vegetable ptyalin, lactic and hydrochloric acids, in combination with sugar of milk, the active constituents of the digestive secretions of the salivary glands, stomach and pancreas, and consequently would naturally be indicated in any diseases or disorders, either due to or complicated by a deficiency or morbid character of these juices. Experiments go to show that it will convert albumen into albuminoid, starchy food into glucose, and emulsionize fatty food, and that it possesses much greater digestive power than pepsine alone. The New York Pharmaceutical Association deserve the thanks of the profession and the public for bringing into notice this preparation, to the great value of which many eminent physicians bear testimony. We have used it with gratifying success in dyspepsia, both in infants and adults, in gastralgia due to disordered digestion, in vomiting of pregnancy, and in infantile vomiting and diarrhoeas due to indigestion. Very many American physicians speak in terms of the highest praise of its beneficial effects in cholera infantum. It is equally indicated in digestive disorder, functional (so-called), and in that due to, or complicating, organic disease and mal-assimilation, and can be advantageously given along with other remedies that may be indicated. By its power as an artificial digester it gives the stomach rest, and supplies it, through the blood, with assimilable materials to repair its weakened secreting powers.

Book Notices.

Transactions of the Detroit Medical and Library Association, April, 1879.

Rhymes of Science: wise and otherwise. With illustrations. New York: Industrial Publication Company, 1879.

Hints in Obstetric Procedure. By W. B. ATKINSON, M.A., M.D. Philadelphia: D. G. Brinton, 1879.

Chloral Inebriety. Read before the King's Co. Medical Society. By J. B. MATTISON, M.D., Brooklyn, N.Y.

Circulars of Information of the Bureau of Education. No. I., 1879. *Training School for Nurses.* Washington: Government Printing Office.

Photographic Illustrations of Skin Diseases. By GEORGE HENRY FOX, A.M., M.D. New York. Part I.

From our personal acquaintance with the author we expected that his proposed publication would be one of great merit, but we were not prepared to see a work so excellent in every particular as the one before us. The photographs are true to nature, and, in our opinion, give a better idea of the minute appearance of the diseased skin, than any plates we have yet seen. The text accompanying the photographs is plain and practical, and will give the practitioner a good idea of the treatment of the several affections taken up. It is certainly very creditable to the American School of Dermatology, that two such excellent series of plates as those of Drs. Dühring and Fox are being published on this continent.

QUEEN'S UNIVERSITY, KINGSTON—*Graduates in Medicine*, 1879.—*Doctors of Medicine*—Order of Merit—William H. Henderson, Kingston; J. C. C. Cleaver, Trinidad, W.I.; P. O. Donovan, Campbellford; W. A. Lafferty, Perth; R. A. Leonard, Westbrook; R. N. Horton, New Dublin; Geo. Judson, Frankville; Wm. F. Cleaver, Trinidad, W.I.; Geo. Newlands, jr., Kingston; Thomas R. Hassie, Perth; R. K. Kilborn, Frankville; R. H. Abbott, Wolfe Island; James A. McCammon, Gananoque; W. Clark.

Meetings of Medical Societies.

COLLEGE OF PHYSICIANS AND SURGEONS.

ANNUAL MEETING OF THE COUNCIL.

The annual meeting of the Medical Council of the College of Physicians and Surgeons of Ontario commenced on Tuesday, 13th of May, at the Council Chambers, City Hall.

After the reading of the minutes, it was decided that the Registrar, Dr. T. Pyne, occupy the chair during the election of the officers.

Dr. J. ROSS moved, and Dr. JOHN HYDE seconded, "That Dr. Macdonald be President."

Dr. J. D. MACDONALD was elected on a stand-up vote by a majority of one.

Dr. LOGAN was elected Vice-President.

It was moved by Dr. C. V. BERRYMAN, seconded by Dr. M. LAVELL, "That the following gentlemen be a Committee to appoint Standing Committees:—Drs. Aikins, Geikie, D. Clarke, W. Clarke, Macdonald, Vernon, Irwin, Berryman." The motion was carried.

On the re-assembling of the Council all the Committees were passed separately, with the exception of the Executive Committee.

A petition was presented on behalf of the medical students, praying that they be re-examined.

It was moved and seconded, "That the petition be referred to the Education Committee." Carried.

A petition was also read from Leonard J. McKinnon, for a consideration of his case. Referred to Education Committee.

Peter H. Brice's petition for permission to be examined in his second year's papers was referred to the Education Committee, as was also the petition of W. M. Howing, M.D.

Petitions from John F. Piper, G. H. Christie, and John McCarrow, for permission to practice, were referred to the Registration Committee.

The Report of the Board of Examiners was read. For the most part the report was a defence of the Examiners to the charges made against them by the students and others.

It was acknowledged by several speakers that there was a feeling of dissatisfaction among the practitioners throughout Ontario, and that action should be taken to rid the Council of the reports that had been circulated.

Dr. AIKINS thought that the fullest examination of the circumstances connected with the late trouble should be made. If any of the examiners were drunk, he would wash his hands of the affair. He thought no man should be re-appointed to any position who might degrade the Council.

EVENING SESSION.

The President took the chair at 8 p.m. After the minutes of the afternoon session had been read and approved,

Dr. GEEKIE presented the petition of Dr. Burk, praying for protection to practice until the next examination.

