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CANADA

MEDICAL JOURNAL.

ORIGINAL COMMUNICATIONS.

The Glue Bandage as a primary setting for Fractured Limbs. By
GEORGE ROSS, A.M., M.D., House Surgeon, Montreal General
Hospital.

The use of the *Glue Bandage* as a primary setting for fractured limbs, has been introduced into this hospital by Dr. McCallum, within the past three months for the first time here, and as far as I am aware, for the first time also in this country. It may therefore be of interest to shortly record the following cases which were amongst the first so treated.

The method of applying the bandage being the same in all, one description of the general procedure will apply to all and avoid repetition. First then, it is necessary to procure some good suitable glue—the best for the purpose is Cooper's No. 1 white English glue, or else some of the finer sorts in thin sheets, which are manufactured in this country; it is prepared by first soaking in water for an hour or two, and then melting in a common carpenter's glue-pot; also some fine sheet-wadding, and several rollers made of thin cambric or old worn cotton, (new cotton is objectionable for it will not soak up the glue so thoroughly, and will make a less firm bandage.) The limb is then entirely swathed in a thin layer of wadding made by splitting the ordinary sheet in the middle to avoid unnecessary bulk, and then whilst carefully held in position by an assistant, the first roller is applied in the ordinary way; this done, it is smeared all over by a brush, or better still by the hand, with a good layer of the melted glue to which one-fifth part of alcohol has been added to accelerate the evaporation. The second roller is then applied, and in like manner coated thickly with glue. Some strips of bandage 10 or 12 inches in length, are then thoroughly soaked in the glue and placed over the seat of fracture, some vertically and others diagonally, so as still further to strengthen this part. The third roller is finally secured over the whole and covered with a thick coating of glue.

It is necessary now to sling the limb so that the air may have equal access on all sides to dry it. I have found that the outside coating will become quite dry in from 3 to 5 hours, when the sling may be removed, but the entire thickness of the bandage will not be found entirely consolidated for about 48 to 60 hours. After the lapse of this time, the leg is found to be encased in a perfectly-fitting boot, more solid than the thickest sole-leather, and can be moved in any direction without pain. In none of the cases has there been any complaint of pain from the swelling that we might expect to find occur shortly after a fracture had been sustained. On the contrary, the patients have all expressed themselves as feeling extremely comfortable. As soon then as the bandage has completely consolidated, it becomes necessary to split it down the front from one end to the other. Owing to the extreme hardness of the splint, this is a matter of some difficulty, except in the event of one's possessing a pair of powerful properly-constructed bandage-pliers: failing this however, the simplest plan is to slip a very thin piece of wood beneath it, and then cut on this with a sharp strong knife. Having thus split the bandage from end to end, a number of holes are bored on either side with a brad-awl, and a long tape being passed alternately through these, it is laced up like a lady's corset. The apparatus is then entirely complete, and may remain without being touched until union is perfect. The above description might lead some to suppose that the process was long and tedious, and in consequence objectionable, but our small experience with it in this hospital is such as to make us believe that by reason of its increased comfort to the patient, and of the facts that patients can sooner get up with safety with this than any other form of splint, and that it will never get out of order, and consequently never require re-adjustment, the advantages secured by its employment greatly counter-balance any slight trouble that it is necessary to take to ensure its proper application at first.

At this hospital, the above-described method has been put into practice in several cases of simple and compound fracture of the leg, and in all with most satisfactory results. In the majority of cases, the patients were permitted to get up on crutches on the third day from the receipt of the accident. In two, it was thought advisable to make use of a box splint for a few days previous to the application of the bandage on account of considerable swelling and rapid vesication.

The following short notes give an account of four of the cases so treated:—

Antoine M., aged 30, transverse fracture of both bones of the

leg, from a weight falling upon it, admitted 6th September, 1871. Glue bandage immediately applied, was allowed crutches, and to get up with the leg slung from his neck on the third day. Suffered no pain, and there was no swelling. Was discharged at his own desire on the 23rd September. The bandage was removed after six weeks, when a good, firm, straight union was found.

Severe P., aged 26, oblique fracture of both bones of the leg from a fall, admitted 5th September, 1871. Glue bandage immediately applied. Got up on the fourth day and walked on crutches from that time until the completion of the cure without any detriment to the limb. He was discharged on the 10th October, well.

Donald McL., aged 55, transverse fracture of both bones of the leg, about $2\frac{1}{2}$ or 3 inches above the ankle joint, from a heavy fall from a load of hay, was admitted on the 1st October, 1871. In this case there was considerable swelling about the joint and parts above it, and consequently it was thought advisable to make use of a box-splint until this should have subsided. This form of apparatus was therefore kept applied during one week, at the end of which time a glue-bandage was arranged on the limb in the ordinary way. On the second day subsequently, he was allowed to get up and move about. The bandage was retained for the space of six weeks, at the expiration of which time the fracture was found quite firmly united, and in a few days he was able to walk with a stick only.

Benjamin S., aged 16, was thrown from a horse on the 7th October, 1871, and sustained a fracture of both bones of the leg, just above the ankle joint. On admission a few hours after the occurrence of the accident, it was found that there was but little swelling, and consequently it was determined to apply the glue bandage immediately. This was done, and after it had been slit and laced in the manner already described he was able to get up on crutches on the third day. Although this patient was a very restless and careless lad, and very soon took great liberties with his limb, yet at the end of four weeks, on the removal of the apparatus, it was found that an admirable union had been effected, and after a few days longer he could walk without any assistance whatever.

It is needless to multiply examples; the above will amply serve to show what results may be obtained by the use of this form of apparatus, which I am sure needs only to be more used to be more fully appreciated.

Hospital Reports.

SURGICAL CASES OCCURRING IN THE PRACTICE OF THE MONTREAL
GENERAL HOSPITAL, UNDER THE CARE OF G. E. FENWICK, M.D.

Case 5—Wound of the Anterior Interosseous artery of the Right Arm, formation of a traumatic Aneurism, and subsequent ligature of the vessel at the point of injury. Reported by Mr. G. A. STARK.

C. P., æt 40 years, a native of Canada, was admitted into the Montreal General Hospital on the 25th September, 1871, under the care of Dr. Fenwick.

On examination it was found that his right arm and hand were tightly bandaged, and a compress of lint situated in the centre of the front of the fore arm, these on being removed showed the hand and fore-arm uniformly swelled from the tips of the fingers to the elbow. The swelling was hard and firm, no fluctuation was apparent, and the radial pulse could not be felt. Near the middle of the fore-arm, (palmar aspect) three inches above the wrist joint, there existed a transverse wound about an inch in length, the edges of the cut looked as if blocked up with lymph, and the surrounding parts were red and angry. On the posterior aspect at a point five inches above the wrist-joint, there was a small flattened elevation resembling a boil, from which there was a slight discharge of pus. Says he does not think that the knife which inflicted the wound transfixed his arm. The patient was confined to his bed, the arm bandaged, but not as tightly as before, the limb was suspended, ice-water applied, and a tourniquet was loosely applied over the brachial artery, with instructions to tighten it should bleeding set in.

HISTORY—He is by trade a butcher, and resides some few miles from the city of Montreal. It appears that on the morning of Tuesday, 12th September, while in the act of dividing a side of lamb at the back of his cart, his horse became restive and moved off, he ran the knife through the side of lamb and started to restrain his horse; on his return to complete his work, he did not notice that the point of the knife was directed towards him, at this moment the horse backed up and the knife came with some force against his arm and inflicted the wound referred to. Blood spurted out with considerable force and in jets, but it gradually slackened, and at the end of half an hour when the doctor of the village saw him, the hæmorrhage had ceased, but the man felt faint and weak. The wound was dressed, restoratives given, and absolute rest enjoined.

Two days afterwards the arm began to bleed again, the limb was somewhat swollen, the hæmorrhage was considerable, sufficient to make an impression on his system, and he felt faint. The doctor when he arrived at the house applied a bandage from the hand up to the axilla, and a tourniquet over the brachial artery, this had the desired effect of stopping the bleeding. He could not bear the pressure of the tourniquet very long, so that it had to be removed, this was followed by fresh bleeding after the lapse of some hours, which was again controlled by the tourniquet. This state of things was allowed to continue, successive bleedings occurring, and the man fearing the loss of his arm determined to apply for further advice and treatment, and came to the Montreal General Hospital.

September 24th—Passed a good night, rested well, complains of numbness in the fore-arm and hand, no pain nor bleeding, the limb is still suspended above the level of his body, he is confined to bed, and ice water constantly applied. The tourniquet is loosely retained over the situation of the brachial artery.

27th.—The patient is very comfortable, no pain, the numbness continues, no return of the hæmorrhage, no change was made in the treatment.

28th—This morning early while turning in bed he experienced a sensation of warmth about the arm, and noticed that he was bleeding freely. the tourniquet was at once tightened, which arrested further loss of blood. Dr. Fenwick received early intimation of this circumstance, and came to the hospital before the hour of visit, when he decided on cutting down and ligaturing the bleeding vessel at the point of injury.

The patient was removed to the operating theatre and placed under the influence of chloroform. The tourniquet was removed and also the bandage; the brachial artery was given to an assistant with instructions to exert pressure if necessary, and the operator commenced his incision from below upwards, bisecting the original wound, the incision extending from one inch above the wrist, and seven inches upwards, rather inclining to the ulnar side, and on slitting up the fascia, the palmaris longus muscle was observed to have been divided by the original wound. The finger of the operator was then introduced through the wound in the muscular structures, and he found that he entered a well defined aneurismal sac having a lining membrane, and the direction of which led upwards between the superficial and deep layers of muscles. To reach this and the interosseous space, the flexor sublimis digitorum was separated from the flexor carpi ulnaris, this was effected with the finger, the loose intermuscular septum yielding

readily, and the former muscle was drawn to the radial side. The aneurismal sac was then opened, and all clots of blood turned out, and at the lower edge of the aneurismal tumour, the interosseous artery was felt pulsating, and on removing with the finger the fibrine which had formed around, two bleeding points were observed, which were readily secured and ligatured, all clots were removed, the parts sponged out with a lotion of carbolic acid, and the integument brought together at its upper and lower end. Three interrupted wire sutures were inserted above and one at the lower part, the central portion of the wound being left gaping, so as to permit of free discharge, a piece of lint dipped in carbolic acid lotion was applied and covered with oiled silk, and the patient removed to bed.

Evening—Is comfortable, does not complain of any pain, pulse 120; no oozing of blood, says he does not know from present feelings that any operation had been performed.

29th—Passed a good night, slept comfortably, no oozing, pulse 112; the wound looks well, says he feels no pain nor uneasiness.

30th—Slept well, no pain in the arm of any account, pulse 100; bowels acted without medicine, his appetite is improving, and he relishes his food, slight discharge of pus from the wound, the same treatment of the wound to be continued.

October 1st—Progressing favourably, there is very little pus escaping, but what is secreted has free exit, pulse 92.

3rd—The ligature at the distal extremity of the artery separated and came away this morning, and three sutures were removed. The discharge which is small, has free exit, the part was ordered to be washed out by injection with a syringe with a lotion of carbolic acid (1 to 40) the general symptoms are improving, he asked for more to eat, and a mutton chop was ordered with a pint of ale.

4th—The ligature from the proximal extremity of the artery separated and was removed, the edges of the wound were brought together with adhesive straps; he is gaining strength, and expresses a desire to leave his bed.

5th—Was allowed to sit up, the arm being supported in a leather sling, the wound looks well and is granulating, the pus which is small in quantity is healthy, cicatrization is advancing, and he can move the fingers without much pain or uneasiness.

7th—The wound is smaller, the upper part nearly united, very little suppuration, he expressed a desire to leave the hospital and return home, which was assented to, instructions being given to continue the dressings, and commence passive motions of the hand and wrist. Discharged.

Case 6—Penetrating wound of the Chest, with wound of the Right Lung.

Reported by Mr. AUSTIN PEGG.

Felix Barré, a powerfully built Canadian, aged 22, bargeman, was admitted at 2 a.m., on the 23rd November, 1871.

The following is the account given by him of the manner in which he met with the accident. He had been drinking with some friends in a tavern, and just as he was leaving, about 10.30 p.m., he was struck a violent blow on the stomach from a large stone thrown by one of two unknown men, who had been apparently lying in wait for him; enraged at this, he gave chase, caught one of his assailants and threw him to the ground; then whilst he was engaged in the tussle with the one, the other came up behind him and dealt him a blow from a knife in the back. He immediately fainted, and was carried by his friends to the barge to which they belonged, when he vomited freely, and is said to have spat up some blood. The hæmorrhage from the wound up to this time had been very considerable. On his admission it was found that there existed a wound about $1\frac{1}{4}$ inches in length, running in a vertical direction, and situated midway between the scapula and the vertebral column, opposite the 6th and 7th dorsal spinous processes. There was then no hæmorrhage. No exploration of the wound was made at the time, as it was deemed inadvisable. There was pretty extensive emphysema of the back of the right chest, extending as high as the top of the right shoulder, down to the edges of the ribs and to a considerable extent round the side. Percussion gave a decided amphoric note over the lower lobe of this lung, and the breathing was extremely weak and distant. By reason of these symptoms the diagnosis was that of perforation of the lung with pneumothorax. His general condition was good; pulse 90; respiration 22; does not complain of much pain in the affected side.

