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Original Communications.

THE PULMONITIS OF PARALYTICS AND DEGENERATION OF THE VAGI NERVES.

By DR. BIANCHI,

Director of the Psychiatric Clinique of the University of Palermo.

Translated and Abstracted by Dr. Joseph Workman, Toronto.

We are indebted to the illustrious author for a copy of the above very interesting brochure, containing 42 pages, and illustrated by three beautifully executed plates. Dr. Bianchi is well known as one of the most assiduous cultivators of experimental physiology and general pathology of the present day. It would be no unpleasing labor to turn into English the whole of his present valuable contributions to the rational practical study of the influence of nerve degeneracy in the etiology of a disease, which, up to the present, has continued to be a *quasi opprobrium medicince*. We allude to that now too widely extending malady, known to alienistic physicians under the designation of *general paralysis*, or, more appropriately, *general paresis of the insane*. Italian psychiatrists name it *progressive paralysis*, which is an improvement on the misleading English title, yet not unobjectionable, for, as Dr. Christian has contended, actual *paralysis* has never been observed in its course, before the final supervention of lethal prostration, or absolute coma.

In prosecuting his study, Dr. Bianchi experimented pretty freely on rabbits and dogs, and he availed himself of the instructive clinical and pathological materials furnished by the Palermo

Asylum for the Insane. It is not our present purpose to reproduce the details of these experiments and observances, but to submit to the reader the conclusions deduced by the author from the facts stated in the preceding portion of his article. Without further preface, we now proceed to the abstract—

“ Though it is evident that the pulmonites of paralytics (paretics) is the prototype of the so-called vagal pulmonites, and that a genetic relation exists between the degeneration of the vagus and the development of the pulmonitis, yet is the mechanism by which this pulmonitis is developed after lesions of the nervous system very obscure.

As we have before observed, an interpretation based on the vasomotor doctrine, even admitting that the vagus may contain vasomotor fibres for the lungs, is not admissible.

On the other side, we have experimentally demonstrated that section of only one vagus, both in rabbits and dogs, produces only transient phenomena, which are discoverable only in the respiratory rhythm, by means of pneumographic tracings; and if this disturbance of rhythm occurs instantly on cutting the vagus, and is therefore announced in a very short time, and is fleeting, why should it be ascribed to vasomotor congestion, which is usually of much slower determination?

If again we reflect that the disturbance in the respiratory mechanism disappears, vanishing almost as rapidly as it appeared, which is not usual in the behaviour of vasal neuro-paralysis, and when no fresh stimulus interferes and acts, as in our case, we should be led to exclude the hypothesis that vasomotor paralysis, *per se*, is the cause of all that follows in the lungs after section of the vagus, and this, we hold, even taking into account the possible anastomoses of the two vagi, by which means the interrupted vasomotor innervation on one side would be compensated by the vagus of the other side.

That the entrance of foreign substances into the air passages is, *per se*, equally inadequate to explain to us the reason of the phenomena which are developed in the respiratory apparatus, either when the vagus degenerates, or when it is experimentally cut, we assume from other facts now submitted.

(a) In the first place, the grave disturbances of the respiration, after cutting the vagi in the neck, appear relatively too soon to be ascribed to the foreign substances, which, because of paralysis of the larynx and œsophagus, may enter into the air passages. After some seconds, or, at most, after a few minutes, that intense characteristic dyspnoea sets in, which accompanies the life of the animal operated on up to the last breath.

(b) The very same phenomena are provoked, and in the same succession, when, by means of ligaturing the trachea, and introducing a tube for the animal to breath through, alimentary substances and the buccal fluid are prevented entering the air passages, and the only difference between the rabbits spared from tracheotomy and those on which it is practised, is that the latter live longer, yet present the same morbid form, and no less grave anatomical alterations in the lungs. On this fact and the next one, we cannot at all agree with the assertions of Traube.

(c) The injection of one or two syringefulls of buccal liquid and fragments of food received by a rabbit having the vagi cut, does not usually provoke anything analogous in rabbits which have the vagi intact, and even less hurtful is the sole presence of a tube, when no obstruction in it is present.

The doctrine of Traube, which has been so vigorously defended by Frey,—that is, that the broncho-pulmonitis is provoked only by foreign substances (the buccal liquids and bits of food), entering into the air passages, in consequence of the conjunct paralysis of the larynx and œsophagus, does not withstand the evidence of the facts. We, in truth, hold that the entrance of foreign substances into the bronchi may be one of the factors which may co-operate in determining the pulmonary lesions mentioned; we would indeed say that it is the most efficient factor in determining a process which finds, in the altered physio-anatomical conditions of the pulmonary parenchyma, the most favourable conditions for its development.

We do not lean towards the doctrine of Fovelin, who ascribes to the altered chemistry of the respiration the chief importance, because he found the quantity of carbonic acid, emitted after section of the vagi, increased. In many other circumstances,

even in man, the carbonic acid expired is augmented without those pulmonary lesions, found by us in paralytics, having been presented.

There is yet the mechanical theory, which has been maintained principally by Bernard and Boddaert. It furnishes a plausible, though a venturesome interpretation of the facts. Bernard holds that the respiration increases in intensity, because whilst a normal rabbit inspires 20 c.c. of air, after cutting the vagi, it emits 32 cc. of it, so that the pulmonary vesicles become distended beyond measure, and from this there results that traumatic emphysema, which is one of the most constant of the anatomical findings in animals subjected to these experiments, together with blood engorgement and finally rupture of the vessels and infiltration of blood in the air channels.

Boddaert, in his very interesting work, holds that by section of the vagi, not only is the sensibility of the air passages abolished down to the pulmonary vesicles, but also, and principally, the contractility of the bronchi, and hence the air is not all expired, and the respiration is diminished and aggravated by the consecutive repletion of the blood vessels, and by ecchymoses, hemoptysis, oedema, emphysema and atelectasis. On the other hand, because of the increased activity of the heart, increased blood pressure takes place in the pulmonary system, and in consequence, hemorrhage and serous exudation in the pulmonary alveoli. The atelectasis would in part result from the emphysema, and in part from the obstruction of the bronchi by serum, mucus, &c. True inflammatory processes, according to this author, are not verified; he thus seconds the theory of Traube, which ascribes the morbid conditions to the entrance of particles of food and the buccal fluids into the air passages.

This is, within certain limits, true. The mechanism of respiration is notably changed by section of the vagi; but whilst in rabbits the thoracic expansion becomes more extended than in normal conditions, and there is, therefore, as Bernard states, a more active exchange of gas, so that the the alveoli remain distended; in dogs, on the contrary, the respiratory movements are slow, and they are deep only under the influence of emotions

and strong muscular action; the pauses are very long; it is therefore more logical to admit collapse of the alveolar walls. In man with degenerate vagi the respiration is reduced to a minimum, apart from its disorder and arhythm, and these last characters much resemble the respiration of rabbits having the vagi cut.

Now it is very difficult to see how, with a mechanism so different that the exchange of gas may be exaggerated or diminished, pulmonary inflammatory processes may be developed similar in man to those in rabbits and dogs.

That the vagus influences the mechanism of respiration, the rhythm, the proportional duration of the inspiration and expiration, and the pause, cannot be doubted when we look at the tracings taken on both man and other animals; but here we slide from the simple disturbance of the respiratory mechanism to an inflammatory process in the lung.

Nor does the pulmonary congestion, concomitant with the altered mechanism, fill up the great lacuna. If we should confine ourselves to the discussion of this disturbance only, we might find ourselves again facing the difficulties of the interpretation of the pulmonitis in the rabbits on which the canula was applied, with results contrary to the theory of Traube, and the pulmonitis in dogs which did not present laryngeal œsophageal paralysis.

Much value has been accorded to laryngeal paralysis, and we have observed it in rabbits and some paralytics; but in dogs and some other paralytics we could not admit it. Yet the pulmonary processes in dogs with the vagi cut are similar, as well as in paralytics (? *paretics*) without distinction. In dogs the cutting of the vagi below the recurrent does not produce laryngeal paralysis, but it produces the special form of pulmonitis. We have observed many paralytics who did not present any disturbance of deglutition, nor any change in the timbre of the voice; rather, indeed, were they often, up to a few days before death, loud scolders; but the pulmonary lesions in these did not present the same characters as they did in others who had been mute in the last weeks of their existence, or had presented some slight

changes of voice. On the other hand, it is known that section of the recurrenents in dogs (Arnsperger), just as paralysis of the laryngeal muscles in man, from whatever cause, does not give place to pulmonary diseases. Laryngeal paralysis, like the entrance of buccal fluids and fragments of food, is, *per se*, inadequate to the explanation of the facts observed by Nasse and Bernard; the former having ascertained that the lung of the side on which the vagus had been cut had been more diseased than the other, the vagus of which was cut some time afterwards; the latter found pulmonary disease only on the side on which the vagus had been cut. A remarkable contribution to this subject has been presented in the experiments of Genzmer, who observed no pulmonary lesions in rabbits on which he cut one vagus only.

Recently a parasitic doctrine has entered the field. Schow, in three out of seven cases of pulmonitis in rabbits with both the vagi cut, succeeded in discovering an elliptic coccus of medium size, which was not colored by the method of Gram. This coccus he regards as pathogenetic of vagal pulmonitis. When directly injected across the thoracic cavity, or through the trachea, into the lungs, in the form of a culture, it developed a typical vagal pulmonitis. But this coccus was found in only 1 out of 25 animals, the buccal liquid of which was examined; it could not from the mouth pass into the air passages of the rabbits on which the trachea had been cut and a canula inserted to continue their respiration; it could not be the cause of pulmonitis in dogs in which the cutting of the vagus did not produce paralysis either of the larynx or the œsophagus. It might, at the most, be found in the air inspired through the larynx or the canula; but then, even admitting its specificity, this would not explain why, after cutting the vagi, that is to say, after preparing a soil suited to its development and its pathogenetic action, or, in other words, creating pathological, structural and functional conditions, without which, at least in dog and man, it proves ineffective.

The fact that the form of pulmonitis spoken of is frequently associated with degeneration of the vagus, inclines us to regard it, as does Vulpian, as a trophic disturbance, arising directly or indirectly from the degeneration of the pneumogastric.

We do not desire to present here a sample of the old debated doctrine on the trophic nerves; but science now possesses a not despicable number of facts which demonstrate that the innervation of an organ presides over its nutrition, and guarantees resistance against disorganizing agents. The most acceptable form in which the question of trophism may be presented by anyone like ourselves in this case, is that which avoids going to the bottom of the question. We should now be engaging in a fruitless work did we affirm either the one or the other of the conceptions by which it has been sustained or upset, but never settled. It may be affirmed, on the basis of a large case history and experimental proofs, that the inflammation or the irritation of a nerve, or of certain centres, is followed by more or less notable trophic changes in the organs innervated by them. Thus zoster (herpes) in intercostal neuralgia; decubitus (bed-sore) in the neurites; lesions of the cornea from alterations and sections of the trigeminus; atrophies in different affections of the central nervous system; cutaneous affections in tabes; fatty degeneration of the testicle from section of the spermatic nerve, &c., &c.

On the other part, we have records of the existence of pulmonary affections from lesions of the central nervous system; the facts were well known long ago by Cruveilhier, and they have since been well studied by Ollivier, Navarre, Durand Fardel and Fabre.

Cases of pulmonitis from compression of the vagus nerve are known. Thus, *e. g.*, a case of aneurism of the aorta recorded by Gull; the patient died of pulmonary gangrene with multiple foci; the aneurismal sac compressed the vagus. Three cases have been recorded by Dessenos, observed in patients with cancer of the œsophagus, which pressed the pneumogastric. Two others are recorded by Eichhorst.

We admit, with Arnozam, that Fabre has gone too far in forming a class of nervous pulmonitis, and that Fernet has erred in believing that frank, acute fibrinous pulmonitis is attributable to hyperæmia of the pneumogastric, merely because he succeeded in demonstrating its existence in three cases. We are unable to attach any very great importance to the coincidence



of the pneumotic forms, studied by us in the insane, with degeneration, more or less advanced, of the pneumogastrics.

As a slight compression, from which the tissues in their normal conditions feel nothing, produces a bed-sore rapidly or slowly, when a neuritis, or an inflammatory process exists in the spinal centres, so also does a degenerative neuritis of the vagus changes the conditions of nutrition in the pulmonary parenchyma, and in these altered conditions stimuli, which previously were harmless, may become pathogenic, reaching the lungs through the larynx, the mouth, or the tracheal tube in the air inspired.

Hyperæmia, if it is present, the disturbed respiratory mechanism, increased endoalveolar tension, paralysis of the muscular fibres of the bronchi, insensibility of the mucosa of the deep respiratory passages, are but concomitants, so many factors, concurring to disturb the process of nutrition, which is so intimately connected with the function of all the anatomical elements that constitute an organ so complex as the lung; but the inflammatory process with ready exit into necrobiosis, may spring from those stimuli—the buccal detritus or the coccus of Schow—which, in normal conditions, are ineffective. Even gangrene, which is so common a finding in the pulmonitis of paralytics, and in rabbits, simply indicates the frail vitality of the pulmonary tissues; perhaps, too, preceding lesions in the vessel walls have contributed in determining the facile and prompt death of the tissue, however trivially more intense may have been the stimulus which it has been unable to resist.

## SULPHONAL.\*

BY JAMES STEWART, M.D.,

Professor of Pharmacology and Therapeutics, McGill University.

This paper† is based on observations made in 52 different cases, where sulphonal was administered to induce sleep. In nearly every case, before administering the drug, the precaution was taken to confirm the statements of the patient that there was actual insomnia. Such a precaution is especially necessary in hospital patients and those suffering from neurasthenia in its varied forms.

Where the drug induced a sleep of from seven to ten hours duration, the effect is described as a marked action. A three to five hours sleep is referred to as a moderate action, while a sleep of less duration than two hours is classed under the heading of negative results.

Out of the total of 52 cases, the drug had a marked action in 39 cases—*i.e.*, in 75 per cent.,—a moderate action in 13 per cent. and a negative action in 11 per cent. of the cases.

In a large proportion it was administered on several different occasions with the almost invariable result that, if it induced sleep on its first administration, the same result followed subsequent doses.

The cause of its partial or entire failure in 26 per cent. is clear when we consider the cause of the sleeplessness.

The seven partial failures were in the following series of cases:—

1. In chronic interstitial nephritis with dyspnoea, and restlessness in an alcoholic subject.

2. In chronic interstitial nephritis with dyspnoea due to lead poisoning.

3. In acute parenchymatous nephritis with Cheyne-Stokes respiration.

4. In mitral incompetence with great dyspnoea.

5. In typhoid fever with peritonitis.

6. In chronic myelitis with distressing girdle feeling.

\* Read at the Banff meeting of the Canadian Medical Association.

† The writer is greatly indebted to Drs. England, Brown and Low for the report of the cases on which this paper is founded.

7. In subacute rheumatism where pain was moderately severe.

The complete failures occurred in :—

1. Aortic aneurism where pain was a continuous symptom.
  2. Lead poisoning where abdominal pain was severe.
  3. In acute pneumonic phthisis with great dyspnœa.
  4. Acute parenchymatous nephritis with dyspnœa.
- 5-6. Were in two of Dr. Gardner's cases (gynæcological), where pain was complained of.

The cause of the sleeplessness in seven of the above thirteen cases was pain of varying degrees of intensity. Where the pain was moderate the sulphonal had a slight action, but where it was severe the result was practically negative.

In the remaining six cases dyspnœa was the active factor in preventing sleep, and over which sulphonal was powerless.

In a case of aortic aneurism with great distress, the continuous use of morphine in doses of  $\frac{1}{3}$  of a gr. two or three times during the day, and a xxx. gr. dose of sulphonal at night gave greater relief than much larger doses of morphia alone. This and the experience in many other cases show that sulphonal is not entirely destitute of analgesic powers.

The following case is a good illustration of the powerful hypnotic action of this drug, and also of its analgesic effects.

A highly neurotic subject was admitted to the Montreal General Hospital, complaining of pain in the abdomen, diarrhœa, headache and sleeplessness. These symptoms had been troublesome at intervals for years.

On July 14th he received 20 gr. of sulphonal, and fell asleep in an hour, which lasted till morning. He says it is the best sleep he has had since giving up morphia, three years ago. On the following night, no sulphonal—very little sleep. Next night, sulphonal gr. xx.—excellent sleep. Next night, no sulphonal—no sleep. The following night, sulphonal gr. xx.—within one hour he was asleep, and slept thoroughly well till the morning. The following night he had no sulphonal—no sleep. The next night 20 gr. of sulphonal was followed by a good night's sleep.