On motion, the petition was referred to the Education Committee.

It was moved by Dr. D. CLARKE, seconded by Dr. McLAUGHLIN, "That an announcement shall be made public to any person or persons, who shall give competent evidence in respect to the recent alleged irregularities in connection with the Council examinations, to present themselves before the Committee appointed to investigate the matter at any time during the sittings of the present Council up to Friday noon; and no student who will give such evidence shall thereby compromise his position nor affect his interests in any way by so doing." Carried.

The Committee appointed to look into the credentials of Dr. Husband, reported that he was duly accredited to the Medical Council.

SECOND DAY—MORNING SESSION.

The proceedings of the Council were continued; Dr. J. D. Macdonald, President, in the chair.

The petition of F. H. Mewburn to have his examination in the matter of anatomy reconsidered, and his whole case referred to the Education Committee, was read.

After some remarks from Dr. W. CLARKE as to the propriety of acceding to the petition,

The petition was referred to the Education Committee.

Dr. ALLISON moved, and Dr. McLAUGHLIN seconded, "That leave be given to bring in a by-law to amend the election by-law of 1870, and that the by-law be read for the first time." The motion was carried.

Dr. ALLISON stated that the by-law was for the better election of territorial representatives to the Council.

After considerable discussion Dr. Allison's motion, seconded by Dr. McLaughlin, "That the by-law be read a second time and referred to the Committee of the Whole," was carried.

Dr. BERRYMAN then moved, and Dr. SPRAGGE seconded, "That the sympathy of the Council be conveyed to Mrs. Campbell, on the death of our late President. We also would like to place on record the good services and constant action and intelligent administration of our affairs during his administration, and that a copy of the resolution be duly engrossed and furnished to the widow of our late President."

The report of the proceedings of the Executive during the year was then read.

AFTERNOON SESSION.

The Council assembled at 2 p.m., and went into a Committee of the Whole to consider the report of the Executive Committee of their proceedings during the past year. It was dealt with clause by clause. That which referred to the protest of students of Trinity Medical School against a by-law of the Council, insisting that the students shall give evidence of having attended 75 per cent. of the lectures delivered before they can be admitted to examination, was discussed with some spirit.

Dr. GEEKIE stated that the students of Trinity School objected to be held by a resolution not observed by other schools as regulated by the Council. Several of the professors considered it derogatory to their position to be compelled to call the roll every day in order to see who were present. This school would be willing to abide by regulations of the Council provided that all the schools were dealt with alike.

Dr. McLAUGHLIN thought that the students should be held to the requirements of the Council in order that they might be able to prove that they attend 75 per cent. of the lectures delivered during the six months.

Dr. SPRAGGE regretted that the students of Trinity School had sent such a protest, and had threatened to test the matter in a Court of law if the Council insisted upon adhering to the resolution requiring their attendance at 75 per cent. of the lectures.

The clause was passed without any action being taken upon the protest.

Dr. WM. CLARKE spoke at great length as to the visit of the deputation to Ottawa for the purpose of soliciting the repeal of the British Regulation Act, which repeal was earnestly desired by the medical profession of Canada. Sir John A. Macdonald had received the deputation and promised to get the Act repealed, so far as it concerned Canadian students. His Excellency the Governor-General also received the deputation, and sympathizing with the profession, promised to make the necessary representations to the Imperial Government to have the Act repealed. If that were not done, great injustice would continue to be done to the profession here, as Canadian students might go to Britain, pass the examinations, return and compel registration. The position of the medical profession in Canada would be endangered if that were allowed. Sir John promised that the Canadian profession should have a copy of the Act.

Dr. BERRYMAN thought the Council were indebted to Dr. W. Clarke for the report he had given of the doings of the deputation.

The Committee rose and reported progress. It was then moved by Dr. D. CLARKE and

seconded by Dr. LAVELL, "That the report be read and adopted." The motion was carried.

Dr. Allison's by-law as to territorial representatives was read the first time. In the second-reading thereof the Council went into Committee of the Whole. The various clauses of the by-law were considered and passed, and the Committee rose.

The by-law was read a third time.

The report of the Building Committee was read by the Registrar, and adopted.

The Treasurer, Dr. Aikins, read the report, from which the statement of receipts and expenditure is taken, as follows:—

Receipts—Balance in bank from last year's meeting, \$8,423 81; Dr. Pyne, registration fees, \$1,442 64; professional examinations, \$5,447; matriculation examinations, \$1,090; interest allowed by bank, \$165 56; miscellaneous, \$45 80. Total receipts, \$17,414 81.

Expenditure—Expenses in connection with last meeting of Council, \$1,265 38; accounts ordered to be paid at last meeting of Council, \$1,050 47; Executive Committee meeting, \$638 70; on account of church building, Bay and Richmond streets, Toronto, together with legal services and insurance in connection therewith, \$8,997 05; matriculation examiners and expenses of matriculation examination, \$417 75; officers salaries, \$750; miscellaneous expenses, \$636 70. Balance in Treasurer's hands, \$3,658 76.

Dr. BETHUNE moved, and Dr. BERRYMAN seconded, "That the report be received." Carried.

EVENING SESSION.

The proceedings were resumed at 8 p.m., Dr. Macdonald, President, in the chair.

