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THE
Canadian Journal of Medical Science.
A MONTHLY JOURNAL OF MEDICAL SCIENCE, CRITICISM, AND NEWS.

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SUBSCRIPTION, $3 PER ANNUM.

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TORONTO, AUGUST, 1881.

Original Communications.

GRANULAR OPHTHALMIA WITH PANNUS, TREATED BY INOCULATION.

BY T. BULLER, M.D.,
Ophthalmic Surgeon to the Montreal General Hospital.

Notwithstanding the great advances made in Ophthalmology within the last half century, one of the commonest and most easily recognized diseases of the eye still remains a real opprobrium to the healing art.

Essentially chronic in its nature, granular ophthalmia at best runs a tedious and protracted course, but when corneal complications arise, and more especially when the condition known as trachomalous pannus, has become developed, the chances are the sufferer will become weary of himself, of the disease, and of his medical adviser, long before he reaches the end of his troubles. Although nature, perhaps assisted by art, may still, sometimes, achieve a final, though tardy victory, there remains a no inconsiderable proportion of these cases that bid defiance both to nature and to all the resources of the pharmacopœia.

These are the cases that come to the specialist, often in a state of blank despair, and with the sorrowful record of having been everywhere and tried everything without obtaining relief. Desponding and dejected to the last degree, they are willing to submit to any plan of treatment that holds out a reasonable hope of cure. For them a desperate remedy has no terror and they cheerfully take the chance, though the odds are represented as being strongly against success.

Fortunately there is one remedy that rarely fails when judiciously used, to effect a complete and permanent cure of this distressing condition, and the worst cases are, with the exceptions presently to be mentioned, the most suitable for its application. As a general rule it may be said the more complete and the longer the duration of the pannus, the better the results obtained by inoculation.

I have twice seen a moderate degree of pannus cured in both eyes by the unintentional auto-inoculation from gonorrhœal virus in consequence of the filthy practice, so common among the lowest classes, of using urine as a wash for sore eyes; probably some such observation first led to the employment of the mode of treatment known as inoculation.

It has been said that every case of granular ophthalmia might be treated and cured by inoculation, if some efficient means could be found to protect the cornea from the destructive effects of the resulting purulent ophthalmia, a desideratum not yet obtained and probably not attainable.

Inoculation then for the cure of granular ophthalmia is only justifiable when all the ordinary remedies have failed *and when the cornea is completely covered with blood-vessels.* If the latter are but thinly scattered over the surface, or if any part of the cornea is clear the danger is considerable but if so dense as to hide the colour of the iris and pupil, the procedure is a safe and certain cure excepting in feeble and strumous subjects or where the general health is very much deteriorated. Under these circumstances, I believe the resulting purulent ophthalmia is more likely to be of a virulent type and the resisting powers of the

cornea will very likely not be sufficiently great to withstand the tendency to ulceration.

Unfortunately these are just the sort of cases in which granular ophthalmia is most likely to be associated with an inveterate pannus, and the temptation to make use of some radical means of cure is the strongest. To ensure success then, no little discrimination is required in the choice of cases, as well as in the selection of pus used for exciting the necessary inflammation. I have little or nothing to add to the experience of earlier writers on this subject.

I have never used urethral pus for this purpose of inoculation. The objections to its employment are of too formidable a character to be set aside. I have sometimes employed the pus from eyes previously inoculated though unwittingly, for I greatly prefer that obtained from the eyes of infants suffering from an ophthalmia neonatorum that has lasted several weeks, and not caused any corneal complications, the pus at this stage of the disease, usually being pale, and of a somewhat creamy consistence. Yellow or greenish yellow pus is too virulent and should not be employed.

It is held by some authorities that the fact of one eye being healthy is an absolute contra indication to inoculation of the other diseased eye. In these cases I have always protected the healthy eye by means of my watch-glass protector and have not as yet had any cause to regret the risk. When the danger is explained to these patients, I found them most assiduous in keeping the little apparatus properly adjusted, and under these circumstances infection of the healthy eye is almost an impossibility. The protector seldom requires to be worn for more than four or five weeks, and whilst in use the patient is perfectly well able to help himself, which, of course, he could not do if the healthy eye were hermetically sealed up in the manner commonly recommended.

A pannus condition, even of one eye, is usually sufficiently distressing to keep the sufferer in idleness most of the time, and, therefore, the necessity of effecting a cure is almost as great as when both eyes are involved.

I have notes of nineteen eyes inoculated during the past four years without going into the details of each case. The following remarks are intended to give an idea of the general results :—

Group I.—In six cases only one eye was affected, of these four made a perfect recovery and regained excellent vision with the inoculated eye. In the two remaining, ulceration of the cornea occurred resulting in a small leucoma adhærens in the affected eye, with a good prospect of some useful vision after an iridectomy had been done. The other of these two cases was a delicate boy, ten years of age, with ozœna and an inveterate pannus of three years duration. An intense purulent ophthalmitis of a diphtheritic character, set in four days after inoculation and a rather large perforating ulcer of the cornea ensued. An increasing prolapse of iris resisting other means employed to check its progress necessitated removal of the lens. Since which the cornea has recovered to a surprising extent, and there seems a prospect that some vision may be obtained by an artificial pupil. The case is still under observation. It is worthy of note that a peritomy had been done on this eye some nine months previously; as far as it goes, the fact is opposed to the reputed protective influence of this procedure in cases of otherwise doubtful fitness for inoculation.

Group II.—In three cases, only one eye was considered fit for inoculation, the other being duly protected from infection just as the healthy eye had been in the first six cases. Of the second group one eye recovered without complication; one with perforating central ulcer of the cornea, but no prolapse of iris; one with perforating ulcer and prolapse of iris which required an iridectomy to check the tendency to corneal staphyloma. Both the latter cases are still under observation and the final result not yet determined.

Group III.—In five cases both eyes were inoculated. In one both at the same time; one after five days, with pus from the other eye; one after seven days, also from the other eye; two after ten days, from the other eye.

Of these five cases three recovered without any complication and obtained good vision with each eye. In the remaining two perforating ulcer occurred in the cornea of the right eye. In one of these there was prolapse of iris which yielded to the usual remedies for this condition

but a month after the patient had returned home, secondary glaucoma came on and the patient disregarding strict injunctions to present himself at once if any trouble occurred, finally came with a large staphylomatous formation at the seat of prolapse, and vision reduced to perception of light. An iridectomy greatly reduced the staphyloma and restored vision so far that he was able to count figures at three feet distance. The other imperfect result was in a feeble woman about forty-five years af age. A small perforating ulcer occurred in the centre of the right cornea three weeks after inoculation. The ulcer healed and vision began to improve after an iridectomy downwards. The final result will probably be satisfactory, since a considerable improvement in vision has taken place already and the inoculation was only done eleven weeks ago.

To sum up the result of the nineteen eyes inoculated, thirteen recovered perfectly without any complication. In six perforating ulcer of the cornea occurred. The ulcer being nearly central, they all required or will require an iridectomy for artificial pupil. In only one instance, the youngest of the list, can the eye be said to have been lost for visual purposes, but even here the cure of the disease and the relief given by removal of the constant irritation is a real boon to the patient, as he will be able to use the healthy eye without discomfort.

A somewhat significant fact was the occurrence of ulceration of the cornea in the three youngest patients. In one of them the eye seemed in every respect most favourable for inoculation. If any conclusion can be based upon this limited observation, it is that inoculation in early life, or before puberty, is peculiarly hazardous. In adults this method of treatment is, *in suitable cases*, perfectly satisfactory and cannot be too highly recommended. I could not make up my mind to follow the advice of authorities on this subject and always leave the eye entirely without treatment, excepting occasional washing with simple water after the inoculation.

Whenever the case was uncomplicated, I adopted this plan with hesitation, but so soon as I found ulceration of the cornea I always treated the purulent ophthalmia with a view to lessening its intensity and to arresting the ulcerative process in the cornea, and I feel satisfied that by so doing the eye was more than once rescued from impending destruction

A CASE OF COMPLETE RUPTURE OF THE PERINEUM WHICH UNITED SPONTANEOUSLY.

BY J. H. RADFORD, M.D., GALT.

I have thought the case cited below well worthy of record, because, first, it seems to me to go far to decide the advisability of immediate operation in such circumstances, and second, the method of treatment adopted, although not distinctly recommended by Thomas, resulted so satisfactorily that it may be considered well worthy of trial in similar cases.

In regard to the first point it is well known to all students of this department that there is a wide diversity of opinion as to the time for operation, some urging immediate action, some advising delay for a few days, while others advise delay until the effects of parturition are over.

To the first class belong Baker-Brown, Scanzoni, and Thomas; to the second, belong Velpeau; and to the third, Nélaton, and Verneuil.

I think, after due consideration of this case, the profession will strongly favour the first method of treatment, because if one out of twenty would succeed it would save a good deal of needless pain and suffering to such unfortunate victims.

Before entering into the details of the case I desire to call your attention to Dr. Thomas' remarks. He says that "when the rupture has been complete it has been asserted that spontaneous cure has taken place," but such reports need confirmation. He also mentions a case in which recovery was said to have taken place, but which, when examined thirty years after, showed the rupture still ununited.

The case is as follows:—Mrs. B——, aged 35, primipara, with a small pelvis.

On the 18th May, I was summoned to attend her as she was about to be confined. On my arrival I found her having pretty severe pains

which were coming on very regularly. I made an examination per vaginam and found a thin, soft, dilatable os, about the size of a crown piece. In the course of an hour I made another examination and found the os dilated to its full size, after which the pains began to diminish and continued to do so for about an hour. I then gave her an enema and a dose of ergot which did not have much influence over the uterus, so I gave another ʒss dose, which had a decided effect.

Pains came on and in spite of all my efforts to prevent rupture, by smearing with olive oil, dilating with fingers, supporting the perineum, and shoving up the head, it was torn through the sphincter ani. Case lasted ten hours.

Treatment—After washing the part thoroughly I put in two silver wire sutures and tied the knees together, placed her on her side in which position she was kept. I kept the bowels confined for ten days by morphia. Drew off water for the first week twice a day, after that time she made it while lying on her abdomen. The vagina was washed out twice a day with a carbolic solution.

On the tenth day I gave her an enema and broke up the fæces with a pair of forceps. She then got an enema for the five following days. About the 13th day I removed the sutures and found good union. Have examined her twice since last time, about four weeks after the rupture took place. Diet consisted of beef-tea, chicken broth, and milk. No solid food whatever.