The following night he had sulphonal, gr. xxx., at 8.30 p.m. He kept awake as long as possible to notice the effects of the drug. He first experienced a general pricking sensation, soon his eyelids became heavy, and, in spite of all efforts to keep awake, he fell into profound slumber an hour after he had taken his dose. He volunteers the statement that he feels no disagreeable after effects from sulphonal, as with morphine, cocaine and caffeine, all of which he has used largely.

On the following night he complained severely of headache, for which antipyrine was prescribed with little benefit, 30 gr. of sulphonal apparently having more effect than 15 of antipyrine.

This patient was an unusually intelligent man for an hospital patient. He thoroughly entered into the spirit of the investigations, and being an old morphine, chloral, cocaine and caffeine eater, his observations were of considerable value and interest.

In the cases where sulphonal acted in inducing from seven to ten hours sleep, are included a great variety of both acute and chronic diseases. The essential disturbing element in the majority was a condition of restlessness, due usually to pyrexia, cardiac insufficiency or that general condition of erethism of the nervous system included under the term neurasthenia. It is in the latter class of cases that sulphonal acts with the greatest certainty. I question very much whether we have any drug to compare with it in these troublesome conditions. It is not the purpose in this paper to discuss to what extent hypnotics are useful or advisable in neurasthenic conditions.

*Untoward Effects.*—In estimating the value of any drug, the first and most important question to consider is, What are its untoward effects? Unfortunately many of our most highly prized hypnotics act at times so that any good effect that may be produced is more than counterbalanced by the subsequent evils.

How much more valuable opium would be were it not for the disagreeable symptoms that follow its use?

As regards the use of hypnotics in certain diseases we require to be especially guarded. Many a beginning neurasthenic has been converted into a hopeless incurable by the injudicious administration of hypnotics, especially opium.

So far as I have been able to make out from the use of sulphonal, there is no danger whatever in the acquirement of a habit. On the contrary, all to whom it was administered for any length of time were only too glad to give up its use, and felt no desire whatever to continue it after the cause for which it was employed had passed away.

This negative action on the higher centres I believe to be one of the most important advantages possessed by sulphonal over the more commonly employed members of this group of agents.

When sulphonal is given in doses of about 40 grains and upwards, there is occasionally a peculiar effect on the locomotion. It induces ataxia and giddiness. In the cases reported there is an account of these symptoms being present in three instances :

1. A woman received at 8 p.m. 30 grains of sulphonal. An hour afterwards she complained of nausea, but quickly fell into a deep slumber, which lasted ten hours. The following day she complained of giddiness and was so ataxic that she was unable to walk without support.

In another case, female, 20 gr. of sulphonal were administered in the evening. Was restless up to 1.20 o'clock, when she had a troubled sleep lasting two hours. On awakening she complained of nausea and dizziness, had sensations as if her bed was tumbling over her. She had to hold the sides of the bed to prevent her from falling out. When she closed her eyes, she had sensations of objects passing before them. These symptoms continued in a lesser degree during the two following days.

The night following the complete disappearance of these symptoms, another dose of gr. xx was administered with the effect of a good sleep and no untoward symptoms whatever.

The third case, also a female, received 20 gr. of sulphonal at 8 p.m. In three hours she awoke with a feeling as if her head would burst, complained of great nausea, dizziness, and felt as if she was falling through the bed. These symptoms continued for eighteen hours, and were followed by a deep dreamless sleep. A subsequent dose produced a deep sleep and no untoward effects.

The fourth case was in a male, of a highly neurotic temperament, suffering from neurasthenia from over-study. 25 gr. of sulphonal induced giddiness and ataxia almost invariably. In one case of ataxia there was also loss of the knee-jerk. It quickly re-appeared after the complete elimination of the drug.

Dr. Roddick had in his practice a case of very profound ataxia, following the administration of a 40 gr. dose of sulphonal.

It is an important point to decide, how is the sulphonal ataxia induced? Is it a cerebral or spinal ataxia? Judging from the loss of the knee jerk in the case referred to, it is probable that it is of spinal origin, and if so, we are brought face to face with an important problem—Is it possible for a permanent spinal degeneration to be caused by the long continued use of sulphonal.

We know that other hypnotics do, when long employed, induce changes—molecular and probably gross in the higher centres—and it is not at all unreasonable to believe that permanent organic change may be induced in one or other of the spinal systemic tracts. At present I am conducting a series of experimental investigations, with the object of endeavoring to prove whether it is possible for sulphonal to bring about changes of a sub-acute or chronic degenerative character in any of the spinal systems. At present it is well to be cautious in giving sulphonal for a long period, especially to patients who are apt to become ataxic from it.

*Action of Sulphonal on the Circulation.*—In not a single instance was there noticed any depressant action on the heart, even when given in the largest doses, and continuously for several nights. It is very well adapted therefore in the delirium of broken-down drunkards, a state where chloral is a dangerous remedy, owing to its powerful cardiac depressant action. Chloral not only acts directly on the heart muscle as a depressant, but it lowers the blood pressure also. A few cases have been reported where a depressant action on the heart has been observed to follow the use of sulphonal.

*Action on the Stomach.*—In only six cases was there any nausea or vomiting attendant on the administration of sulphonal.

and in all these cases it was late in making its appearance and was attended by giddiness. This points to the probability that sulphonal does not act directly on the stomach in causing nausea and vomiting, but indirectly through its action on the nerve centres.

There is no record in any instance of an untoward action on the skin in the cases reported.

*The Dose and Mode of Administration.*—The adult dose of sulphonal varies from fifteen to fifty grains. Thirty grains may be considered an average dose, and in a first administration should not be exceeded.

Doses of fifty grains and upwards are apt to be followed by ataxic symptoms.

As the drug is not soluble in water at the ordinary temperature, it is best administered in a warm fluid, as beef tea or gruel. It is practically free from odor and taste.

As the salivary glands take part in its elimination, it is not uncommon to find patients complain of a peculiar, but not disagreeable taste 12 to 24 hours after its administration.

## TWO INTERESTING QUESTIONS IN GYNÆCIC SURGERY, ILLUSTRATED BY CASES.

By T. JOHNSON-ALLOWAY, M.D.,  
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*First—The Relation of Schröder's Hystero-trachelorrhaphy to future Parturition.*

*Second—The failure of Electrolysis, faithfully carried out for one and a half years, to influence a hard, slowly-growing Myofibroma Uteri. Removal of Appendages by Laparotomy, immediately followed by premature menopause and return to health.*

Two years ago I read a short paper at the Ottawa meeting of the Canadian Medical Association on "*The Comparative Merits of Schröder's and Emmet's Hystero-trachelorrhaphy.*" In this paper I embodied the results and experience obtained from fifteen hospital and twenty-two private cases. During the discussion which followed the reading of this paper, the question was asked,

“What effect would the operation have upon future pregnancy and parturition?” This question I could not satisfactorily answer from personal experience up to that time. I have since been informed by the attending physician of a few of the cases I had operated on, that they had confined their patients without any unusual complication. But I was anxious to have personal experience of this nature with a few of these cases. The opportunity presented itself to me some months ago. I was thus enabled to make some valuable observations during the progress of labor.

The first case of which I will speak had borne three children within the space of six years. She had been in very poor health for some time past, and was a subject of all the reflex neuroses which accompany a badly lacerated cervix complicated with chronic metritis and profuse purulent uterine leucorrhœa. A few months after the operation she regained her health and became again pregnant. She was carefully watched during the pregnancy, as she had suffered two miscarriages before the operation. It was interesting to observe the effects of the operation in this direction, whether it would have a tendency to favor the occurrence of the accident or otherwise. In this case no pregnancy ever progressed to the end more favorably. The observations made during the progress of labor were indeed interesting. Labor had just begun when I made the first examination. The pains were extremely light, and it seemed to me as if several hours might elapse before attendance would be required. On introducing my finger into the vagina I was surprised to find the bag of membranes distended to complete fullness occupying the vagina, and nothing else to be felt. There was no evidence of the usual resisting ring through which the membranes protrude; nothing, in fact, could be felt but this boundless bag of water containing, high up, the head. I ruptured the membranes, and before I could remove my coat the foetus was expelled. The placenta presently followed, but the uterus remained a little soft. External manipulation was kept up for some time, still there seemed to be a want of reflex irritability about the organ. I introduced my hand into the cavity, but found no



clots to speak of. The uterus soon afterwards recovered its tonic contractility and remained hard and small. During the time my right hand was in the cavity of the uterus I could distinctly feel what appeared to be the narrow, thin edge of Bandl's ring. The convalescence of this patient was most satisfactory. The cervical opening had the same appearance as directly before impregnation, and involution of the pelvic organs have been very perfect.

The second case of this nature occurred in a lady who had borne eight children, but who had not been pregnant during the past eight years. She suffered from incomplete uterine prolapse and general failure of health. One year after I had repaired the cervical and perineal lacerations she became pregnant. Pregnancy followed a very even course; but when labor set in the pains were so violent that chloroform had to be given. On making the vaginal examination the same condition presented as in the first case—*i. e.*, the bag of membranes completely filled the vagina, no cervix being within reach. After the membranes were ruptured the labor soon terminated. There appeared in this case also a slight degree of inertia of the uterus. When, however, the uterus once contracted firmly, it remained so. This patient made a good convalescence, and the uterus involuted well.

In regard to the changed condition of the uterus induced by amputation of the cervix which was especially high in these two cases, and to the course future pregnancies would follow, it has been a matter of some question. Some have suggested that the operation rendered pregnancy less likely to occur afterwards. On this point my experience has pointed to the reverse, and it is that which should be expected. An old hypertrophied, cystic and bulbous stump discharging large quantities of muco-pus has been converted into a hollow-shaped cone with a small opening in the centre, absolutely free from abnormal secretion. There is to me no condition of the parts in question so favorable to impregnation, and in the last case recorded it proved an actual cure for the relative sterility.

Further experience regarding this point, however, will be

required in order to enable me to speak more definitely. The question of the liability to early interruption of pregnancies can be answered, I think, negatively. I have not seen a case where early abortion could be attributed to the operation, and anatomically it would not be indicated.

In regard to the influence of the operation upon full-term labor, it certainly hastens it, renders it a much less painful and tedious process, and does away with all possibility to traumatism of the cervix, and therefore lessens the liability to infective disease. This latter is a most practical point, and in importance cannot be over-estimated. The relation which the cervix uteri bears to the whole female sexual system in the matter of septic infection is well recognized and needs no further comment. I do not mean by this that there has been a developmental error in the process of progressive evolution, but I certainly do mean that I have seen more evidence pointing to the cervix as an object of danger than I have to it being one of usefulness. And should experience prove that this operation will not involve any very serious drawback, I am afraid my convictions in this respect will rather gain than lose strength.

## II.—*Case of Uterine Myoma treated by Electricity, and eventually by Laparotomy.*

This case was referred to me by the late Dr. R. P. Howard in April, 1888. History as follows: Married eight years; never been pregnant. For the past three years she has been losing blood very freely at each menstrual period; duration of flow from ten to twelve days, accompanied with a great deal of pain. Leucorrhœa very profuse. Extreme anæmia and general failure of health.

*Examination.*—Interstitial myoma apparently occupying the right anterior segment of uterus. Uterus mobile and not tender to manipulation. Sound enters 12 cm. and in a straight direction. Auscultation gives a distinct bruit over tumor. The tumor reached to within half an inch below the umbilicus, and could be freely moved in every direction.

After explaining to the patient the different methods of treat-

ment adopted for the relief of her condition, she selected electricity. From May 10th to August 18th, 1888, she received thirty-one applications, chiefly of the positive pole, averaging from 70 to 100 ma. for five to ten minutes each application. During some of these sittings she suffered a good deal of pain, and I had often difficulty in encouraging her to continue the treatment. Towards the end of this course she became much improved in her general health. She seemed to gain color, and the blood condition was certainly much improved. She was stronger, evidenced by her being able to walk longer distances. She returned to her home, and spent August and September at an inland summer resort. In October she began to fall a little back in health, and the hemorrhages became again excessive, also some pelvic pain. She returned to me for treatment on October 11th, and remained until January 9th, 1889, receiving thirty-four applications of positive pole of strength 70 to 100 ma., as in first series. I was under the impression that she suffered more pain during this series, and I had greater difficulty in encouraging her. The monthly hemorrhages lessened and she again became stronger. During the six months of almost constant treatment the tumor never diminished nor changed its character permanently in any way. At times I would think it was smaller, but it would regain its size without any accountable reason.

She again returned home for a short time. In May, 1889, she visited me and received ten applications as before. In October she became discouraged, having received no lasting benefit from the electrical treatment, and asked me to remove the appendages. This was done on the 4th of October. I found some difficulty in reaching the appendages on account of the size of the tumor, but as there were no adhesions this did not matter. This patient returned home on the 9th November. She has, since the operation, passed two periods practically without discharge. Her pains have all disappeared, and she is as much improved in general health as could be expected in the time.

During the electrical treatment of this case I had been most

careful to take a record in detail of the effect of each application, and I am now convinced that my patient suffered more at each seance of over 70 ma. than she did during the whole of the period of convalescence following the operation. It therefore cannot be wondered at, although surgeons are straining every nerve at present to give the votaries of electricity in gynæcology as much rope as possible, that they break out sometimes in condemnation of the method, with what seems a feeling of just indignation.

### NOTE ON PEROXIDE OF HYDROGEN AS A SOLVENT FOR THE MEMBRANE OF DIPHTHERIA.

BY GEORGE W. MAJOR, B.A., M.D., &c.,

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*(Read before the Medico-Chirurgical Society of Montreal.)*

Solution of peroxide of hydrogen, or hydroxyl in aqueous solution, has been used in France as a surgical dressing for ten years.

Its use as a solvent for the membrane of diphtheria is of much more recent origin. In so far as I have been able to ascertain, Dr. Love, of St. Louis, was among the first to call attention to hydroxyl as a valuable agent in the treatment of diphtheria. He employed it in a solution containing from 0.5 to 3 per cent., using most frequently, however, a strength of one per cent., diluting the medical "ten volume" peroxide with two or three times its bulk of water. Of its value in clearing away and effectually deodorizing the decomposing exudate in cases of diphtheria he speaks in the most emphatic terms.

Dr. Glasgow, of St. Louis, informs me that he has used hydroxyl for the past three years, and that it has given him very satisfactory results. He uses it locally as well as constitutionally in nasal, naso-pharyngeal, faucial and laryngeal diphtheria. He says it will do all that is claimed for it.

My individual experience of the remedy extends over a period of two years, and, though not as extensive as I would

wish, still it may prove of sufficient interest to occupy a few minutes.

I have used hydroxyl in aqueous solution (formula  $H_2O_2$ ) in 22 cases of diphtheria in my own private and in consulting practice. The cases were all of more than average severity with decided septic tendency. The nasal chambers were invaded in fourteen. To sum up—

Hydroxyl possesses the following advantages:—It offends neither the sense of taste nor smell—being tasteless and odorless.

When applied locally it causes no irritation and occasions no pain.

When swallowed it is harmless, as it is not poisonous.

It is a powerful antiseptic and deodorizer.

It in no way precludes the simultaneous use of any other local remedy.

It is a perfect solvent for the exudate of diphtheria.

When used locally the membrane seems to corrode and comes away in fragments of a more or less porous character.

I have seen it remove membrane as quickly as it could form. In nasal cases it keeps the nose free from membrane and gives the bichloride or other solution a chance to act. In the most offensive cases it deprives the discharges of their unpleasant odor. In the larynx it occasions a little alarm by the escape of gas as it comes into contact with the membrane, but it does not in any way interfere with respiration. I generally commence its use as a 60 per cent. solution, increasing to the full strength of the so-called "ten volume" peroxide of hydrogen. When used internally the dose is  $\frac{1}{2}$  to 2 drams.

## IODOFORM IN CHRONIC CYSTITIS.

BY C. J. EDGAR, M.D., SHERRBOKE, QUE.

A few weeks since there appeared in some of the medical journals a notice of the treatment of chronic cystitis, by Dr. V. Moestig-Moorhof, of Vienna, with iodoform injections. Having on hand at the time several cases of decidedly chronic cystitis, which did not show satisfactory signs of improvement under ordinary treatment, I decided to treat one-half the cases (3) with the iodoform injections. The bladder was first washed out with moderately hot water, as usual, and then an injection of the following emulsion made:—

Iodoform, ʒx.  
Glycerine, ʒi.  
Tragacanth gum, gr. i.  
Distilled water, ʒii.