After the minutes of the previous session had been read and adopted,

The accounts for the extra charges of the Examiners were then presented, and referred to the Finance Committee.

On the motion of Dr. BETHUNE, the Council adjourned to meet again at 10 o'clock next morning.

THIRD DAY—MORNING SESSION.

The Council met at 10 a.m., Dr. Macdonald, the President, occupied the chair.

After the reading and passing of the minutes, Dr. ALLISON moved, "That in consequence

of certain irregularities having crept into the Board of Examiners, it is deemed expedient that in the appointment of examiners in the future no member of this Council shall be nominated to that Board."

Dr. GEIKIE considered that the Council should be free of the Board, so that additional weight might be given to the decisions of the Examiners.

Dr. McLAUGHLIN disapproved of Dr. Allison's resolution. In amendment he moved, "That the Council will always endeavour to select from amongst the registered practitioners of Ontario the best available examiners." He thought that if Dr. Allison's motion were carried out the Council would be thrown into a great many difficulties. He had known that some men appointed to be examiners, who were not of the Council, did not appear to perform their duties when the time of examination came. By having members of the Council on the Board it was possible to render great assistance to the other members of the Board. He considered that they should select the best men of the profession, whether in the Council or not.

Dr. BETHUNE supported Dr. McLaughlin.

Dr. W. CLARKE thought that the motion of Dr. Allison and such speeches as he had made, would have the effect of bringing the Council into contempt.

Dr. HERRIMAN considered that the resolution was misunderstood, and he was in favour of having the Board independent of the Council. There were members of the profession in all parts who were thoroughly capable of conducting examinations; and in the case of students having grievances it was better that they should have the opportunity of appealing to an independent Council.

Dr. LOGAN approved of Dr. McLaughlin's amendment. He felt that more errors would be committed if the examiners were selected outside of the Council than if they were not.

The PRESIDENT here mentioned that Dr. Allison had substituted the word "difficulties" for the word "irregularities."

Dr. D. CLARKE said he must oppose Dr. Allison's motion. It assumed that which had not yet been decided by the Council. Neither had it been proven that the examiners appointed by the Council had been to blame. He agreed with Dr. McLaughlin that they should select the best men, whether inside or outside of it.

The CHAIRMAN here ruled the motion of Dr. Allison out of order.

Dr. ALLISON then amended his motion to read as follows:—"It is deemed expedient that in the appointment of examiners in the future no member of this Council shall be nominated to that Board."

The amendment was then put, with the following result:—Yeas, 17; Nays, 3.

On the request of Dr. ALLISON the original motion was voted on:—Yeas, 3; Nays, 17.

The original motion was declared lost.

Dr. HENWOOD considered that the territorial representatives were not numerically strong enough in comparison with the school repre-

representatives. He thought if there were more country representatives in the Council it would give great satisfaction to the profession, and in view of that he moved,

"That the Ontario Legislature at its next meeting be petitioned to so amend the Ontario Medical Act as to enable each of the territorial divisions to return two representatives to the Council instead of one as at present.

Dr. LAVELL claimed that the schools should have proper representation, and said that they would never relinquish that claim.

Dr. D. CLARKE spoke to the motion. He favoured an increase, but not so large a one as that proposed by Dr. Henwood.

Several notices of motion were presented, and the Council adjourned, to meet at 2.30 p.m.

AFTERNOON SESSION.

The PRESIDENT took the chair at 3 p.m.

The minutes of the previous meeting were read and adopted.

Dr. GEIKIE moved, seconded by Dr. Morden,

That hereafter for the fees for the matriculation examiner in Toronto or Kingston, or to the Registrar of the College, a duplicate receipt be given in every case where a fee is received, one copy being sent to the Treasurer as his voucher, and one to the candidate.

The motion was lost:—Yeas, 4; nays, 16.

Dr. BERRYMAN moved, seconded by Dr. Geikie,

That no permanent position or paid office shall be occupied by any member who is in any way engaged in teaching in any university or teaching body of medicine, the meaning of the aforesaid resolution being that it alludes to the Treasurer and Registrar of the said body of the College of Physicians and Surgeons of Ontario.

During the taking of the vote on the foregoing resolution Dr. Geikie said that unless the motion was carried an appeal would be made to have it altered by Act of Parliament.

Dr. Clarke and Dr. Geikie spoke, and

Dr. LAVELL claimed that he was not excluded from any position in the Council, and held his position equally with representative men; and so long as this Council gave him a position he would attempt to discharge his duties fairly. He knew Dr. Aikins was a man whom the Council could trust, and would not take advantage of his position. He did not care whether Dr. Aikins or Dr. Geikie got the position, but he thought the motion was a reflection upon the former of these gentlemen.

Mr. SMITH, the detective, made a lengthy statement as to work done by him, and as to the difficulties under which he had to labour from time to time in the prosecution of quacks, and the expense to which he had been invariably put in such prosecutions. He said that he would perform the duties of prosecutor for \$1,000, and if the total of the fines amounted

to less than that sum he would do so for what he could get.

Dr. HYDE asked Mr. Smith whether he had received all the fines that had been exacted from offenders through his prosecution.

Mr. SMITH replied that he had not.

Dr. W. CLARKE moved, seconded by Dr. MORDEN, "That the case of William Smith be referred to a Special Committee."