[If care be taken always to pass the sutures deeply, so as to restore the perineal body, we are satisfied the immediate operation will often prove successful as it did in the above case.—Ed.]

Joseph Skoda, formerly Professor of Medicine in the University of Vienna, and the last link between the old Vienna School, as represented by Oppolzer, Rokitansky, and Hebra, and the present, died on the 13th June, last, after a lingering and painful illness, at the age of seventy-five. His chief work was on Auscultation and Percussion.

HYOSCYAMINE.

BY C. K. CLARKE, M.D.,
Asylum for the Insane, Hamilton.

So much having been said in praise of hyoscyamine as a sedative we determined to try it in this asylum, a few months since.

Mack's crystalline, was the only preparation used, and the patients treated, were cases of acute, chronic, and recurrent mania.

Case 1—J. S., male, aged 57. Admitted November 12th, 1880. Came in labouring under an attack of acute mania, was extremely violent, boisterous, and difficult to manage. Became so unmanageable during the day that it was found necessary to restrain him.

November 13th.—There was no improvement in the condition of the patient. One-tenth grain of hyoscyamine dissolved in alcohol was ordered, and had a wonderful effect, quieting the patient down until the 15th November. Upon that day he again became unmanageable and one-fifth grain was prescribed. The patient kept under the influence of the drug four days, receiving each day one-fifth grain. He received the last dose on the 18th November, and from that date until the 30th November, when he left our charge, remained perfectly quiet and was apparently very well, although we did not consider him perfectly recovered. After leaving the asylum, he returned to his home, the old exciting influences upset him, and he was brought back in two weeks time, nearly in the same condition as when first admitted. One-fifth grain hyoscyamine was immediately prescribed and the dose repeated next day, when our patient again quieted down and remained quite well until March 30th, 1881, when he was discharged perfectly recovered. Is working regularly, and at present date is as well as ever.

Case 2—J. R., male, aged 17. His aunt was insane. Patient has frequent attacks of recurrent mania, and when under their influence is extremely troublesome and dangerous. His attacks are generally of three weeks' duration at the very least.

The patient having been excited for a week, one-tenth grain of hyoscyamine dissolved in alcohol was given, but produced no effect. This

was on the 13th November, 1880. Next morning the dose was increased to one-fifth grain, and in an hour the patient had quieted down and kept quiet until next day, when he became violent once more. He took one-fifth grain on the 15th and the same dose the day following, when it was not found necessary to prescribe any more of the drug, the patient having become perfectly quiet and manageable, remaining so until the next period of attack, some six weeks later. Again the hyoscyamine had the desired effect and cut the paroxysm short. These two cases are, perhaps, as typical as any we can enumerate. In the case of recurrent mania, chloral had often been tried, but beyond controlling the mania for the time being, did not seem to exert any beneficial effect, and did not shorten the duration of the attack. Hyoscyamine acts very speedily and the patient seems at first like one intoxicated. In a short time there is mild delirium, and if not watched the patient is apt to crawl about the floor and grasp at imaginary objects. In all the cases under our care where hyoscyamine was given, marked dilatation of the pupils resulted. The after effects are merely a little dryness of the mouth and difficulty in distinguishing, objects owing to the dilatation of the pupils.

We have tried the drug in a fair number of cases and have come to the following conclusions in regard to it:

If any sedative is *really* required in the treatment of mania, hyoscyamine is the drug most applicable to the majority of cases.

It cannot be claimed to have any curative effect, but as a controlling agent is very valuable.

We believe it cuts short attacks of recurrent mania, and in many cases of acute mania will give much needed rest.

Not having any faith in the use of chloral in the treatment of acute mania we are glad to welcome hyoscyamine as a sedative which leaves such trivial after-effects.

Chloral seems to *lengthen* attacks of mania, hyoscyamine to shorten them.

There is at present one drawback in the use of this preparation, and that is the great cost of the article. The present price places it beyond reach for ordinary use. [Especially in public hospitals.—Ed.]

Selections: Medicine.

STERTOROUS BREATHING IN APOPLEXY AND THE MANAGEMENT OF THE APOPLECTIC STATE.

BY ROBERT BOWLES, M.D., FOLKESTONE.

In the investigation of the causes of stertorous breathing in apoplexy, I found that they were mechanical, and could at all times be so changed as to alter altogether the nature of a case, and often to make the difference of recovery or death; and, moreover, that the principles involved applied not only to apoplexy, but to many abnormal conditions allied to it. The subject having been now before the profession for twenty years, one is surprised to find how little attention appears to have been directed to it in our medical schools. Younger members of our profession to whom I have spoken, certainly do not realize its importance; and yet the value of a knowledge of it in the management of the apoplectic state is far greater than bleeding, blistering, calomel, crotonoil, and the rest.

The removal of the causes of stertor so immediately changes the aspect of a case, that the question of blood-letting is at once solved in the clearest and surest manner. The truth is, two separate conditions of the apoplectic state have been jumbled together and treated as one: the cerebral affection, and the condition of suffocation consequent upon it. Stertor, in one sense, is but a croupin the pharynx, or apoplexy *plus* suffocation, as croup is laryngitis *plus* suffocation. We feel it necessary to relieve croup by a serious operation; whereas stertor is left to itself, although it may be relieved by merely changing the position of the body.

On referring to the literature of the subject, I have been astonished to find how difficult it is to draw any conclusions from the descriptions of the disease, or the treatment to be adopted. Authors are not agreed, and one of our most distinguished neurologists, in an article on Apoplexy, in a recent important work on medicine, with infinite labour, appears to arrive at the conclusion that, in apoplexy, we can know nothing, we can foretell nothing, and we can do

nothing. This confusion arises in great measure from the stertorous breathing, converting all cases in which it is present into cases of apoplexy *plus* suffocation.

It is agreed that there are cases of apoplexy in which the face is pale, and the pulse small, and in which bleeding is not to be thought of, and also that there are cases in which stertor is not present; but I cannot, with all my diligence, find out from any works that have been open to me, whether these two conditions, that is, the pale face, and the absence of stertor, were co-existent. There are no observations made by any author as to the position of the patient in the non-stertorous case.

Suffocation, added to grave mischief in the brain, must of necessity affect not merely the symptoms of progress of cases, but also their mortality. Those only who have observed the extraordinary change on the removal of suffocative stertorous breathing, can judge how the diagnosis and prognosis are affected by it, and, not less so, the treatment and morbid anatomy.

Most modern writers on apoplexy adopt the general views of Dr. Abercrombie, and naturally, from the broad division of cases into sthenic and asthenic, are disposed to bleed in the former, and to avoid it in the latter; whereas, if we look upon the hard slow pulse, as the result of the heart labouring to overcome an obstruction in the lungs (suffocation), we shall at once see that our first duty is to remove this obstruction, and thus simplify the case.

Heberden and Fothergill were opposed to bleeding in any case, and the latter has made some curious suggestions which pertain to the subject of this paper. He says that "even the hard, full, and irregular pulse, which seems imperatively to call for a free use of the lancet, is often an insufficient guide, since it may be that struggle which arises from an exertion of the *vires vitæ* to restore health." From what has already been said, you will readily guess that I should say, "this strong pulse arises from an exertion of the *vires vitæ* to overcome vascular obstruction caused by gradually increasing suffocation."

Niemeyer, more than others among recent authors, has attempted to be systematic, and to clear away the confusion attached to apoplexy; but, like others, he fails, from not discriminating between the apoplexy and the suffocation. He believes that the shock and oppression of the apoplectic state arise from anæmia of the brain-substance, from sudden compression of the cerebral capillaries; this anæmia is always seen after death, and is shown during life by the very symptom which has always had a contrary interpretation—"a remarkable pulsation of the carotids." This, instead of being a sign of increased pressure of blood to the head, really indicates that the flow of blood into the skull is obstructed "by the space", he says, "in the skull being affected, so as to prevent the escape of blood from the afferent vessels;" throwing the blood back, as it were, into the carotids.

As a consequence of this view, under the head of treatment, he says, "it is evident that, under some circumstances, venesection is a very useful remedy; under others, it is very injurious, and the indications for it may be very exactly given. In order that as much arterial blood as possible may enter the brain, we must try to facilitate the escape of venous blood, without however, diminishing the propelling power too much" (what a plea is this for removing suffocation); then, he continues, "if the impulse of the heart be strong, and its sounds loud; if the pulse be regular, and no signs of commencing œdema of the lungs exist, we should bleed without delay. If on the contrary, the heart's impulse be weak, the pulse irregular, and the rattling in the trachea has already begun, we may be almost certain that bleeding would only do harm, since the action of the heart, which is always weakened, would be still more impaired, and the amount of arterial blood going to the brain would thus be still more decreased."

The simple illustration of some of my early cases will best illustrate what usually happens in a case of apoplexy, and how it may best be managed.

CASE.—In October, 1863, Miss B. was seized with apoplexy. On my arrival there was a partial return to consciousness, and the left side was found to be paralysed; there was pharyngeal stertor when in the recumbent pos-

ture, and she appeared uneasy when placed on her right side; she was, therefore, placed on her left when the stertor ceased. A blister was applied to the nape of the neck, and she remained in this position for nine days. She was now better and spoke to me. Fearing a bedsore, I desired the nurse to change her position, by turning her from her left to her right side. Soon after this was done, she was distressed for breath, and the countenance became livid. On my arrival, I found the difficulty of breathing gradually increasing; the blistered surface, as well as the ear upon which she had lain, of a dark purple hue; and the pulse, which had before been weak and irregular, full and bounding. There were large mucous *rales* over the whole chest; she was quite unconscious, and death from suffocation was imminent.

Finding that these symptoms supervened upon the change of position, I had her placed upon her left side, and immediately the pulse sank, the mucous stertor ceased, the breathing was relieved, the lividity of countenance passed away, and the blistered surface, which had been almost black, resumed a bright cherry-red color. This additional shock, however, proved too much for her, and she died the same day, peaceful and conscious.

The salient points of this interesting case are these: 1. Pharyngeal stertor ceased when the patient was placed on her side; 2. There was a slow but gradual improvement subsequent to this; 3. Mucous stertor and imminent death supervened when she was changed to the opposite side; 4. Instant relief followed on resuming her original position; 5. A return to consciousness was coincident with the cessation of stertor; in other words, with the removal of the respiratory difficulty.