Patient was put to bed and water dressing applied.

November 24th—Slept pretty well for a few hours. Complains of some pain on right side, slight cough, no expectoration, pulse strong and hard, 72 per minute. and respiration 28. Physical signs similar to what was found at the original examination.

25th—Considerable pain and distress, especially on lying down, which has continued through the night, cough troublesome and painful, no expectoration, the emphysema persists; pulse 62; respiration 25.

26th—Passed a restless night, somewhat feverish to-day, tongue thickly coated; pulse 82, full and incompressible; respiration 29; inspiration is still accompanied by considerable pain in the side. The emphysema is less. The percussion note seems less of a

tympanitic character, and the respiratory murmur is beginning to be heard much more distinctly, no friction sound.

27th—Rather more feverish, tongue thickly coated; pulse 90, hard and somewhat irregular; respiration 34, and chiefly abdominal; breathing more jerking and laboured than before; countenance anxious; complains of pain extending from the base of the lung, past the wound up to the right shoulder; emphysema nearly gone; wound suppurating. To relieve the distress exhibited in the chest, he was bled from the arm to about 15 ozs., the blood was taken from a large opening in the vein, whilst he was in the sitting posture, and continued until syncope was threatening.

28th—Rested well last night; pulse 75, and regular; respiration 28, and more thoracic; small quantity of healthy pus coming from the wound; pain is completely relieved since the bleeding, cough disappearing, and now unaccompanied by pain; slight emphysema still perceptible.

29th—Feels much better, free from pain, emphysema all disappeared except in the immediate neighbourhood of the wound itself.

30th—No cough, no pain, pulse 70; respiration 25. The Edinburgh red wash was substituted for the previous dressing, wound granulating well.

December 1st—Pulse 63; respiration 23; feels well and appetite returning. The abnormal resonance of the chest has nearly disappeared, and the right side expands now nearly equally with the left.

He was allowed up on the 5th December, and was discharged on the 7th December quite well.

Case 7.—Cancerous Tumor of Groin of large size.—Removal by Excision.—Pyæmia.—Death.—Reported by Mr. D. C. CRAM.

Thomas B., a tall spare man of decidedly sallow and unhealthy aspect, aged 58, was admitted into the Montreal General Hospital on the 2nd December 1871, suffering from a large tumor situated in the left groin, occupying the whole of the lower half of Scarpa's Triangle and overlying the Saphenous opening. It is seen as a projecting mass, measuring 9 inches in its vertical diameter and 7 inches in its transverse diameter, its surface generally is smooth but irregular, presenting several nodular elevations which give a most distinct simulation of the feeling of fluctuation. The appearance of the integument is unaltered, except at the lower extremity of the tumor where it presents a dark red color: at this point also, for a space of about 1½ inch in diameter it seems

to be somewhat adherent. The tumor seems freely movable in all directions, the firmest point of attachment being at the extreme upper part. The growth was first noticed as a small painless lump three years ago; it increased in size but very slowly until last spring at which time it was about the size of large hen's egg; up to this period also he had experienced no pain in it; from this date, however, the tumor grew rapidly and pain in it began also to be felt—this was of a lancinating or shooting character and paroxysmal. About two months ago he felt considerable heat and soreness in the lower part of the lump, which was accompanied by redness. He applied then for the first time to a medical man who, believing it to be an abscess, made an incision into it; no matter was found, but it bled rather profusely. About one week after, hæmorrhage from the small wound again ensued and was with difficulty checked. Three days before admission into hospital severe bleeding had also been experienced. After consultation, the opinion generally held was that the tumor was of a malignant nature but had not yet involved the surrounding structures, while some believed that the nature of the tumor was probably fibro-cystic, in support of which view was advanced the distinctness of the fluctuation in the nodules before mentioned and the slow growth of the tumor at first. The advisability of its immediate removal was agreed upon by all.

Accordingly, on the 4th December, with the patient fully under chloroform, Dr. Fenwick proceeded to its excision in the following manner. In order to preserve as much integument as possible and at the same time to remove all the skin which might be involved in the growth, an incision was first made in a circular direction, completely surrounding the reddish portion of skin which has been mentioned as occupying the apex of the tumor, from the upper margin of this, a second incision was carried vertically upwards in a straight line for a distance of about 4 inches. The flaps thus mapped out were then dissected up and the whole tumor was exposed; it was then found that it lay entirely upon the fascia lata, and the deeper parts of the tumor were rapidly separated by the fingers and the removal was completed. One small vessel only required ligature; the large saphena vein was exposed for a distance of three or four inches in the course of the dissection and was carefully separated from the tumor without sustaining any injury; a branch of the vein, however, was cut across, which it was thought advisable to secure as it bled pretty smartly and his strength had been already severely taxed by the previous bleedings; it was therefore fastened by an acupuncture needle, the method by the quarter twist being made

use of. The wound was then washed out with solution of carbolic acid 1 to 40 and closed by means of metallic sutures, there being ample integument to cover the whole surface—dressings of the same solution were applied over all.

5th December.—Rested well after an opiate but has had considerable pain in the wound from which there is a slight sanious discharge; dressings were renewed. Pulse 100. Tongue furred and some thirst.

6th December.—Restless during the night. Wound discharging considerable amount of sanious pus. Three or four sutures were removed and the whole was thoroughly syringed with the solution of carbolic acid. Pulse 120. Tongue rather dry in centre.

7th December.—Passed a bad night. Wound looks unhealthy and discharges profusely a thin ill-smelling fluid, the thigh is considerably swollen and a slight red streak is perceptible running down the line of the lymphatics on the inner side. His appearance is anxious and depressed. Pulse 130. Tongue dry and brown. Temperature $104\frac{1}{2}$. It was noticed to-day that the urine had become of very dark olive-green color, in fact almost black. This condition being doubtless due to the free use of the carbolic acid, plain water was substituted for the previous lotion. Ordered an extra quantity of beef-tea and 6 oz. wine.

8th December.—Is quite sallow-looking and greatly depressed. Wound sloughy-looking; lymphatics red and prominent as far as the inner ankle, thigh greatly swollen. Pulse 140. Tongue very dry and brown. Temperature 104. Black urine persists. Yesterday afternoon had a severe rigor which was followed by high fever and sweating. He complains to-day of soreness in the backs of both hands; these points present a red appearance and are tender to the touch, abscesses evidently threatening to form. Ordered: Poultices to the wound—4 oz. Brandy—and the following. R. Potass; Chlorat. ʒii . Tr. Ferri Mur. ʒiv . Quinæ Disulph gr. xii . Aquæ ad. ʒviii . M. To take one table-spoonful every 4 hours.

9th December.—From the time of last report he rapidly sank, pyæmic deposits being distinctly perceptible on the backs of both hands by 8 p. m. yesterday, and tenderness and pain having been developed in both elbows and both shoulders. He died at 10 a. m., this day. No post mortem examination was permitted.

Description of Tumour.—Upon examination the tumour was found to be entirely encapsulated, so that in its removal very little difficulty was experienced. Its weight was 1 lb. $13\frac{1}{2}$ ozs., and it presented on its surface several nodules, which were perfectly

diffluent, and gave the impression of the presence of fluid contents. Those on the surface of the tumour appeared to be distinct, as though they were separate cysts.

On cutting into the mass it resembled somewhat the structure of brain, only firmer in consistence. The nodules before referred to, extended through the mass and were separated by strong septa.

A considerable number of small vessels existed in the centre of the tumour, and which appeared to be in direct communication with the wound which had been made with the lancet of his former medical attendant. When scraped or pressed upon, a thickish juice exuded. The microscopic examination yielded the characteristic features of soft cancer.

Correspondence.

DEATH FROM HYPODERMIC INJECTION OF MORPHIA.

To the Editor of the Canada Medical Journal.

SIR,—I send the following paragraph, containing a statement of the death of the late Dr. Stanton, of New Brighton, Penn., from effects of Hypodermic Injection of Morphia, deeming it of sufficient interest to the profession at large to be inserted in the CANADA MEDICAL JOURNAL.

DR. DAVID STANTON.

CAUSE OF THE DEATH OF THE AUDITOR-ELECT OF PENNSYLVANIA.

A letter from Mr. D. McKinney, JUDR., and Mr. J. E. Jackson, friends of Dr. Stanton, and who were with him at the time of his death, gives the following interesting particulars:—

The lamentable death of our friend Dr. Stanton has been so variously explained, that it is due to his memory that a truthful statement of the case should be given to the public.

About six weeks ago Dr. Stanton made two post-mortem examinations, in doing which he had to handle for over an hour decomposing tissues, and inhale the impure air from the opened bodies.

No immediate bad result was noticed, but two weeks ago he spoke to his professional friends about it, and said he believed his system had been slightly poisoned, as he had not felt perfectly well since the examinations. Last Friday a small erysipelas inflammation appeared on his left cheek, accompanied by a slight chill; on Saturday, at five p.m., the erysipelas involved the whole of the cheek and one-half of the nose. There was also a slight fever. The portion of the face involved in the disease was exceedingly tender, and he said the burning in it gave him no rest.

As his physician was leaving him he remarked that he had lost so much sleep for several nights, that he seemed to have got past his rest, and thought it best to take a small injection of morphia to enable him to pass the night comfortably. His physician offered to give him the injection, but he said he would administer it himself, as he did not wish to take it until near bed-time. At this time Dr. Stanton was cheerful, but

manifested no excitement. He was not confined to bed, and he walked about the room with almost his usual vigor.

Dr. Stanton took the morphia between seven and eight p.m., inserting it deeply into the inner part of the arm near its junction with the shoulder; the dose was about one grain. For a while afterwards he conversed pleasantly with his family, and then went to sleep. About half-past nine p.m. his wife became alarmed at the character of his breathing, and finding it impossible to awake him, sent for neighboring physicians. Medical attendance reached him by ten p.m. His breathing was then stertorous, his heart's action feeble and irregular, his pupils greatly contracted, his extremities cold, and his stupor profound. Every remedy and appliance known to science were promptly used for his relief but without avail. He continued to sink until half-past one o'clock on Sunday morning, when he expired. In the opinion of those physicians who witnessed this sad death scene, Dr. Stanton's death was caused by the unusually prompt and complete absorption of the morphia, prostrating a system already struggling with cadaveric poisoning. Thus perished one of the brightest ornaments of the medical profession; a victim to his professional devotion, and to the remedy he had so often successfully used to relieve the sufferings of his fellow-men.

From the above statement of the unfortunate result attending Hypodermic injection of Morphia, it would be well for the medical profession to be warned against its indiscriminate use, especially in all cases where symptoms indicate a tendency to cerebral congestion, as in all probability was the case of the late Dr. Stanton; the fatal effects of which, was more certainly produced by the morphia being inserted in the proximity of so important and numerous vessels as surround the Axillary Plexus.

The unfortunate result of the late Dr. Stanton's case should be a warning to the medical profession, to be guarded in their post-mortem examinations, as well as to diagnosis with much care the cases coming under their supervision, whether Hypodermic operations can be safely performed, and upon what parts morphia can be inserted with least danger of fatal results. "Have you any statistics showing whether any, and how many fatal cases there have been from Hypodermic injections of Morphia and what remedies, if any, have been used to counteract its effects?"

In cases where there is restlessness and loss of sleep, would not Chloral Hydrat be preferable to Hypodermic injection, especially where any possible doubts existed as to the use of the latter. I should be glad of your opinion and also of any remarks that might throw light upon this subject, with a view of eliciting further inquiry and discussion amongst the profession at large. It is very much to be regretted that the medical gentlemen who attended Dr. Stanton, did not hold a post-mortem, and give results for the benefit of the profession throughout the land.

I may remark in conclusion, that Dr. Stanton was a relative of the late Honble. Mr. Stanton, Secretary at War of the United States, during their recent civil war, and had by his many years experience and observation in the army, director in hospitals, and

in private practice, become one of the most distinguished medical men in the vicinity of New Brighton, Penn. In fact he held so distinguished a position, that he had been recently elected as Auditor General of the State of Pennsylvania. His untimely death has caused a deep feeling of regret by a large circle of friends, as well as by his confreres in the vicinity of New Brighton and other tracts of Pennsylvania. *Requiescat in pace.*

FRELIGHSBURG, J. CHAMBERLIN, M.D.
 1st December, 1871. Ex-President of Col. Phy. and Surgs.,
 Lower Canada.