Dr. BERRYMAN said that he thought there had been a great waste of time; that a report should have been given to the Council by Mr. Smith, and it could then have been referred to the Registration Committee.

Dr. HYDE moved in amendment, seconded by Dr. D. CLARKE, "That the case be sent to the Registration Committee."

The amendment was carried.

Dr. AIKINS stated, as a matter of privilege, that the fees for 170 matriculants paid at the Treasurer's office he (Dr. Aikins) had only received the fees from three. This explanation was given to show that he did not use the influence of his position as Treasurer to induce students to go to any school in particular.

The Council adjourned to meet at 8 p.m.

EVENING SESSION.

The President took the chair at 8 p.m.

Dr. HENWOOD moved, "That the Legislature be applied to at its next session to so amend the Ontario Medical Act as to increase the territorial representatives by five."

Dr. ALLISON thought that the Colleges should not evince opposition to the motion, and that it would be better to agree with the territorial representatives.

Dr. LAVELL was not able to see wherein the Schools had placed themselves in opposition to the profession. He said that the existence of the Council was owing to the Schools. The Schools had elevated the character of the profession. He was not afraid, nor were the professors (although such had been suggested) afraid, that by an increase of the territorial representatives their rights would be encroached upon. He said that when the Schools had conceded everything the profession had conceded nothing. He opposed the motion on account of increased expenditure, and because he thought the increase of members would decrease the efficiency of the Council.

Dr. HENWOOD said that the School men had gradually assumed control of the affairs of the Council, and the profession generally were dissatisfied with that state of things. He thought that amongst additional members they might find some whom they could place confidence in and from whom they could obtain advice.

Dr. McLAUGHLIN considered that the state

ment as to the Council being controlled by School men was not true. He said that the most influential spirits of the Council had been territorial representatives. He thought that if the increase were asked for both the Homœopathists and the School men would seek an increase.

On being put to a vote the resolution was lost. Yeas, 9; Nays, 12.

A letter inviting the Council to visit the Hospital, received from Dr. O'Reilly, was read, and it was decided that the Council do accept the invitation.

After transacting some miscellaneous business the Council rose, to meet again next morning at ten o'clock.

FOURTH DAY—MORNING SESSION.

The Council met at 10 a.m., the President occupied the chair.

After the reading and passing of the minutes, Moved by Dr. SPRAGGE, seconded by Dr. W. CLARKE,

That the by-law requiring students to present themselves for examination before the Council in each year be amended, and that a by-law requiring students to pass a primary and final examination be substituted.

In accordance with the suggestions of several members, the motion was allowed to stand over until after the report of the Education Committee.

Dr. GEIKIE gave notice that at the next sitting of the Council he would move,

That in all cases of unsuccessful candidates, whose examination fees have exceeded \$10, the Treasurer shall be and hereby is directed to repay the amount, less the sum of \$10, this amount to be retained for expenses.

Also, that at the same sitting he would move—

That the Executive Committee of the Council be and hereby is directed by the Council to apply to the Legislature for a grant in aid of the Council, setting forth in the said application the claims this Council have upon the Legislature and upon the people at large—claims greater than can be urged by many bodies, however good, receiving public aid, and that such aid is necessary to assist in the establishment of a public library and museum, and to enable the Council to do all in its powers to maintain and elevate medical education in Ontario.

The Council then went into Committee of the Whole to consider By-laws 1 and 2 relating to the registration of graduates, Dr. Herriman in the chair.

Dr. CLARKE showed that the by-laws introduced were intended to operate in favour of the students of this country by making a general registration fee of \$400, and granting a rebate of \$550 to Canadian graduates. The system in England of granting diplomas to men who could

not pass the examination here, and their being allowed by the British Medical Act to compel registration in the colonies, was a bad system, and he felt that unless the by-law were passed or the Medical Act repealed the Council would be soon broken up.

Dr. MACDONALD conceived that the sum of \$400 was large, but if it were the will of the Council to fix that as the sum, he had no objection.

Dr. GRANT spoke as to the Imperial Medical Act. The status of the medical profession in this country was higher than it was thought to be by the profession at home. He considered it was high time that the Council should stand up for the rights of the Canadian profession. He believed that the British Government would not object to grant what was properly due.

The Committee rose after some further consideration of the by-laws, which were afterwards read a third time and passed.

AFTERNOON SESSION.

The Council met at 2 p.m.

It was moved by Dr. ALLISON, seconded by Dr. IRWIN, "That Dr. Pyne be appointed Registrar for the present year." The motion was carried unanimously.

Moved by Dr. ALLISON, seconded by Dr. CLARKE, "That Dr. Aikins be appointed Treasurer for the current year." The motion was carried.

Dr. GEIKIE's motion, seconded by Dr. HUSBAND, to petition the Legislature for aid (as stated in the report of the morning's session), was read and carried.

Afterwards Dr. D. CLARKE introduced a by-law which was read as follows:—"It is expedient that provision should be made by by-law for fixing the day upon which the registrar is to summon the members to meet for the transaction of business.

"Be it therefore and it is hereby enacted that the Registrar shall summon the members-elect to meet on the second Tuesday in July, 1880, for the transaction of business and organising the Council in Toronto."

The by-law, after some discussion in Committee of the Whole, was read a third time.

The Council adjourned at 4-30 p.m.

Upon the resumption of business, the order of the procedure was suspended to allow the introduction of by-laws.