Sig. One tablespoonful to a pint of lukewarm water, well stirred, for one injection—*injection made every second day.* The first part of the mixture was injected and held about half a minute, until the iodoform had settled, and was then allowed to come away clear. The latter part was ordered to be retained as long as possible without pain.

The day after the first injection, the patients all agreed in finding micturition, less difficult, less painful, and much less frequent. They had all noticed also that the urine had deposited a yellow sediment—the iodoform. The effect of the second injection was still more marked, and the third injection completed the cure, leaving them perfectly free from any symptoms whatever of their old trouble. The remaining three cases were then put on the same treatment, with the same result, excepting that the two worst cases required five injections before they confessed themselves quite cured. Of these cases three were gonorrhœal, one from cold and two, cause unknown, and had all been under medical treatment for periods ranging from six months to three years. The treatment in these cases was alike for all, independent of their causation, and was followed by a

uniformly good result. In one case treated last week, the iodoform was simply mixed with warm water and injected, but the patient—a male—complained that the gritty powder hurt him in coming away, and was stuck in masses like little calculi. The effect on the disease, however, was identical with those mentioned before. I have not had the opportunity of testing the use of this drug as an injection in other affections of the bladder, but certainly in the cases mentioned, and occurring in both sexes, its action was most satisfactory.

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### MISSED ABORTION.

By GEO. T. ROSS, M.D.,

Professor of Physiology, Bishop's College, Montreal.

Mrs. A. B., *æ*t. 40, the mother of six children, became pregnant with the seventh in September of last year. Her former history was good, having been ill only from diseases incident to child-bearing. She has evidence of a strumous constitution, the irritable mucous membranes showing not only in herself but plainly in her living children. She is of thin, spare habit of body and an active nervous temperament. Several years ago the husband was treated for specific trouble. Before this the mother had miscarried three or four times, the foetus in every case being discharged without unusual features.

The patient's condition was as follows:—Up till the end of the fourth month of this pregnancy no symptom of a remarkable character was presented. The ordinary signs of the patient's state in January last were to her unmistakable. The foetal movements were very distinct during some three weeks, after which they ceased entirely. There seemed no reasonable ground to doubt the nature of the uterine contents from the exact history given regarding all the indications. The mother, an intelligent woman, had experienced the usual phenomena too often to be mistaken in their nature this time, and the well-defined foetal movements, if the history were credited, seemed to place the case beyond a doubt. A short time subsequent to the change noticed by the mother I was consulted regarding it. On

examination I was unable to discover the foetal heart-beat, and found that the breasts, from being enlarged and turgid, according to patient's statement, were soft and flaccid; other indications also pointed to cessation of uterine activity. The general rule being that two weeks after the death of a foetus it is aborted, and finding the patient in good health, with nothing existing to justify interference, I advised waiting for further indications. An interval of several months now elapsed and I was again consulted regarding the non-progress of gestation. It was quite evident now that since last interview no growth had occurred in the uterine contents, the size of the tumor being about the same, if anything it was smaller. Vaginal examination showed the os to be undilated, although somewhat patulous. Uterus was uniformly enlarged, such as would still be not inconsistent with a four months foetal growth. At this time, say seven months after what was believed to be conception, there did not exist a single symptom calling for interference beyond this, that if conception had taken place, and the patient was right regarding the foetal movements, it was certain growth had ceased during the past three months, and consequently a dead foetus existed in utero. I was naturally surprised at not hearing from the patient long before this with evidence of the onset of a miscarriage, but the only symptom at all attributable to her condition was an occasional hardening of the uterus, which was readily noticed, the hard, round tumor being very plainly shown through the thin abdominal walls. No hemorrhages had ever shown themselves at any time. General health continued unimpaired, and still adhering to the expectant treatment, I advised further delay. As long as nothing existed calling for action on my part I felt that, notwithstanding the time that had elapsed, any day might bring evidence of uterine expulsive efforts. The risks attending the artificial emptying of the uterine cavity being greater than what attended the present condition and the expected natural expulsion, I inclined to wait further, warning her that at the first appearance of any unfavorable sign to at once notify me. During the next few months and in my absence from town I heard nothing further from her, but in September



she again called upon me, this being one year after the supposed conception, and eight months after cessation of foetal life. The same general condition of good health existed now, with the difference of slight tenderness on pressure over uterus. I felt that now much longer time had elapsed than I had intended should before interfering, and in consultation with Dr. Gardner I arranged to remove the uterine contents the following day. In the evening I inserted a faggot of four laminaria tents covered with iodoform, retaining them with a tampon of absorbent cotton, and gave a mild opiate. Next day I found the os fairly dilated and proceeded to extract the foetus. The patient declined to take an anæsthetic, and assisted me throughout the operation. Through the membranes I felt the child's feet presenting. On rupturing the membranes, which were so strong and fibrous that a steel hook was required to penetrate them, about half a pint of a chocolate-brown semi-viscid fluid escaped. Using my nose as the instrument of diagnosis, I found no putridity existing, the fluid being odorless. By conjoined manipulation I extracted the foetus all but the head, which the os held firmly. Taking a medium-sized Barnes dilator I passed it through the os alongside the foetal neck; then gradually filling the dilator, uterine contractions set in vigorously and quickly. The head being thus delivered I had now the foetus complete with the umbilical cord intact, still united to the retained placenta. After some difficulty, owing to cessation of uterine contractions, the placenta was extracted, considerable hemorrhage resulting. I now gave an intrauterine sublimate injection, inserted a gr. x iodoform suppository, and ordered vaginal douches every six hours. Pain across abdomen was complained of greatly, but an occasional opiate gave comfort. After seeing patient every other day for a week, without a bad sign, I ceased attending. On the twelfth day I was requested to call, and now for the first time since emptying the uterus I found the patient sick. Temperature  $104^{\circ}$ ; pulse 120; anxious look; coated tongue; loss of appetite; some marked abdominal tenderness and lochia arrested. On examination the os was plugged with whitish, thick tenacious mucus. No bad odor evident. The parts being cleaned I gave

another intrauterine sublimate injection, inserted a suppository, and ordered the latter every six hours. Hot poultices were put on abdomen and antipyrine gr. viii every four hours given. Next morning the temperature was normal and general condition much improved. Substituted quin. sulph. gr. v morning and evening for antipyrine. On the evening of this day the temperature rose again to  $103^{\circ}$ , with pulse 80, but on following day—viz., the third day after onset of fever—the temperature was normal and remained so, with a continuing progressive convalescence.

After being dead eight months in the uterus, I looked for a mummified condition of the foetus, but quite the contrary was the case as far as appearances went. Even the umbilical cord was about the natural size and fairly well preserved, not tearing easily on being dragged upon. The flesh, however, had assumed a brownish color, and was easily torn. The placenta had the appearance of a mass of very firm fat, dull white in color everywhere except the surface of its attachment to the uterine wall, where the circulation apparently had been recently interrupted. The decidual membranes were very thick and tough, and could not be ruptured by the finger-nail.

Matthews Duncan says that missed abortion is a subject lying between obstetrics and gynæcology, but inclines to include it more under diseases of women than obstetrical diseases. A missed abortion is not a threatened abortion, nor is it an imperfect abortion. A threatened abortion is a very common occurrence. When a woman has a threatened abortion she suffers pain, has a bloody discharge, and the mouth of the womb may be found open. An abortion may only get the length of being threatened; that is to say, it may be averted and pregnancy may go on healthily, even when you have been able to feel, through the neck of the womb, the ovum as it hangs in the uterus. Cases have been known of the separation of considerable decidua and its discharge without abortion taking place. Among these cases of threatened abortion may be included cases of extreme rarity, viz., the abortion of one of twins while the other remains in utero and goes on in its development. This abortion of one of twins may be a missed abortion, or the miscarriage of one of

twins may be a missed miscarriage. Again, missed abortion is neither a threatened abortion or miscarriage, nor an imperfect miscarriage. What is a perfect or complete miscarriage? If the foetus alone, or the entire ovum alone, comes away, the woman has miscarried or aborted, as the case may be; but the coming away of the ovum does not involve a complete miscarriage, and an imperfect miscarriage is often a very disastrous thing. The ovum sometimes comes away alone without any of its uterine or maternal membranes. The foetus also may come away alone without even the ovuline membranes. Again, sometimes the ovum comes away and the maternal membranes or decidua imperfectly. Sometimes only a bit of placenta is left. Imperfect miscarriage is a dangerous thing owing to the frequently recurring bleedings that result from it. It not very rarely leads to death from mere putrid intoxication, or septicaemia, or pyaemia, just as happens after full-term delivery. This is especially liable to occur if the miscarriage has come on in consequence of extensive endometritis, such as is found in pregnancies occurring during typhoid fever. Imperfect miscarriage is also often disastrous by inducing endometritis, generally purulent in nature, and this frequently in connection with putrefaction of the parts left behind. In some respects missed miscarriage or missed abortion is even more important than missed labor: for in a case of missed abortion the history of the woman and her size may have led either to no suspicion of pregnancy having commenced, or to suspicion which may have been dissipated by the further history of the case. In a case of missed abortion or missed miscarriage, the important element of suspicion as to the real condition may not have come into the mind either of the patient or her physician. Mistake is then extremely liable to occur. This is not so likely in missed labor; for in that condition the woman's size will almost certainly have made her aware that she is in an advanced state of pregnancy, and her friends will know it also. Missed labor may be a subject of great medico-legal importance; the same is true, and even more so, of missed abortion or missed miscarriage. If, for instance, a woman passed a two months foetus at the end of a five months

so-called pregnancy, and were to tell the husband, who had been away from home during the five months, that his wife had had a two months child, rather unpleasant consequences might ensue. The importance can be appreciated by the practitioner, therefore, of counting a woman's pregnancy not up to the time when the foetus was discharged, but back to the time when it died, if any evidence of death can be adduced.

When a woman has a missed miscarriage or missed abortion the foetus dies, the symptoms of pregnancy are arrested, milk signs appear at the breasts, and hemorrhages may or may not occur. If the liquor amnii is not discharged it is absorbed, and the contents of the uterus either macerate or become mummified. If the membranes remain entire, the process is that of mummification. It is only when germs are admitted, and generally after rupture of the bag of membranes, that putrefaction and maceration take place and the more or less complete dissolution of the ovum. If the uterus has been felt, the remarkable observation may be made that while a woman is apparently going on in pregnancy the organ is becoming smaller instead of bigger, and at last the ovum may be at any time unexpectedly expelled. When expelled, you have a mass nearly dry, of a dirty brown color; the foetus and membranes may be concealed, being rolled up in the placenta, which is too firm to be compressed, and embraces the whole ovum. The remarkable freshness, if it may be so called, of the foetus in the case which I bring to your notice, after remaining eight months in utero, does not correspond to the usual appearance of such cases, as above defined, and is my apology, if any be necessary, for bringing the subject before your attention to-night.

## Retrospect Department.

### QUARTERLY RETROSPECT OF OBSTETRICS.

PREPARED BY J. CHALMERS CAMERON, M.D.,

Professor of Obstetrics, McGill University; Physician-Accoucheur to the Montreal Maternity, &c.

*The Uncontrollable Vomiting of Pregnancy.*—M. Guéniot, Chirurgien en chef de la Maternité de Paris, has recently made a lengthy communication on this subject to the Academy of Medicine (*Archives de Tocologie*). Every year, as the result of prolonged vomiting during pregnancy, a large number of women perish or have their health seriously impaired, while in many cases the life of the foetus is destroyed and abortion produced. The waste of life is serious, yet, notwithstanding the numerous therapeutic and operative measures commonly in use, the treatment of this affection does not seem to be established upon a rational basis or to yield satisfactory results. Guéniot suggests a rational basis and recommends a plan of treatment which he claims to be effectual in most cases of so-called uncontrollable vomiting, saving the life of both mother and child.

The first essential of success is to find out the pathogenic cause of the vomiting; this may usually be referred to

- (1) *Uterus*, which is not only the organ which contains and nourishes the foetus, but is also the source of special excitation of other organs;
- (2) *Nervous system* (spinal and ganglionic), which by means of its reflex powers transmits excitement to distant organs;
- (3) *Stomach*, which suffers excessively from the effect of uterine stimuli, and is the organ chiefly involved in this affection.

Between ordinary benign vomiting and the graver forms, the difference seems to be one of degree rather than of cause. If the ordinary pathogenic causes happen in any case to be reinforced by some pathological state, their action is intensified and vomiting becomes more persistent and severe; if the attacks are very frequent and do not yield to treatment, the patient becomes exhausted and the vomiting uncontrollable. The cause of vomiting can seldom be referred solely to either the uterus, nervous

system, or stomach ; usually all three factors cooperate, but not to an equal extent,—one generally predominates. While the treatment must manifestly therefore be complex, its general character should be determined mainly by the nature of the predominating pathogenic factor ; and success in any given case will depend very largely upon the ability of the practitioner to determine the relative value of the causative factors. In all cases the stomach is weak and irritable, and should be spared as much as possible by administering food and medicine by the rectum or skin, or hypodermically, whenever practicable. A cheerful, hopeful frame of mind should be encouraged ; a gloomy prognosis, despondency, fear and anxiety have a very detrimental effect. Distressing thirst is a common symptom, and unless the patient is under the charge of a responsible attendant who is intelligent, discreet and firm, liquids are apt to be taken in improper quantity or of improper quality. The fundamental indications for treatment are :

1. To allay morbid or abnormal *uterine excitability* by removing the various pathological conditions which produce it. Flexions or displacements interfering with uterine circulation may be relieved by posturing, the Gariel pessary, etc. Tumors must receive appropriate treatment, operative if necessary. Abrasions or ulcerations of the os and cervix must be treated by local applications. Hyperæsthesia of the passages with more or less inflammation yields generally to emollient or narcotic vaginal injections, pomades or vaginal suppositories. Belladonna, cocaine and morphia are the most efficient local sedatives. When the exciting cause of exaggerated uterine reflex is chronic or sub-acute inflammation of the appendages, rest in bed in the horizontal position is essential, with poultices and emollient sedative vaginal applications. If all other measures fail, dilatation of the cervix according to Copeman's method may be tried.

2. To diminish the activity or suppress the exaggeration of reflex excitability. The bromide of potassium or sodium (grs. xv-xxx) with chloral (grs. x-xxv) in warm milk (2-4 oz.) by the rectum usually allay irritability and produce sleep. Chapman's ice-bag applied to the dorso-lumbar region for several days

consecutively sometimes gives relief; ether spray to the same region produces similar effects. Galvanism has been recently much extolled. Mental tranquility must be secured.

3. To overcome the irritability of the digestive apparatus, particularly the stomach. Morbid conditions liable to provoke or increase vomiting must be cured, such as gastritis, hyperacidity of secretions, etc. The diet must be carefully regulated, both as regards quality and quantity of food, and the frequency with which it is to be taken. Milk and light broths are the best foods, given alternately (day about) to prevent disgust, beginning with small doses—a tablespoonful every half hour or hour. Ice and alkaline waters may be sparingly used—five or six small lumps of ice and two or three tablespoonfuls of Vichy in the twenty-four hours will be enough at first. In a few days, as the stomach becomes stronger, the liquid nourishment may be cautiously increased and the ice stopped.

During the first few days of treatment no drink must be allowed other than Vals or Vichy water and ice in the quantities prescribed. Lemonade, wine, alcohol, orange and lemon juice, and all fruits should be absolutely prohibited. Thirst is so urgent, and acid drinks so grateful, that it is difficult to prevent the patient breaking through rules; but strict abstinence from such things is essential to success. The intolerable thirst is relieved by alkaline waters, but aggravated by acids and wines. Frequent gargling with Vichy water generally affords relief more promptly than anything else. Rigid observance of the treatment is essential. Flying blisters to the epigastrium, followed by morphia applications, sometimes have a prompt effect; ether spray to the same region acts in a similar manner. If constipation exists, laxative enemata or suppositories should be used; if diarrhoea occurs, narcotics or astringents may be administered per rectum.

There is no specific treatment or drug; each case must be treated upon its own merits. In the great majority of cases judicious management will carry the patient safely through without serious damage either to herself or her child. The artificial induction of labor is the "*remedy of despair*," rarely to be invoked.