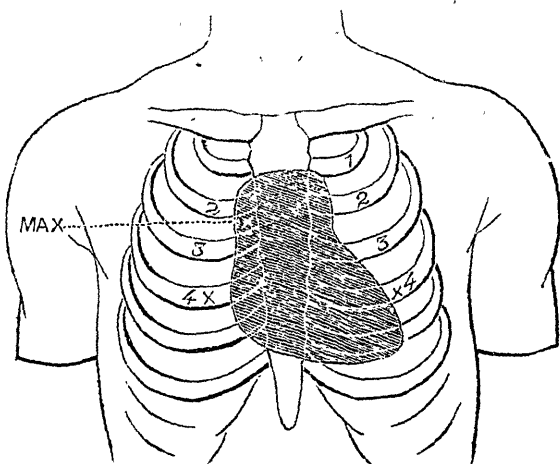
Proceedings of Societies.

Proceedings of the Medico-Chirurgical Society of Montreal, 4th November, 1871.

The Society met at the rooms of the Natural History Society. The President, HECTOR PELTIER, Esq., M.D., Edin. in the chair. After preliminary business, R. P. Howard, Esq., M.D., read the following interesting paper on Thoracic Aneurism:

MR. PRESIDENT,—Having lately met with two cases of Thoracic Aneurism in private practice, and had an opportunity of inspecting the bodies after death, I thought a record of their chief features, and an analysis of some of their more important symptoms might interest the Society this evening.

CASE No. 1.—On the 17th June, 1871, a powerful French carter



of about 38 years of age, called upon me for examination of his chest, and informed me that Dr. Hingston had sent him.

I was rather pressed for time, but made the accompanying diagram of the physical condition of the chest, with the following note of the more important physical signs.

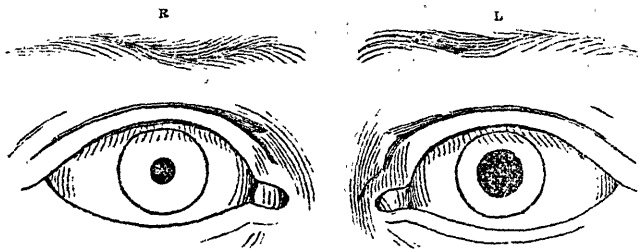
Visible pulsation between 2nd and 3rd right ribs along border of sternum; and dullness on percussion at same point.

Double murmur of maximum force over this spot; transmitted up side of neck and down lower sternal region, and feebler at xyphoid, and at 4th right cartilage than at 3rd; this especially true of the diastolic murmur. Only a systolic murmur audible at left nipple. No murmur on left side of neck. No dullness over course of arteria innominata, nor across upper part of sternum above level of 1st inter-costal space.

Right pupil smaller than left:—^R 0 ^L O

Slight internal strabismus of right eye.

Visible pulsation of radial arteries."



This man had a weak husky voice as if he had chronic laryngitis, and there were signs of hypertrophy of the heart, the impulse of which was heaving and powerful. He was subject also to dyspnoea. After the examination I sent him back to Dr. Hingston, with this diagnosis written. "Aneurism of ascending portion of aortic arch not involving the innomina, but implicating the recurrent laryngeal nerve," or words to that effect.

The man returned twice subsequently, to show himself to me, and in the month of July or August following, his brother-in-law called to say that he had died suddenly, and that he (the messenger) had just been at Dr. Hingston's to inform him of it, but learned that the Doctor was from home.

I begged an examination of the body, and not being able to be present, wrote to Dr. Ross to make the inspection for me, and repeated the above diagnosis in my note to him. As you will see, thanks to Dr. Ross, the post-mortem dissection confirmed the anti-mortem opinion to the letter.

The ascending aorta is greatly dilated from its origin to about the giving off of the innominate artery. The dilatation presents a moderate pouch or lateral dilatation in the cavity of the arch,

about the point of union of its ascending and transverse divisions. A much larger pouch occupies the posterior aspect of the ascending portion. The circumference of the vessel at this pouch is nine inches. The great vessels arising from the arch are normal; as are the aortic valves. The heart is affected with considerable eccentric hypertrophy.

The notes of Case No. 2, I will read as they were taken.

CASE No. 2.—Aged 63, a tall man 6ft. 1in. in height, was examined by me some time ago (10 or 12 years ago he says,) and pronounced to have disease of the heart, and warned not to over-exert or otherwise expose himself.

Last night, October 17, 1871, about 10 o'clock, while sitting and conversing, he was suddenly seized with violent pain at mid-sternum, extending to inter-scapular region, and soon down both arms; he felt faint and unable to breathe, and thought himself about to die. The pain in a milder degree continued most of the night, and about 5 a.m. of the 18th, his daughter called upon me to relate the above.

I visited him at 1.30 p.m. on that day, and found him in bed and relieved of the pain, although soreness remained. The external jugulars on both sides much distended and large; not pulsating—the visible area of cardiac pulsation not increased, indeed cardiac pulsation not marked; and apex beat not easily felt—it falls within vertical line of left nipple—impulse not strong.

Dullness on percussion marked along upper sternal region from 4th rib upwards, and for a full inch to right of sternum from the base of the heart to first right inter-costal space—does not extend to left of sternum. Indistinct systolic, but no diastolic murmur audible from xyphoid cartilage up to level of 4th inter-costal space. Here systolic murmur is rather louder, muffling the 1st sound, and ending in a short 2nd sound which is free from murmur.

The systolic murmur is single to the level of 3rd right cartilage, and then it is replaced by a double murmur which is audible chiefly along right border, and to outside of that border of sternum, from 3rd rib to upper border of 2nd. its point of maximum loudness being at level of 2nd interspace, and just outside right border of sternum. No pulsation to be felt over the centre of dullness, and double bruit. The murmur is peculiar, somewhat sharp and high pitched, both parts somewhat alike, but sufficiently unlike to be differentiated.

Murmur not transmitted up innomina or carotids. Episternal pit allows finger to become conscious of pressure of aortic arch,

Pupils alike, and of medium size, radials calcareous and equal in rythm. Detect no difference in respiration in corresponding regions of front of chest, a few sputa lately expectorated contain blood.

Query? Is there aneurism of ascending aortic arch or dilatation of same part of aorta?

7 P.M.—Daughter had called to say the pain had returned severely within an hour, and was worst in left arm, of which he appeared to have lost power.

19th.—No double murmur audible to-day at base of heart, or right edge of sternum, the systolic basic murmur too is very feeble. He feels very much better. The cervical veins are quite as turgid; no traces of disease in lungs, except a little remote blowing respiration at root of right lung. Says that the weakness of left arm has been present from the outset of the attack, although he did not mention it to me before. Has perfect feeling in it, but wants muscular power very much. Can't grasp my hand. Left leg and left side of face unaffected. Pulse about 80.

20th.—Pain returned suddenly at 2 a.m., when his daughter held him up in bed; he said the pain began in back, and then was instantly felt at mid-sternum. The veins of neck appeared to be bursting; he did not cough, but lay back off his daughter's arm and was dead.

AUTOPSY.—On raising the sternum found a thin layer of coagulated blood infiltrating the anterior mediastinum—over a pint of blood in left, and in right pleura respectively.

LUNGS—healthy. Pericardium contained somewhat over a pint of blood, most of which formed a soft coagulum about the heart; no signs of pericarditis present. The aortic arch is dilated uniformly from its origin at the heart, to where the innomina is given off, and blood is extravasated between its coats, chiefly about its concavity.

LIVER normal. Both KIDNEYS granular.

HEART slightly enlarged. Aortic orifice admits thumb readily. Two semilunar segments united together, and the seat of thick deposit of calcareous matter; these by their union and thickening seriously obstruct the orifice. The other segment tolerably healthy, and when down almost closes the orifice, but may admit a slight regurgitant stream. The dilatation of the aorta begins immediately above the aortic valve, and involves the vessel tolerably uniformly, although the coats bulge a little upon the convexity of the ascending portion; the width of the vessel an inch above its origin, is six inches. On slitting up the vessel, a T

shaped rent is found in its coats, occupying the concavity of the arch. The transverse rent is two inches long, and runs directly across the vessel, and involves the internal and middle coats; the vertical rent corresponds with the axis of the vessel, is about an inch long and somewhat jagged and irregular, as compared with the transverse slit, which is clean as if cut with a knife. Blood is extravasated for some two inches between the vessel and its sheath. The edges of the vertical rent appear to have been ulcerated along their internal surface: the coats at this point present the opacity indicative of degeneration. This vertical slit corresponds with a vertical rent three-quarters of an inch long in the external coat, and serous covering of the arch upon the posterior aspect of its concavity.

The first question which would occur to the physician after having examined the two patients, whose clinical histories have been given, would be: Are they the subjects of Aneurism or of true Intra-Thoracic tumour?

I inferred the former on the following grounds:—1st. Aneurism is very much more frequent than intra-thoracic tumour. 2nd. The ascending portion of the aorta is particularly obnoxious to sacculation and dilatation; and the visible and tangible pulsation, dullness on percussion, and maximum of double murmur in No. 1; the dullness on percussion and maximum of double murmur in No. 2, corresponded in site to the situation of the ascending aorta, viz.: From the base of the heart to the second rib, coasting along the right border of the sternum. This accurate localization of the ordinary physical signs of aneurism in the anatomical situation of the ascending aorta is (I am almost inclined to say) infallible evidence of aneurism of that portion of the vessel.

But 3rd intra-thoracic tumour could scarcely by any possibility correspond in exact site with the course of the ascending aorta, and if it did, it would be very unlikely to develop a double murmur of maximum intensity in the second intercostal space near the right border of the sternum. 4th. The most frequent variety of intra-thoracic non-aneurismal tumour is cancer, and is apt to co-exist with tumours elsewhere, and to give rise to varicose enlargement of the veins of the front of the chest, base of the neck and arm, conditions that did not obtain in these patients, and do not occur in aneurism.

These two specimens of aneurism affecting the same portion of the aortic arch are interesting in many respects, and amongst others as illustrating to some but not marked extent, the two varieties of that disease, to which this portion of the aorta is especially liable viz. lateral or sacculating and peripheric (or

dilating) aneurism. Some of the most reliable points in my estimation of distinction in the diagnosis between these two forms of aortic aneurism, are well brought out in the cases just read.

IN THE SACCULATED No. 1.

IN THE DILATED No. 2.

Distinctly localized pulsation perceptible to the eye and hand, over ascending portion of aortic arch.

Absence of pulsation—or if present, not so localized—but diffused and frequently more perceptible above the clavicles than over the arch.

Inequality of the pupils and impairment of the voice—implying compression or stretching of certain nerves.

Absence of those signs indicating intra-thoracic pressure.

However, the most distinctive sign of sacculated aortic aneurism, a pulsating prominence in the course of the vessel, was absent in No. 1 (sacculated,) and a sign rarely witnessed I believe in dilated aneurism, viz.: great distension of the cervical veins on both sides (suggesting intra-thoracic pressure) was present in No. 2 (dilated.)

Another sign existed in this example of dilatation of the arch, which according to Walshe, ought not to have been present. That author says the murmur heard is "systolic only," it was however systolic and diastolic. The cause of this double murmur merits a passing notice. It was not due to a rough and calcareous condition of the lining membrane, that was smooth and free from calcareous degeneration; nor to the diseased state of the aortic valves, for it was not heard at the base of the heart. I incline to refer it to the laceration in the coats of the vessel. The systolic murmur was probably the result of the friction of the blood, projected by the systole of the ventricle against the edges of and through the rent in the vessel, and the diastolic murmur, the effect of the blood wave forced against those edges by the systole of the aorta.

I presume the inaudibility of the double murmur on the 19th, the day after its discovery, was owing to increasing feebleness of the heart, consequent upon a further escape of blood into the pericardium, and perhaps pleuræ. It will be remembered that the systolic basic murmur likewise had become very feeble on that day.

The great distension of the external jugulars in connexion with a dilated ascending aorta, is an interesting feature of one of those cases—and although it may be explained on the supposition that the dilated aorta may have compressed the ascending cava, I incline to the opinion that the compression was really effected by the large quantity of blood extravasated into the pericardium.

Amongst the more characteristic signs of intra-thoracic aneurisms and other intra-thoracic tumours, not the least are those arising out of the compression, stretching or irritation of various nerves, and the cases now under examination afford illustrations of three or four well marked and distinct signs thus induced.

In case No. 1, the patient suffered from weakness and huskiness of the voice, not owing to any disease of the larynx, but to compression or stretching of the left recurrent laryngeal nerve by the aneurism.

It may not be known to all present, that as long ago as 1850, our colleague and fellow citizen, Dr. R. L. MacDonnell, noticed the coexistence of contraction of the pupil and intra-thoracic tumours, and correctly explained the relation existing between them, viz.: compression by the tumour of the sympathetic nerve, which supplies the dilator pupillæ fibres. This valuable sign existed in the first case, not in the second. The Frenchman's right pupil was smaller—about one-half—than the left. In his case there was also an accompanying sign that I do not remember to have seen before, or to have read of in thoracic aneurism, viz.: a slight convergent squint of the same eye.