Dr. CLARKE introduced the following by-law No. 8:—"As it is necessary that the lately printed registrar of the College of Physicians and Surgeons of Ontario should be legalized by by-law passed by this Council,

"Be it therefore enacted that the register last issued by the Council of the College of Physi-

cians and Surgeons of Ontario be now finally approved of and adopted by this Council."

After the by-law had been read twice it was referred to Committee of the Whole. The Committee rose and the by-law was read a third time.

EVENING SESSION.

Dr. Macdonald took the chair shortly after 8 o'clock. The minutes were read and passed, after which

The Council went into Committee of the Whole on the report of the Finance Committee, Dr. Logan being appointed chairman. After some of the items of the report had been amended, it was adopted.

Dr. D. CLARKE remarked in regard to the work done by the examiners that a better and fairer examination never had been made in connection with the profession, and that men were only accepted on their merits.

Dr. LAVELL stated that those who had been rejected from his district were righteously rejected. He felt that the examinations had been fair and honest.

Dr. BETHUNE read the third report of the Registration Committee, which was adopted without the Council going into Committee of the Whole.

THE RECENT MEDICAL EXAMINATION.

The Special Committee, composed of Drs. Allison, Ross, Bethune, Edwards, Henwood, and McLaughlin, to whom was referred the report of the Board of Examiners relative to the trouble with the students at the examinations held recently, presented the following report:—

"The Special Committee appointed to consider the rumours with regard to the conduct of the Examining Board (appointed by the Council) at the late examination, met on Wednesday, the 14th inst., all the members being present.

"After carefully reading the report of the Examiners and making a memorandum of the chief points which required explanation, we then proceeded to take evidence and make all the enquiries we could in regard to the matter as far as we could ascertain from all the evidence. There were several causes to which were attributed those complaints, namely:—

1. That the first cause of dissatisfaction arose among a few students who were rejected. 2. On account of the great number of written papers to be examined and the time that elapsed between the written and oral examinations; the students, having little or nothing to do, naturally became impatient at being kept in suspense; and a few being intoxicated and unruly created a good deal of disturbance, in

which some others joined. Of this we have sufficient written evidence from some of those students who were engaged in fomenting such disturbance. 3. On account of the building lately purchased by the Council not having been in their possession long enough to get it fully prepared for all the purposes for which it was intended, the accommodation was not sufficient for so large a number of students, therefore many of them had to remain on the street or adjourn to the nearest place of public entertainment, which would, perhaps, tend to make them more impatient. 4. As to the conduct of the examiners, all the evidence tends to show that they conducted the examinations in a fair and honourable manner, and there was nothing adduced to lead your Committee to believe that any of the examiners were intoxicated, although at times they were naturally much excited. 5. There is nothing whatever to show that there was the slightest cause of complaint during the time that the written examinations were going on, and the only disturbance that occurred was during the progress of the oral examination. We have also written evidence from several students which proves that all the examinations were conducted in an impartial manner, and that they did not consider there was anything wrong in any of the questions given by the examiners. 6. Our Committee would recommend that at the next annual examination care should be taken to have only a certain number of students admitted at a time for their oral examinations.

"Dr. BETHUNE, Chairman."

The above report was received and unanimously adopted.

After an adjournment to allow of the preparation of the reports, the report of the Education Committee was read, and the Council went into Committee on the Whole to discuss the separate clauses thereof.

On motion of Dr. BETHUNE, seconded by Dr. WM. CLARKE, it was resolved, "That in future students shall be subjected to a primary and final examination, and that the term of study shall be five years." The motion was carried.

It was moved by Dr. McLAUGHLIN, seconded by Dr. LAVELL, "That no change be made in the curriculum for the present year." The motion was lost, eight voting for it and ten against it.

The motion was then referred back to the Education Committee.

FIFTH AND LAST DAY'S PROCEEDINGS.

The business was resumed by Dr. ATKINS moving, and Dr. W. CLARKE

seconding, "That the Finance Committee are hereby instructed to report forthwith the professional assessment for the current year."

The motion was carried.

It was moved by Dr. AIKINS, seconded by Dr. W. CLARKE, "That the Finance Committee are hereby instructed to report on the remuneration of the professional examiners for the ensuing year, and that each examiner on his appointment receive written notice of the same, and that a reply within a month be requested."

The motion was carried.

It was moved by Dr. AIKINS, seconded by Dr. LAVELL, "That the thanks of the Council are hereby given to the matriculation and professional examiners for the great thoroughness of their recent examinations." Also carried.

Moved by Dr. AIKINS, seconded by Dr. LAVELL, "That the Executive Committee is requested to prepare and publish, with all reasonable despatch, a new annual announcement, and send a copy thereof to each registered practitioner in Ontario, and to send also to the same a printed copy of the questions given at the last matriculation and professional examinations, and also a copy of the register."

It was thought by some members of the Council that unless the annual fees were paid by registered practitioners in the Province it would be in the power of the Executive to erase their names from the register, but the opinion strongly sustained in the Council was that that could not be done. And it was decided by an almost unanimous Council that printed documents of the College should be sent to all registered practitioners, and that in cases where fees are refused by these gentlemen, they should be sued for if necessary.