*External Cephalic Version in Breech Cases.*—In France a sharp controversy has been going on respecting the value of external cephalic version as a prophylactic when presentation of the breech is diagnosed during the last month of gestation. Pinard is perhaps the strongest advocate of the operation, and certainly his results in the Lariboisière hospital have been brilliant. His methods have been severely criticised by some of the older members of the Academy of Medicine, and as warmly supported by some of the younger members. Dr. Gaulard of Lille (*Archives de Tocologie*), as the result of his observations, is inclined to take a middle course and circumscribe the field of this operation within somewhat narrow limits. According to Pinard, all pelvic presentations may be divided into *permanent (franches)* and *accidental or temporary*. In the former the breech is always to be found at the superior strait, while in the latter the breech may present at one time and the head or some other part at another. The former is mostly caused by exaggerated volume of the foetal head (hydrocephalus), excessive development of the lower uterine segment, or the accidental premature engagement of the half-breech or feet. The latter is due to globular form of the uterus, hydramnios, or certain conditions of the foetus, such as undue mobility, death, or maceration. Gaulard thinks that version is contraindicated in the permanent variety—that it is then very apt to fail, or, even if successful, the life of the child may be imperilled by undue traction upon the cord (which may be naturally very short or may be coiled around the neck), or by partial separation of the placenta. This controversy is not one of recent date. Hippocrates taught that only head presentations are natural, and that all others should be converted thereto if possible. Ambrose Paré, on the other hand, maintained that presentation of the breech is as natural as that of the vertex, and with care may be conducted to as favorable a termination. The modern controversy is, after all, only a renewal of the old warfare between the pupils of Mauriceau and Levret, who followed Hippocrates, and those of Bandelocque and Boer, who followed Paré. Gaulard thinks that the infantile mortality in breech cases has been placed far too high. Mme. Lachapelle



estimated it at 10 per cent., Hegar at 35-40 per cent., Hecker at 22 per cent., and Pinard at 10-15 per cent. Gaulard considers a high infantile mortality quite unnecessary, and attributes it to anxiety, impatience, or undue interference on the part of the attendant. Premature, precipitate, or violent traction on the trunk, the undue use of ergot, etc., are often responsible for still-birth, whereas when the case is left to nature the child rarely perishes. He urges strongly the claims of a cautious, expectant treatment.

*Curetting in Puerperal Septicæmia.*—The treatment of puerperal septicæmia does not yet seem to be settled down to anything like uniformity. Most authorities approve of local treatment, but differ widely as to what constitutes a safe and at the same time efficient local treatment. Some content themselves with simple vaginal injections, and rely mostly upon supporting constitutional treatment and the elimination of waste products by means of skin and kidneys. Others employ uterine douches, plain or medicated, at more or less frequent intervals; while others prefer a prompt and radical treatment, scraping or brushing away from the internal surface of the uterus any shreds, clots, etc., which may prove a nidus for infection. Against this radical treatment it has been urged that brushing or curetting serve to intensify the risk of infection by denuding large portions of uterine surface, through which absorption of septic matters readily takes place. In reply, it is claimed that there need be very little risk of re-infection after curetting if a strict antiseptic treatment is maintained for some days after the operation. *Dr. Chartier* of Paris (*Nouvelles Archives d'Obstetrique et de Gynécologie*) has published the records of twenty-six cases of curetting gathered from various sources, and summarises his conclusions as follows:—

1. Curetting the uterus is an easy and harmless operation, yielding excellent results in the treatment of puerperal septicæmia.
2. Anæsthesia is useless and dilatation of the cervix generally unnecessary.
3. Antiseptic precautions must be insisted on for several days

after the operation, otherwise there may be phenomena of re-infection.

4. Curetting is indicated whenever intrauterine injections are insufficient to lower the temperature rapidly, especially if some placental debris remains in utero.

5. Complications involving the uterine appendages or even the peritoneum do not necessarily contraindicate the operation.

*Measles in Pregnancy.*—Dr. Lomer of Hamburg (*Central. f. Gyn.*) reports the following curious case. A healthy young woman, 22 years of age, who had never had measles, began her first pregnancy in the beginning of October, 1887, and expected to be confined about the middle of July, 1888. A severe epidemic of measles broke out in the suburb where she lived, and on June 7th she was seized with chills, cough, hoarseness, smarting of the eyes, and diarrhœa. On the evening of the 8th labor pains began, and during the night she was delivered spontaneously of a living child. In the morning both mother and child were seen to be covered with a distinct measles-rash. On the fifth day the mother developed pneumonia, from which she made a slow recovery. The child died in four weeks from diarrhœa and debility.

Cases of pregnancy complicated with measles are rare, and receive but slight mention in the text-books. *Gantier* (*Annales de Gynécologie*, 1879) mentions eleven cases which he had found in looking up the literature of the subject. Of these eleven cases, six became infected during the last month of pregnancy, and the children were all born with measles rash or developed it shortly after birth. In *Gantier's* case, the child was born without rash, and though nursed by its mother did not subsequently develop it. In the remaining four cases, the course of gestation was interrupted by the attack of measles and abortion produced. In this series of eleven cases two mothers died. In *Lomer's* case labor pains began within thirty hours of the initial rigor, and the child was born five weeks before time. The attack had no ill effect upon the course of the puerperium except such as resulted from the pneumonia, and no special ill effect upon the child except such as was consequent to its premature birth.

*The Umbilical Souffle and Uterine Souffle.*—In Breisky's clinic, Vienna, a series of observations has been made by *Ettlinger* (*Centralblatt f. Gyn.*). He examined the *Umbilical* souffle carefully in twelve cases and came to the conclusion that it is only exceptionally attributable to the foetal heart, being in most cases produced in the cord itself by compression of its vessels from knotting, coiling around the neck or body, or from congenital shortness and consequent over-stretching. The *Uterine* souffle was looked for in 100 consecutive cases. It was present in 88 of them, 63 times on the left side, 12 times on the right, 10 times on both sides, and 3 times all over the abdomen. He attributes its frequent occurrence on the left side to the normal rotation of the pregnant uterus to the right; and it is remarkable that in the 12 cases where the souffle was heard on the right side, the uterus was not in its usual physiological position. It was heard post-partum in 60 cases; post-partum souffle is more frequently heard in multiparæ than primiparæ.

*Plugging with Iodoform Gauze in Post-partum Hemorrhage.* (*Lancet.*)—Dührssen has strongly recommended plugging the uterus with iodoform gauze in post-partum hemorrhage from atony, where ordinary measures have failed. He directs the bladder to be emptied, the uterus vigorously kneaded and rubbed, hot and cold intrauterine irrigation, and hypodermic injections of ergot tried; if these measures fail, he directs a speculum to be introduced and the uterus to be filled with iodoform gauze. Active and permanent contraction is thereby set up. He claims that the operation is not only certain but harmless, and easily performed. Olshausen, Veit and Fehling, however, affirm that it is not always free from danger and that contraction is not always permanent. Dr. Piering, assistant in Prof. Schauta's clinic in Prague, after carefully testing the method, praises it highly. In his hands it has always succeeded, and in no case has it yet done any harm. He thinks that its use should not be delayed too long.

*Glycosuria in the Pregnant, Parturient and Puerperal state.*—In the Basel klinik *J. Ney* has been investigating this subject and has recently published his results (*Archiv f. Gyn.*).

After reviewing the work of previous observers he proposes the following questions :

1. Does sugar appear in the urine only before labor, or afterward also? Does the act of labor influence glycosuria?
2. Does sugar appear only during the puerperium and is its appearance in any way connected with febrile processes?
3. Is the appearance of sugar in the urine, either before or after labor, physiological or pathological?
4. How do the children develop where, in a normal puerperium, sugar is present or absent?

He tabulates his observations on 172 women, 148 confined and 24 pregnant, the results of which may be summarised as follows: In the urine of the 24 pregnant women, sugar was found in 4 (16.6 per cent.) The act of labor of itself does not seem to induce glycosuria. When sugar appears in the urine of pregnant women, the breasts are usually well developed and milk can be squeezed from them. In women recently confined, sugar was found 115 times out of 148 (77.7 per cent.) Glycosuria bears no relation to febrile processes. Glycosuria is a normal physiological process in good nursing mothers, but may also be pathological as the result of milk stasis, since engorgement of the breasts (from cracks, fissures or inflammation) is immediately followed by the appearance of sugar in the urine. When glycosuria is abundant and prolonged, the breast milk is usually sufficient for the nourishment of the child. He concludes that when the breasts are well developed and the puerperium normal, the quantity of sugar in the urine and the length of time it persists are a direct measure of the quality of the milk and the excellence of the nurse. The more abundant the sugar and the longer it persists, the better the nurse. When the patients return to their own homes, resume their household duties, and live on a less generous diet, the glycosuria diminishes or disappears. The kind of sugar present in normal physiological glycosuria is always *sugar of milk*, thereby differing from those pathological conditions where *glucose\** is found in the urine.

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\* See report of case of Glycosuria from *nervous* influences where the form of sugar was *glucose*, MONTREAL MEDICAL JOURNAL, Jan. 1889, p. 481.

*The Alcohol Treatment of Puerperal Fever.*—*Dr. A. Martin* read an important paper before the Berlin Obstetrical and Gynaecological Society, giving his results with this treatment. (*Zeitschrift f. Geburts und Gyn.*, Bd. xvii, Hft. 2.) Since 1876, when Breisky and Conrad introduced the treatment, he had used it 18 times, in 3 of pyæmia and 15 of septicæmia. These were all severe cases with unfavorable prognosis, and had been treated more or less locally and with antipyretics before they were seen by him. Alcohol was administered in the form of brandy, rum, champagne, Burgundy or Bordeaux. Out of 18 cases 13 recovered; some very slowly. Of the 5 deaths, 3 were caused by puerperal infection, 2 by phthisis and pulmonary œdema after the puerperal infection had been overcome. The good effect of the alcohol is not in the reduction of temperature, as Breisky affirmed, but in the stimulation of the heart and increase of general resisting power as pointed out by Runge. He tried baths, as recommended by Runge, in only one case, but they were not well borne. In most of his cases he could not do altogether without local treatment and antipyretics. The alcohol acts as a powerful stimulant in such cases, and even when given in large doses ( $\frac{1}{4}$  to  $\frac{1}{2}$  bottle Cognac,  $\frac{1}{2}$  to 1 bottle champagne, 1 bottle Burgundy per diem, along with milk, eggs and beef-tea), produced no signs of intoxication. It is not a specific, but in these desperate cases can do nothing but good. In the discussion which followed, Gottschalk reported five cases of puerperal fever treated by this method, four of the severest forms of puerperal septicæmia and one of pyæmia, all complicated with general peritonitis. Four recovered. Sixteen to thirty fluid ounces of cognac were administered daily. Cocaine was found useful in allaying vomiting. Signs of alcoholism were observed in one case. From his experience he strongly recommends the treatment. Olshausen has not had the same good results from it in puerperal septicæmia.

*Placenta Prævia.*—At the Leeds meeting of the B. M. Association held in August last, a general discussion on Placenta Prævia was introduced by *Dr. Braxton Hicks* (*British Medical Journal*). He remarked that within the last thirty years the

mortality from placenta prævia has been reduced from 30 per cent. to somewhere near 5 per cent., a result attributable in large measure to the early handling of these cases and the adoption of more rigid antiseptic precautions during and after delivery. He submitted the following propositions :—

1. When the placenta is inserted somewhere within the lower third of the uterus, there is generally a liability to hemorrhage, which may be expected before or upon the supervention of labor, whether premature or at full time.

2. When once hemorrhage has declared itself, there is no security for the patient, but her life is in imminent danger from liability to recurrent bleedings.

3. The relative position of the placenta to the os has no influence on the frequency or quantity of the blood loss. Whether it be marginal insertion or central, the risk is the same.

From these propositions he deduced the following rules of practice :

1. After the diagnosis of placenta prævia is made, pregnancy must be terminated as soon as possible.

2. When once we have begun to act, we are to remain by the patient.

3. If the os is fully dilated and the placenta marginal, we rupture the membranes and wait to see if the head is soon pushed by the pains into the os.

4. If there be any slowness or hesitation in this respect, then we employ forceps or version.

5. If the os be small and the placenta more or less over it, the placenta is to be carefully detached from around the os ; if no further bleeding occur, we may elect to wait an hour or two. Should the os not expand, and if dilating bags are at hand, the os may be dilated. If it appear that the forceps can be admitted easily, they may be used, but if not, version by the combined external and internal method should be employed and the os plugged by the leg or breech of the foetus ; after this is done the case may be left to nature, with gentle assistance, as in footling and breech cases.

6. If the os be small, and if we have neither forceps nor

dilating bags, then combined version should be resorted to, leaving the rest to nature, gently assisted.

7. If during any of the above manœuvres sharp bleeding should come, it is best to turn by the combined method in order to plug by the breech.

8. Where the fœtus is dead, or labor occurs before the end of the seventh month, combined version is the best method, no force following.

9. After-treatment must be conducted on modern principles. Should oozing occur after the expulsion of the placenta, the swabbing of the lower uterus with styptics will be easy. Inasmuch as the outlet of the uterus is liable more especially to be blocked by adherent clots, it will be wise to irrigate the uterus daily with some antiseptic solution, or insert iodoform pessaries in the vagina, particularly if irrigation cannot be done.

## Hospital Reports.

### MONTREAL GENERAL HOSPITAL.

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

*A True Relapse in Typhoid Fever.*—Genuine relapses are not very commonly met with. Murchison puts their frequency at 3 per cent., MacLagan at 13 per cent. The true figure lies between these extremes. John A., one of the cases of typhoid fever sent to us from Lachine, was admitted on the 4th October. The original disease was very severe, very tedious in its course, and it was not until he had been thirty-nine days in hospital that a normal night temperature was registered. The fever was high, the bowels had been somewhat loose, and the eruption was scanty. Convalescence was fairly established when the temperature began slowly and steadily to rise, until in four days it reached  $104^{\circ}$ , where it remained for about nine days with very slight lowering in the morning. At the outset of the relapse there was very severe frontal headache and pain in the right iliac fossa. On the sixth day of the relapse a rash appeared on the chest and abdomen, and remained for about a week. This rash was very profuse, better marked and of a darker color than the

common typhoid rash, and almost was dark enough to classify among the "taches bleuâtres." Convalescence was gradual, but quite satisfactory.

*Cheyne-Stokes Breathing with Hypertrophy and Dilatation of the Heart.*—In the Hospital Reports already published (MONTREAL MEDICAL JOURNAL, Vol. xviii., p. 296), mention is made of the case of a French-Canadian farmer, 60 years of age, who presented the physical signs of a large heart, and whose breathing was of the Cheyne-Stokes character. There was a history of rheumatism in recurring attacks, but no evidence whatever of valvular disease. The apex beat was one inch outside the nipple line, but there was no enlargement to the right of the middle line of the chest clearly made out during life. The heart's action was weak, diffuse and laboured, and the sounds distant. Pulsation was visible but not forcible in the external jugulars. The exact duration of the whole cycle, 1 minute 40 seconds; respirations, 44; period of dyspnoea, 40 seconds; period of apnoea, 40 seconds. No sphygmographic tracings could be obtained. At the end the symptoms seemed to undergo some improvement under treatment (tincture of digitalis, 20 minims, every four hours), but on the 19th day of his stay in hospital he dropped dead in crossing the ward (against orders). There were no evidences whatever of renal disease.

The autopsy, which was made by Dr. Finley, showed that the heart was greatly enlarged, with its left border lying an inch and a half outside the mammary line, and it weighed three and a half times the normal weight; the walls of both ventricles were somewhat thickened and firm, and the cavities were much dilated, the right containing loosely adherent ante-mortem clots; the tricuspid orifice was dilated to almost double its natural size, whilst the mitral was normal; the aortic valves, though slightly atheromatous, were perfectly competent, and the coronary arteries were healthy: the lungs were somewhat œdematous, but there was no pleurisy; the liver was of the nutmeg kind, and the kidneys had undergone cyanotic induration; there was hyperæmia of the stomach with eight or ten hæmorrhagic



erosions, and œdema of the upper part of the small intestine. Microscopic examination showed that the muscular fibres of the heart were healthy, and that there was no material increase of connective tissue.

The sequence of events appears to have been hypertrophy of the heart, dilatation of cavities, especially of the right side, which permitted tricuspid regurgitation and subsequent changes in the various organs. We have no cause to assign for the Cheyne-Stokes breathing except that of disturbed circulation in the respiratory centres.