May the convergence of the optic axis in this case be thus explained, if it were really caused by the aneurism?

The paralysis of the sympathetic nerve, and through it of the dilator pupillæ fibres permitted the sphincter fibres of the pupil supplied by the third nerve to contract and diminish the pupil—and the functional activity of the branch of the third nerve, supplying the iris, extended to the branch of that nerve which supplies the internal rectus, and hence the internal squint. The objection to this is that the external rectus supplied by the sixth nerve, ought not to have permitted the internal rectus to overcome it.

Or was the convergence an associated movement? We know that when looking at an object held close to the eye, the pupil contracts, and the optic-axis is made to converge. Now may not the paralysis of the sympathetic nerve caused by the pressure of the aneurism, have been followed not only by contraction of the pupil, but by convergence of the optic axis in obedience to this law or habit of associated movement?

Patient No. 2 suffered from three or four seizures resembling and apparently identical with Angina pectoris. A sudden and violent pain starting from mid-sternum, extended to the interscapular regions, and thence down both arms, attended with a sense of impending death.

The occurrence of Angina pectoris in thoracic aneurism, particularly if Dr. Gairdner's opinion prove to be correct, that it is "almost confined to aneurisms of the ascending aorta, especially in the immediate neighbourhood of the heart," tends to corroborate the view which refers Angina to an affection of the cardiac plexus of nerves—for those nerves surround the roots of the aorta and pulmonary artery, and give branches to the heart, some of which communicate with the cardiac ganglia.

In this instance, as the Angina was not experienced till within three days of death, and appears to have coincided with the rupture of the vessel, it may be inferred either that some of the filaments of the cardiac plexus were torn or stretched when the arterial coats gave way, or that they were irritated by the pressure of the blood extravasated into the pericardium.

There are many other circumstances clinical and pathological connected with these two examples of aortic aneurism deserving of analysis, but as you must have already thought me tedious, I will conclude with an allusion to a symptom which I do not remember to have seen recorded in similar cases.

From the moment of the first seizure with Angina, No. 2 suffered almost complete loss of *motor* power in the left arm. The corresponding side of the face and the lower extremity on that side, were unaffected. What was the cause of this local paralysis?

It was not, in my opinion, due to obstruction of the subclavian or axillary artery by a fragment of fibrin washed from the rent in the aorta, because the radial pulse was good at the wrist, and the hand was not colder than its fellow. Nor to an embolus in a branch of the internal carotid—otherwise the loss of power would have involved the left side of the face and the left leg, as well as the left arm. It appears to me that the doctrine of *inhibitory* nerve influence taught by Pflüger and Lister, will satisfactorily explain the paralysis upon physiological principles. Lister's statement of the doctrine is, "that one and the same afferent nerve may, according as it is operating mildly or energetically, either exalt or depress the function of the nervous centre on which it acts."

In this case then I infer that the afferent nerves, which were the seat of each agonizing pain during the attack of Angina, acted ^{so} energetically as to depress the function of the nervous centre from

which the brachial nerves obtain their motor force; and that the so called "inhibitory" paralysis resulted. I cannot conceal my doubt however, that the so-called inhibitory influence is anything more than exhaustion of the centres from over excitement.

I am aware that Brown-Sequard's views as to the mechanism by which "reflex" paralysis is induced, may be applied in explanation of this case, but for reasons which time will not allow me to give, I prefer the above view. I conclude by thanking the Society for the patience with which it has listened to my observations.

MEETING HELD NOVEMBER 18th, 1871.

The President HECTOR PELTIER, Esq., M.D., Ed., in the chair.

COLIN C. SEWELL, M.D., Ed., L.R.C.S.E., read the following paper on

ANEURISM.

As a commentary on the very interesting paper, showing the perfection of diagnosis, read by Dr. Howard at the last meeting of this Society, I propose reading to you this evening the report of a case showing the difficulties sometimes experienced in arriving at a correct opinion, though the presence of an aneurism be suspected and carefully looked for.

Mr. C., æt 34, consulted me about four years ago, giving the following history: He had enjoyed good health up to the year 1861, when he contracted chancre, and consulted an irregular practitioner, under whose care he remained for three weeks without deriving any benefit. He then went to Dr. Lizars, of Toronto, who prescribed mercury internally, applied caustic to the sores, and reported him cured in about six weeks. He now enjoyed good health till 1865, a period of three years, when he had a bad attack of intermittent fever, which, though it quickly yielded to quinine, was immediately followed by the appearance of the rash of secondary syphilis, accompanied by ulcers in the throat, and other symptoms of this disease. He consulted a medical man here, under whose care he continued for twelve months, during which time frequent crops of ulcerating sores appeared on the chin, buttocks, &c. He then gave up all drugs till 1867, when he came to me to get advice about the remains of a secondary syphilitic eruption on the back. I ordered him mercurial baths, with lod. Pot. and cod liver oil internally, and under this plan of treatment the rash entirely disappeared.

Mr. C. did not again consult me till the autumn of 1869, when

he returned complaining of a pain across the loins. He stated that about a week ago while witnessing a lacrosse match, he felt a sharp pain, without any warning, in the small of the back; it, however, soon passed off, and he remained to the end of the match. From that day he has had a constant soreness in the lumbar region, with occasionally a severe paroxysm, when the pain would extend into the left groin and testicle. On examination, no tender points in the spinal column, or other sign of disease could be found; auscultation and percussion elicited normal sounds over the whole abdomen and thorax; pulse 80, and of natural strength; urine healthy in quantity and quality; bowels regular; in fact there was a total absence of symptoms, except the neuralgic pain and a slight retraction of the left testicle. Iodide of potassium and Quinine were prescribed, the latter greatly relieving the pain, to use the patient's own words "it acted like a charm," cutting short the severe paroxysms, but not entirely eradicating the soreness across the loins.

I did not see Mr. C. again professionally, till the winter of 1870, when he came to me, again complaining of the pain in the lumbar region, which he stated had never entirely left him, was again recurring in paroxysms, and extended as before into the left groin and left testicle. On examination the patient was found much in the same condition as he was fifteen months ago, except that the exacerbations of pain were more regular, and more severe, and intense dyspeptic symptoms had now declared themselves. Antiperiodic and antineuralgic remedies were tried without affording more than a temporary relief. He was afterwards seen by Drs. Campbell, Craik and Howard, the latter making careful examinations, on several different occasions, with the special view of discovering aneurism, should one exist, but without success. The pain had now shifted to the hepatic region, and presented this important feature, namely, that the patient gained instant relief from it by assuming a bending posture, resting upon his hands and knees. Nevertheless, concluding from the periodical exacerbations of the pain and the history of the case, that the trouble was due in some measure, at least, to the intermittent fever, quinine was again ordered. Upon this treatment our patient's health improved, He gained flesh to a slight extent, became more cheerful, and in every way did well for a short time, when the paroxysms of pain and other adverse symptoms returned. Our former plan of treatment was again tried, but this time without effect. He then forsook us to try homœopathy, under which treatment he continued till his death.

An examination after death was made by my friend Dr. Rose

and myself, in the presence of Dr. Howard. On inspection, the body was found much emaciated, but still presenting the well developed muscular system of an athlete.

N.B.—I omitted to mention in my synopsis of the case, that Mr. C. had been fond of gymnastic exercises, and had been accustomed to work two and three hours daily at them.

On attempting to cut through the thoracic walls, we found the cartilages to a considerable extent ossified, and on raising the sternum we noticed an absence of adipose tissue in the anterior mediastinum. The thoracic organs were in their natural position and healthy. On continuing our dissection, and opening into the abdominal cavity, we found all the organs apparently in their proper positions, but on raising the peritoneum and the intestines, a mass of coagulated blood was seen occupying a portion of the right hypocondiac and lumbar regions, and extending into the right iliac fossa, showing the immediate cause of death to have been internal hemorrhage. On further examination we found the ruptured sac of a small sacculated aneurism springing from the abdominal aorta, and lying across the 1st and 2nd lumbar vertebræ, between the crura of the diaphragm; these vertebræ were deeply eroded, and formed the posterior wall of the aneurismal sac.

My case, Vide specimen, is interesting in so far that it shows the difficulties sometimes experienced in arriving at a correct diagnosis, for, though we were led from the neuralgic character of the pain, the peculiar posture assumed by the patient with relief, and by the "gristly" feel of the radial artery, to suspect the existence of an aneurism, the absence of a pulsating or other tumour, our inability to discover any abnormal sounds in the course of the abdominal aorta, and the undeniable relief gained from the use of anti-periodic and antineuralgic remedies, all tended to make it difficult indeed, almost impossible to arrive at a correct diagnosis.

Dr. HOWARD—As one of the gentlemen who had failed to make a correct diagnosis of the case just related by Dr. Sewell, he would be expected to make some observations, if not enter upon his defence. At the first consultation in which he saw the patient, the attending physician raised the question of hepatalgia. But as that is probably a very rare disease, even the existence of which has been called in question by experienced pathologists, he examined carefully for abdominal aneurism—but failed to discover tumour, pulsation, or bruit, in the course of the abdominal aorta—nor was a bruit to be heard along the dorsal or lumbar vertebræ. He (Dr. H.) then suggested that the neuralgic-like pain might be either due to malaria, as the patient had had intermittent fever, or to some syphilitic affection either of the nerves or spinal mem-

branes, and it was interesting to note that under five grain doses of quinine, the symptoms were markedly relieved. The Iodide of potassium, which the patient had been taking, was continued, owing to the doubt respecting constitutional syphilis. When Dr. Sewell informed the speaker of the sudden death of the patient, Dr. H. at once said "then it has been either an abdominal aneurism near the diaphragm, or a gastric ulcer which has proved fatal by perforation."

Judging from his own experience, abdominal aneurisms were more frequently obscure than thoracic, as well as much less common. In the light of this case he was disposed to regard the symptoms of abdominal aneurism mentioned by Dr. Stokes, viz.: relief of the pain by lying on the face, as highly suggestive of that disease; in this case even when sleeping under the hypodermic dose of morphia, the patient preserved that posture. He never had seen the symptom so marked in any case of simple ulcer of the posterior wall of the stomach.

Reviews and Notices of Books.

PHYSICIANS VISITING LIST.

We are in receipt through the kindness of its publishers, Messrs. Lindsay & Blakerton, of a copy of their "Physicians Visiting List," for the year 1872. It is beyond all doubt, the most complete, and yet the simplest Visiting List which is published. In our opinion it is invaluable to the Practitioner in busy practice, and besides saving him a great deal of trouble, will prevent his losing a considerable sum of money during the year, by neglecting through forgetfulness, to enter visits made. Those who have made use of this Visiting List, would not be without it for thrice its price. We therefore know, we are doing our readers a good turn, when we strongly recommend it to their attention. It can be had from our publishers, Messrs. Dawson Brothers, St. James Street.

A Practical Treatise on Fractures and Dislocations. By FRANK HASTINGS HAMILTON, A.M., M.D., L.L.D., Professor of the Practice of Surgery with operations, in Bellevue Hospital Medical College, &c., &c., &c. Fourth edition. Revised and enlarged. Illustrated with three hundred and twenty-two wood-cuts. 8vo: pp. 789. Philadelphia: Henry C. Lea, 1871.

This work is so well known to the profession, that it is unneces-

sary to say more than that the author has issued this the fourth edition. Every man who wishes to be posted in Fractures and Dislocations, cannot avoid procuring a copy of Dr. Hamilton's standard work, it is the only one on the subject on which it treats in the English language, if we except Sir Astley Cooper's work on the same subject, which is out of print, and very difficult to procure, and which does not give to the surgeon the amount of practical information as regards treatment, which will be found in Dr. Hamilton's treatise.

The author has long enjoyed the reputation of being an authority on the subjects of Fractures and Dislocations.

The author has enriched this edition by adding an increased number of wood-cuts, much new matter has been incorporated, and to preserve the size of the volume he has omitted discussions on disputed points, which in former editions occupied much space. The publishers have done their work in the usual creditable manner, and have given us a handsome volume well impressed, and clearly printed on excellent paper. To be had of Dawson Bros., St. James Street.

PERISCOPIC DEPARTMENT.

Surgery.

(From the "New York Medical Journal").

REMARKS UPON THE DIAGNOSIS OF OVARIAN TUMOURS FROM FIBRO-CYSTIC TUMOURS OF THE UTERUS.

By CHARLES C. LEE, M.D., Surgeon to the Charity Hospital, formerly Surgeon to St. Vincent's Hospital, etc.

(Concluded.)

CASE X.—A case, in many respects analogous to this, was reported to the New York Pathological Society in 1865, by Prof. H. B. Sands,* who excised the uterus and uterine appendages on account of a tumour which he suspected to be of uterine origin, although "certain facts in the patient's history and in her physical condition pointed strongly to the existence of ovarian disease."