As to the collection of the annual fees, Dr. AIKINS moved, seconded by Dr. LAVELL, "That the Executive Committee are requested to make a thorough collection of all annual fees due by the members of the profession to this Council, making use of such means as may be necessary to effect the very earliest collection of the same." Carried.

The recommendation of the Education Committee to make the examinations preliminary and final, instead of annual, as at present, caused a lengthy discussion; but it was ultimately adopted, with some slight modification as to those who have already passed their primary.

The Finance Report, which was read and adopted, recommended that the assessment be as heretofore, viz., \$1 on each registered practitioner; that examiners be paid \$100 and travelling expenses for their session; also, that the examiners in anatomy receive an additional fee of \$50.

Dr. MACDONALD briefly returned thanks, and the Council adjourned at 2 p.m., to meet again on the call of the President.

Miscellaneous.

Prof. Gubler, of Paris, is dead.

Charles Murchison, M.D., F.R.S., died suddenly from heart disease, on April 23rd.

ENLARGED LYMPHATIC GLANDS.—

R. Iodoform 1 part.
 Collodion 15 parts.
 M. Apply locally.

CANADIANS IN ENGLAND.—G. H. Cowan, M.B., and A. M. Baines have passed the primary examination of the Royal College of Surgeons, England. Chas. M. Sheard, M.B., has passed the final examination of the Royal College of Surgeons, England, for the diploma of membership.

UNIVERSITY OF TORONTO SENATE ELECTIONS.

—Hon. E. Blake was re-elected Chancellor. Prof. Loudon and Drs. Thorburn and J. E. Graham were elected to the Senate by the following vote: Loudon, 362; Thorburn, 248; Graham, 210; Houston, 202; Burns, 106.

IT is affirmed that strong coffee, without sugar or milk, in doses of a teaspoonful every ten minutes, will arrest the vomiting in cases of cholera infantum; and a tablespoonful as often administered to an adult will arrest the vomiting in cholera morbus.

RELIEF OF PAIN FROM THE APPLICATION OF SULPHATE OF COPPER—Dr. Pick, of Vienna, observes that it was by mere accident that he discovered the means of relieving the intense and enduring pain caused by the application of sulphate of copper in diseases of the conjunctiva. As in purulent ophthalmia these applications have sometimes to be made daily, for months, the relief of such suffering is of great importance. The plan consists in sprinkling calomel over the parts to which the sulphate has been applied, four or five minutes after they have been touched. The pain immediately diminishes; and after from three to six days of this procedure, the calomel may be applied immediately after the touching with the caustic, and then the pain instantly disappears.

ANEURISM OF THE RENAL ARTERY.—Dr. L. A. Stimson presented an aneurism of the renal artery. It was removed from the body of a man, of sixty-five years of age, who died of gouty kidneys. When first removed it was about one-half an inch long, and of ovoid shape. It was situated just above the bifurcation. There were also several fusiform dilatations of the branches of the artery. He had not found a recorded case of aneurism of the renal artery. There were no other aneurisms in the body.—*N. Y. Patholog. Soc.*

PRESERVING GRAPES.—Travellers say that the Chinese have a method of preserving grapes so as to have them at command during the entire year by cutting a circular piece out of a ripe pumpkin or gourd, making an aperture large enough to admit the hand. The interior is then completely cleaned out, the ripe grapes are placed inside, and the cover replaced and pressed in firmly. The pumpkins are then kept in a cool place, and the grapes will be found to retain their freshness for a very long time.

A CAUSE OF ANÆMIA.—"As soon as the change is made in the dress, from that of a child, custom demands also that she should be protected by veil and gloves from the rays of the sun, and she soon becomes as blanched as a well-cultivated celery stalk. And since the blood needs the chemical effect of sun-light acting directly on the skin, anæmia is established chiefly from the deprivation. This state of the blood is a potent factor in the generation of all diseases depending on impaired nutrition, and entails conditions likely to baffle all medical effort at their removal during the menstrual life of the female."—*Emmet's Gynecology.*

A FORERUNNER OF DEATH.—Dr. Chiappelli says, in *Lo Sperimentale* (No. 1, 1879) that he has frequently noticed in patients who were apparently very far from death an extraordinary opening of the eyelids, so as to give the eyes the appearance of protruding from the orbits, which was invariably a sign that death would occur within twenty-four hours. In some cases, only one eye is wide open, while

the other remains normal; here death will not follow quite so rapidly, but in about a week or so. It is easy to observe this phenomenon when the eyes are wide open; but when, as is generally the case, the eyes are half shut, and only opened from time to time, it will be found advisable to fix the patient's attention on some point or light so as to make him open his eyes, when the phenomenon will be seen. The author is utterly at a loss to explain this symptom, and ascribes it to some diseased state of the sympathetic nerve.

KOUMYSS FOR CHILDREN.—Koumyss is recommended not only in the intestinal disorders of children, but also in all diseases characterized by defective nutrition, and the following rules should be observed in its administration:—In giving koumyss to children under one year of age, always empty the contents of the bottle into a pitcher, and from that into another, and so continue to pour it back and forth until all, or nearly all, the gas is eliminated—say for about ten minutes. Then take what is necessary for one dose, and pour the remainder back into the bottle, cork, and keep in a temperature between 50° and 60° Fahr. By thus always corking and placing the bottle in a cool place after taking the dose from it, it is possible to keep it for twelve hours. It should never be warmed, sweetened, or diluted, under any circumstances whatever, nor should it ever be given less than two hours after the administration of any other form of milk.—Dr. P. Brynberg Porter, in *N. Y. Med. Journal*, March.