Another interesting case in which Cheyne-Stokes breathing is marked is at present (Dec. 7th) in Dr. Molson's wards. In this case, as well as in both those which I have reported, mental derangement is a marked feature of the case, and in all three a similar unrestful state of mind is present. They could not be kept quiet, they must be continually getting in and out of bed, and although they did what they were told, yet they immediately repeated the offence the moment the attendant's back was turned.

*Hæmoptysis from Mitral Stenosis.*—On Nov. 18th one of our old patients reported himself for examination. He was pale and thin, and said he had suffered from slight cough and shortness of breath on exertion for the last three years. He had twice lately been in hospital with severe attacks of hæmoptysis, and he had somewhat the appearance of a phthisical patient, but further enquiry established the fact that the hæmoptysis depended upon quite a different cause. He had had acute rheumatism on several occasions, and again last winter in hospital, and, moreover, there had existed a systolic thrill, and at the time of examination a pre-systolic murmur which many of the students had an opportunity of hearing. The lungs were in a perfectly healthy condition.

*Thoracic Aneurism.*—Nov. 22nd—At to-day's clinic, D. J., aged 64, came for examination. This was the man who spent the winter of '85-'86 in the hospital with an aneurism of the descending arch, which projected in the back. There was localized sweating. (For full report see *American Journal of the*

*Medical Sciences* for March 1883.) The symptoms are by no means as severe as they were four years ago. He has been taking ten grains of iodide of potassium every day since. Improvement was noted in the degree of dyspnoea and pain; the tumor was apparently smaller. The pulse was noted formerly as being collapsing, but now it certainly has not that character. The improvement after the administration of the iodide showed itself at best for two years; during the last year he has felt feeble, and has suffered from paroxysms of very severe coughing.

*Locomotor Ataxy: Symptoms suddenly developed after an Injury.*—A man, set 44, three months ago fell into a hole about six feet deep, coming down upon his feet. He did not feel at all injured, but two days afterwards he felt a severe pain in the back, which lasted two days, and was immediately followed by severe vomiting at short intervals for six days; then the gait became unsteady, and numbness in his feet and fingers was perceived; no pain nor interference with sphincters of rectum or bladder; no history of syphilis. On admission, three months after the accident, the patellar reflex was found to be absent, and there was great wavering of the limbs on an attempt to stand upright with the eyes shut; gait is decidedly ataxic; never had any lightning pains. After a month's stay in hospital there was considerable improvement showing itself by an almost loss of the numbness and by a much improved gait, but after spending three weeks at his home, the numb sensations returned and the unsteadiness increased. On readmission, it was found that the gait was steadier than when he left, but there was no change in the knee reflex phenomenon. Neuro-retinitis present in both eyes.

*Cancer of Stomach with secondary Cancer of the Liver and secondary deposits in the Peritoneum.*—The patient whose symptoms are reported on page 451 in the last issue of this JOURNAL died on the 3rd of December. As was expected, the symptoms became more urgent, emaciation was rapid, and the pain very severe. Death appeared to have been caused by exhaustion. Three weeks before death ascites made its appearance, and this was the result of a recent peritonitis of cancerous origin, for the

membrane was reddened and the inflammation appeared to originate in a mass of jelly-like foreign material in the pelvis between the rectum and the bladder. The stomach was not dilated. There was an ulcer at the pylorus and the tissues about were thickened, but a little finger could be passed through the opening. This was in accord with the symptoms, for although there had been a history of copious vomitings, we had not observed any while he was in hospital. The salol passed through the stomach within the normal time limits (2½ hours). There was no hydrochloric acid in the vomit. The nodule we had felt through the abdominal parietes in the right mammary line was present, and there were very many more, but being situated flatly in the surface of the liver failed to make themselves perceptible. The liver weighed very nearly twice its natural size: spleen small.

*The Co-existence of Cirrhosis of the Liver and Tubercular Peritonitis.*—In the MONTREAL MEDICAL JOURNAL of May, 1889, p 317, there will be found some reference to the coincidence of these two affections. On the 4th December, 1889, Dr. Johnston made an autopsy on a case which Dr. Molson had had in his ward, and which he had very kindly allowed my class to examine. The liver was very small and hobnailed, and the peritoneum studded with tubercle. There was also a deposit of the same material in both lungs.

The clinical history was briefly as follows: The patient, aged 49, was admitted on the 15th November with jaundice, ascites and œdema of the legs. History of spirit drinking. Present illness was said to have begun eight weeks ago with jaundice and pain at the pit of the stomach, which was followed in a fortnight by dropsy of the belly and afterwards swelling of the feet and legs. A brother died of dropsy and jaundice after an illness lasting five months. There were on admission, evidences of fluid in the peritoneum, enlarged abdominal veins, deep jaundice, subcutaneous ecchymoses, which were especially extensive over the inner side of the right thigh.

## Reviews and Notices of Books.

Report on the Sanitary State of Montreal for the Year 1888. By LOUIS LABERGE, Medical Health Officer.

We are willing to acknowledge that in the city of Montreal there are many natural obstacles to the progress of sanitary reform, and, moreover, that our population is made up of so many kinds of men professing so many different kinds of faiths, religious and political, that the sanitary reformer has a task before him of more than ordinary difficulty. We have not space to say all we think about the sanitary state of Montreal, but we shall merely point out some of what may charitably be called, the peculiarities of the City Health Office.

To begin with, the salary of the medical health officer is absurdly small, and were the office to become vacant to-morrow, no medical man of any ability or professional standing would accept the duties at the price. The city doctor receives about half the salary of the city lawyer. Next, in the pamphlet before us we perceive that there is no assistant medical officer on the permanent staff, and that the only professional gentlemen connected with the office are the vaccinators, who, we believe, do not give up their whole time to the public service.

That there is no sanitary engineer connected with the Health Department accounts for much of the drain disease in the city. There is *one* drain inspector (who is not a qualified engineer) for the whole city. We are willing to admit that this gentleman performs his duty as well as the demands upon his time will allow, but the fact remains that, beyond this one unqualified sanitary inspector, there is no one in connection with the office whose experience and education enable him to lay claim to that knowledge of sanitary engineering which would render him useful to the citizens.

The statistics relating to the distribution of disease in the city are absolutely worthless, owing to the fact that but a small percentage of infectious cases are reported. This is not the fault of the health officials, but of the medical men in charge of the patients.

We turn with eagerness to the section relating to vaccination. That the epidemic of 1885-86 came to a full stop because it had consumed all the unvaccinated is, we take it, universally conceded. We ourselves feel confident that there is being accumulated an abundance of fuel for the next epidemic in the shape of a continually increasing unvaccinated infantile population, and that in the course of some five or six years, when people begin to forget about 1885-86, then there will be another epidemic and another 5,000 victims of ignorance and official incompetency will be laid in their graves.

Let us see what the city is doing. There are but three public vaccinators in the employ of the Board of Health. What can one expect in a population of 200,000 from the efforts of three vaccinators, whose time is but partially given up to the service. During the year, the sanitary police collected the names of 3,022 unvaccinated children, and during the months of July and August the vaccinators prepared an index containing the names of over 6,000 children. Altogether, about 6,000 children are born in Montreal every year, and if the city can only secure the vaccination of 2,802 every year, it is easy to see, even taking into account the proportion of children vaccinated by their own medical men, that we are rapidly accumulating a mass of inflammable material, and we only need a spark to set up a blaze.

Montreal owns up to a mortality in 1888 of 28.86 per 1,000 and the population is officially stated to be 201,743. Compare the death rate of other places. The death rate of twenty-six of the principal cities of America with a gross population of 9,873,448 is 20 per 1,000. (We take our figures from the president's address delivered at the meeting of the American Public Health Association, at Brooklyn, on Oct. 22nd, 1889.) The death rate for London for the year 1888 was 18.5 per 1,000. Now if we could reduce our high death rate to a figure as low as that of London it is easy to calculate that we should lose but 3,732 lives per annum instead of the 5,824 we put into their graves last year. In other words, sanitary supervision could save every year 2,092 lives in this city of Montreal.

But we are constantly being told that a high birth-rate com-

pensates for this great loss. Those who give the subject attention, know that high death rate is the cause of high birth rate, and that high birth rate in no way, except by the most ignorant or by those who seek to deceive the most ignorant, can be regarded as compensatory.

There is no analysis done in the Board of Health, because the city will not pay for an analyst. Consequently poisoned food is sold in many a shop in this city. We have already called the attention of the public to the large number of cases of lead poisoning. During the last summer a great deal of the ginger ale sold in the city contained lead in poisonous quantities, and we have every day patients in the General Hospital who have been poisoned in factories. We do not believe the civic board have ever taken a single step in this matter.

How can we expect a reasonable rate of mortality when we allow the land on which the city is built to be riddled by some thousands of privy pits, and when we allow streets to be made and houses put up on them without the necessary drains to conduct away the excreta of the inhabitants.

**The Insane in Foreign Countries.** By WM. P. LETCHWORTH, President of the New York Board of Charities. New York and London: G. Putnam's Sons, the Knickerbocker Press. Montreal: Wm. Foster Brown & Co.

This beautifully printed and well illustrated volume is the outcome of a visit made by the author to ascertain "from a practical point of view what are the most advanced, the most humane, and the most economical methods of caring for the insane."

In the introductory chapters a sketch is given of the treatment of insanity as conducted in the early decades of the present century. Looking back from the present on these dark days, what is surprising is the slowness with which the modern humane methods found acceptance. In many instances this cruel apathy was not owing to the want of desire on the part of the medical superintendents to change for the better, but rather to the lay governors. A notable instance is recorded where an able and

enlightened medical superintendent was compelled to resign because he attempted to introduce mild means of dealing with his patients. The prejudices against reforms in the treatment of insanity have now well nigh completely disappeared, except in places where ignorance is more than usually prevalent. Good accounts are given in these pages of the more important asylums in England, Scotland and Ireland, and also of the leading continental asylums. The work is a valuable one, as it is the result of a careful enquiry into an important subject.

**Gedenkrede auf Ludwig Türck.** Vorgetragen Am 22. März 1889. In Der Feierlichen Jahressitzung der K. K. Gesellschaft der Ärzte in Wien. Von Dr. M. HEITLER, Docent an der Universität. Wien und Leipzig: Urban & Schwarzenberg. 1889.

Dr. Heitler in this pamphlet gives a graphic account of the life and work of Ludwig Türck, a name that will go forever down into medical posterity. Few men of the present century have such a record of indefatigable and productive work. Türck's most important contribution to medicine is the explanation of the secondary contractures that occur in cases of cerebral paralysis. This, as was first pointed out by Türck, is due to secondary spinal degenerations. The methods through which he demonstrated these secondary changes is a brilliant example of keen foresight coupled with profound patience in working out details. Türck worked in many different fields, many of which he notably enriched; he will, however, be known mainly by the observations already referred to and the prominent part he took in introducing and perfecting the laryngoscope.

**J. J. Rousseau's Krankheitsgeschichte.** Von P. J. MÖBIUS. (The History of J. J. Rousseau's Malady, by P. J. Möbius.) F. C. W. Vogel, Leipzig. 1889.

Dr. Möbius has come to the conclusion that the famous Rousseau was insane, and maintains this through almost two hundred pages with characteristic German tenacity.

Rousseau that has puzzled almost every serious student of his character is clearly enough understood by this writer.

It is easy enough for the average man to pass judgment on an individual of Rousseau's type, but for most men really to understand in a true sense the nature of the Rousseaus of this world is we believe impossible. After all, we can understand others only through our own experiences—transient and feeble in most cases they must be,—but still from this source comes the only true light.

If this be so, what probability is there that a man of a healthy body and only mediocre intellectual and moral endowments can ever properly understand (realize the nature of) either the genius or the lunatic of a certain class? Perhaps those who have studied Rousseau most have been the slowest to decide as to the man's real character. That he was gifted with genius none can deny; that he was erratic in the extreme is equally plain. But was he insane? Dr. Möbius says he was of a "neuropathic" nature, and without doubt such he *ultimately* became. But that men of the Rousseau type are bound to become insane, no matter what the circumstances of their lives, is just an open question. Genius is "to madness close allied" was the verdict of a great man—one with a capacity for understanding his fellows that has probably never been equalled.

The perils of genius in a world of mediocrities is very great—*i.e.*, genius of a certain kind. That so many poets have made shipwreck of life in the ordinary sense of being unsuccessful in the struggle for existence is worthy of serious thought. That the great mass of men can in any adequate degree understand a Byron, Shelley or Burns is not probable. The really profitable thing is to see the relation of such organizations to the environment. A human being of ordinary development has much to be thankful for; he is in reality best adjusted to the environment; best fitted for the struggle for existence, though he can and will do little to modify the surroundings and make them more suitable to those of a finer, *more delicately balanced* organization.

Now and then, as with a Shakespeare, a Goethe, and, still oftener, with the genius whose special insights are into things rather than man and men, do we find great strength and pene-



tration united with very stable mental and moral balance. But is this the rule or the exception with the genius? We think the work of Dr. Möbius interesting, but for ourselves we still prefer to believe there are more things in heaven and earth than are dreamt of in this writer's philosophy. W.M.

### Society Proceedings.

#### MEDICO-CHIRURGICAL SOCIETY OF MONTREAL.

*Stated Meeting, 15th November, 1889.*

G. E. ARMSTRONG, M.D., PRESIDENT, IN THE CHAIR.

Dr. JAMES BELL presented a patient suffering from "multiple fibroma of the skin and nerves," whose right leg he had amputated in the upper third of the thigh for a recurrent sarcoma of the popliteal nerve. The patient, a man aged 37, a French-Canadian, had had a number of fibromatous growths in the skin ever since he could remember. For four or five years past a great many new growths had been constantly appearing, and in 1886 he noticed a growth about the size of a pigeon's egg in the right popliteal space. He also began to suffer from pain in the leg and foot. The tumor increased in size, and in a few months the pain ceased and complete paralysis of the anterior leg muscles supervened. The tumor continued to increase in size until August 6th, 1889, when it was removed by Dr. Fenwick, who found it to be an encapsuled (apparently) fibrous growth of firm consistence, about the size of a man's closed fist, and growing from the sheath of the popliteal nerve, which had produced a deep sulcus along its posterior surface. The wound had scarcely healed when the whole boundaries of the popliteal space were invaded by a rapidly growing and infiltrating nerve growth. Microscopical examination of the removed tumor demonstrated that it consisted largely of fibrous stroma, but contained in some parts nerve elements and in others sarcomatous tissue. The thigh was amputated on the 22nd of October, when the recurrent growth proved to be a spindle-celled sarcoma. The stump healed without trouble, and the patient was shown to the members of the society on the 23rd day after the operation.

Dr. BELL considered this case a typical example of a rare and interesting disease, the clinical and pathological history of which was somewhat obscure. It was described by dermatologists as *molluscum fibrosum*, and although it had been carefully studied by American dermatologists lately, and a number of cases had been reported, it seemed to be looked upon as evidently a skin disease, sometimes attacking the large veins at a late period of its course, and sometimes (apparently accidentally) ending in sarcoma (just as other persons were attacked by sarcoma). Recklinghausen had investigated this subject, and in 1882 had published a work in which he showed that these skin tumors were generally, if not always, outgrowths from nerves. Other German and Continental observers had noted the special tendency to development of sarcoma in cases of this disease. Dr. Bell also mentioned two similar cases which had come under his observation some years ago, and expressed his opinion that probably the disease described as multiple sarcoma was an allied condition and not in reality a sarcoma at all.

Dr. SHEPHERD did not think there was so much obscurity about the case as Dr. Bell thought. He considered the case one of fibroma molluscum, and where several tumors ran together, a condition of dermatolosis resulted. The difference between multiple sarcoma and fibroma is distinct. In sarcoma the tumors are never pedunculated, and are of a rose red color. The subject has been worked out by Heintzman and others. It is not very strange that these tumors should take on a malignant and sarcomatous action, for instance even in warty growths. The prognosis of such cases is always unfavorable, usually ending eventually in death. Their connection with the nerves has long been recognized.

Dr. BELL, in reply, regretted that he had been misunderstood. He did not claim that there was anything mysterious about the disease, but that the same disease was described by American dermatologists and European surgeons and pathologists from entirely different standpoints, and in such a way as to confuse readers, and lead to the impression that two distinct diseases existed instead of one. He had no personal knowledge of mul-

tipic sarcoma, never having seen a case, but could not reconcile it as described with the well and generally known disease sarcoma, which possessed such definite and distinct clinical and anatomical characters. He reiterated the opinion that a more careful study of such growths and on broader grounds would result in placing them all in one group—essentially “neurofibromata, tending to a termination in sarcoma”—although, perhaps, differing in detail.