On a careful examination of the chest after she became quiet, I found all *rales* slowly fade away from the right side, or that which was uppermost, and the natural breathing return; but the left lung, which had been dependent throughout, was dull on percussion, and deficient in respiratory murmur.

The explanation now became clear, viz., that the dependent lung had become filled with some mucous fluid, and that, on changing the side, the fluid by gravitation was finding its way across the trachea to the opposite lung; but, in doing so, it had been churned to foam by the ingoing air, giving rise to mucous stertor; and this foam, by filling up the larger bronchial tubes, was quickly causing suffocation, with all its usual results.

As a point of management, then, in cases of apoplexy, it would appear necessary to keep the patient on one side, and not to change it; but which should this be? Healthy people, when lying on the side, breath chiefly with that side which is uppermost, for the intercostal and other thoracic muscles of the lower side are fixed between the weight of the body and the bed, and the breathing of this side is almost entirely diaphragmatic. It must be remembered, too, that in placing the paralysed side downwards, the injured side of the brain is upwards, and, therefore, relieved from hypostatic congestion, a condition always liable to occur when an injured part remains dependent.

In my original paper, in the *Transactions* of the Royal Medical and Chirurgical Society, three varieties of stertor were defined:

1. *Palatine Stertor*, when the air, in rushing through the nose or mouth, causes a vibration of the soft palate.

2. *Pharyngeal Stertor*, when the air passes through the narrowed interval between the base of the tongue and the posterior wall of the pharynx.

3. *Mucous Stertor*, depending upon air bubbling through mucous in the larger air-tubes.

Besides these, there is occasionally, but only very occasionally, what may be called a *laryngeal stertor*, heard most commonly during the inhalation of chloroform, which has been pointed out by Professor Lister. Whether this arises from a spasm of the glottis, or from paralysis of some of the laryngeal muscles, I am not prepared to say. There is, however, a *nasal stertor* which belongs more to the apoplectic state, and, as far as my experience goes, is often a symptom of the gravest kind. It arises from paralysis of the nerves supplying the elevators and dilators of the alæ nasi; so that the ingoing air, as in sniffing, draws the alæ nasi towards the septum, and sometimes causes a serious obstruction to the breathing, and certainly hastens death, as well as needless-

ly distresses the bystanding and sorrowing relatives.

CASE II.—A lady, sixty years of age, fell head-foremost down stairs, and was taken up unconscious. She had complained much of head-discomfort in the morning, but nevertheless had been out for a short walk. The weather was thundery. On my arrival, immediately after the fall, there was considerable ecchymosis at the outer angle of the left orbit; but there was no bleeding from the ears, nose or mouth; nor was there any extravasation between the ocular conjunctivæ. I found her wholly unconscious, breathing stertorously, and vomiting. The right pupil was dilated and fixed; the left very sluggish. When she was turned on her side the stertor ceased; the aspect of the face became almost natural; and she moved her left arm and leg, and remained like a person quietly asleep for twenty-four hours. At this time, *nasal* stertor commenced, and gradually increased in intensity; and *pari passu*, the face became congested and turgid, the veins of the temple stood out in bold relief, and in about an hour she died.

Dr. Monckton saw this case with me in consultation; and I was able to demonstrate to him how stertor and its consequences instantly recommenced in this poor lady's case when she was placed in the supine position, and also how easily nasal stertor could be removed either by pressing the tip of the nose upwards, or by dilating the nares with the handle of a salt-spoon.

There is yet one other form—the puffing out and flapping of the cheeks and lips—which may be fairly dignified with the title of *buccal* stertor. Now, although this last does not give rise to any respiratory difficulty, it is nevertheless, like nasal stertor, of importance in prognosis, and useful for purposes of definition. Like nasal stertor, it is dependent on paralysis of the portio dura, and therefore, indicates the approach of the intracranial mischief towards that part of the brain which governs the functions of organic life, or (which is a very important alternative that both it and nasal stertor may arise simply from venous engorgement at the base of the brain, in consequence of the suffocative stertors damming the jugulars.

Authors have always looked upon this symptom as an extremely dangerous one; and so no doubt it is, in the combined conditions of apoplexy and suffocation; but, as I have observed both it and nasal stertor, in a modified degree, in the snoring sleeper, and as cases of suffocative apoplexy, in which it has been most marked, sometimes make a rapid recovery, I withhold my opinion for the present.

Indeed, it is almost impossible, from the writings of the past, to arrive at any conclusion as to the value of any symptom of apoplexy. We must now observe from a new point of view (apoplexy without suffocation), and draw our conclusions in the future. The following short case is a happy illustration of some of these remarks. I am indebted to Dr. Lewis, of Folkestone, for the notes.

CASE III.—A lady, sixty-seven years of age, was found in her bed in an apoplectic condition. There was total loss of consciousness; the pupils were of about the usual size, but fixed; there was slight reflex action on touching the eyeball, and an occasional involuntary movement of the arms. The face was turgid, and there was both *pharyngeal* and *buccal* stertor. On being placed on her side, the stertor instantly ceased, and she gradually improved. In twelve hours, she had perfectly recovered consciousness; the respiration was normal; the face very pale, and the pulse quick and feeble; and there was no paralysis.

Surely no case could have looked more unpromising than this, when the age is taken into consideration.

Nasal stertor is unaffected by the position of the body, but may always be relieved by mechanical means.

Palatine stertor is usually of the least consequence; *i. e.*, it obstructs the breathing only very partially, and cannot always be removed by changing the position of the body. It is affected by the size of the tongue, the length of the uvula, the position of the chin, and other incidental conditions, all of which may be obviated if the obstruction to the breathing be sufficient to render it worth the doing.

Pharyngeal stertor is the most common, in severe cases of apoplexy, when patients are recumbent. This may always be obviated by

properly arranging the position of the patient; allowing the paralysed mass—the tongue—to gravitate to one side, rather than against the back of the pharynx.

Mucous stertor, when unconnected with lung-engorgement, the consequence of suffocation from stertor, only occurs in very serious cases, depending upon interference with the nutritive processes of the lung-tissues—probably arising from accident to, or pressure upon, the medulla oblongata. This can always be satisfactorily removed by proper attention to the position of the body.

These principles apply not merely to apoplexy but also to all apoplectic conditions. Especially I would mention drowning, epilepsy, convulsions in children, meningitis with effusion, death-rattles, fracture of the skull, concussion, bronchitis, (especially that of old people) sudden œdema of the lungs, large hæmorrhage from the lungs, great exhaustion, chloroform-poisoning, drunkenness, opium-poisoning, and all conditions in which mucous or fluid exists in the lungs; and also all conditions allied to the apoplectic, whether there be mucous or not.

I have seen and treated all these conditions, and invariably with a similar result—an unfailing relief to the distressing symptoms and their consequences; and in many instances, both in my own as well as in the practice of my friends, ultimate recovery has occurred in cases which must, we believe, have terminated fatally if the obstruction to the breathing had been allowed to continue unrelieved.—*The British Medical Journal.*

Cholera Infantum.

℞ Argenti nitrat.....gr. j.
Acid. nitric. dil.....*m* viij.
Tinct. opii deodorat .....*m* viij.
Mucil. acaciæ ..... ℥ ss.
Syr. simplicis ..... ℥ ss.
Aq. cinnamomi..... ℥ j.

M. Sig.—A teaspoonful every three, four, or six hours to a child one year old.—Bartholow.

This combination is remarkably beneficial after the acute symptoms have subsided.—*Michigan Medical News.*

VARIETIES OF ACUTE LOBAR PNEUMONIA.

M. DIEULAFOY.

If lobar pneumonia always presented itself to you with the frankly acute character, it is very certain that errors in diagnosis would not be produced, and the disease could never be mistaken.

Unfortunately, it is not so in practice, and this phlegmasia, so frank, and so clear, which I have just described to you, affects certain varieties which you ought to know.

We can immediately arrange these varieties in three great classes which we will afterwards subdivide.

Varieties according to the *situation* of the phlegmasia, according to the *age* of the subject, and lastly, according to the medical constitution of the period.

To the first of these varieties belong the *central* pneumonias, double pneumonias, and those of the apex. In these different forms you will find all the phases of lobar pneumonia frankly acute: the anatomical lesions will be quite the same: but the patient not re-acting in the same manner, will offer to you a train of symptoms which might deceive you if you were not forewarned.

In *central* pneumonia, the patient will present himself to us saying that he has had a single internal chill with a consecutive stitch in the side. You will observe a very pronounced dyspnœa, the pulse is large, the countenance empurpled: everything confirms you in the idea of a pneumonia, and as your patient has been suffering for from twenty-four to thirty-six hours, you auscultate him with the certainty of finding crepitant râles, but you hear nothing: you make your patient cough, always with the same result. You ask to see the sputa, there is none, or it has been thrown away. In presence of these facts, you are truly perplexed. The onset is certainly that of pneumonia, the temperature is equally conformable to what you know, 39 degrees (102·2° F.), but there are no crepitant râles! Are you to conclude from this that there is no pneumonia?

No, wait until the morrow, and you will have the rusty sputa, but it will often be only on the fourth day that you will perceive the

cerpitant râles and the tubal souffle. You were in presence of a central pneumonia which took four days in reaching the periphery of the lung. In these cases the diagnosis ought to be made at once, for in no other disease will you find a unique chill followed by pain in the side with a temperature of 39° (102·2° F.), and 40° (104° F.) at the second and third day.

Another case may present itself: it is that in which a patient, already attacked with unilateral pneumonia, will be taken with double pneumonia towards the fifth or sixth day of his illness. Let us suppose, for example, that we have a left pneumonia. All has proceeded regularly. Your patient is better, the temperature is falling, and nothing causes you to foresee a complication. The next day, that is, on the fifth, you take the temperature, and you are surprised at finding it still 39°, 39°5 (102·2°—103.°1 F.) You question the patient, who says he is getting better. There is no quickening of the pulse, nor increase of cough, nor pain in the side, the dyspnæa is not more pronounced. On auscultation you find always your crepitant râles and tubal souffle. In a word, the patient is better, the temperature alone does not satisfy you.