LOCAL APPLICATION OF CHLORAL IN DIPHTHERIA.—Dr. Rokitansky of Innsbruck has used a 50 per cent. solution of chloral hydrate in three cases of diphtheria where the ordinary methods had failed entirely, and was astonished at its striking effect upon the local processes. The solution was applied with a hair pencil every half hour. The pain caused by it was severe in only one case, in which the under surface of the tongue was thickly covered with a diphtheritic deposit. Intense salivation occurred after each application, and in a few minutes the pain ceased entirely. In two cases, in which the diphtheritic layer partially covered both tonsils, the pen-

cilling scarcely produced a sensation of pain. After three applications of the solution, *i.e.* in an hour and a half, large pieces of the membrane were removed with the pencil, without difficulty. The surface thus exposed was reddened; in the deep portions the finest granular formations were visible. In the two other cases the diphtheritic layer was removed after two days; the surface of the wound had granulated. In the first case the entire process had disappeared after four days. As soon as it was remarked that the normal tissue appeared the solution was gradually weakened, until, after eight days all the treatment could be stopped, since the cure was complete.—*Med. Newigh.*, No. 2. 1879.—*Lancet and Clinic.*

MR. BRYANT, at the Meeting of the Medical Society of London, read a paper on "Operative Interference in the Treatment of Inflammation of Bone." The following conclusions were drawn:—That in acute periostitis or endostitis a free incision down to the bone, by relieving tension and giving exit to inflammatory effusion, does nothing but good, and that it should be made as early in the progress of the case as the diagnosis will justify, and, if possible, before pus has formed. The very commonly fatal termination of these cases by blood-poisoning, when left to run their course unchecked, rendered the measure imperative. That in all forms of endostitis or osteo-myelitis of long bones, in which more or less intense and persistent pain is a prominent symptom, the operation of drilling, trephining, or making a free opening into the bone, should be entertained, as any one of these measures tends to check the progress of the disease, and in most cases relieves pain. In flat bones, such as those of the head, and in cases in which the preceding measures seem too severe, the simpler operation of cutting down upon the bone and separating the periosteum from it should be performed. That in all cases of suspected abscess in bone the same operative proceedings should be carried out, the operation of trephining inflamed bone suspected to be the seat of suppuration being generally as successful in relieving pain and effecting a cure as it is well known to be when a local abscess in bone is found to exist.—*London Lancet.*

TURPENTINE IN WHOOPING COUGH.—(*Wiener Allegem. Med. Zeit.*)—Dr. Gerth cured a case of laryngeal catarrh by placing twenty drops of turpentine on a handkerchief, held before the face and causing about forty deep inspirations to be taken. Repeating this thrice daily, the cure was quite rapid. In the same family he found an infant fifteen months old in the convulsive stage of whooping cough, quite exhausted, and vomiting all ingesta. There was at the same time slight bronchial catarrh with slight evening rise of temperature. Gerth decided to experiment here also with turpentine. He directed the mother to hold the moistened cloth as above, before it when awake, and to drop the oil upon its pillow when asleep. The result was most happy. Within the twenty-four hours the frequency and severity of the attacks notably diminished. The child's strength was sustained by stimulants, and improvement was very rapid. Within a year pertussis became epidemic in his vicinity, and he repeatedly tested the drug in this way. He gave it to children of all ages, and in any stage of fever. The initial catarrh, the convulsive, and the final catarrhal stages were all decidedly benefited, the spasmodic attacks being in many cases aborted.—*Chicago Med. and Sur. Jour.*

ELASTIC ADHESIVE PLASTER.—W. P. MORGAN, M.D., writes to the *Boston Med. and Surg. Jour.*: I have been trying to find an elastic covering that, being attached to the skin, would yield to the movements of that membrane and the parts beneath it without causing an unbearable sensation of stiffness or an uncomfortable wrinkling. As there was nothing in our market to suit me, I procured some india-rubber, and giving it a coat of plaster, such as is recommended in Griffiths' Formulary under the name of Boynton's adhesive plaster (lead plaster one pound, rosin six drachms), I found the material I wished. After using it as a simple covering for cases of psoriasis, intertrigo, etc., I extended its use to incised wounds, abscesses, etc., and found it invaluable. Placing one end of a strip of the plaster upon one lip of the wound, and then stretching the rubber, and fastening the other end to the opposite lip of the wound, I had perfect apposition of the severed parts, the elastic rubber acting continually to draw and keep the parts together. When I have been unable to get the sheets of rubber, I have used the broad letter bands (sold by all stationers) by giving them a coat of the plaster.—*New Remedies.*