The enlargement had begun seven years before, in the left iliac fossa, the growth being at first gradual, but in a year's time very rapid. Menstruation had sometimes been suspended, but no men-

* New York Medical Journal, December, 1865, p. 188.

orrhagia of any kind had existed; the patient was single, 45 years old, and of healthy parentage. Examination of the abdomen, which was rendered more difficult by ascites and a large umbilical hernia, revealed the outlines of two or three swellings, with obscure fluctuation. The uterus was very high, to the left of median line, and admitted the sound to the depth of four inches. It was immovable on the sound, except in conjunction with the tumour, which was very mobile; and this conjoined mobility of uterus and tumour was the feature that led Dr. Sands to suspect it was of uterine origin. A formal consultation determined the propriety of an operation, which was performed June 12, 1865. The abdominal cavity was reached with ease, and, when the tumour was brought into view, its nature was still so uncertain that it was tapped, but no fluid was obtained. No serious adhesions existed above, but in the pelvic cavity they were extensive and formidable. The tumour being found inseparable from uterus, Dr. Sands, whose brilliancy as an operator is well known, determined, with the concurrence of those present, to remove the whole *en masse*, which was accordingly done above the line of implantation of the vagina into the cervix uteri. Alarming hæmorrhage ensued, chiefly from a rent in the common iliac vein, but the bleeding points were secured as rapidly as possible. The operation had lasted for an hour and a half, and, in spite of active stimulation, the patient sank and died a few minutes after its completion. Death was attributed to exhaustion from hæmorrhage, which Dr. Storer* thinks was due to the use of the knife instead of the *écraseur*. The mass removed, which weighed about twenty pounds, was composed of the uterus and three large outgrowing fibroids, which were in many parts so soft as to resemble œdematous connective tissue, and the largest tumour containing a number of cysts filled with serum. The womb was greatly hypertrophied, measuring 9 inches in its longest diameter, and admitting the sound through 7 inches of a somewhat tortuous route.

CASE XI.—In December, 1847, a single woman, aged 27, was admitted to the Massachusetts General Hospital, under care of Dr. Samuel Parkman† for the relief of an abdominal tumour, which was first noticed a year before this date. General health good; no menorrhagia or dysmenorrhœa; abdomen about as large as at seventh month of pregnancy, the tumour occupying hypogastric, right and left iliac, umbilical, and left lumbar regions. The mass was well defined, with rounded edges, very movable, not distinctly

* *Loc. cit.*, pp. 123, 127.

† American Journal of Medical Sciences, April, 1848, p. 371, *et seq.*

fluctuating, but "giving the sensation of being composed chiefly of an elastic texture containing cysts scattered through its substance." Vaginal and uterine examination negative. The absence of distinct fluctuation was thought the only lacking symptom of its ovarian character, and the diagnosis of probable (but not certain) multilocular ovarian cyst was thereupon given. The patient had previously been tapped by another surgeon, who obtained no fluid. As the woman urgently demanded an operation, gastrotomy was performed by Dr. Parkman, January 8, 1848; anaesthesia by chloroform. When the tumour was exposed its nature was still doubtful, and it was tapped in two places, without effect; it was then lifted gently out of the pelvis, when its uterine nature was first detected. No serious adhesions existed, nor had the tumour any pedicle, but the womb "appeared to expand itself and grow gradually into the enormous mass." A strong double ligature was passed through the body of the uterus, which was firmly ligated, and the whole mass above that point removed by the knife. No bleeding occurred, and the pelvis was therefore sponged clean, and the abdominal wound closed by sutures and adhesive strips. The patient rallied quickly, and did well until evening, when she suddenly began to sink, and died of secondary hæmorrhage from the uterine incision 12 hours after the operation. A careful examination of the tumour, and of the parts left in the pelvis, showed that it sprang from the left side of the uterine fundus, involving the left Fallopian tube, and immediately expanded into an ovoid mass, with triple lobes, between 8 and 9 pounds in weight. It presented none of the hard, grisly character of true fibrous tumour, but was soft and compressible like sponge, "presenting large meshes, containing considerable quantities of clear, serous fluid, which leaked from its incised surfaces." All the physicians who saw the case concurred in Dr. Parkman's diagnosis.

CASE XII.—In 1855, Dr. E. R. Peaslee reported* the case of a widow aged 35, who consulted him in August, 1853, for a pelvic and abdominal tumour, which had appeared 21 months previously, after a tedious and difficult confinement. It extended nearly to the umbilicus, was firm and smooth, freely movable, not sensitive, but productive of much distress by pressure on the bladder and rectum. When examined *per rectum et vaginam*, it was only perceptible on the right side, and involved the right ovarian region—uterus very movable in all directions except to the left, and quite independently of tumour; sound passed to depth of 3½ inches.

* American Journal of Medical Sciences, April, 1855, p. 394, *et seq.*

Fluctuation not marked, growth steady and rapid: patient pale and emaciated. The tumour was judged by Dr. Peaslee to have "commenced in the right ovary and not yet adherent to any other part or organ, except to the uterus, by its natural but enlarged attachments." Its removal was decided upon if the patient's general health could be improved; and, in six weeks' time, this was so much better that gastrostomy was performed, September 21, 1853. At this time another careful examination was made of the tumour, which had manifestly increased in size, and now gave an evident, though not very distinct, feeling of fluctuation. This fact served to confirm the previous diagnosis.

The abdomen was opened, and the tumour reached in the usual manner, the patient being thoroughly etherized. The tumour was smooth, of a pale, livid colour, free and unattached above, and so distinctly fluctuating to the touch that it was at once tapped; no fluid being obtained, the abdominal wound was enlarged, and the tumour found to be continuous with the fundus of the uterus. No other serious adhesions existing, and the uterus being elongated and slender at its lower part, it was at once decided to remove the whole mass; which was done by excision with the knife, after securing the uterus as low as possible in the pelvis with a strong double ligature. Only one artery had to be secured in the uterine stump, the entire hæmorrhage not exceeding six ounces. The left ovary, being diseased (but not connected with the tumour,) was excised with the uterus; the right was healthy, and left *in situ*, and the abdominal wound was closed with harelip-needles, sutures, and adhesive strips. Complete reaction followed; but, on the next day, a hernial protrusion of the bowel occurred through the wound, and, the gut becoming strangulated, death ensued on the fourth day after the operation. No secondary hæmorrhage occurred. The tumour proved, upon section, to be a large out-growing uterine fibroid springing from the right of the fundus, and already softening and degenerating in its central portions; to the latter condition, and to the dilatation of the uterine sinuses in the vicinity of the tumour, was due the deceptive feeling of fluctuation. The body of the uterus was also elongated, the cavity when straightened admitting a sound to the depth of five and a half inches; but two inches below this point the cavity of the uterus was flexed sharply to the left, which rendered the farther passage of the sound impossible before death.

for the following details of a second case* upon which he operated in February, 1868;

The patient had detected a pelvic tumour several years previously; its growth was very slow, over three years from its discovery before tapping became necessary. The fluid then obtained was of a dark-brown (chocolate) colour, like what is occasionally (though rarely) obtained from an ovarian polycyst. At the date of the operation abdominal fluctuation was distinct; the uterus was of normal depth and in the central position, and was freely movable in all directions independently of the tumour. All the other means of exploration pointed to the diagnosis of ovarian cyst, which was the diagnosis adopted; although some doubt of its accuracy lingered in Dr. Peaslee's mind, from the slow rate of growth, and the nature of the fluid obtained at the previous tapping. Gastrotomy was performed, and it was only after the fluid was again drawn off that the tumour was found to be of uterine origin. Numerous and extensive adhesions existed, but the mass fortunately had a distinct pedicle three-fourths of an inch broad, and one-fourth of an inch long, which grew from the middle of the top of the *fundus uteri*. This was securely tied, the ligatures being cut short and left in the pelvic cavity, and the large fibro-cystic growth excised above the line of ligation. The peritoneal cavity was thoroughly sponged out; and a tent of moistened and firmly-twisted linen, projecting into the abdomen for a half inch, was left between the lower two sutures in the abdominal wound, for fear of secondary hæmorrhage. The patient entirely recovered, and two and a half years after the operation remained in perfect health.

CASE XIV.—In Dr. Routh's *brochure* upon uterine tumours,† and in "Hewitt's Treatise on the Diseases of Women" (London edition, 1863, p. 403,) is narrated the following case, occurring in the practice of Mr. F. D. Fletcher, of Liverpool.

A widow, aged 40, who had borne five children, and had three miscarriages, had observed an abdominal tumour 13 months before applying for treatment. Mr. Fletcher thought the growth ovarian and decided to remove it, which was done May 14, 1862. On opening the abdomen, the mass was found adherent to the omentum and to the abdominal wall. Numerous cysts were punctured, and the tumour was then found to spring from the lower part of

* American Journal of Obstetrics, vol. iii., No. 2, where the case is incidentally alluded to in article on "Injections of the Peritoneal Cavity after Ovariectomy."

† "On Some Points connected with the Diagnosis, Pathology, and Treatment of Fibrous Tumours of the Uterus." London, 1864. Tab. ii., Case 13.

the womb to the left of the median line. The pedicle was broad and well developed, and this was divided by the *écrascur*, after which two short ligatures were applied. Recovery was complete; and, when, a few months after the operation, the patient reapplied for treatment on account of an eczema, she was fat and quite well.

CASE XV.—A married woman, 42 years old, consulted Mr. Hakes,* for an abdominal swelling which had begun 15 months previously. She had two children, the youngest 15 years of age. A careful examination of the tumour led to the conviction that it was an ovarian cyst, and it was twice tapped, but soon refilled. Its removal was decided on, and on January 29, 1863, gastrotomy was performed for this purpose. The tumour was found adherent to the omentum and intestines, but had a slender pedicle, which grew from the uterine fundus. It consisted mainly of numerous small cysts, two or three of which were filled with old clots of blood. The pedicle was secured by two distinct ligatures, reinforced by another strong ligature around the whole mass. The tumour was then cut away, but the patient gradually sank, and died 33 hours after the operation. Both ovaries were diseased, but not connected with the tumour.

CASE XVI.—A single woman, 45 years old, consulted Mr. Baker Brown,† in 1860, for an abdominal tumour which had begun to develop in the right iliac fossa eight years previously. At first its growth was almost imperceptible, but during the last six months the increase was very rapid. A very thorough examination convinced Mr. Brown that the tumour was ovarian, and, under that belief, gastrotomy was performed, May 15, 1860. Very extensive and formidable adhesions were found; and, while separating some of these, one of the compartments of the cyst was ruptured and a quantity of liquid poured into the abdominal cavity. The mass was now discovered to be a fibro-cystic tumour of the uterus, neither ovary being involved in it. Its removal was deemed injudicious, and a part of the cyst was excised and the wound closed. The patient progressed pretty well for ten days, when a little fluctuation was discovered in the abdomen. This was followed by an attack of erysipelas, extending to the right leg and gradually becoming phlegmonous. Death ensued on the 24th day.

CASE XVII.—In 1855, Dr. W. L. Atlee,|| reported the case of an

* British Medical Journal, February 28, 1863,

† Routh, *loc. cit.*, Tab. iii., Case 26.

|| American Journal of Medical Sciences, April, 1855, p. 388, Case 6.

unmarried woman, 43 years of age, who had applied to him six years previously for the relief of an abdominal tumour which he considered ovarian. For this purpose he operated, October 13th, 1849: "Incision from one inch above the umbilicus to pubis; tumour uterine with large cystiform bodies incorporated with it. Non-adherent; not removed. Anæsthesia; recovery. Died between three and four years afterward, from progress of disease. Weight of the mass removed after death, 50 pounds."

CASE XVIII.—A married woman, 36 years old, consulted Mr. I. B. Brown, in 1862, for a tumour which was first observed six years before. She had been tapped once only, when nearly two quarts of a brownish liquid were drawn off, and the tumour was thought to be a multilocular cyst of the ovary. She was subjected to operation (*gastro-tomy*;) December 11, 1862, when the following condition was revealed: Ascites, tumour not ovarian, but a fibro-cyst of the uterus with extensive adhesions; two endo-cysts were tapped, and about a quart of muddy, yellowish fluid drained off; tumour not removed, as that would have involved ablation of the womb.