Dr. SMITH then read a paper on a case of *Fibro Cystic Tumor of the Ovary*, as follows:—

I have to bring before your notice this evening a somewhat interesting case, a very brief history of which is as follows: D. S., æt. 39, was sent to me on the 19th March, 1888, by the kindness of Dr. Reddy, who was the first to discover that a large tumor filled the entrance to the superior strait, extending two inches above the umbilicus, and which had apparently been growing for several years. He had already sent her to the Women's Hospital for consultation, when the opinion of the majority was that it was a fibroid of the uterus. This opinion was based upon the following points:—1st, the uterus moving with it; 2nd, its very solid feeling, there being only a suspicion of fluctuation; 3rd, the sound could not be passed; 4th, there was great pain in it all the time, especially at the menstrual periods, which lasted fifteen days, the abdomen was so tender that she could not bear to be touched and walking was almost impossible; 5th, great difficulty in micturition and defecation; 6th, the fact of the patient being 39 years of age and single.

In view of her very helpless condition, which was getting worse, and that she had to earn her own living as a domestic, combined with the gravity of the prognosis of operative interference if the tumor turned out to be a fibroid of the uterus, Dr. Reddy decided to give her the benefit of the galvanic treatment, which I carried out for him.

She began treatment on 17th March, 1888, from which date till the 25th May, 1889, I gave her 70 uterine galvanic cauterizations, mostly negative, and varying from 100 to 250 ma. in strength. At the end of a month she was able to resume her

duties as cook, and to walk long distances, and to micturate and defecate with perfect ease. At the end of two months she had decreased six inches in size around the largest part of the tumor. At this stage her progress was so satisfactory that I showed her to the Society, when the members were able to see the reduction in size by the length of the loops she had had to put on her clothes, and which were no longer necessary. Soon after beginning treatment I was able to introduce the sound a distance of two and a half inches by bending it sharply forward to the right.

After four months the patient felt so well and the tumor was apparently so much reduced in size, its upper margin having come down midway between umbilicus and pubis, that she left off treatment with my sanction.

A year later, while she was at her home in the country, the tumor rapidly increased in size again, and I reported her as a failure in one of my recent papers. But why electricity failed we shall presently see.

In the meantime the mortality having diminished considerably since the adoption of the extra peritoneal or outside treatment of the stump and the use of Kœberle's *serre nœud*, I strongly advised abdominal section, to which she consented. On placing the case before my esteemed colleague, Dr. Perrigo, whose term of service it was at the Women's Hospital, he kindly agreed to take her into his wards. Another consultation was held, at which Dr. Marcy, of Boston, was present, and the advisability of operating was concurred in, although the majority were of the opinion that it was either a fibroid or a fibro cystic tumor of the uterus. The operation was undertaken with considerable anxiety by Dr. Perrigo, assisted by myself and Dr. Reddy.

On opening the abdomen, the tumor was at once seen, and presented distinctly the appearance of a cyst, but on plunging the trocar into it no fluid escaped. The abdominal incision was therefore rapidly extended several inches above the umbilicus, and there being no adhesions of consequence, the tumor was gradually delivered without any great exposure of the intestines.

It weighed about 26 pounds before the blood drained out of it. The pedicle was broad and was tied in two segments, the left Fallopian tube, which was elongated and stretched out over its anterior surface, was tied and removed. The abdominal incision was united with deep silver wire sutures, which brought the peritoneal surfaces accurately in apposition, with superficial silk ones for the skin. There being no oozing, no drainage tube was used. The operation took 39 minutes. Neither was any opium required. Flatus was passed on second day, and the bowels were moved by enema on the fourth day. The patient made an uninterrupted recovery, was up on the thirteenth day, and returned to her home in the country on the nineteenth day. I have since heard from her, and she was so far in the enjoyment of perfect health.

*Comments.*—This case is of interest to the gynecologist, as well as to the general practitioner, for several reasons. First, the difficulty in diagnosing. It is no disparagement, however, to admit that it is sometimes impossible to say positively what the exact nature of hard or semi-solid abdominal tumors may be, until the abdomen has been opened. Many of the ablest diagnosticians have told me that they have frequently been deceived, in spite of the greatest care. In case of doubt, I think it is wisest to give the patient a short course of galvanism, and if she does not greatly improve, to make an exploratory incision, at the same time being prepared for either ovariectomy or hysterectomy. I felt so sure, from the hardness of the tumor and other symptoms, that this was a fibroid of the uterus that I reported her case as a failure of electricity to cure a uterine fibroid, but in so doing I did Apostoli's method an injustice. It is highly probable that many others fail for the same reason, viz., error in diagnosis.

I might mention in this connection that I wrote to Apostoli to ask him if he had ever failed to benefit a fibroid of the uterus, to which he promptly replied that he had failed in several cases of fibro-cystic tumors of the uterus, but never in a case of pure fibroid.

The next question is how are we to explain the marked dimin-

tion in size. I think, as was pointed out by Dr. Trenholme, at the meeting at which I showed her, that it is due in part to the tonic effect on the walls of the intestines, which thus expel their gaseous contents, and of the blood-vessels, which are diminished in calibre. This makes the tumour a little smaller, but not enough to take off the pressure from the iliac and ovarian veins, the obstruction of which is, I am sure, responsible for a great deal of the œdema of the tumor. For in this, as in other cases, I have noticed a pasty swelling, which could be indented by firm and prolonged pressure with the finger, which has invariably disappeared soon after the patient has come under treatment.

The application of the negative current had the effect of dilating the cervical canal so that the finger could be inserted into it, but after treatment had been left off for a few months, it had retracted again to almost a pinhole. This is a general result when very high currents are employed, but it can be avoided by insulating the cervical portion of the electrode.

The sudden increase in size, after she had become so much smaller, was in all probability due to hemorrhage into the cyst, for the part of the tumor that was cystic was filled with a semi-solid material, having the consistency of clotted blood. The uterus was almost imbedded in the anterior wall of the tumor, which explains its moving with the uterus; the latter was normal in size but not adherent.

*Discussion.*—In discussing this paper, Dr. Alloway said that from the title on the notice card of Dr. Smith's specimen, he understood it to mean a fibroma of the ovary, in which cystic change had taken place. Under these circumstances it was a remarkable specimen on account of the extreme rarity of such growths and of the large size of the specimens. He would, therefore, suggest to Dr. Smith the advisability of having the specimen examined by the pathologist to the society, and a report submitted at a future meeting. In regard to the error made in diagnosis, and to the electrical treatment, which was carried out for so long a period, he thought it a severe blow to the reliability of the so-called relief claimed for the treatment of these conditions by electricity. He thought the society should

feel grateful to Dr. Smith for having, in so straightforward a way, placed before it, side by side, the relative merits of electrolysis and section in the treatment of abdominal tumors. He said the method spoken of by Dr. Gurd was different to that applied by Dr. Smith to his patient. The former had reference to passing grooved directors through the abdominal wall—one on each side—into the cyst contents. This method was introduced by Dr. E. Cutler, of New York, and is still practiced by him, but by no one else at present, on account of the high mortality connected with it.

Dr. LAPHORN SMITH, in reply to Dr. Alloway, said that it was only by faithfully reporting failures as well as successes that the truth could be found out about the electrical treatment of fibroids. This he was determined to do. He had no other object in employing this treatment than to give it a fair and impartial trial, and if it were found to be useless, he would willingly discard it. Many cases of failure were, like the one he had shown this evening, due to error in diagnosis, and so employing the treatment for cases in which it was not suitable. He admitted that fibro-cystic tumors of the ovary were somewhat rare, but not so much so as to prevent one turning up once in a great while in Montreal. He was willing to hand it over to the pathologist of the society for a report.

Dr. ALLOWAY related a case of distressing incontinence of urine in an old lady (aged 60). There was no pain, but a constant desire to pass a few drachms of urine. On examination he found an old cicatricial stricture completely surrounding the upper part of the vagina, about on a level with the external os uteri. This stricture had in some way involved the walls of the bladder by traction upon them, so that the latter became divided into two portions, a very long one above and a very small one below. It appeared that the upper larger reservoir received the urine from the ureters and emptied itself only by overflow into the smaller one below, which, in its turn, quickly voided its contents, to be rapidly filled again from the upper reservoir. It was quite evident that there had been a myopothic process established, in so far as the upper portion of the bladder was

concerned, and that there was a true senile paresis of the detrusor complicating this peculiar sort of structure.

The treatment adopted consisted in breaking down the vaginal stricture by digital dilatation. This was followed by complete relief to the symptoms, but unfortunately, as the stricture again contracted on cessation of dilatation, the symptoms returned. Dr. Alloway said that he intended shortly to resect the cicatricial vaginal ring, with the portions of the vagina above and below. He showed a crayon drawing of the condition and spoke of its rarity as a cause of bladder trouble. He said it was caused primarily by an injury to the vagina during parturition.

Dr. LAPTHORNE SMITH said that these cases of traumatic atresia of the vagina were becoming very rare, in fact could only be found in women who had been confined many years ago, because no medical man of the present day would leave the head long enough in the pelvis to cause death of the tissues. A cause which is still somewhat common is scrofulous vaginitis with destruction of mucous membrane and even adhesion of the anterior and posterior walls.

He thought that Dr. Alloway was mistaken in thinking that he had only a stricture of the vagina to deal with, for the reason that no stricture of the vagina could constrict the bladder so as to form an upper and a lower chamber. Such a condition never followed upon Lefort's operation, in which the surgeon artificially caused an atresia of the vagina. He thought that no amount of traction on the posterior wall of the bladder could cause a stricture; in fact it would be much more likely to cause dilatation. The true condition in Dr. Alloway's case was probably a stricture of the bladder, caused by destruction of the mucous membrane at the same time that the injury was taking place to the mucous membrane of the vagina.



## NEW YORK ACADEMY OF MEDICINE.

At the meeting of the New York Academy of Medicine, held on November 7th, 1889, the President, Dr. Alfred L. Loomis, in the chair,

DR. SIMON BARUCH read a paper entitled "*A Plea for the Practical Utilization of Hydrotherapy.*" The fact that water in the treatment of disease had been chiefly employed by empirics seemed to have prevented in some degree general recognition of its virtues by the medical profession. The author justified his appeal for its more general utilization by physiological laws and clinical results, both ancient and modern. The literature showing the value of hydro-therapeutics was very extensive, yet modern text-books dismissed the subject with a few words. There were at present but three cities in which it was much used in the general hospitals, Vienna taking the lead. In spite of professional and lay prejudice, the remedy had stood the test of time better than any other. A review of the experience of those whose names had become prominently associated with hydrotherapy was given, and brief quotations were made from such modern therapeutists as Niemeyer, Dujardin-Beaumetz, Hoffmann, etc., testifying to the value of the method. But proof of its value did not rest alone on clinical experience; it was fully supported by ascertained physiological laws. What other agent than water could produce such a variety of results, according to its mode of application? Its stimulating or depressing effects could be made to manifest themselves either directly upon the skin where applied, or upon internal or remote organs, through reflex influence. One example of reflex influence was seen in the response of the blood-vessels of the pia-mater to a stream applied to the surface; if the stream were cold, they become dilated; if warm, they become contracted. The hand immersed in cold water increased in size, showing that by the use of water the blood could be driven from one part of the body to another. Water applied to the feet exerted an influence upon the cranial circulation; applied to the back, it influenced the circulation in mucous surfaces, etc. The heart also responded

to temperature impressions upon the periphery. A low temperature briefly applied accelerated the heart's action; prolongation of it diminished the action. Evanescent application of a high temperature to the skin caused a decrease of the pulse-rate, quickly followed by an increase. By cooling the blood in fevers, the heart's action could be slowed, and an invigorating effect thus brought about. Having stated that the vascular tension could be modified by hydropathic procedures, he said that this influence upon the circulation was so decided, indeed, that hydrotherapy became in reality a hydraulic problem. It was a most perfect means of influencing the vascular system. He said it was to be remembered also, in discussing the value of hydrotherapy, that the vital process by which the system sought to protect itself against thermic changes had also been ascertained. Vascular spasm protected the internal organs against too rapid cooling of the surface, while the secondary effect was reaction and vigorous dilatation of the cutaneous vessels. It had been shown that by hydropathic treatment the blood-cells could be increased in number, and also improved in quality. This, and the influence upon the nervous system, produced a healthy change in the functions of nutrition, secretion, and excretion. In this country, Dr. Putnam-Jacobi was one quoted as having added to our knowledge of the physiological and therapeutic action of water. In discussing the clinical aspect of the subject, he said he agreed with Dr. F. A. Hoffmann in the statement that he did not deal with the disease, but with the sick man. He approved of Hoffmann's classification of the treatment as direct (removing the cause) and indirect, but he would add a third method, that by which he could so impress the various functions of the body, chiefly innervation, as to enhance the resisting powers of the patient, and thus enable him to pass over danger-points. He claimed for hydrotherapy only the position of being a valuable but indispensable auxiliary to other treatment. By hydrotherapy he meant water at any temperature, in any form, used internally or externally in the treatment of disease. Of the three therapeutic methods mentioned, the removal of the cause of the disease directly was not always practical because

of our ignorance of the ætiology. In the case of gastric and intestinal diseases, we seemed to be on the threshold of discovering the cause through bacteriology. In the removal of this and restoring gastric function, water had been used with great success. Intestinal irrigation, by means of the fountain syringe and Nélaton catheter, was the most efficient method of treating several types of summer diarrhœa. The value of sipping hot water in gastric troubles had been demonstrated. Other cases in which he had found the method of marked benefit were those of neurasthenia and other nervous diseases, rheumatism, gout, scrofula, etc. The neurasthenic cases were treated differently according to whether they were of an crethitic or an asthenic nature. Two cases were cited to show that much depended in the treatment upon the temperature of the water and the uniformity and frequency of its repetition. He said that hysteria was among the affections which would almost certainly yield to the water treatment when aided by other measures. They had discharged three cases from the Montefiore Home as cured, notwithstanding they had been sent there as incurables. No patients of any kind were admitted to this institution, except those who had been considered incurable; yet by hydropathic measures they had sent out a number as cured, who had had gout, rheumatism, sciatica, hysteria, etc. Chorea often yielded to this treatment; the active impact of very cold water by the douche was necessary here. Many cases of neuralgia were connected with anæmia and chlorosis, and were cured by hydropathic treatment; indeed, he said that if there was any condition in which the tonic effects of hydropathy were pronounced, it was functional anæmia. During the winter it was often sufficient for the patient to stand with the feet in warm water, and splash cold water on the body, the duration being only until the entire body had been wet. The result of hydropathy in the treatment of phthisis had been also satisfactory at the Montefiore Home, and one pronounced case of the morphine habit was cured. Statistics had demonstrated that the mortality of typhoid fever could be reduced from twenty-five per cent. to two per cent. by this treatment. The fact should not be overlooked that the object was not to

reduce the temperature, but to refresh the nervous system, that the body might be enabled to withstand the disease. The bath should be adapted to each particular case.

DR. GEORGE L. PEABODY, having been asked to open the discussion, said he would speak only of the application of water to the treatment of a form of acute disease which was of common occurrence here, and in the treatment of which our results had been almost uniformly discreditable to medical practice. He referred to typhoid fever. It was a matter of surprise that in this city, where physicians sought to introduce into their practice all that was good and new from all parts of the world, it was necessary for one to urge the desirability of trying this procedure. He thought that the sooner we rid our minds of the fallacy that it was likely to do patients with a high temperature harm to expose them to a considerably lower temperature, the sooner would we get at the rational treatment of this grave malady. It was almost impossible to give a patient cold who had a temperature much above the normal ; it was not likely that a patient with a temperature of 104°F. would take cold, even if he kicked the bedclothes off and lay entirely exposed. He thought the mortality from typhoid fever in our hospitals was quite unjustifiable ; it ranged anywhere from twenty-five to thirty per cent., and, here and there, it rose to fifty per cent. In the German army, where this treatment had been carried out in a large number of cases, the mortality had been reduced to below four per cent. Perhaps one reason why it had not been applied, except in a few instances, in our hospitals, was that it required two attendants and a portable bath-tub. Regarding the method of applying it, he thought there could be no question but what the full bath, of a temperature of between 65° and 80°F., was best ; the patient should be put into the bath at as frequent intervals as the temperature indicated. The temperature should be kept at or below 102°F. throughout the entire course of the disease. How much more rational was this treatment than that which he had often observed, of administering antipyretic drugs, bringing the temperature down from 105° or 106°F. to normal or below, allowing it to rise again equally high, and again bring-

ing down with the drug. A good many patients were brought to the hospital in a very unfavorable state, and in that case, instead of plunging them into a cold bath, he would apply the wet pack. Personally, he did not like the graduated bath; it was far more troublesome, and was less comfortable to the patient. Cold affusions on the Kibbee cot produced rather too much shock. He thought it was folly to apply cold to the surface of the body when it was already cool. We often found profound depression in typhoid fever in which the surface was cool and the internal temperature high. It was certain that no routine habit of applying cold to the surface would apply in these cases. He could conceive of no other direct object in applying cold than to increase surface radiation, and if the heart was too feeble and could not be stimulated to pump the blood to the surface, there was no reason in cooling the surface further.