The next day, not only the thermometer still marks 39° (102·2° F.) but the evening before it had marked 39·8° (103 6° F.), and yet the patient feels always just as well. Be not deceived by what he tells you, seek—auscultate on the right, and most often you will find there the explanation of the maintenance of the temperature at 39° (102·2° F.) A *second pneumonia* (mark that I do not say secondary) will have declared itself. A single fact may put you on the track of this second pneumonia; put the same thermometer in the left axilla, the side in which existed the first pneumonia, then in the right axilla; if the two temperatures are sensibly equal, there will be a double pneumonia. It will happen even that the first pneumonia being on the way to resolution when the other begins, the temperature will be less elevated on the side of the first, than on the side of the second. These second pneumonias, which are shown in about one-fifth of the cases, are not grave, and in no way hinder the recovery of the patient: they are rather hyperæmic than frankly phlegmasic pneumonias.

A third variety of pneumonia may present itself, as to its situation: it is pneumonia of the apex, whose prognosis is so grave that Cruveilhier said it was always mortal, and he is right, in the majority of cases. Not, as some authors have pretended, that this gravity is due to the situation itself of the pneumonia, but to the constitution of the individuals in whom it declares itself. Professor Peter has conclusively demonstrated that, if pneumonia of the apex is dreaded, fatal, and often proceeds to suppuration, this is due to the individuals themselves, who are alcoholics, cachectics, debilitated by one cause or another, and in whom pneumonia is localized by preference in the apex of the lung: such is the veritable cause of its gravity, without being obliged to accuse the situation. In these patients the pain in the side will sometimes be wanting, the initial chill will be less marked, the expectoration itself may not be characteristic, and lastly, on auscultation, you will not find crepitant râles, if you have not in mind this variety of pneumonia. To discover the pneumonia centre, you ought to separate the arm from the trunk of the patient and apply the ear to the upper portion of the axillary space. It is there only that you will perceive the crepitant râles which will allow you to diagnose a pneumonia of the apex.

In addition to these varieties pertaining to the seat of the pneumonia, there exist others relative to the *age*. We will pass over pneumonia of the adult which we know, to speak only of that of the child, and of the aged.

Of the child, I will say only a word, for in it the disease is very rare, and when it is present it is without gravity; the pneumonia of the child is lobular pneumonia, of which I have spoken to you in my preceding lectures, and of which you know all the gravity.

Acute lobar pneumonia is very rare and benign in the child, it is unfortunately not the same in the aged in whom it is frequent, and takes a peculiarly grave character, which made Cruveilhier say that one-fourth at least of the aged died of pneumonia. How will you make your diagnosis? Here you are in the presence

of an old man who during the day was well; in the evening he was taken with *malaise* and vomited his dinner, the night has been bad.

You find that the tongue is dry, the eye brilliant, the cheeks red, and if you take the temperature you find at the maximum 39° (102·2° F.) In the presence of such symptoms can you recognize an onset of pneumonia? Your patient has not been cold, he has had neither chill nor pain in the side, and yet, if you auscultate, you will find, in place of the crepitant râles, dry and fine of the adult, large crepitant râles of return—humid râles. There is a pneumonia, and a grave one, and one to which the patient most often will succumb at the end of a few days.

We are very far from finding that *ensemble* of symptoms so clear and so characteristic, that I described to you in the adult. Remember the old man was not chilled, or at least had but a slight chill; in him the re-action is almost *nil;* pain does not exist; expectoration does not take place, for the aged expectorate with difficulty, and not expectorating, death takes place by suffocation.

Retain this then: every time that you find an old man, taken suddenly with *malaise*, having the cheeks red, the eye brilliant, and the temperature high, practice auscultation, and you will find the signs of a pneumonia, which though not provoking any suffering, is none the less of the highest gravity.

It remains for me to speak to you of certain varieties of pneumonia which are difficult to describe, for they submit to the influence of the medical constitution of the period, and that of each particular individual. We have seen how we may arrive at recognizing the varieties of pneumonia according to their situation and the age of the subject; but what I cannot trace for you here, is the form that these pneumonias will take according to the condition of the patient. You all know, to cite only one example, that in alcoholics, this disease takes the ataxic character, that we see subdelirium seize upon these individuals and that death is most often their termination.

Each individual will re-act according to his own constitution, and the disease will take such, or such a character in relation with that constitution itself.

But, besides the patient, there is what is called the medical constitution of the period. You all know that there exist certain periods during which diseases affect a strange form. The symptoms are not those that we ordinarily meet with, there are certain years in which all diseases, smallpox, typhoid fever, or pneumonia, have a tendency to take the bilious, adynamic, or ataxic form, without our knowing why. You have a patient suffering from acute lobar pneumonia, all goes well for a certain time; then without anything to justify the change, your pneumonia becomes bilious, and the patient succumbs where he should have recovered. Why? We do not know, we can only state the fact. To get an account of the influence of the medical constitution upon the prevalent diseases, I advise you to read the remarkable work of Stoll on the medical constitution of 1775 and 1776, and the study of Chauffard on the medical constitution of 1862, in the *Bulletin de la Société Médicale des Hôpitaux*, 1863.—*Gaz. des Hôpitaux.*

Treatment of Frequently-recurring Erysipelas of the Face.—This affection is very annoying to the patient, for, in spite of every precaution, it will recur again and again. If any cause can be discovered, such as bad drainage, it should at once be remedied; but, whatever other hygienic or medical treatment be employed, some local application is generally necessary. All these applications are either disfiguring or disagreeable, or totally inefficient. For many years, my father and I have used, with entire success, a strong solution of tannin (four to eight grains to the drachm of spirits of wine and water.) This application, which is not disagreeable to the patient, should be painted over the parts affected with a soft brush every two or three hours, and allowed to dry, the patient being careful to keep the face from the fire. If there be a tendency to frequently recurring erysipelas, it is well to keep the tannin at hand, as it will always arrest a threatened attack.—James Braithwaite, M.D., in *British Medical Journal.*

SYPHILITIC AFFECTIONS OF THE LUNG.

In a paper lately published in the *Giornale Italiano delle Malattie Veneree e della Pelle*, Professor Gamberini, of Bologna, enters at some length into the subject of pulmonary syphilis. Besides relating two cases of his own, which were judged to be instances of early syphilitic affection of the lung, the author quotes fully a number of cases recently reported by other observers.

The following are the general conclusions at which Gamberini has arrived after a careful study of his own cases and those of others. The existence of a simple inflammatory syphilitic pneumonia may be admitted, but it is not yet conclusively proved. The occurrence of a gummy form of disease of the lung is established beyond doubt. True pulmonary tuberculosis may be associated with syphilis, but it preserves always its own pathological characters. To distinguish between the syphilitic and the tubercular forms of lung-affection, the author proposes for the former the title of "consumptive pulmonary syphilis." The influence of specific treatment is, at the present time, the best therapeutic means of diagnosis between tubercular and syphilitic diseases of the lung. The author agrees with Schnitzler that pulmonary disease as a consequence of late g neral syphilis, or even of acute secondary syphilis, is not a rare occurrence. Laryngeal lesions often precede or accompany syphilitic pulmonary affections. This has been proved by the observations of Schnitzler, who, indeed, affirms that the diagnosis of syphilitic lung-disease may be made by means of the laryngoscope alone. The symptoms of syphilis of the lung are generally those of pneumonic phthisis, from which, during life, there may be no certain means of distinguishing it; even after death, the distinction cannot always be made between gumma and tubercle, especially when the gummy nodules are in a state of caseation, or are infiltrated. It must be noted, that syphiloma most usually spares the apex, whereas tubercle most frequently attacks that portion of the lung. This, however, is not constant, as has been shown by Fournier. The course of pulmonary syphilis is usually slow and apyretic, which is not usually the case in tubercular phthisis. Syphilis, also, is accustomed to attack only one lung, and one part of the lung. This tendency to localisation is considered by the author to be a very important point in the diagnosis of pulmonary syphilis, whether the lung be attacked at an early or at a late stage of the disease.—*British Medical Journal.*

OCULAR SYMPTOMS IN DIFFERENT DISEASES.

Dr. Gorecki, as stated in the Glasgow *Medical Journal*, has tabulated his views as follows:

Blepharoptosis, or the falling of the upper eyelid, indicates paralysis, complete or incomplete, of the third pair.

Lagophthalmos, or inability to close completely the palpebral fissure, is a sign of facial hemiplegia, idiopathic or a symptom of cerebral disease.

Strabismus occurring suddenly, and accompanied by diplopia, is most frequently the result of some cerebral affection.

Xanthelasma (a yellow lamina sometimes met with in the skin) of the eyelids, occurs in certain alterations of the liver.

Sub conjunctival ecchymoses are frequent in whooping cough, and may sometimes, at the beginning of the complaint, clear up a difficult diagnosis.

Redness of the conjunctiva, watering of the eye, etc., indicate in the child the outbreak of some eruptive fever, particularly measles. The prognosis is favorable if the tears come when the child cries, but fatal if the secretion of the tears is arrested.

Spots on the cornea are often the indication of a strumous constitution.

Dilatation of the pupil, or mydriasis, indicates excessive fatigue, the existence of intestinal worms, meningitis in the second stage, or a true amaurosis. The dilatation is most frequently connected with atrophy of the optic nerve. It is seen also during an attack of epilepsy, on coming out of chloroform, after belladonna poisoning, etc.

Unequal dilatation of the two pupils points to the onset of general progressive paralysis.

Contraction of the pupils is one of the early symptoms of *tabes dorsalis*. It is met with also at the beginning of meningitis, in opium poisoning, and in the first stage of chloral poisoning.

Deformation of the pupil, particularly after the injection of atropine, indicates an old iritis, in nine cases out of ten, of syphilitic origin, if not depending on some disease of the neighboring parts.

Cataract in subjects under say forty or fifty, is frequently of diabetic origin, and constitutes soft cataract.

Finally, the ophthalmoscope enables us to recognize the retinitis of albuminuria in Bright's disease, of simple polyuria, and sometimes in the case of women during pregnancy. Retinal hemorrhages, œdema of the retina, and embolism of its central artery, are sometimes met with in organic affections of the heart. Optic neuritis and perineuritis and atrophy of the disc are symptoms of syphilis, or of tumors in the neighborhood of the cerebellum or the *corpora quadrigemina.—Phil. Med. & Surg. Reporter.*

ON HERPES FACIALIS.