Six days afterward a violent attack of coughing reopened the wound, through which the serous fluid drained for several days. The tumour increased rapidly in bulk, vomiting and pyæmic symptoms ensued, the wound gaped, and death followed on the 26th day. †

Judged by the ordinary standards of diagnosis, the foregoing cases certainly exhibit no very hopeful prospect of avoiding similar errors in the future. For not one of these was undertaken hastily, or without the most careful examination, and yet in none but those of Peaslee, Storer, and Sands, did the operator entertain even a doubt of the correctness of his opinion until the operation had reached a point from which retreat was impossible. In Case XII. the history of development and the symptoms were antagonistic; and Dr. Peaslee thought the growth might *possibly* be uterine, but on the whole thought it ovarian. Case IX. was so obscure that Dr. Storer only adopted the diagnosis of ovarian multilocular cyst by exclusion, although not entirely satisfied of its nature. In Case X., Dr. Sands suspected that the tumour *might* be of uterine origin, although certain facts in the history and physical examination pointed to the existence of ovarian disease, which latter was the diagnosis of others* who had the case in

† Transactions of the Pathological Society of London, vol. xiv., p. 193, Case also quoted by Kœberlé, Gazette Hebdomadaire, March 12, 1863, p. 164.

* Dr. Emmet, however, whom the patient had previously consulted, informs me that he was satisfied of the fibro-cystic nature of the tumour.

charge. Nor is this difficulty lessened by an appeal to systematic writers on the subject, who unanimously state that no accurate diagnosis is possible between the two affections.

Thus, Grailey Hewitt ("Diseases of Women," ed. 1863, p. 403,) says: "These cases" (of fibro-cysts of the uterus) "are very rare, and it seems almost impossible to say how they are to be distinguished from cases of ovarian tumours during life." And again, p. 575: "This disease has never, so far as I am aware, been diagnosed during life, but it has on more than one occasion" (we have instanced 18 such, without by any means exhausting the list) "been mistaken for an ovarian tumour." Mr. Baker Brown states† that "the diagnosis between these very rare tumours and encysted ovarian disease must be more difficult even than in the case of solid tumours. Indeed, I know of no distinguishing marks between the two."

Mr. Spencer Wells' opinion already quoted, is still more explicit, for he says: "Even after an exploratory incision I know of nothing but a rather darker—less pearly blue—aspect of the tumour, which would put the surgeon on his guard." †

Dr. Peaslee, who is justly celebrated as a diagnostician in ovarian pathology, informed the writer, in reference to the difficulties surrounding Case XIII. of this series, that, up to the present time, he "knows of no means of positively deciding in such a case" between an ovarian cyst and a fibro-cystic tumour of the womb.

Professor Kœberlé, of Strasbourg, has, however, published in the *Gazette Hebdomadaire** a paper characterized by great ingenuity and research, in which he claims that the diagnosis of fibro-cystic growths can with certainty be established by attention to the following points:

1. The discoloured hue and dejected expression of the face, or the so-called *facies uterina*, of the patient.
2. The variable consistence of the growth, as shown by abdominal palpation.
3. The results of tapping. If the trocar touch a fibrous spot in the tumour-wall, blood will flow; even when the cyst is reached, the fluid never presents the clear, viscid character of ovarian cystic fluid, but is either yellowish, thin, serous, and rich in lymph or cholesterin, or it is brownish, muddy, seropurulent, or bloody.
4. The indurated (or nodulated) feeling of the tumour after tapping.

‡ "Surgical Diseases of Women," second edition, p. 310.

† "Diseases of the Ovaries," vol. i., p. 362.

* March 12, 1869, p. 163.

5. The uterine connections of the growth, as made out by careful vaginal and uterine examination.

By these means M. Kœberlé was able to diagnosticate with precision the following interesting case, which is reported in the same connection.

CASE XIX.—An unmarried lady of Wiesbaden, aged 34, consulted him in 1868 for an abdominal tumour, which was first observed two years previously; although three years before that time her health had become impaired by excessive constipation and other irregularities which seemed due to pelvic obstruction.

During the last year the abdomen had rapidly enlarged, and, at the date of consultation, was quite filled by a rounded tumour, fluctuating at some points, solid at others, and giving the general impression of a multilocular ovarian cyst. The pelvic cavity was also filled by the mass which seemed continuous with the posterior part of the *cervix uteri*, which was pushed forward, and to the left. The hymen was so tight and dense as to preclude the use of the sound.

Two of the largest compartments of the tumour were tapped, and yielded $2\frac{1}{2}$ quarts of a serous fluid, containing large quantities of cholesterin. This fact, with the *cervix uteri*, and the marked *facies uterina* of the patient, convinced him that it was a fibro-cyst of the uterus, in spite of its rapid development and multilocular character, which indicated an ovarian origin.

The patient, who had undergone a variety of useless treatment, imperatively demanded an operation, from which M. Kœberlé tried in vain to dissuade her; but, after fully explaining its risks and the improbability of a successful termination, he consented to attempt gastrotomy. Operation, August 31, 1868; anaesthesia by chloroform. Short median incision, afterward enlarged. When exposed, the tumour was lifted with great difficulty from the abdominal cavity; and, after numerous tapplings, which obtained only $3\frac{1}{2}$ quarts of fluid, it was found to spring directly from the posterior uterine wall, without involving the neck or fundus. Both ovaries were healthy.

The pelvic portion of the tumour, which was comparatively very small, formed a kind of pedicle for the rest. The punctures made by the trocar bled so freely that an iron-wire ligature was thrown around the pedicle as close to the womb as possible, and the abdominal tumour excised. The pelvic portion was separated with extreme difficulty, being intimately adherent to the recto vaginal cul-de-sac, and the posterior vaginal wall; it was gradually enucleated, without injury to the pelvic vessels, and the womb left intact.

Hæmorrhage very copious; arrested by metallic ligatures cut short, the actual cautery, and perchloride of iron.

The operation lasted $2\frac{1}{2}$ hours, and the patient was exceedingly cold and feeble; reaction was gradual but complete, and in 29 days she was walking about, and soon returned home.

A careful histological examination of the tumour showed conclusively its uterine origin and its fibro-cystic structure.

It is not to be supposed that every case of fibro-cyst of the uterus will exhibit all the distinctive marks noted by Kœberlé, and a glance at the cases already detailed will show the need of bearing other points equally in mind.

For instance, as to time or progress of development—although generally slower than ovarian growths, this will depend upon whether the original fibroid is interstitial or merely subperitoneal. In the latter case, its cystic degeneration and growth may be quite as rapid as ovarian disease.

Again, menorrhagia, as a forerunner or coincident symptom, is seldom found to exist in fibro-cystic disease, because the neoplasm is extra-uterine from the beginning, at least only slightly invading the uterine wall, whereas the true fibroid is more deeply seated. The disregard of this fact, and the fictitious value attached to the absence of flooding, have powerfully contributed to errors in diagnosis.

Thirdly, independent mobility of the wound really indicates nothing but the absence of pelvic adhesions: for, if the fibro-cyst have passed into its second stage of development, and undergone extensive cystic degeneration, it will scarcely ever be affected by uterine motion—especially if a moderately small pedicle exist; and lastly, the uterine hypertrophy or increased length of the cavity, upon which much reliance has been placed, is shown to be of very doubtful value by Dr. Routh, who has found the greatest amount of elongation in certain ovarian cases.*

M. Kœberlé is of opinion that fibro-cystic disease never appears under 30 years of age, although, among the preceding cases, two exceptions to this rule are found. With these general facts in mind, the differential diagnosis between uterine fibro-cysts and ovarian cystic tumours may be pretty confidently stated as follows:—

IN OVARIAN CYSTS.

IN FIBRO-CYSTS OF THE UTERUS.

- | | |
|--|---|
| 1. Disease may occur at any period, even before puberty. | 1. Scarcely ever occurs under thirty—generally from forty to fifty. |
|--|---|

* Transactions Obstetrical Society of London, vol. viii., pp. 128, *et seq.*

2. Development rapid—usually under two years.
3. Aspect of face unaltered, if general health be fair.
4. Fluctuation equable over whole surface of tumor.
5. Vaginal examination shows little displacement of uterus—mass smooth and distinct from uterus.
6. Mobility of uterus independent of tumor from beginning—pelvic adhesions rare.
7. Tapping causes complete collapse of unilocular cysts—in polycystic tumors, it reveals the endocysts.
8. Fluid clear, straw-coloured, serous; or viscid, clear, mucoid, albuminous.
9. When exposed by gastrotomy, sac is pearly blue, or white and glistening; rarely vascular.
2. Development slow; generally over two years.
3. "Facies uterina" generally marked; expression anxious and dejected.
4. Fluctuation confined to certain regions—generally to upper portion, while lower is hard and dull.
5. Vaginal examination shows uterus high up or displaced. Mass either not detected, or continuous with uterus.
6. Independent mobility of womb confined to last stage of disease. Pelvic adhesions common.
7. Tapping causes only partial collapse, leaving base of tumour firm and indurated.
8. Fluid either brownish, bloody, sero-purulent, muddy; or thin, yellowish, containing shreds of lymph or cholesterolin.
9. Exposed sac dark, vascular, thick, and frequently fasciculated with fibrous bands.

The following Chronological Tables, compiled upon the basis of the valuable Statistical Tables of Mr. John Clay, of Birmingham, exhibits at a glance the salient points of the preceding cases, which, for purposes of analysis, have been reported in greater detail.

No. of case.	Date of operation.	Name of operator.	Age and social state of patient.	Duration and progress of the Disease.	Anæsthetics used or not.	Proceedings of the operation.	Result.		Source of information.
							Recovery.	Fatal, and cause of death.	
1	Feb. 14, 1844.	Mr. Lane, London.	43, Married, no child'n.	Disease had existed 8 or 9 years; cyst disappeared spontaneously five times; tapped three times; general health good.	Not used.	Abdominal incision of 7 inches; pedicle secured by temporary ligatures, then covered and secured by 6 permanent ligatures.	Patient recovered in 3 weeks; died 4½ years afterward.	Death from secondary hæmorrhage, in 12 hours.	Clay's translation of Kisch's lectures, Appendix, p. 166.
2	Jan. 8, 1848.	Dr. Sam'l Parkman Boston.	27, Single.	Tumor noticed 1 year before; general health good; abdomen about as large as at seventh month of pregnancy; no menorrhagia or dysmenorrhœa.	Chloroform given.	Usual incision in median line; no serious adhesions, and no pedicle; uterus transfixed with ligatures, and excised with knife.	Recovery; died between 3 and 4 years after, from progress of the disease.	Death from secondary hæmorrhage, in 12 hours.	Amer. Jour. Med. Sci., April, 1848, p. 371.
3	Oct. 13, 1849.	Dr. W. L. Atlee, Philadel.	43, Single.	Not stated.	Anæsthesia.	Incision from 1 in. above umbilicus to pubis; tumour non-adherent; not removed, as it was continuous with body of uterus.	Recovery; died between 3 and 4 years after, from progress of the disease.	Death on 4th day from strangulation of bowel, which protruded through the abdominal wound.	Amer. Jour. Med. Sci., April, 1856, p. 388.
4	Sept. 21, 1853.	Prof. E. R. Peaslee, Buffalo,	35, Widow, Multipara.	Tumor appeared 21 months before—following a tedious and difficult labor; growth slow; much depressed and exhausted; mobility of uterus, independent of tumor; fluctuation.	Sulphuric ether given.	Gastrostomy by usual incision; tumor continuous with uterus, which was excised above a double ligature passed through the cervix; left ovary also removed.	Recovery; died between 3 and 4 years after, from progress of the disease.	Death on 4th day from strangulation of bowel, which protruded through the abdominal wound.	Amer. Jour. Med. Sci., April, 1856, p. 394, et seq.