DR. A. A. SMITH hardly knew where to begin to discuss so extensive a subject. In Bellevue Hospital he had continued the treatment of four cases of typhoid fever, begun during the service of Dr. Flint, and all recovered; since then he had had five cases, in none of which the use of the cold bath seemed to be justified, since the temperature did not rise above 103.6°F. They all recovered without such treatment. This, he supposed, would be the experience of others. Unless the bath was used in a large number of cases, it would be difficult to draw any conclusions regarding its superiority over other methods of treatment. He was, however, a warm advocate of hydro-therapeutics. He said that if there was any class of cases which made him very unhappy, and which he failed to make very happy, it was that of the neurasthenics. If Dr. Baruch could teach us how to cure these patients by hydrotherapy, he would put us under great obligations. Regarding the cure of hysteria by this method, he must admit to some scepticism, yet he hoped others would try it and have equal success. Patients with hysteria deserved our earnest attention, for he believed that underlying almost every case there was some cause in irritation, or disturbance, which should not be ignored. He was a great believer in the wet pack, and he thought that its only benefit did not consist in reducing

the temperature; he had felt that the soothing of the nervous system was as great an object to attain as the reduction of the temperature. Warm water had been of great service in reducing the temperature. He had known the temperature in scarlatina to fall a degree and a half from no other treatment than wrapping the patient in a sheet wrung out of warm water, repeated several times during the twenty-four hours. It often banished delirium and muscular disturbance, caused sleep, and reduced the temperature.

DR. M. PUTNAM-JACOBI gave the details of a case of typhoid fever treated in the New York Infirmary by cold-baths. She differed from Dr. Peabody in the view that the benefit was alone from the reduction of the temperature. She saw no reason for pushing it further than to produce the desired reduction of the temperature and beneficial influence on the circulation and nervous system. She did not think, therefore, that hard and fixed rules for its use in typhoid fever should be necessary.

DR. G. B. FOWLER thought the physical properties of water commended its use in the treatment of disease to all physicians, and he was rather surprised to hear that the bath was as little used as Dr. Baruch had stated. He certainly had used it ever since he began practice, in all cases of hyperpyrexia. In the angina of scarlet fever, diphtheria, etc., he kept the throat almost frozen, using ice, and certainly with very good results. He expected it to do more than reduce the temperature. Its results were less violent than those of the therapeutic measures usually employed. The author had only hinted at one method of using water, namely, by drinking. Dr. Fowler regarded this as important in the treatment of fever as the external use of water. He gave his patients an excess to drink, and in the sickness of children gave it to them in the nursing-bottle. He saw a great many cases sometimes called neurasthenia; women with constipation, loss of appetite, catarrh of the alimentary tract, etc., the blood-corpuscles on the glass sticking to one another, crumpled, the urine scanty, want of free perspiration. Here the clinical facts pointed to a deficiency of water in the system. One might as well try to raise a crop without rain as to nourish an individual properly without water.

DR. BARUCH closed the discussion.—*N. Y. Medical Record.*

## Correspondence.

### PROVINCIAL MEDICAL BOARDS.

*To the Editors of THE MONTREAL MEDICAL JOURNAL.*

SIRS,—In the Introductory Address by Dr. MacDonnell, printed on page 321 of the MONTREAL MEDICAL JOURNAL for this year, the lecturer inveighs against provincial medical boards in general, and that of British Columbia in particular. The “some fifty practitioners in that province” do not constitute the Medical Council of Physicians and Surgeons of British Columbia, nor is their motto, “Now, we have got in, let us keep others out.” The British Columbia Medical Council was incorporated in April 1886, and since that time twenty-two men have presented themselves for registration. Of these twenty-two, all have now their licences except one, who, if the Council had “contented themselves with examining diplomas and rejecting those that came from indifferent colleges,” would probably have had a license also. However, by going through the formality of an examination it was found that although this candidate came from a reputable medical college in the United States his “fitness and capacity to practice as a physician or surgeon” was very doubtful. In reply to the question “Define caput succedaneum,” this candidate stated that “caput succedaneum was an eruption which appeared upon the chests of patients suffering from typhoid fever.” If Dr. MacDonnell thinks that an examination of this gentleman’s diploma would have determined his fitness or unfitness to practice, I must beg to disagree with him. Rather than make my letter too long I purposely refrain from noticing many other points in the lecture where Dr. MacDonnell might be corrected, just pausing to mention the fact that the Medical Council of British Columbia at least has made no pretence of regulating the course of study pursued by those who apply for its license beyond the regulation that they must come with a diploma from a school which exacts at least three years of professional study. The profession in this province is not in the least afraid of honest competition, and McGill men in particular have nothing to fear from the examination here. Out of

sixty-three men registered in the province eleven come from McGill—more than from any other one school—and I have never heard any of them complain of the severity of the examinations.

Hoping that Dr. MacDonnell, as well as others in the east, may at least give us credit for fairness both as regards our professional examination and fees,

I remain, very sincerely yours,

W. A. DEWOLF SMITH.

NEW WESTMINSTER, B.C., Dec. 9th, 1889.

### Selections.

**The Operative Treatment of Perityphlitis.** (By Prof. Sonnenburg, Berlin.)—At the meeting of the Association of Surgeons of Berlin, Prof. Sonnenburg demonstrated two patients upon whom he had successfully operated for perityphlitis. He thought that operative treatment in this disease was confined to those cases in which there were encapsulated exudations or abscesses, and that if general suppurative peritonitis had already developed an operation could be of little service. There are a number of cases of perityphlitis in which, as early as the first day, resistance and dullness, without fluctuation, can be made out, while on the next day these signs are obscured by commencing meteorism, and palpation is impossible on account of the great tenderness of the abdomen. It is well known that most deaths from perityphlitis occur during the first week; and in order not to lose a favorable opportunity the author recommends that the abdomen be opened down to the peritoneum by a curved incision similar to that used in ligation of the iliac artery, or by an incision at the outer margin of the rectus abdominis. Palpation may now be practiced through the peritoneum, and it will often be found possible to detect resistance again and discover the abscess, which should then be opened. But there are cases in which, owing to protrusion of loops of intestine or the deep situation of the abscess, palpation through the peritoneum affords no positive data, and in these an expectant plan of treatment should be pursued. The abdominal wound should be tamponed with iodoform gauze, care being taken not to injure



the peritoneum, and on the following day the tampons are removed and the examination repeated. Under this mode of treatment the abscess, which grows toward the point of least resistance, can be usually detected on the second or third day and successfully opened. In two of the author's cases the abscess was detected on the second and third day respectively after the incision of the abdominal wall. Another advantage of the double incision is that in non-suppurating cases in which the peritoneal incision is not required, no harm results from the division of the skin and abdominal muscles. In one of the patients the tumor, which could be distinctly made out through the peritoneum, did not go on to suppuration, and the peritoneal incision was dispensed with, the abdominal wound healing promptly, and the patient making a good recovery.

In the discussion which followed, Prof. Küster expressed his objections to the double incision. In extra-peritoneal perityphlitic abscess no incision of the peritoneum is required, and in intra-peritoneal suppuration he regarded Sonnenburg's procedure as not wholly free from danger, since under this expectant treatment the abscess might rupture into the abdominal cavity. It has always been his practice to incise the peritoneum if infiltration could be detected, and even if no abscess is found the incision is of value for diagnostic purposes.

Dr. Hahn reported a case of peri-cœcal abscess in which the peritoneum was opened, but immediately sutured. In spite of all antiseptic precautions, however, a general peritonitis was developed which terminated fatally. He thought that if the operation had been completed in two stages, the abscess would have ruptured into the wound and a general peritonitis could have been avoided. Since this unfavorable experience he had made it a point, after cutting down to the peritoneum, not to proceed any further unless distinct fluctuation was present. All exploration for small abscesses is dangerous, owing to possible injury of the peritoneum and the rupture of adhesions in the manipulations.

Prof. Volkmann regards a long curved incision, similar to that employed for ligation of the common iliac artery, as best adapted

for the opening of perityphlitic abscesses, since it enables us to avoid wounding of the peritoneum. The incision should be made large enough that both hands can be introduced and a good inspection of the parts obtained. He has never found it necessary to resort to the double operation. If pronounced fluctuation is present in other parts of the abdomen any other incision may be employed, and if on cutting down no abscess is found he would proceed as recommended by Sonnenburg. He thought that typhlitis and perityphlitis were diseases which should be treated exclusively by surgeons. Even if no pus is found by the incision no harm results, and the cures effected by internal measures in these diseases lose in value on account of the frequency of recurrences with fatal termination. He has always observed dangerous results from the application of ice-bags in perforative and infectious peritonitis, since they induce peristaltic contractions. Warm applications are much better borne and more efficient. Injection of morphine in many patients produce increased peristalsis, and may be advantageously replaced by tincture of opium.

Prof. Bergmann also employs the long curved extra-peritoneal incision, and if on cutting down to the peritoneum no pus is found, he tampons the wound and waits. Under this expectant mode of treatment the abscess may rupture into the wound, or the swelling may subside without rupture, as he has observed in one of his cases.—*Deut. Med. Wochen.*, Sept. 5, 1889; *International Journal of Surgery*.

**The Therapeutics of Rheumatism in Infants and Children.** By Dr. A. Jacobi. Read before the Medical Society of the County of New York. (From the *N.Y. Medical Journal*.)

Dr. Jacobi opened by calling attention to the frequency of rheumatism in infants and children. Valvular diseases of the left heart are generally due to rheumatism and not to scarlatina, and often it is the first symptom. The slightest symptoms of chorea minor should lead to an examination of both heart and joints. Cases of rheumatism in children were too often diagnosed

as "dentition," "malaria," "worms," or "colds"; this being due partly to the difficulty of diagnosis and partly to the common idea among practitioners that they are of rare occurrence. Fever in rheumatism might be slight and irregular, and, moreover, it is a common symptom due to slight distension. Swelling of the joints is apt to be trifling in amount and easily overlooked; and the pain might be much less than pain due to fatigue, rickets, syphilis, etc. The heart and joints should always be examined when the child shows discomfort and the diagnosis is obscure. Diagnosis is especially hard when only a single joint is affected. Only too often is the pain called "growing pains," and in the majority of cases the "growing pains" indicate the presence of rheumatism and the liability to irreparable heart injuries. As regards treatment, a change of residence from localities in which rheumatism is apparently epidemic is often desirable. Alkalies are often indicated. The systematic use of cold water often modifies, sometimes removes, the tendency to rheumatism of children born of rheumatic parents. A cold wash, sponge, wet sheet, shower-bath, or bath (according to the child's strength or power of reaction) should be given daily; then warm clothing should be worn the rest of the day. As local measures he advised swathing the swollen and painful joint in cotton and flannel, or the application twice a day of a solution of iodoform in colloidion. For endocarditis he recommends absolute rest, cold applications over the heart, and salicylate of sodium. The best preventive for muscular rheumatism, when a tendency to the affection had appeared, is the regular and systematic use of cold water. When real inflammation is present in the muscle, a mild continued current and small doses of bichloride of mercury do good.

Dr. W. H. Thomson said that his attention had been called to the etiology of rheumatism years ago, and that he had heard that it was as common among the Arabs of the desert as among the fishermen of Norway and Scotland. He had sought the reason why it should appear under exactly opposite conditions of soil and climate, and he was convinced that the cause must be a common one, namely, chilling of the skin when moist. This could happen equally well in either extreme. He emphasized

the importance of examining the pulse, and then the joint alone, in making the diagnosis. He was inclined to believe in the existence of some yet unknown function of the skin connected with the respiration in the widest sense; and he thought failure of skin-action of some sort was a means of causing the accumulation in the body of matters which were morbid of rheumatism. A chilling of the skin was usually present in the genesis of rheumatism, so the warm bath naturally acts as an anæsthetic as well as rendering urine alkaline. Flannel and oily inunction—especially with cod-liver oil—were useful. He agreed with Dr. Jacobi as to the liability of endocarditis, and has seen it develop when the joint trouble was very slight. To prevent this injury we must be on the lookout for the first symptoms of rheumatism, and especially for chorea. He dreaded “growing pains,” and always immediately put the child on cod-liver oil and advised the use of flannel, etc. He believed salicylic acid only useful for the joint troubles and not for endocarditis; for the latter he prefers antipyrine or phenacetine. He thought the reason why the heart lesions were so much more apt to remain permanent than the joint trouble lay in the fact that the heart was in constant motion and could not be given entire rest as a joint can, and since the heart-beat is more rapid in children than in adults, therefore heart lesions are more apt to be developed. For this reason he advises aconite and not digitalis. Alkalies are also to be given and the skin well protected, especially that of the chest.

Dr. J. Lewis Smith said he had kept a record of all cases of rheumatism in children under 15 years of age which he had met with in the outdoor department at Bellevue. In 78 there had been a cardiac bruit, and in only one case had the patient been under one year old, and very few under two. In three cases in young children there had been very little swelling, but some tenderness in the joints. Generally the disease began in the lower extremities and tended to travel upward. The local manifestations were much less than in adults. He had often found a cardiac bruit in cases which gave the history of former “growing pains,” and he thought the laity should be taught the

danger that lay behind "growing pains." The heart generally becomes enlarged after the disease has lasted about a year. He agreed with Dr. Jacobi that rheumatism was often the underlying cause of chorea minor, and in 165 cases of the latter he had found 18 due to the former. He found salicylate of sodium of great value if given early, and he also packed it around the affected joints.

Dr. H. D. Chapin thought the diagnosis difficult, though we now know it is a common disease in children. We must take in the whole picture and not depend on individual symptoms. Pain around the joints may be due to many causes, and is especially common from over-exertion; when due to this cause it is usually present in the evening, while the soreness due to rheumatism is more common in the morning. Heredity should be given much weight. Wandering pains, endocarditis, hydæmia and chorea are manifestations of one and the same condition. He thinks we do not insist enough on a long-continued rest in children with endocarditis. In 15 or 20 cases out of 60 he had found tonsillitis either before or after the attack of rheumatism. The causes of rheumatism are acidity of the stomach and bowels, derangement of the hepatic function, and a checking of the action of the skin. Hot alkaline baths, a careful diet, and iron internally would often prevent the recurrence of the attack.

Dr. A. Seibert thought rheumatism in children due to infection quite as much as heredity. He had seen it develop in young children whose parents had never suffered from it, but attacked some time after the children had it. This happened in people who lived in damp and dirty dwellings. Its infectious origin explains the development of the endocarditis before chorea in the joint trouble. He placed it in the same category with fibrous pneumonia, meningitis and diphtheria; and it was most frequent in the same houses as the latter. He did not believe mere chilling of the surface could cause all the manifestations of rheumatism, and, moreover, children were not exposed to cold and wet weather.

Dr. J. C. Peters replied to this that the dwellings of the poor were often cold and damp, the mothers careless about the chil-

dren's underwear, and he had often been obliged to order better underclothes. He had found lithia (as distinguished from lithia water) of considerable value in treatment.