The following extract is from a lecture by Dr. J. M. Finny, published in the *Medical Press and Circular* :—

Herpes facialis—a better name than *herpes labialis*—is met with most usually on the lips, at the muco-cutaneous juncture ; but it occurs also on cheeks, ears, and nose. Though an accompaniment of an ordinary cold or dyspeptic attack, *herpes facialis* is present in pneumonia, cerebro-spinal, intermittent, and scarlet fevers. During the present session you have seen it in both scarlet fever and pneumonia, and you will recollect the different significance which may be attributed to it in these two diseases. In the latter, so usually do the patients who present it recover that some authorities consider it a most favorable prognostic ; while in scarlet fever it is an omen of a severe type, in which nasal discharges, arthritic complications, and a prolonged fever may be expected. The late Dr. Stokes used to lay down, as a maxim worthy of note, that a vesicular complication of fever was ever one of serious import.

The most extensive case of facial herpes I ever met with occurred in a patient, aged sixty-six, who was admitted to this hospital in 1879, for pneumonia, as the whole of his right cheek, extending from the zygomatic arch to the nose was one mass of herpetic clusters, which became confluent. He made a rapid and good recovery. Notwithstanding the frequency of the favorable issue of pneumonia attended by herpes, I would not have you lay too much stress upon the value attaching to this symptomatic rash, inasmuch as most cases of sthenic pneumonia have a tendency to recovery, and many cases in which herpetic rashes are absent do equally well.

The ordinary cases of facial herpes present no difficulties of diagnosis, but you should remember it may attack the mucous membrane of the mouth and palate. Should it be confined to these places, you may find some difficulty in recognizing the disease.

Within the last couple of months I came across a rather puzzling case of herpes, in consultation with Dr. Wm. Lane, in the person of a well-known clergyman of this city. The whole soft palate, uvula, and arches of the palate were studded with vesicles standing on a reddened base. At first sight scarlatina or diphtheritic inflammation passed through my mind ; but the absence of the characteristics of those diseases, and the presence of a most copious vesicular eruption on the alæ and dorsum nasi, the upper lip, and the adjoining surfaces of the cheeks and chin, made the diagnosis easy.—*Phil. Med. & Surg. Reporter.*

Dr. Warburton Begbie's prescription for troublesome cough, with copious expectoration in Phthisis :—

℞ Liq. Morphiæ Hydrochlor.
Acid. Hydrocyanic. dil. āā *m* xviij.
Spts. Chloroform.
Acid. Nitric. dil. ..... āā ʒj.
Glycerine..... ʒiij.
M Infus. Quassiæ..... ..... ʒij.

A sixth part to be taken three or four times a day.

In this mixture, Dr. Lauder Brunton says in

a letter to the *London Lancet*: "We find the sedatives, morphia, hydrocyanic acid, and chloroform, to lessen the excitability of the respiratory centres; we find glycerine, which will tend to retain the sedatives for a longer time in contact with the back of the throat, and will also act to some extent as a nutrient. We have combined with these nitric acid and quassia, which have so-called tonic action in the stomach." The nitric acid will diminish the pulmonary secretion and therefore expectoration; but on the other hand, when as under certain circumstances is the case, the cough is very troublesome with insufficient secretion and expectoration, potash has a marked effect in rendering the pulmonary secretion more fluid and abundant. This effect of potash is specially referred to by Dr. Andrew Clark.

Surgery.

IODOFORM IN SKIN DISEASES.

The idea of using iodoform in the treatment of skin-diseases other than those due to syphilis has occurred to others as well as to Dr. Balmanno Squire. For some time past, it has been employed at University College Hospital: first by my colleague Mr. Godlee, and subsequently by myself. He had used it, in combination with the oil of eucalyptus, in some cases of eczema, and in lupus after erasion; the formula most used being iodoform gr. x, oil of eucalyptus ʒss to ʒj, vaseline ʒj. I have used the iodoform without the eucalyptus with success in some cases of subacute eczema, mainly on the back of the hands and forearms; in suitable cases, the result was often very rapid. I have now a boy under my care with eczema of the head, in which there was a profuse sero-purulent discharge, which became offensive in a short time; to this, an ointment, with ten grains of iodoform to the ounce of lard, was applied, speedily removing all fœtor, and reducing the discharge to serous only. It was, however, rather too stimulating at this stage to be continued long. Its penetrating and disagreeable odour necessarily limits its employment, though the oil of eucalyptus partially obviates this, besides increasing the solubility of the iodoform. It is slightly stimulant as well as antiseptic, and must, therefore, be restricted to cases requiring some stimulation. I can well believe that it would be efficacious in impetigo contagiosa, by destroying the micro-organism on which the inoculability of the disease probably depends; but the less unpleasant ammoniated mercury ointment will be preferred by most, as it is so very efficient.—*H. Radcliffe Crocker, M.D., 28 Welbeck Street, Physician to the Skin Department, University College Hospital.—British Medical Journal.*

Depilation by Resinous Application.—Dr. L. D. Bulkley, of New York, recommends the following formula and process for depilation in cases of favus:

Yellow wax.....	ʒ iij;	12.00 Gm.;
Shellac.....	ʒ iv;	16.00 "
Resin.....	ʒ vj;	24.00 "
Burgundy pitch...	ʒ x;	40.00 "
Gum dammar.....	ʒ x;	40.00 "

Melt them together and form into sticks from one-fourth to three-fourths inch in diameter, and two to three inches long. The hair having been cropped short, the stick is applied with a slight rotary or twisting motion, and after a few minutes removed by bending it sidewise, by which movement the hair adhering to it will be withdrawn. The hairs thus left on the stick are burned off. In ringworm of the scalp the disease renders the hairs so brittle that they will break before being pulled out, so that the method will not be applicable in this disease.

Mr. John Croft has been elected to the recently instituted chair of Clinical Surgery in St. Thomas' Hospital, London. Dr. C. S. Roy of Cambridge, has succeeded to Dr. Greenfield, in the Brown Institution.

The rare occurrence of the simultaneous occupancy of the Presidential chairs of the Royal Colleges of Physicians and Surgeons, by members of one hospital and school, was this year celebrated by a banquet given to Sir William Jenner, and Mr. Erichsen, by their colleagues at University College.

Midwifery.

RUPTURE OF THE PERINEUM.

THOS. A. ASHBY, BALTIMORE.

1. The question of "support and non-support" must be determined by the condition of the perineum.

2. An attempt to preserve the integrity of the perineum may, under some circumstances, be attended with greater injury to both mother and child than a rupture. The lesion of greatest consequence to both mother and child must be considered.

3. The forceps, if carefully used, are of great aid in preventing lacerations, and should be employed to assist in extending and delivering the head when the condition of the perineum strongly opposes or arrests its passage.

4. The administration of ergot before the head has been brought to bear upon the perineum may give rise to violent expulsive effort and force a rupture of this body.

5. Lacerations play an important part in the induction of bodily and mental disease, and should be recognized at the time of their occurrence with a view of determining the necessity for surgical closure.

6. Perineal lacerations, even when simple in character, ought, as a rule, to be closed by primary union.—*Maryland Medical Journal.*

CHLORAL IN LABOUR.

Dr. Kane formulates the following propositions:

1. Chloral may be employed in normal labor for the purpose of blunting sensibility, quieting nervous and hysterical manifestations, shortening labor, and destroying pains.

2. In complicated labour it has three uses, *i. e.* (*a*) to relieve pain; (*b*) to hasten dilatation of the os uteri; and (*c*) to increase the force of the uterine contractions.

3. Chloral, even when pushed to the production of anæsthesia, does not destroy the force of the uterine contractions.

4. The alleged danger of post-partum hemorrhage has no foundation in fact.

5. In moderate doses it is never dangerous.

6. The slight delirium that sometimes occurs is ordinarily removed by a second dose and need cause no alarm.

7. It is rarely necessary to use more than ʒj. in any one confinement.

8. It is best given by the rectum, in the form of enemata or suppositories.—*St. Louis Courier of Medicine.*

[Care should be taken that the chloral is pure.—ED.]

Correspondence.

To the Editor of the CANADIAN JOURNAL OF MEDICAL SCIENCE.

DEAR SIR,—The Ontario Medical Council in its mightiness has decided that the most "inexpensive method" of licensing homœopaths is to pitchfork them into a quasi-security by a farcical examination. In our profession "good men and true" strive to act up to the motto "Miseris succurrere disco;" but surely the member of the Council and his followers who advocated the "inexpensive method" have (unwittingly of course) misapplied the motto, and placed the would-be licensed in the place of those who may be tempted by the M. C. P. & S. O., to entrust their health to his *licensed treatment.*

Yours,

VACUUS VIATOR.

Messrs. Wm. Wood & Co., the well-known New York medical publishers, have issued a special edition of their catalogue, beautifully printed and elegantly bound in blue satin with gilt edges, containing in addition to a list of their works the daily programme of the International Medical Congress of 1881, and a number of blank pages designed for annotations and memoranda. A copy is presented to each delegate to the Congress.

Henry A. DeLom, of the Toronto and St. Thomas' Hospital, has passed the Primary Examination of the Royal College of Surgeons.

The Bill requiring New York and Brooklyn plumbers to be registered, and to subject all their work to the inspection of the City Health Board has become law.

PRESIDENTIAL ADDRESS.

BY WM. CANNIFF, M.D., M.R.C.S. ENG.

Delivered before the CANADA MEDICAL ASSOCIATION, in Halifax, N.S., on 3rd August, 1881.

GENTLEMEN,—It is customary for the President at each annual meeting to deliver an address upon some topic which he may select, bearing upon the subject of medicine, or matters appertaining to the interests and welfare of the Canada Medical Association. I do not expect to bring to my task the ability and eloquence which characterized the address of last year with which we were favored by my distinguished predecessor, nor of any of the learned and prominent gentlemen who have graced the chair since the organization of the Association. But it is my duty to meet your expectations on the present occasion so far as may be in my power.

Before I proceed I wish to express my thanks for the honor the Association conferred upon me by placing me in the position I occupy to-day, an honor which I feel is greatly enhanced by the fact that I succeed one so eminently gifted, so universally esteemed, and in every way so worthy of the position. Of course, it makes it more difficult for me to follow one thus fitted for the duties of presiding officer; but trusting to your good nature and charity, I will at once proceed to the subject-matter of my address.

After some consideration, I decided, although it is somewhat a departure from the course hitherto pursued, to bring to the attention of the Association and the profession generally afresh the code of Medical Ethics which this Association adopted at its organization, hoping at the same time that the attention of the public might become engaged in a consideration of the mutual obligations and responsibilities resting upon the medical profession and the public at large. Perhaps I could not have done better than simply to have read the Code as it is found in the Transactions of the Association; but there are some facts, some points, and some considerations not referred to in the Code with which it may be desirable to deal. And I shall take the liberty of clothing some of the ideas contained in the Code in fresh language, although it may not possess the same lucidity and conciseness.