5	May 15, 1860.	Mr. I. B. Brown, London.	45, Single.	Swelling first noticed in right iliac fossa, 8 years previously; growth slow at first; very rapid within last 6 months; health much impaired.	Not stated.	Gastrostomy as usual; adhesions ruptured while freeing adhesions; part of cyst-wall cut away, but the rest not removed.	Erysipelas on 10th day involving abdomen and right lower extremity; death on 24th day.	Recovery complete.	Points connect. with Diagn. etc of tors Womb, Leon. '64, tab. iii., case 26.
6	May 14, 1862.	Mr. F. D. Fletcher, Liverpool.	40, Widow, multipara.	Abdominal tumor noticed 13 months before; patient had had 5 children and 3 miscarriages; health moderately good.	Not stated.	Gastrostomy by usual incision; strong adhesions to abdominal wall and omentum; cysts sprung from left side of uterus, low down, by pedicle, which was tied, and divided by <i>écroseur</i> .	Routh, Loc. cit., tab. ii., case 13; also (Grailley Ilowitt, p. 403.		
7	Dec. 11, 1862.	Mr. I. B. Brown, London.	36, Married.	Tumor first observed 6 yrs. ago; increase gradual; fluctuation distinct; tapped once, yielding peculiar brownish fluid; health failing.	Anasthesia by chloroform.	Gastrostomy as usual; adhesions extensive; two large endocysts tapped, but tumor, which was continuous with uterus (without pedicle), not removed.	Abdominal wound reopened by violent cough and retching; gradual development of pyæmia; death on 24th day.		Trans of Path. Soc. of Lon. v. xiv. p. 133. Also Kæberlé (Arch. Hebdoin, Mar. 12, '65), p. 164.
8	Jan. 20, 1863.	Mr. Hakes, London?	42, Married.	Abdominal swelling observed 15 months previously; two children; growth of tumor gradual; twice tapped, cyst refilling rapidly; health fair.	Chloroform.	Gastrostomy as usual; adhesions to intestines and omentum; tumors from fundus uteri by slender pedicle; no connection with ovaries; pedicled tied with double ligatures and then excised; hæmorrhage considerable.	Death from exhaustion, 33 hours after the operation.		Brit. M. Jour. Feb. 28, 1863, cited by Kæberlé (Gazette Méd. Mar. 12, 1863), p. 165.
9	April 30, 1863.	Mr. T. Spencer Wells, London.	53, Unmarried.	Tumor discovered 9½ yrs. before; increase very gradual; patient emaciated, but general health fair; dysmenorrhœa, but no menorrhagia.	Anasthesia by chloroform.	Incision 9 inches long; extensive adhesion, and no pedicle; womb transixed below Fallopian tubes, and tumor tied and cut away; hæmorrhage rather free.	Death in 3 hours from apparent shock of operation.		Spencer Wells's "Diseases of the Ovaries," vol. i., p. 354.
10	June 10, 1864.	Mr. Spencer Wells, London.	45, Single.	Two solid tumors found 10 years previously; no decided enlargement until within 1 year; patient emaciated; never tapped; menstruation irregular, never profuse.	Anasthesia by chloroform.	Tapping followed by gastrostomy; two large cysts found, both springing from uterus; only the smaller was cut away—the other being too extensively adherent to permit removal.	Death from shock never recovered consciousness.		"Diseases of the Ovaries," vol. i., p. 356.
11	Sept., 1864.	Prof. J. P. White, Buffalo.	About 45, Single.	Tumor large, movable, fluctuating, presenting typical signs of ovarian tumor, never tapped; health fair; menstruation not noted.	Not stated.	Gastrostomy as usual; no serious adhesions, and ovaries found intact; cyst tapped and cut away from fundus of womb, with which it was continuous.	Death a few days after operation from apparent exhaustion; no secondary hæmorrhage.		Verbal statement of operator to reporter.

Chronological Tables. Concluded.

No.	Date of operation.	Name of operator.	Age and social state of patient.	Duration and progress of the disease.	Anæsthetics used or not.	Proceedings of the operation.	Recovery.	Result.	Source of information.
12	Sept. 23, 1865.	Prof. H. R. Storer, Boston.	47, Single.	Tumor appeared 5 years before; enlargement steady; much dyspnoea and difficulty in walking; menstruation scanty but regular; tumor filled whole abdomen; localized fluctuation.	Sulphuric ether given.	Gastrostomy by customary incision; numerous adhesions; imense abdominal and pelvic tumor, continuous with uterus; removed with <i>Écraseur</i> above a clamp which was secured around cervix; hæmorrhage rather copious but not alarming.	Recovery without a bad symptom; returned home on 37th day after operation.	Fatal, and cause of death.	Amer. Jour. Med. Sci., Jan'y, 1866, p. 114.
13	October 1865.	Prof. H. B. Sands, New York.	45, Single.	Tumor appeared 7 years before in left iliac fossa; growth slow at first; menstruation irregular; but no menorrhagia; distention very great; umbilical hernia complicating tumor.	Anæsthesia by sulphuric ether.	Gastrostomy by short median incision, afterward enlarged; adhesions trifling above, but large and firm in pelvis; tapped; no fluid; mass cut away with great difficulty; above ligatures passed through <i>cervix uteri</i> ; profuse hæmorrhage from common iliac vein; bladder accidentally ruptured.	Death immediately after operation, from combined shock and hæmorrhage.	New York Med. Jour. Dec., 1865, p. 158.	
14	Nov. 16, 1865.	Dr. C. H. F. Routh, London.	26, Married.	Abdomen began to enlarge 17 months previously; at first very slowly; no children; one miscarriage; no menorrhagia; fluctuation distinct; uterus apparently normal.	Anæsthesia by chloroform.	Gastrostomy as usual; adhesions slight; sac tapped, and sero-purulent fluid withdrawn; sac then closed by ligature, and replaced; hæmorrhage from mesentery copious, and controlled by actual cautery.	Death from exhaustion, at end of 2nd day after operation.	Trans. Obstet. Soc. of Lond., vol. viii., p. 122, et seq.	
15	Feb'y, 1868.	Prof. E. R. Pease, New York.	Not stated.	Tumor detected several years before; growth slow; tapped once; fluid chocolate-colored; fluctuation distinct; uterus normal and freely movable.	Not stated.	Gastrostomy by median incision; extensive adhesions; tumor tapped, and then found to spring from <i>ovarian uteri</i> ; pedicle ligated, cut, and returned to pelvic cavity; linen tent left in abdominal wound.	Recovery complete; in perfect health 24 years after operation.	Communicated by letter from operator to reporter.	

<p>16 June 10, 1868.</p>	<p>M. De-marquay, Paris.</p>	<p>43, Single.</p>	<p>Tumor appeared in right iliac region two years before; abundant menorrhagia before appearance of tumor; fluctuation and mobility distinct; no uterine examination; health fair.</p>	<p>Chloroform given.</p>	<p>Gastrotomy by customary incision; sactapped and bloody fluid drawn off; tumor now found of uterine origin, and ablation of uterus effected with <i>Craswell</i>; hæmorrhage checked by actual cautery; wound closed with metallic sutures.</p>	<p>Death from exhaustion and hæmorrhage, in 36 hours afterwards.</p>	<p>L'Union Méd., Sept. 22, 1868, p. 431.</p>
<p>17 Aug. 31, 1868.</p>	<p>Prof. E. Kœberlé, Strasbourg.</p>	<p>34, Single.</p>	<p>Tumor observed 2 years previously, although suspicious pelvic and abdominal symptoms existed for 5 years; increase rapid; health feeble; <i>facies uterina</i> marked; tapped once; tumor large, irregular, bosselated; fibro-cyst of uterus diagnosticated; uterine examination impossible.</p>	<p>Anæsthesia by chloroform.</p>	<p>Gastrotomy by short incision, then enlarged; tapping, very little fluid obtained; tumor found to arise from posterior wall of body of uterus; pedicle strongly ligated, and tumor cut away; hæmorrhage copious—arrested by actual cautery and styptics; uterus not incised or removed; wound closed by metallic sutures including peritoneum.</p>	<p>Recovery complete in 29 days; health good 6 months afterwards.</p>	<p>Gaz. Hebdom. 25 Février, 1868, p. 135, et seq.</p>
<p>18 Nov. 2, 1869.</p>	<p>C. C. Lee, New York.</p>	<p>45, Single.</p>	<p>Abdominal enlargement noticed 2 years before; increase rapid; tapped once; general health fair, but patient chlorotic and depressed; menstruation irregular; no menorrhagia; <i>facies uterina</i> very marked.</p>	<p>Anæsthesia by chloroform.</p>	<p>Gastrotomy as usual; sactapped, and large amount of brownish fluid withdrawn; formidable adhesions to mesentery, intestines, and pelvic organs; no pedicle; cyst developed from fundus uteri, from which it was detached with scissors; uterus not removed; hæmorrhage copious, checked by ligatures and styptics; small intestine lacerated; wound closed with metallic sutures, including peritoneum.</p>	<p>Death, from exhaustion and incipient peritonitis, 31 hours after operation.</p>	<p>Vide supra.</p>
<p>19 Nov. 29, 1869.</p>	<p>Dr. J. L. Little, New York.</p>	<p>44, Single.</p>	<p>Patient began to enlarge 4 years previously; increase slow; fluctuation distinct in tumor which gave all typical signs of ovarian cyst; menstruation not noted.</p>	<p>Not stated.</p>	<p>Gastrotomy as usual; adhesions numerous; no pedicle; sactapped, but origin of tumor not found; a portion of the sac drawn through the wound, cut off, clamp applied, and wound closed by silver sutures.</p>	<p>Death from exhaustion in about 10 days; after death the tumor was found to be a fibro-cyst springing from the cervix uteri.</p>	<p>N. Y. Med. Rec., Jan. 15, 1870, p. 520. Read by operator.</p>

PENETRATING WOUNDS OF THE CHEST.

Dr. W. F. BREakey speaks of the treatment of these wounds by hermetical closure, in the *Michigan University Journal*, as follows:

A more specific report of the following cases, was furnished the Surgeon General as material for the medical history of the late war, but as the publication of that history is so long delayed, perhaps, as repeatedly suggested to me by medical men, the tabulated facts are of sufficient importance to merit publication.

It may be generally remembered that during the late civil war, Dr. B. HOWARD, Assistant Surgeon U. S. A., recommended the revival of an old method of treating penetrating wounds of the chest by hermetically sealing them. At the battle of Gettysburg, July, 1863, he obtained permission of the medical director of the 5th Corps to have such cases turned over to him for treatment, and about twenty were so treated. His method of operating was, simply to convert the ragged wound into a clean, fresh, elliptical incision by paring the edges of the wound, closing the incision by deep, close metallic sutures, cut short and covered by fine lint and collodion.

Dr. Howard, in a paper published about the close of the war, claimed for this treatment a greater success than for the ordinary treatment: stating substantially that the results of hemorrhage and suppuration would be removed by expectoration and absorption.

As the result of these cases is unfavorable to Dr. Howard's claims, I am sorry that I cannot find his paper and quote from it literally, though as only a statement of facts is intended here, and not a discussion of theories, no injustice will be done him.

I may remark that the Surgeon General, in acknowledging the reception of the report, stated that "many facts at variance with the conclusions of Dr. Howard in relation to penetrating wounds of the chest, have already been reported to this office."

It was the opinion of most of the medical men in the corps, whose opinions I heard at the time, that the theory was not sound, and that the practice indiscriminately applied would be no improvement over the old method of simple water dressings, leaving the wound open, and the result of these cases would seem to justify such opinions.

It is but fair to state that some of these cases were very unpromising at the time of the operation, being greatly depressed from shock, hemorrhage, and impaired respiration. Also, that Dr. Howard's plan contemplated immediate operations, while some of these men had been wounded twenty-four hours; though I think

their condition would average as good as that of the whole number of that class of wounded, resulting from the battle.

I was present and assisted in a number of these operations, and received from Mr. H. when he moved on with the army, July 5th, a list of fourteen cases, which he requested me to look after. As they were in different hospitals, I only saw a part of them daily, but heard from others while they lived, and collected the results given below from the records of the general hospital and medical director at Gettysburg in October, 1863.

In addition to this list of fourteen cases, the names of three others were found, who were known to have been thus treated, and another of whom it was not positive, but all the information obtainable rendered it probable that he had been so treated, making eighteen in all, of whom thirteen were known to have died within one month, and seven of these within from one to four days after the operation. The names of two could not be found on the register; one was recorded as "gun shot wound of shoulder" and "sent to Gen'l Hospital July 9th;" and another as sent to general hospital, July 24th—both dates prior to the reception of patients at the general hospital at Gettysburg, so that they must have been sent to some more distant hospital. I have tried to get further information of these four men, but thus far in vain; while the only one of the eighteen known to be living on the 1st of September, two months after the battle, was L. G. Bradley, corporal, Company B, 136th N. Y. Volunteers, of whom the Adjutant-General of New York, wrote me that he was discharged in August, 1863.

Thus, excluding one sent to general hospital and not heard from, two not on register, and one registered "gun shot wound of shoulder," there would be fourteen left, of whom thirteen died; and including these four very doubtful cases, it still leaves a mortality of over 75 per cent.; while of about *seventy* cases of penetrating wounds of chest (the whole number made during the battle, and including prisoners,) about forty were living on September 1st, while the thirty deaths included Dr. Howard's fatal cases.

Taking out his eighteen cases would leave *fifty two* cases and *twelve* deaths, or about 25 per cent mortality for the ordinary treatment. It is also worthy of remark that in all of these cases that lived beyond one or two days, the wounds became open and suppurating, and could hardly have been benefitted by being temporarily closed. A very full and fair consideration of this plan of treatment, and of the limited class of cases in which it may be applicable, will be found in Dr. Frank Hamilton's *Work on Mili-*

tary Surgery. Dr. Hamilton thinks the error is in applying it indiscriminately to all cases. Also may be found in the Medical Record, Vol. iv. p. 412, an interesting report by Dr. A. H. Smith, of New York, of a case or cases of collapse of lungs from gun shot wounds, recommending hermetical closing of the wound in such case, but without reference to Dr. Howard's theory or plan of treatment.

CERTAIN POINTS RELATIVE TO GENERATION.