UNIVERSITY OF TORONTO EXAMINATIONS IN THE FACULTY OF MEDICINE.—*Degree of M.D.*—

Passed, Clarke, C. K.; Langstaff, J. E.; Lett, S. *Degree of M.B.*—Passed, Anderson, J. D.; Armstrong, G. S.; Black, F.; Bowlby, D. A.; Bremner, W. W.; Buchner, D. C.; Burt, F.; Caughlin, J. W.; Chappell, W. F.; Chisholm, T.; Clapp, R. E.; Dryden, J. R.; Duck, W. B.; Geikie, A. J.; Gould, D.; Hamilton, C. J.; Head, J. G.; Hyde, J. G.; Kidd, T. A.; Lehman, W.; Lesslie, J. W.; Mills, R. P.; Mackid, H. G.; McCarrol, J.; McDiarmid, A.; McIlhargey, J. J.; McLean, P.; McKinnon, J. A.; McNamara, G. W.; Nelles, D. A.; Park, T. J.; Prouse, E.; Rowe, G. G.; Sharpe, J. W.; Shaw, F. W.; Spencer, B.; Stevenson, F. C.; Sullivan, E.; Todd, J. A.; Van Norman, H. C. *University Gold Medal.*—Awarded to Burt, F. *University Silver Medal.*

—1. Mills, R. P.; 2. Chappell, W. F. *Starr Gold Medal.*—Burt, F. *Primary Examination.*—Passed, Aikins, W. A.; Beatty, W.; †Beck, G. S.; Bentley, F.; Bentley, L.; †Brownlee, M.; Burt, J. C.; Cattermole, J. F.; Chafee, C. W.; Clemens, G. H.; Clemens, L. B.; Cotton, R.; Ellis, J.; †Gilpin, W. C.; †Gunn, W.; †Haken, G. W.; Hamill, W. E.; Howitt, F. W.; †Hunter, J. A.; Jones, A. C.; Lundy, F. B.; Machell, A. G.; *May, P.; Meikle, Hamilton; Milese, G. L.; †Munro, L. J.; †McCracken, C. L.; †McKechnie, N. J.; McNaughton, J. A.; †McPhatter, N.; †McTavish, D. A.; Shaw, J. E.; Shaw, J. M.; Smith, H. W.; Soper, A.; Sweetman, L. M.; Thompson, G. B.; Tracey, W. J.; Vandervoot, E. D.; †Walsh, G. J.; †Watt, H.; Wotherpoon, W. L. *First Professional Examination.*—Passed, §Bell, J. F.; Cleland, G. S.; Duncan, J. T.; Eastwood, W. F.; Ferguson, A. H.; Ferrier, James; §Fisher, R. M.; §Hanbridge, W.; ||Jackson, H. P.; Johnson, W. H.; Kent, F. D.; Knill, E. D.; Lafferty, J.; ¶Mennie, J. G.; Milroy, T. M.; **Montgomery, D. W.; McMahon, T. E.; Oliphant, W. H.; Panton, A. C.; Rogers, S. R.; ||Rose, D.; Wallace, R. R.; ||Woolverton, F. E. *Scholarships awarded as follows:*—Third year, Cross, W. J.; second year, Duncan, J. H.; first year, Wallace, R. R.

* To take Physiology over.

† To take Materia Medica over.

‡ To take Botany over.

§ To take anatomy over.

|| To take zoology over.

¶ To take chemistry and natural philosophy over.

** To take botany over.

TORONTO MEDICAL SOCIETY.—At the annual meeting, held May 1st, the following officers were elected:—President, Dr. J. Worman (re-elected); First Vice-President, Dr. Winstanley; Second Vice-President, Dr. Raddell; Recording Secretary, Dr. A. H. Wright; Corresponding Secretary, Dr. R. B. Nevill; Treasurer, Dr. Geo. Wright. Council, in addition to the above-mentioned, who are members ex-officio: Drs. Oldright, McFarlane, and C. Ernton. The President read his annual address. Dr. Oldright exhibited a specimen dropsy of the amnion, containing a foetus about half an inch long and an umbilical cord five or six inches in length. Dr. Zimmerman showed a heart weighing seventeen ounces, with an unusual dilatation of the commencement of the right coronary artery, and endocarditis affecting the aortic and right mitral valves.

APPOINTMENTS.

Dr. E. W. Jenks, of Detroit, has been appointed to the chair of Medical and Surgical Diseases of Women and Clinical Gynaecology. John Nelson Byers, of the Village of Lloydtown, Esquire, M.D., to be an Associate Coroner in and for the Counties of York and Simcoe.

Births, Marriages, and Deaths

BIRTHS.

At Kingston, on April 23rd, the wife of Dr. R. Fenwick of a son.

In London, on April 24th, the wife of Dr. C. Moore of a son.

At Toronto, on May 14th, the wife of Dr. May, of a daughter.

On May 10th, at Montreal, the wife of Dr. Land, of a daughter.

MARRIAGES.

On May 2nd, Harry S., son of Dr. James A. of Toronto, to Julia, daughter of Mr. Henry Fox.

At Ottawa, on the 8th of May, Hon. R. W. Carroll, M.D., of Victoria, B. C., to Mrs. E. Gordon, of Goderich, Ont.

At Holley, N. Y., on April 30th, A. Alt, M.D. of Toronto, to Helena, second daughter of the T. W. Houghbating, of Albion, N. Y.

DEATHS.

At Lynedoch, April 23rd, W. C. Hagerman.

At Toronto, April 24th, Marian Augusta, second daughter of J. T. Small, M.D.

At Bobcaygeon, on April 16th, Mary Eliza Phillips, wife of W. McCamus, M.D., aged 39.

At Florence, Ont., on May 8th, Hannah, beloved wife of Dr. G. A. Sivewright.