The Code of Medical Ethics of the Canada Medical Association consist of—

1. The duties of physicians to their patients, and the obligations of patients to their physicians.
2. The duties of physicians to each other, and to the profession at large.
3. The duties of the profession to the public, and the obligations of the public to the profession.

THE DUTIES OF PHYSICIANS TO THEIR PATIENTS.

It is one of the first and almost continual difficulties met with by the medical practitioner in administering to the needs of his patients, to give only the necessary attention a case in practice requires, and secure the approbation of his client. On the one hand he wishes to bestow the requisite time and thought necessary to restore the patient or allay pain, as far as the resources of medical science will enable him. On the other hand, he is often fearful that his attention may be considered unnecessarily diligent or prolonged. It is, therefore, most necessary that the physician should be fully imbued with the responsibilities of his office, consider the necessities of the case, and then unhesitatingly devote such time and energy as he believes the case demands, regardless of any other consideration. At the same time it is not improper for him to exceed what he may think necessary should the patient wish to have extra attention.

When two or more cases simultaneously claim the attention of the physician, he is bound to give the most urgent his first consideration, irrespective of the position of the patient, unless relieved of responsibility by another practitioner.

The response of the physician to a professional call should always be prompt, notwithstanding the fact that he is too often summoned in unnecessary haste and put to great inconvenience, when he might safely have made the required call in his ordinary daily round of duties. Those who have had experience know full well that there are some thoughtless or selfish people who, when they have decided to call in the doctor, desire him to neglect every one else, and come at once with all possible speed, re-

gardless of his other duties and obligations, or his own convenience. But the physician who feels the duty he owes to those who confide in his care, will charitably make allowance for the natural anxiety which has culminated in his services being sought, and should betray no annoyance because he may have been called with unnecessary haste, and has had his arrangements for the day, perhaps, destroyed. At such times not only the sick, but the sick one's family, may not be quite responsible for their precipitate conduct.

Under all circumstances, the demeanour of the physician should be calm and his words tranquil. He must not be gloomy at any time but treat the case with a smile and all the quietness of manner it will permit. The physician should ever come into the sick chamber as a sunbeam, never as a thunder-cloud. Again, he ought to be natural in his manner. No two are alike, and every one has his peculiarities; and for one physician to try to pattern after another, is to detract from his self-reliance, and diminish his usefulness. I trust it is unnecessary for me to say to the members of the Canada Medical Association that it belongs exclusively to the charlatan to magnify the danger or nature of the disase he is called to treat, so that the recovery which will follow, perhaps would follow without treatment, may seem to betoken great skill on his part.

The most skillful and observant physician is often unable at first to determine the nature of the malady he has to contend with; but it is no disparagement in the minds of the ordinarily enlightened public to honestly state he is as yet unable to say positively what may be the matter.

Now and again we have to endure annoyance after expressing our opinion candidly at the bed-side, wishing to conceal nothing from the patient, by a member of the family, in an outer room, or at the gate, or, it may be, by a neighbour on the road, asking the question, "Now what is your opinion? I will not tell any one." But an ever-repeated reply, that you have already given your opinion to the patient, will in time educate the public that you do not tell two stories. Of course there are occasionally cases when you cannot state fully your views in the presence of the patient; but it is a safe and proper rule to conceal nothing from him. He should know the worst as well as the best, especially when you think he is sick unto death. It is wrong to deceive, and a mistaken view that for him to learn and understand the danger, will militate against recovery. To allow one to approach the dark valley, ignorant of the terrible and solemn fact is, in my opinion, inexcusable. On this point I am somewhat at variance with what is laid down in the Code; but I have no hesitation in saying, from experience I believe that the course I have recommended can be pursued without discouraging the patient, depressing his spirits, increasing the danger, or hastening a fatal end. No doubt "the life of a sick person can be shortened, not only by the acts, but also by the words, or the manner of a physician," as stated in the Code; but the considerate physician can so blend a true statement of the case with every reasonable ground of hope that no additional element of danger will result.

The relationship between physician and patient is one of confidence and trust. Fidelity and honor as the custodian of secrets connected with the patient, are strictly to be observed. To betray such confidence, or in any way refer to him, so that even an injurious construction can be placed upon your words is a violation of confidence. Yet, at times, it may be difficult to observe so manifest a rule of duty. In illustration, permit me to refer to an instance in my own experience. Not very long ago while in professional attendance upon a respectable employee in a leading hotel I declined to answer all the questions of the manager as to the nature of the illness, (it was not a question of contagion) whereupon I received a threat of expulsion from the building.

Moreover, to quote the language of the code, "The obligation to secrecy extends beyond the period of professional services; no circumstance connected with the privacies of personal or domestic life, infirmities of disposition, or stain of character, observed during professional attendance, should ever be divulged by the physician, except when he is imperatively required to do so."

In seemingly hopeless cases you are required "not to abandon the patient. Your attendance may continue to be highly useful to the patient and comforting to the relations around him, even to the last period of a fatal malady, by alleviating pain and other symptoms, and by soothing mental anguish." While it is your duty to candidly state your opinion when you consider the case hopeless, you must remember, not merely the old adage, that "while there is life there is hope," but that in many cases the physician is mistaken in measuring the resources of the patient's constitution to resist and overcome disease, as well as the efficacy of his treatment. It is no infrequent occurrence to have a patient seemingly stricken with a fatal malady unexpectedly rally, perhaps for a time, perhaps to recover. I have repeatedly known the too conscientious physician superseded by the assumptious charlatan, or sectarian doctor, who reaped the benefit of the previous skilful treatment, in connection with the unsupposed power of nature to restore. It is only a few weeks since I was told by a doctor of divinity that one of the most distinguished specialists in the United States had been actually poisoning him by his treatment, and would soon have killed him if he had not been induced to go to a homœopathic establishment. Here, he affirmed, in less than forty-eight hours, he was rescued from the "current of death," and new life was infused into his system. From my knowledge of the history of the D.D., who I may say was never a patient of mine, and of the deserved reputation of the physician accused of poisoning him, I have no doubt the latter was the means of preserving his health and senses so far as he now possesses them.

Consultations.—The physician, old as well as young, should never object to or discourage consultations. In fact he should be the first to suggest one. Consultations are desirable when life seems to be in danger, or when the case is a protracted one and does not yield to treatment. The physician may feel satisfied that he quite understands the case, and how to treat it; but he must consider the wishes of those concerned and the natural solicitude of the family. Moreover, very often, it is a relief to have another to share the responsibility. It need not be considered a reflection on the physician's skill to have a consultation, even with a junior. When a young practitioner, I remember a consultation with me was objected to on the ground that it would be bringing coals to Newcastle. At the same time, it must be said that a consultation may be, indeed, I fear often is, detrimental to the patient. Apart from the injurious effects the excitement may have upon the patient, it must be admitted that the consultation too often leads to a compromise, and the views of neither as to treatment are fully carried out, while the treatment of either might alone have proved successful. I read lately an extract from one of Bulwer's novels in which he defines a medical consultation as "a meeting of physicians in which the councillors agree with the attending physician, and change the treatment." It would be in many cases a more correct statement to say that the attending physician would probably have modified, or changed his treatment at that particular juncture in the case, if a consultation had not been held. When the attending physician suggests a consultation he is usually asked to name the person he would prefer; but it is often desirable to have one chosen by the patient. It is needless to say that in the event of the physician selecting a councillor he should obtain the services of one he deems best qualified to render him assistance in the management of the case. When the patient makes the choice, unless the one chosen be unqualified, the attending physician should unhesitatingly accept the proposal. But the physician will positively refuse to consult with one not belonging to the regular profession. It is no part of the physician's duty to his patient, in any case, to depart from this rule. A demand is sometimes made that the physician shall have in consultation one who gives to himself a specific name,—who belongs to some *pathic* school. The regular physician possessed of the honor which belongs to a learned profession, and imbued with the spirit of scientific medicine destests any distinctive appellation in addition to physician. The followers of a sectarian school delighting in the name of homæopath, have applied to the scientific physician

the term "allopath." But we recognize no such distinction. We profess to be simply scientific physicians and surgeons. Not long ago a great cry was raised by the public, especially in England, because when a great statesman was the patient, a member of our profession refused to degrade himself by consulting with a homœopath. Sir Wm. Jenner was censured unsparingly by the press because he would not violate his principles and meet Dr. Kidd. The reply to this unwarrantable attack upon our profession, by the *London Lancet*, sufficiently covers the ground, and is quite to the point. "There was nothing personal in this refusal. The course taken was that to which every practitioner of scientific medicine must have felt himself impelled. No grounds exist for consultation between the ordinary physician and the professor of a particular school. Medicine is not a science which admits of sectarian views. If two mariners, one of whom believed the earth to be a flat disc, while the other held the commonly-received hypothesis of its spheroidal form, were asked to act together in navigating the same ship on a voyage round the world, how could they cooperate? We do not wilfully refuse to meet homœopaths; we simply decline because it would be a grim farce and a practical imposition to do so. The result must be a failure of justice to the patient, which may jeopardise his prospect of recovery. The course which practitioners should pursue in an emergency of this kind is very clear." These views of the *Lancet*, a journal which represents the profession of England, are the views of the profession everywhere. We are not called upon to contend with homœopaths. We may believe them to be sincere in their profession; but we can have nothing in common with them.

Another duty of the physician to his patient is to give him judicious advice, when he has become convalescent, as to the future. This advice may refer not alone to his physical and mental well-being but also to his moral behaviour. Sometimes the sickness has been due to the faulty or vicious life hitherto led; and with the bed of sickness have come earnest resolutions to reform and lead a new life. In such cases happy the physician who can from the fullness of his heart strengthen good purposes and give proper guidance. "A word spoken in due season how good is it!"

OBLIGATIONS OF PATIENTS TO THEIR PHYSICIANS.

The first and second paragraphs of our code are as follows: "The members of the Medical Profession, upon whom so many arduous duties are imposed, and who are required to make so many sacrifices of ease, comfort, and health for the welfare of mankind, have certainly a right to expect that patients should entertain a just sense of the duties which they owe to their medical attendants. The first duty of a patient is to select as his medical adviser one who has received a regular professional education. In no trade or occupation does mankind rely on the skill of an untaught artist; and in medicine, confessedly the most difficult and intricate of the sciences, the world ought not to suppose that knowledge is intuitive."