Dr. F. J. Brown writes to the *British Medical Journal*:

It is well known that by cultivation the floral envelopes of plants may be changed in form and function—single flowers becoming double or infertile monsters. Similarly the floral envelopes of a human female become changed, and infertility is usually found to prevail. The labia majora represent the calyx in two segments, and the labia minora and clitoris the corolla in three segments. The os uteri is equivalent to the base of the pistil (this organ having been cut off.) Lock wards present numerous instances of misshapen hypertrophy of the clitoris and labia minora, resembling the changes in the floral envelopes of plants. Infertility is caused not only by over-culture of the generative function, but also by luxurious habits; the individual being cultivated and developed rather than the race.

Another curious subject is the attractiveness of the floral envelopes of plants. Insects aid in the fructification of the vegetable kingdom whilst they enrich themselves with its spoils; but I have never read any explanation of the fact that women delight themselves with flowers to a much greater degree than men as a general rule. I imagine that there are sympathies aroused in women, and that love and beauty are developed and intensified by the form, colour, and scent of flowers. The power of scent over the generative function is well known in animals, and the most energetic scents (castor and musk) are procured from animals. Women are sometimes rendered hysterical by powerful scents. The subject deserves study.

There is parallelism betwixt the generative function of plants and animals in the secrecy of generation. Germination occurs in the dark, whilst animals are entombed in some secret place in the womb during development. Wild animals generate in secrecy; and man does the same, showing shame at generation. Secrecy obtains in both the vegetable and animal kingdom, and shame, as well as secrecy, in the higher animals, including man. To this rule there are exceptions. Domesticity alters this characteristic in

some degree, and many individuals, and some tribes, exhibit shamelessness. All the mental traits of the animal world are developed in man more or less perfectly, rendering one man different from another, and one race the contrast of another race. This is true in matters of generation, as well as on other points; and we find one man happy with one mate, like the dove; whilst another man, like the peacock, requires many wives. Again, one man makes a good parental nurse, like the stickleback; whilst another, like the hart, would injure his offspring, if they were not removed from his company (as occurs with the hind and her young.)

Midwifery.

CHANCES OF LIFE IN OVARIAN TUMOUR.

Dr. Atthill, in his lectures in the *Press and Circular* (Dublin), gives the following statistical information:—

The most reliable data from which we can form an estimate as to the probable duration of life in cases of cystic disease of the ovary, are those supplied from the tables of Mr. Stafford Lee. Of 123 cases tabulated by him, nearly a third died within a year, and rather more than one half within two years, from the date at which the first reliable symptoms of the disease were noticed, a duration hardly longer than that of cancer, while but seventeen lived for nine years or upward; of these seventeen one survived for fifty years. From these tables we may fairly assume that the duration of life in cases of the disease under consideration is unlikely, on an average, to exceed three or four years. As a rule, you may consider that the chance for life being prolonged is in an inverse ratio to the rapidity of the growth of the tumour, for if this be rapid, the patient will speedily be worn out and die, exhausted no less by the distress caused by the size of the tumour itself, even should no inter-current attack carry her off at a brief illness.

The simple unilocular form seldom becomes dangerous to life, till the tumour by its great size interferes with respiration, and by its pressure impedes the abdominal viscera in the due performance of their functions. When this stage is reached, if with the view of relieving the patient's sufferings we have recourse to tapping, we may actually accelerate the fatal termination of the case. The drain on the system caused by the refilling of the sac, increasing the previously existing exhaustion.

The rupture of a cyst is another possible cause of death; this seems to be more likely to happen in the multilocular than in the unilocular tumour, but it certainly is not of very frequent occurrence; in all these cases there is a great proneness to inflammation of the abdominal and even thoracic viscera, and an attack which would in others be of no importance, becomes when supervening in the patient suffering from ovarian dropsy, a very serious matter, and therefore not a few die of disease not directly connected with the original malady, but which is not the less on that account chargeable with the result.

The certain and speedy death which, in the majority of cases, awaits the sufferer from ovarian disease, has decided surgeons to attempt its cure by the extirpation of the diseased organ. The question, then, which, in each case, has to be decided, is, will the patient, if left alone, have a fair chance of being one of the fortunate twelve who, out of every one hundred, may be expected to live for ten years or upward, or one of the eighty-eight who, if not operated on, must, in a third of that time, be consigned to their graves? In deciding on this momentous question, we should never for one moment lose sight of the fact that there are but two possible terminations to operations for the extirpation of ovarian tumours—the one being perfect recovery, the other speedy death.

According to the *British Medical Journal*, a Bedlamite named Sir Charles Dilke, addressed his constituents in a speech concerning the Medical appointments of the Royal Household, "You would hardly credit" he said, "the number of medical gentlemen who are required for the service of the Household, but I am aware that some of them are unpaid. There are three Physicians in Ordinary, three Physicians Extraordinary, one Sergeant Surgeon Extraordinary, two Sergeant Surgeons, three Surgeons Extraordinary, one Physician of the Household, one Surgeon of the Household, one Surgeon Apothecary, two Chemists of the Establishment in Ordinary, one Surgeon Oculist, one Surgeon Dentist, one Dentist in Ordinary, and one other Physician; while the Prince of Wales has for his special benefit, three Honorary Physicians, two Physicians in Ordinary, two Surgeons in Ordinary, one Surgeon Extraordinary, one Chemist in Ordinary, or more—making thirty-two doctors in one family." Will not some one of the thirty-two doctors above named, look after the poor daft gentleman, and see that he does not injure himself or others, as we should judge him to be dangerous, if permitted to be at large without a keeper.

Canada Medical Journal.

MONTREAL, DECEMBER, 1871.

SANTARY REFORM.

There is no subject of more engrossing interest than the sanitary condition of a community. There is no subject less understood, or on which people as a rule forbear to think about, or neglect to study than the laws bearing on the general sanitary condition of themselves and their habitations. As long as individuals enjoy the blessings of health, they thank God in a Pharisaical spirit, but care little about the comfort or well-being of their neighbours. It requires the occasional afflicting hand of Providence to bring out the finer feelings of our nature, and to induce man in a spirit of self preservation to seek to ameliorate the misery, and allay the suffering of his fellow man.

We are at the present time throughout the country suffering from epidemic disease. Typhoid Fever, Small Pox, Scarlet Fever, Measles, are unusually prevalent, and in some localities these diseases have proved of a severe type. The well ascertained fact that these diseases are fostered and propagated by local conditions, either defective drainage, bad water supply or over-crowding of individuals in ill-ventilated houses, should be sufficient to excite public attention, and stimulate to earnest and pains-taking exertion to remedy these evils.

What is everybody's business is nobody's business, and therefore a degree of laxity if not aversion, is exhibited on the part of the public generally to deal with the question of sanitary reform. If an individual suffers, then perhaps is he inclined to consider himself badly used, and to abuse generally the city in which he lives, the drainage, the water supply, ay verily the country and all in it, for not having had the foresight and good sense to guard him against an attack perchance of Small Pox or Typhoid Fever. With regard to Small Pox we can hardly close our eyes to the fact that it is on the increase in Canada, and while other communities are endeavouring by isolation and the erection of temporary Small Pox hospitals, to do away as far as possible with contagion, we in

Montreal, at least, are permitting the disease to spread gradually from house to house, thus neglecting one of the most efficient means recommended to arrest its fearful ravages.

It is true we have a Fever Hospital connected with the Montreal General Hospital, and built on the ground in rear of that institution; at the time of its erection we were doubtful as to the propriety of placing it on the present site, but since then having noticed the difficulty of preserving perfect isolation, we are convinced that the views then expressed on this subject were correct.

Persons suffering from Typhoid Fever, Measles or Scarlet Fever, cannot be placed in that building when Small Pox patients are there, without running a serious risk of contracting Small Pox, and even the inmates of the General Hospital are liable to contract the disease, at least in too many instances this has been noticed. We understand that changes in the construction of the present building are contemplated with a view of separating entirely the Small Pox patients from those afflicted with other fevers, but before further expense is incurred it would be well for the Committee of Management to consider the propriety of devoting that building to some other charitable purpose, and of putting up a fever hospital or pest house somewhere in the outskirts of the city. We doubt much if this is not the duty of the municipal body.

We are suffering from epidemic disease, many valuable lives have already been sacrificed, and we fear that greater evil is ahead.

It is a fitting time for the Government to consider the propriety of appointing a general Board of Health for the Dominion. This should be done without delay, as there is every prospect of epidemic Cholera making its appearance during the coming summer. Canada is in a bad sanitary condition for such an event, and if as is feared, Cholera does advance westward and invades our country, it will in all probability be the most severe epidemic of the kind that we have ever experienced. There is no time to exhibit indolence and lack of exertion, much has to be done, and the time is short in which to do it.

The Government of the country should without further delay initiate proceedings and create a Board, whose authority should be unmistakable, and by whose advice the evil may under Heaven be obviated. Much good followed the working of the Central Board of Health in the year 1866. During that year we were threatened with epidemic Cholera, but wise and timely ordinances were enacted, strict quarantine was enforced, sanitary regulations put in action, the cities and towns of Canada cleansed of much of their filth, individual exertion was stimulated, and we happily passed

through the period of alarm without injury. We have greater reason at the present time for anxiety, as not only is the disease Cholera smouldering in Europe, awaiting a favourable opportunity to break forth with unsparing virulence, but our own condition from a sanitary point of view, is very much worse than it was six years ago. We hope that in calling together a Board of Health for the Dominion of Canada, that the selections will be carefully made, and that the highest talent in the country will be secured, independent of sectional considerations. The profession have always been ready to give their time and advise on similar occasions.

In England the "Royal Sanitary Commission" is at work, and the report recently published by that body recommends sanitary reforms, which are being rapidly put in force. The report referred to recommends that in every district there shall be one local health authority, and that every local authority so constituted, shall have one Medical Officer of Health, and that every such officer shall have the power of an Inspector of Nuisances. It would take up too much of our space to discuss the various clauses of this report. We refer to it merely to show that earnest work is being done in England with a view of preventing as far as possible the spread of contagious diseases.

Dr. Lankester in his annual report of the sanitary condition of St. James', Westminster, gives a clear account of contagious diseases in his parish, and of the modes of preventing them. In the course of his report he estimates that the losses from Scarlet Fever, throughout Great Britain during the last sixteen years has not been less than 100,000 lives. And in Westminster, Mr. Barnard Holt states that 233 lives fell a sacrifice to Small Pox during the year 1871, against 13 who died of that disease the year previous. All these facts point to the necessity of earnest and painstaking exertion on the part of Governments and communities to adopt means for the arrest of the progress of epidemics.

Medical News.

SIR ROBERT CHRISTISON, BART.

The honour of baronetcy conferred by Commission on Professor Christison, of Edinburgh, is a just recognition of his well-earned position at the head of the profession in Scotland. Professor Christison already holds the appointment of Honorary Physician to the Queen in Scotland, and is President of the Royal Society of Edinburgh. He has received the honorary doctorate of

Oxford, and has been twice President of the Royal College of Physicians of Edinburgh. He has been a Professor of the University of Edinburgh since 1822, and is the author of a work on Poisons, which, although written many years since, is still a standard authority; and of a highly esteemed treatise on *Materia Medica*. Sir Robert Christison is a Crown Member of the General Medical Council, and took a leading part in framing the authorised edition of the *British Pharmacopœia* issued by the Council. Recently, as a mark of especial esteem and respect from his colleagues in the University of Edinburgh and other friends, his bust was sculptured by subscription, and placed in the library of the University—an honour which, we believe, had not before been conferred on any professor during life.

PRUSSIAN ARMY MEDICAL DEPARTMENT IN THE LATE WAR.—Sir Randal H. Roberts, Bart., in his recently published book, "Modern War, or the Campaigns of the First Prussian Army, 1870-71," says, "Perfect, however, as the organization of the Prussian army is in most respects, one portion seems to require a most thorough remodelling. I refer to the Medical Department. As it was in our service, so it is here: many an officer would rather endure pain and suffering than send for his regimental persecutor." The passage concludes thus: "It is true that during the war many eminent medical men from Berlin and all the German towns flocked to assist their country; but I am sorry to say that the want of good and efficient medical men, was deeply and fearfully felt." Sir R. Roberts went out at the commencement of the war as special military correspondent to the *Daily Telegraph*, and followed the fortunes of the first Prussian army from the beginning to the end. His book, therefore, contains an eye-witness's account.

A NEW REMEDY FOR LEPROSY.—Dr. Bose, Civil Surgeon of Furreedpore, has discovered, says the *Homeward Mail*, a remedy for leprosy, by which he has saved many lives. The remedy is no other than the *Indrajab*, a seed gathered from the famous *Kurchi* of the Indian flora, whose bark is so widely used in curing dysentery. This much has been known, but nothing besides. It behoves our Government to appoint a commission in order that the efficacy of the medicine may be tested, and the result given to the public as early as practicable. Neither "*Indrajab*" nor "*Kurchi*" are to be traced in Dr. Birdwood's "*Vegetable Products of Bombay*."