Dr. A. Caillé took much the same view as Dr. Seibert, and believed the disease to be infectious.—(*Gaillard's Med. Jour.*

### **The Influence of Insanity on History.—**

A complete study of the effects of insanity and the various Protean forms of mental weakness and disorder, on history, could not fail to be of extreme interest both to the historian and the psychologist. A paper on this subject in its general bearings, by Dr. Grissom of Carolina, published some time since in the *New England Medical Monthly*, is highly suggestive, and throws a new light upon the psychological conditions underlying the conduct of the great, the renowned, the gifted, the artistic, and the crowned heads of the world, from the earliest dawn of history down to the present day. What control over the lives and fortunes of their fellow-mortals has rested in the hands of men who, in the light of modern knowledge, cannot be regarded as other than "inspired" lunatics! How often, the author asks, has a paroxysm of mania, an epileptic spasm, or a fit of melancholia, cast the die of war, broken treaties, elevated one gilded puppet or dethroned another, and laid whole nations in tears and their homes in ashes? When one looks back with trembling horror on the scenes in the past which have made this earth a hell, of people constructing and then destroying, greeting and then killing, kingdoms rising on the ruins of kingdoms, and ever the fierce play of individual human passions in the foreground of the action, the question naturally arises, what part did madness play in this kaleidoscope of events? It is not necessary to go very far back to see that formerly only the more salient and obvious forms of mental aberration were recognized. Wild fury and dreary melancholy could be seen and feared by all, but could we apply the torch of modern science, lighting up the obscure places in the physiology and psychology of man, to the great leaders whose influence has directed the lines of history, we should doubtless find many of the mighty movements of men

to have been stirred up by volcanic mental forces, leaping beyond the conservatism of normal life by uncontrollable impulse. We should see, in fact, that the sane were led on by the insane. We are brought face to face with the spectacle which was frequent enough in mediæval times, of strange epidemics of madness, when, for the time being, the reason of the masses was subjugated and overcome by the blast of imperious folly. Earnestness deepens into fanaticism; the whole mental life, perception, memory, conception, will—all the forces combined are eventually swallowed up in the overmastery of a single idea which enslaves the reason and runs its destroying course across the face of society. In social perturbations, such as the Revolution, which changed the structure of the social edifice in France, and thence throughout the world, the effect of gusts of popular passion on the public mind, is well exemplified. The breaking-down of all the traditional harness of thought and action deprives the reason of its mainstays, with the result that minds of unstable equilibrium are unable to resist the torrent, and hopelessly drift down the stream of unreason. English history affords abundant illustrations of our theme, alas! for the divinity that doth hedge in the princes of the earth: as far back as the Henry whose melancholy was so touchingly and truthfully depicted by Shakespeare, and as recently as George III, whose long and distressing dementia is a matter of history. These cases are known to and read in detail by all, but how many more can be detected by the scrutiny of science! Perhaps the annals of no country other than Spain shows such a procession of crowned lunatics, sporting one moment with the grave affairs of what was once the mightiest nation on the globe, and the next absorbed in the last new bauble or antic that attracted or swayed their idiotic brains. The whole line of the Bourbon succession in Spain is a ghastly travesty of dominion. Leaving the musty past, we have but to remind ourselves of the artist King of Bavaria, who plunged into his own lake, dragging with him his physician; of King Otto to-day, whose insanity will end only with the grave; of Frederick William of Prussia, whose insanity forced the late Emperor William to the throne as Regent; and of Dom Pedro, late the

monarch of Brazil, who for years vainly sought relief in travel from the cares of State. The revolution which has swept him from his throne may perchance restore to him that equanimity of mind to which he had long been a stranger. Who can resist the conclusion that the abnormal life of him who lives alone, elevated on an artificial pedestal above his fellows, is surrounded with precipices and pitfalls dangerous both to body and reason!—*Med. Press and Circular.* (*Cincinnati Lancet-Clinic.*)

**The Need of Nourishment in Diphtheria.**—(Dr. J. A. De Armond, in *Weekly Med. Review*, Oct. 26, 1889.)—Feed the patient. He is sick at the stomach and won't eat? Dissolve the membrane two to four times a day and he won't be so sick. He does not want to eat? Then give him liquid food, and milk easily stands at the head of the list. But he won't drink it? Then direct powders of pepsin to be given in two to four or six tablespoonfuls of milk every half hour. Alternate this with your internal medicament and you have a treatment that keeps step with good judgment, and it is strictly in accord with all that is known of the therapeutics of the disease. There is no cure for the disease. It is a self-limited disease, and being that, you cannot fail in preserving the strength of the patient. It is much more rational to help the system from the start than to jump in and fight the disease as an entity, striking right and left, hitting friend and foe alike, only to find in the end that the battle was all too large for the small battle-ground to stand. Of course milk, and by milk I mean the very best of milk, and the more cream the better, if not too hard to digest, will become very tiresome as a regular diet. It can be varied by giving beef broth, malted milk, and any of the prepared foods whose value has met the demands of investigation. Food may be given cold or warm, as best pleases the patient. Many times the allowance will be lost by emesis, but the same thing will occur if simple water is swallowed. I am very sure that by simply directing a powder of pepsin with the nourishment the attendants will not be likely to listen to the pleadings of the patient as when the food is given alone. It may be said that by



giving nourishment so frequently you interfere with the giving of needed medicine. I know of no drug that is likely to be given that will in any way interfere with this system of nourishing the patient. The various forms of iron might, but if it comes to a question of supremacy between tincture of iron and nourishment, you will have no reason to regret the rejection of iron. Indeed there can be no question that in order that enough iron to be of any avail is given, providing it is of any avail—a matter I seriously question—the stomach must be kept in a state of great irritability continuously. After all, nothing has been found to equal good food in the fabrication of good blood. In diphtheria surely the blood suffers soonest. I am well satisfied that if nourishment were given with the same free hand that many drugs of doubtful utility are handed out there would not be so urgent need of battling a desperate foe at the end of the fight with stimulants. After all, stimulants are only valuable because they help to tide over a bad spot. When you come to enumerate the things you can do in diphtheria you find the number is not large. Control fever, dissolve the membrane, keep the nostrils clean and feed the patient. These you can do. Don't neglect their accomplishment in the questionable task of curing a disease which, after all, is only strong in weakness.—*The Epitome.*

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THE Educational Committee of the General Council of Medical Education and Registration of Great Britain have unanimously reported that it is desirable that steps should be taken by the Council to extend the period of medical study to five years. The Committee, while strongly of the opinion that the number of systematic lectures in certain subjects of medical education should be reduced, are not prepared to recommend the method of effecting such reduction till the Medical Council has expressed its mind on the suggestion for an extension of the period of study to five years. The committee's report will be the first business dealt with at the May meeting of the Council, and there appears no doubt but what its suggestions will be carried into effect. A very significant suggestion is the recommendation for lessening the number of systematic lectures given on the great majority of subjects. This is strongly recommended even should the course be extended to five years.

For the credit of the Canadian profession we sincerely hope that the members of our different Provincial Medical Boards will soon see the necessity of placing their houses in order. There is an urgent necessity for every board in Canada to diminish the number of systematic lectures required. Owing to the present faulty system of requiring attendance on so many didactic lectures, the students in this country are placed at a serious disadvantage as compared with their brethren in England and elsewhere. There is no country in the world at the present time that demands of its medical students so much attendance on didactic work. If this extraordinary attendance meant the

turning out of men better prepared for their life work, the result might justify the means employed, but it is well known the contrary is the effect. Canadian graduates, no doubt, as a rule, take a fairly high place, but we feel confident that their position would be still higher if the requirements of our boards were brought more into line with European countries. In Canada we are in many respects keeping pace with the general progress of medical education, but in the matter of attendance on didactic lectures we are several decades behind the times.

At the meeting of the British Medical Council in May last general astonishment was expressed that students were required by some of the degree-granting bodies to attend as many as 1200 systematic lectures during their course. The Quebec Medical Board, which is the greatest sinner in this respect, demands an attendance on upwards of 1800 lectures during the four years course. The other Provincial Boards demand about 1700.

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## THE FACULTY OF COMPARATIVE MEDICINE AND VETERINARY SCIENCE OF MCGILL UNIVERSITY.

A very interesting and important meeting was held in the library of the Medical College, McGill University, on Dec. 6th, being no less than the official inauguration and installation of the Faculty of Comparative Medicine and Veterinary Science.

Sir William Dawson, Principal and Vice-Chancellor of the University, assisted by Professor Craik, Dean of the Medical Faculty, inducted the members of the new faculty. After reading their appointments, and the amended statutes affecting the faculty, the Principal formally handed over the responsibility and direction of the faculty to the newly-appointed Dean.

The faculty consists of the following:—

- D. McEachran, F.R.C.V.S., V.S. Edin. J.P., etc., appointed Professor of Veterinary Medicine and Surgery and also Dean of the Faculty.
- Malcolm C. Baker, V.S., appointed Professor of Veterinary Anatomy.
- Charles McEachran, V.S., appointed Professor of Veterinary Obstetrics and Diseases of Cattle.

And the following Professors in the Faculty of Medicine appointed associate professors of the new faculty, viz., Gilbert P. Girdwood, M.D., Professor of Chemistry; Wesley Mills, M.A., M.D., Professor of Physiology; George Wilkins, M.D., Professor of Histology; D. P. Penhallow, B.Sc., Professor of Botany; James Stewart, M.D., Professor of Materia Medica; and W. G. Johnston, M.D., Demonstrator of Pathology and Curator of the Museum.

The history of veterinary teaching in the province of Quebec is of a comparatively recent date. In 1866, a few months after the arrival of Mr. D. McEachran in Montreal, he commenced to deliver a course of lectures on veterinary science in connection with the medical faculty in their lecture room on Cotte street. In this course he received the sympathy and support of the Board of Agriculture, of which the late Major Campbell was president, Sir William Dawson, the Principal of McGill University, the late Dr. George Campbell, who was Dean of the Medical Faculty, as well as the Professors of the Institutes of Medicine, Chemistry, and Botany. In 1875 the growth of the school was such as to necessitate a special establishment, and the present buildings were erected on Union Avenue at the expense of Mr. McEachran. It may truly be said of this school that it has all along been conducted solely in the interests of veterinary science, and at considerable expenditure of both time and money to its head and founder, as well as those associated with him. From its inauguration, students were required to pass a matriculation examination, and to attend three full sessions of six months, whereas, even to the present time, the majority of veterinary schools on this continent admit students merely on payment of fees and require only two short sessions of attendance. However, the high standing attained by this school both at home and abroad, and the success of its graduates wherever they have gone, many of them being teachers in the numerous veterinary colleges both in Canada and the United States (most of which are off-shoots of the Montreal school), and in agricultural colleges of both countries, besides having furnished most active members of the expert scientific staffs of the Bureau of Animal Industries

in the United States and the stock quarantine service of Canada. It must be very gratifying, indeed, to the teachers of the school to receive such high appreciation of their earnest and successful labors as has just been made by a university occupying such a high position in the scientific world, and, withal, one so conservative. McGill, too, is to be congratulated on her efforts to encourage and promote a branch of medical science which is daily becoming more and more important, not only on account of the direct bearing it has on the great agricultural industries of nations, but also on account of the close and inseparable relations it bears to public health in dealing with and preventing those animal diseases which recent investigations have proven to be communicable from animal to man. The new faculty is to be wished every success, and there is little doubt but the same influences which have maintained it for the past twenty-three years will continue to improve the greater facilities and advantages which it must enjoy as a faculty of McGill, and it is to be hoped, too, that the friends of the new faculty will see that its progress and usefulness will not be hindered for want of means to carry out improvements and extensions incident to its new connection. Other cities and countries have done much to alleviate the sufferings of poor dumb animals by the establishment and endowment of homes for homeless dogs and hospitals for the treatment of the animals of the poor, in which connection the new faculty could be of great service in carrying out the wishes of the humane and charitable. Montreal has reason to be proud of her noble liberality in connection with hospital work, but, as is well known by every member of the Society for Prevention of Cruelty, there is much mute but unalleviated suffering among the animals of the poor. This faculty have already advertised free treatment on two days a week for animals belonging to poor people, and it is to be trusted that their usefulness in this direction will be extended.

## EDITORIAL NOTES.

—The medical department of the University of Maryland has decided to extend its course to three years. When contemplating such changes, it would have been wise to have made the course four in place of three years. Before many years a five years' course will be the rule with those medical schools on this continent who really aim at turning out good men.

—Richard von Volkmann, the distinguished German surgeon, is dead. He was among the first to recognize and put into practice the teachings of Lister in relation to the treatment of wounds. Among his favorite studies was the investigation of cancerous and tuberculous formations. Volkmann will be remembered by many in his fatherland by his poetical effusions, especially his "Reveries at French Firesides."

—Dr. Burgess, of the Hamilton Insane Asylum, has been appointed medical superintendent of the Protestant Hospital for the Insane in this city. Dr. Burgess is in every way highly qualified for the position, and the friends of the institution are to be congratulated on the choice made by the governors. Dr. Burgess has had an extensive experience in the treatment of the insane, having filled important positions in several of the leading asylums of Ontario.

—The *Journal of Comparative Medicine and Surgery* will appear in future monthly instead of quarterly, and under the name of *The Journal of Comparative Medicine and Veterinary Archives*. Dr. R. S. Huide-Koper has undertaken the active management of the editorial department. In the past this ably conducted journal has filled a very important place in medical literature, and we have no doubt that in the future the same high standard will be maintained.

—A recent correspondent in the *Lancet* deplors the prevalence of the "sweating system" in the profession in England. Hard work and any quantity of it, with little remuneration, is, unfortunately, not confined to the medical practitioners of Eng-

land. It is the lot of hundreds of practitioners in Canada and the United States. While we have so many men in our ranks who estimate their services as worth from 50 cents to a dollar per year, we are not likely to have anything better.

—We are pleased to hear that it is the intention of the University of Pennsylvania to establish and thoroughly equip a laboratory for hygiene. The recent great extension of hygienic laboratories is one of the most important and hopeful advances ever made by medical schools. With hardly an exception, all the medical faculties of the German universities have complete hygienic laboratories attached to them. The University of Pennsylvania is to be greatly commended for its spirit and enterprise in being the first to establish a laboratory for hygiene on this continent.

#### NEW YORK POST-GRADUATE MEDICAL SCHOOL AND HOSPITAL.

—The executive committee of this institution have established a clinic for diseases of the rectum, to be under the care of Dr. Charles B. Kelsey, for the treatment of poor persons suffering from these diseases. Dr. Kelsey will also give clinical instruction in the Post-Graduate School on this subject. It is believed that this is the first institution in New York city to organize such a clinic, which has been long needed. The high and wide reputation of Dr. Kelsey, founded upon years of special work, will afford a guarantee that the cases will be skillfully treated. Dr. J. Blair Gibbs will assist Dr. Kelsey in this new departure.

## Medical Items.

The College of Physicians and Surgeons, New York, have decided to raise their tuition fee to \$200 per annum.

PERSONAL.—Dr. T. Johnson-Alloway has retired from the general practice of medicine, and will devote himself absolutely to the practice of his speciality.

—The number of students attending the Medical Faculty of McGill University during the present session considerably exceeds that of any previous year.

—The next meeting of the Congress of American Physicians and Surgeons will be held in Washington, in September, 1891, under the presidency of Dr. Weir Mitchell of Philadelphia.

—We are pleased to learn that active steps are being taken to establish a Maritime Medical Society, to be composed of the members of the profession in Nova Scotia, New Brunswick and Prince Edward Island.

—Prof. William Pepper of Philadelphia has accepted the invitation to deliver the Middleton-Goldsmith lecture before the New York Pathological Society. The subject of the lecture will be "Hepatic Fever."

—A recent number of the *Medical News* contains an account of a will made by an eccentric physician living in Pesh. He left a fortune of \$250,000, with instructions that it should be allowed to accumulate until it reached the sum of \$1,000,000,000, when it is to be devoted to the abolition of poverty throughout the world. It is no wonder that the trustees declined to serve.

—The American Academy of Medicine is endeavoring to make as complete a list as possible of the alumni of literary colleges in the United States and Canada who have received the degree of M.D. All recipients of both degrees, literary and medical, are requested to forward their names, at once, to



Dr. R. J. Duglison, secretary, 814 North 14th street, Philadelphia, Pa.

—The *Ophthalmic Review* begins its new volume with an American editor. Dr. Edward Jackson of Philadelphia, who succeeds Dr. James Anderson of London. It will, hereafter, contain original papers from American as well as English ophthalmic surgeons, with a list of all papers on ophthalmological subjects published in this country or in Europe, and full reviews of the most important of them.

—The eighth yearly issue of the *International Medical Annual for 1890* is announced for early delivery. The prospectus gives promise of excellencies surpassing all former editions. Its thirty-seven editors in the several departments are to give a summary of new remedies alphabetically arranged, also a resume of new treatment in dictionary form; with references to the medical literature of the world pertaining to the year's progress of medicine. Such a practical and helpful volume is of inestimable value to the medical profession. In one volume of about 600 octavo pages; price, \$2.75, post free. E. B. Treat, publisher, 5 Cooper Union, New York.