The patient or the guardian should deliberately select the physician, and having done so should not hastily, or without sufficient reason dismiss him, or call in another. There is a class of people who are continually trying a new doctor; some on account of a constitutional love of change, some because the new doctor is recommended by Mrs. Busybody, or Mr. Touter, or Miss Interested, and some again make a change to be in fashion. Others seek a change from mercenary motives, or because they do not care to attend to a long-standing, unpaid bill. To this class it is, perhaps, useless to speak about the ordinary principles of honor and decency.

There can be no doubt that a physician who has become acquainted with the peculiarities of the constitution of a person or family, has a much better prospect of treating him, or them successfully than one who has no such previous knowledge. Having made a selection there ought to be implicit trust on the part of the patient; and he should be candid and open in his communication. It is neither safe for the patient nor just to the physician to conceal anything of a physical, or mental nature which may bear any relation to his disorder. But while the patient should state everything which may aid the physician in the discharge of his duties, he

must not make him the repository of extraneous secrets, nor should he take up the physician's time in talking about irrelevant subjects. The physician is not a talebearer and dislikes to hear gossip. At least such should be his character.

Too frequently there is a disposition on the part of the patient to delay in applying to the physician. Of course, no one would care to incur unnecessary expense; but a great risk is incurred by much delay. In this connection I venture to say that I think it would be better both for the public and the physician to engage by the year. Let it become the function of the physician not merely to cure disease but to prevent it. By periodical visiting the physician can give such advice and instruction relating to personal, house, school, and I may say business hygiene, as will prevent no little sickness.

Physicians, particularly in city practice are expected to make their calls within a limited number of hours of the day, and patients should remember that his time during this period is precious, and not to keep him waiting while a toilet is made, or a room tidied up. No such infringement upon his time should be made, the professional visit is for a definite purpose and he gives little heed to appearances outside his patient's welfare, his mind being occupied with his professional concerns.

A patient has no right to depart from the instructions of the physician with regard to medicine, or diet, or in any other way. To do so is to risk a danger and to place the physician at a disadvantage. Officious persons often give advice and recommend medicines to the sick; but "patients should never allow themselves to be persuaded to take any medicine whatever, that may be recommended to them by the self-constituted doctors and doctoresses who are so frequently met with, and who pretend to possess infallible remedies for the cure of every disease. However simple some of their prescriptions may appear to be it often happens that they are productive of much mischief, and in all cases they are injurious by contravening the plan of treatment adopted by the physician." It too often happens that the nurse, especially, one that calls herself a *trained nurse* who has read only enough to make her little learning a dangerous thing, will as "fools, rush madly in where angels fear to tread." She wishes to magnify her office and will not hesitate to criticize the treatment and follow it, or change it as she likes.

Many persons thoughtlessly, no doubt, will, while under the care of one physician, seek the opinion and advice of another. I do not refer to a class (I hope not large) who are ever seeking the opinion of medical men respecting their ailments in a casual way, with no intention of offering a fee; but to cases in which the patient is already under treatment and who deliberately go to a second physician, and perhaps a third to obtain an opinion, concealing from each the fact that he is already a patient. This is unfair and not honorable, as any physician may by the use of different terms and language convey the idea of an opinion at variance with that of another, when in reality he holds views precisely the same. It is also reprehensible to call a physician to see a patient under the care of another, which fact is only learned when he reaches the patient; or perhaps he is kept in ignorance. This is gross injustice. We are now and then censured for refusing to see, or prescribe for a patient under such circumstances. It is not many weeks since I was called out of bed and requested by one, whose family I attend, to visit a man supposed to be hopelessly sick, who, I was informed, was under the care of another physician. I was asked to see the patient alone. Of course it is unpleasant to offend a friend, still my duty was obvious. In reply to my suggestion that the attending physician be notified for a consultation, I was somewhat sharply charged with "red-tapeism." Now, I know that my friend in this case spoke without consideration of all the duty which rests upon the physician. This is not merely a question of medical etiquette, the welfare of the public is involved. The principles which guide the profession not only protect its members from interfering with the rights of each other but are a safeguard to the public. If medical men were in the habit of following the footsteps of one another; one prescribing to-day, another to-morrow, and so on according to the behest of vacillating and fickle persons without knowing what the other has done,

it would be impossible to treat patients intelligently and with any prospect of affording relief. And yet because the physician consistently refuses to act so obviously absurd a part he is sometimes not only censured but abused by those who it might be supposed would understand better. It is not long ago that a leading newspaper in the Dominion deliberately stated that "medical etiquette was responsible for a great deal of suffering and death," and that "the medical profession abounds in abuses." These grave and sweeping charges we may hope were made in supreme ignorance of what belongs to a learned and honorable profession, and what is due by that profession to the public.

It is always open to the patient to change his doctor, but an honorable person will not do so without the gravest reasons. If the physician be doing what he can for the patient, it is most unjust to dismiss him in an extreme case of sickness.

Those who have been any time in practice will have experienced a great difference among patients as to considering the convenience of the physician. I suppose we all are afflicted with patients who almost invariably send for us at inconvenient hours. In the country the farmer often will wait until he has finished his day's work, probably because he cannot spare a horse before that time to go for the doctor. The consequence is that he frequently reaches the physician's residence just as he has retired to bed; and you may depend upon this—it is the one who first secures a day's work out of his horse and then drives the tired brute, who will be the one to object to your bill for night service. In the city may be found those who invariably send the summons for the physician after he has started on his daily round, so that when he comes home, he has to retrace his way at once, for this class are usually very urgent in their request. There is also a class who make it a rule to call upon the physician at the hours for meals so as to catch him at home. Now, while the physician will cheerfully respond to any call when an emergency makes delay impossible, and a timely notice is out of the question, and will leave his bed or the table uncomplainingly, it is manifestly inconsiderate and exacting to cause him inconvenience, and infringe upon the hours required for refreshment and repose.

One more duty of the patient toward the physician I will refer to,—namely, to make a proper and, if possible, prompt acknowledgment for services rendered. Why is it that the doctor's bill should so often be the last paid? And there are some who feel offended when the physician renders his account under six months or a year.

The physician rarely asks for his fee when called upon, and it should be a matter of honour with the patient to pay for services without waiting for an account to be rendered. I am speaking of those who would scorn to be regarded as intentional defrauders; but there is a class of beings, I can hardly say human, who, no matter how much care and anxiety they have given the physician, never will remunerate him. Probably give abuse instead.

OF THE DUTIES OF PHYSICIANS TO EACH OTHER, AND TO THE PROFESSION AT LARGE.

"Every individual, on entering the profession, as he becomes entitled to all its privileges and immunities, incurs an obligation to exert his best abilities to maintain its dignity and honor, to exalt its standing, and to extend the bounds of usefulness. He should, therefore, observe strictly such laws as are instituted for the government of its members; and while, by unwearied diligence, he resorts to every honorable means of enriching the science, he should entertain a due respect for his seniors, who have, by their labors, brought it to the elevated condition in which he finds it.

"There is no profession, from the members of which greater purity of character and a higher standard of moral excellence are required, than the medical; and to attain such eminence is a duty every physician owes alike to his profession and to his patients. It is due to the latter, as without it he cannot command their respect and confidence; and to both, because no scientific attainments can compensate for the want of correct moral principles. It is also incumbent upon the faculty to be temperate in all things, for the practice of physic requires the unremitting exercise of a clear and vigorous understanding; and, on emergencies, for which no professional man should be unprepared, a steady hand, an acute eye, and an unclouded head may be essential to the well being, and even to the life, of a fellow-creature.

"It is derogatory to the dignity of the profession to resort to public advertisements, or

private cards, or handbills, inviting the attention of individuals affected with particular diseases—publicly offering advice and medicine to the poor gratis, or promising radical cures; or to publish cases and operations in the daily prints, or suffer such publications to be made; to invite laymen to be present at operations, to boast of cures and remedies, to adduce certificates of skill and success, or to perform any other similar acts. These are the ordinary practices of empirics, and are highly reprehensible in a regular physician.

"In the case, however, of a physician or surgeon commencing the practice of his profession, or removing to another locality, a simple announcement by an unobtrusive card in the public prints is unobjectionable.

"Equally derogatory to professional character is it for a physician to hold a patent for any surgical instrument or medicine; or to dispense a secret *nostrum*, whether it be the composition or exclusive property of himself or others. For, if such nostrum be of real efficacy, any concealment regarding it is inconsistent with beneficence and professional liberality; and if mystery alone gives it value and importance, such craft implies either disgraceful ignorance or fraudulent avarice. It is also reprehensible for physicians to give certificates attesting the efficacy of patent or secret medicines, or in any way to promote the use of them.

To the foregoing I would add, that it is objectionable for the physician to resort to any unusual method of making himself known or spoken about. By peculiar personal dress, or manner, or equipage, or office-surrounding, to gain the attention of the public, is unprofessional. Excentricity is no longer regarded by the discerning public as an indication of genius or skill; nor will, what I may be allowed to call *loud* manners, secure the most desirable *clientèle.*

There is another mode of attracting the public attention none the less a violation of the code of professional honor still pursued by a few, namely, making unnecessary display in the performance of surgical operations. And in connection with this I must refer to the unjustifiable practice, perhaps I should say criminal practice, of performing an operation without the slightest expectation of benefitting the patient. For a surgeon to mutilate a body, or increase the suffering of a patient afflicted with an incurable disease, merely to exhibit the operator's knowledge of anatomy and steady hand, is to make him an object of scorn and loathing. A surgeon who will perform, of two operations, the more dangerous one because it may give him a name, is unworthy of esteem, and should the unnecessary operation prove fatal he would be really guilty of manslaughter.

PROFESSIONAL SERVICES OF PHYSICIANS TO EACH OTHER.

Upon the duties of physicians in relation to each other, I need not dwell, as their principles are usually inculcated when the medical education is received, and are strictly observed by the high-minded physician; and I have already made some remarks bearing upon the subject. But I may remind you, and I wish I could remind some who are not present, that in case of consultations the strictest punctuality is demanded. I regret to have to say that now and again we meet with one who, because of his standing, thinks he may transgress this law of good manners. But the law is so manifestly just that no excuse can be accepted for careless delay in keeping professional appointments. And this law applies to cases of hospital consultations as well as to private practice. No one, however much a senior or uplifted, has a right to withhold from any one he meets in consultation the treatment due to a *confrere.*

For one to seek at a consultation by any mode to produce an impression upon the patient, or his friends, that the attending physician is untrustworthy, or that he himself is more wise and skilful, is a gross violation of the golden rule upon which our code is founded. True greatness is always retiring and considerate for the feelings and character of others. It is gratifying to believe that instances of unprofessional behaviour in this respect are becoming less and less frequent.

If in consultation a physician cannot accept the opinion and views of another, and believes that the welfare of the patient is involved, it is his duty to adhere to his decision, and if necessary withdraw from the case. But such instances are extremely rare. In the words of the code:—

"All discussions in consultation should be held as secret and confidential. Neither by words nor manner should any of the parties to a consultation assert or insinuate that any part of the treatment pursued did not receive his

assent. The responsibility must be equally divided between the medical attendants—they must equally share the credit of success as well as the blame of failure.

"The consulting physician should also carefully refrain from any of those extraordinary attentions or assiduities which are too often practiced by the dishonest for the base purpose of gaining applause, or ingratiating themselves into the favour of families and individuals.

"A physician ought not to take charge of or prescribe for a patient who has recently been under the care of another member of the faculty in the same illness, except in cases of sudden emergency, or in consultation with the physician previously in attendance, or when the latter has relinquished the case, or been regularly notified that his services are no longer desired. Under such circumstances, no unjust, illiberal insinuations, should be thrown out in relation to the conduct or practice previously pursued, which should be justified as far as candor and regard for truth and probity will permit; for it often happens that patients become dissatisfied when they do not experience immediate relief, and, as many diseases are protracted, the want of success in the first stage of treatment affords no evidence of a lack of professional knowledge and skill.

"When a physician is called to an urgent case, because the family attendant is not at hand, he ought, unless his assistance in consultation be desired, to resign the care of the patient to the latter immediately on his arrival.

"It often happens in cases of sudden illness, or of recent accidents and injuries, owing to the alarm and anxiety of friends, that a number of physicians are simultaneously sent for. Under these circumstances, courtesy should assign the patient to the first who arrives, who should select from those present any additional assistance that he may deem necessary. In all such cases, however, the practitioner who officiates should request the family physician, if there be one, to be called, and, unless his further attendance be requested, should resign the case to the latter on his arrival.

"When a physician is called to the patient of another practitioner, in consequence of the sickness or absence of the latter, he ought, on the return or recovery of the regular attendant, and with the consent of the patient, to surrender the case.

"A physician, when visiting a sick person in the country, may be desired to see a neighbouring patient who is under the regular direction of another physician, in consequence of some sudden change or aggravation of symptoms. The conduct to be pursued on such an occasion is to give advice adapted to present circumstances; to interfere no further than is absolutely necessary with the general plan of treatment; to assume no future direction, unless it be expressly desired; and, in this last case, to request an immediate consultation with the practitioner previously employed.

"A wealthy physician should not give advice gratis to the affluent, because his doing so is an injury to his professional brethren. The office of a physician can never be supported as an exclusively beneficent one; and it is defrauding, in some degree, the common funds for its support, when fees are dispensed with, which might justly be claimed."

The physician in active practice requires yearly a rest from its cares and responsibilities. In seeking recreation he has a right to ask a neighbouring brother practitioner to officiate for him. No physician will decline to render such a service. Of course, if the period of absence be prolonged, or the absentee is rather in the pursuit of amusement than recreation, he should not receive from him who labors the fees earned. A physician who is thus trusted by another will not, if an honourable man, endeavour by artifice or intrigue to alienate the patients from their regular attendant.

The instances where a physician is justified in visiting the patient of another practitioner as a friend are very rare. If urgent business or relationship make a visit necessary, the physician will be scrupulously careful to avoid even the approach to a consideration of his disease or of the treatment being pursued.

While the physician will always consider it a pleasing duty to give professional attendance to a neighbouring *confrère*, or his family, when asked to do so, without remuneration, he should not be requested to travel any distance or sacrifice much time without the offer of an *honorarium*, nor should he hesitate to accept it.

By mutual understanding there should be adopted in every community a tariff of fees, to be strictly observed by all. To depart from this on the part of one is to make him chargeable with double-dealing and adopting a disreputable mode of gaining popularity.

DUTIES OF THE PROFESSION TO THE PUBLIC.

"As good citizens it is the duty of physisians to be ever vigilant for the welfare of the community, and to bear their part in sustaining its institutions and burdens. They should also be ever ready to give council to the public in

relation to matters especially appertaining to their profession, as on the subject of medical police, public hygiene, and legal medicine. It is their province to enlighten the public in regard to quarantine regulations—and in regard to measures for the prevention of epidemics and contagious diseases; and when pestilence prevails, it is their duty to face the danger and to continue their labours for the alleviation of the suffering, even at the jeopardy of their own lives.

"Medical men should also be always ready when called upon by the legally constituted authorities, to enlighten coroners' inquests and courts of justice, on subjects strictly medical—such as involve questions relating to sanity, legitimacy, murder by poisons and other violent means, and in regard to the various other subjects embraced in the science of medical jurisprudence. But in these cases, and especially where they are required to make a post-mortem examination, it is just, in consequence of the time, labor, and skill required, and the responsibility and risk they incur, that the public should award them a proper honorarium. Medical men should also be properly paid for attendance as witnesses in criminal cases.

"There is no profession by the members of which eleemosynary services are more liberally dispensed than the medical; but justice requires that some limits should be placed to the performance of such good offices. Poverty, professional brotherhood, and certain of the public duties referred to in the first section of this article, should always be recognized as presenting valid claims for gratuitous services; but neither institutions endowed by the public or rich individuals, societies for mutual benefit, for the insurance of lives (the certificates for which should be sent confidentially to the company and paid for), whether furnished by the medical adviser of the company or by the family physician, or for analogous purposes, nor any profession or occupation, can be admitted to possess such privilege."

OBLIGATIONS OF THE PUBLIC TO THE PROFESSION.

It must be said the public are not disposed to recognize the services of the medical profession, and to avail themselves of their scientific knowledge for the welfare of communities and the State. The salary for a medical health officer, or fees for professional services, are usually grudgingly paid. Notwithstanding the continued efforts of the profession to educate the public in sanitary laws, and prevail upon legislators to enact such laws and create such organizations as will prevent sickness and prolong human life, there seems to be a settled indifference on their part. It might be supposed that conduct, so unselfish, indeed so calculated to diminish the ordinary work of the physician—and at the same time to secure a saving to the individual, to communities, and to the State—would engage the warmest attention of the rulers of the land.

However, I am glad to be able to say that there is a probability of some action being taken by the Dominion Government. A Committee was appointed by this Association at its last meeting, "to continue communication with the Dominion Government, with a view of securing a grant towards carrying out an effective system of health registration." When the report of this Committee is presented, you will learn that the Premier, Sir John A. Macdonald, is not indifferent to the representations which the medical profession have made to him regarding vital statistics and State medicine, and that, had not illness prostrated him last winter, (an illness which I am sure all Canadians deplore,) steps would have been taken ere this to meet the wishes of this Association so far as the Constitution will permit.

Before concluding, allow me to express my deep concern that the continued sickness of our respected General Secretary has made it necessary for him to resign his post, a position he has so long worthily filled. I am sure you will unite with me in wishing his speedy restoration to health. As you can understand, the absence of Dr. David, who was quite familiar with our Constitution and the working of the Association, is a serious loss to myself in the discharge of my duties; but I am thankful to say that Dr. A. H. Wright, whom I requested to act as General Secretary, has, in making the arrangements for this meeting, very adequately filled the vacancy so unfortunately made.

I thank you, Gentlemen, for the kind hearing you have given me, and beg you will generously aid me in the work which falls to me as your presiding officer.

Professor Austin Flint, of New York, has received the degree of LL.D. from Yale College.

THE CANADIAN
Journal of Medical Science,
A Monthly Journal of Medical Science, Criticism, and News.

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

TORONTO, AUGUST, 1881.

☞ We have delayed the appearance of this issue in order to present our readers with the text of the President's Address, delivered at the meeting of the Canada Medical Association, in Halifax, on the 3rd inst., and have extended the issue to 36 pages.

THE INTERNATIONAL MEDICAL CONGRESS.

The International Medical Congress of 1881 meets in London this month, from the 2nd to the 9th, inclusive. Notwithstanding that in the past crowned heads and municipal corporations in other lands have vied together to do honour to our craft on such occasions and ensure the success thereof, yet the coming meeting in the world's metropolis gives ample promise of exceeding both in scientific interest and utility all its predecessors. The Congress will open under the Presidency of the veteran, Sir Wm. Jenner, universally acknowledged, alike in scientific attainments, clinical skill and judgment, didactic power and probity of character, the head of the profession in the Motherland. He will deliver the address of welcome, but fears are entertained that he may not be able to take an active part in the scientific discussions of the meeting. Addresses will be delivered by Sir James Paget, the most accomplished of British medical orators, by Professor Huxley, on the Connection of the Biological Sciences with Medicine; by Prof. Volkmann (in German), on Modern Surgery; by Rudolph Virchow, on the Bearing of Pathological Experiments on Medicine; by Surgeon Billings, on Medical Literature; and Prof. Maurice Raynaud, the most polished and brilliant of French medical orators (whose names are many) was to have read an address on Scepticism in Medicine in Past and Present Times, but his lamentably sudden death from angina pectoris, on the 30th of June, has marred this, one of the most attractive features of the programme. The address, however, has been found completed, and it is hoped that M. Noel Gueneau de Mussy will perform the painful but still pleasing duty of giving utterance to his dead friend's words.

It is expected that between 2,000 and 3,000 medical men will be in attendance, and as many of the powers have nominated representatives to attend, and many of the first names in medicine have promised to be present, it seems likely that a totally unprecedented gathering of the sons of Æsculapius will be witnessed.

The business of the Congress will be transacted in 16 sections, most of which will meet in the various scientific societies' rooms in Burlington House, and the remainder in the Royal Institution, Willis's Rooms, the University of London, Burlington Gardens, and the Royal School of Mines. The social features will be as numerous and attractive as the time unoccupied by business will allow. Her Majesty has expressed the interest she feels in the occasion; and the Prince of Wales will attend the opening meeting, lunch with Sir Jas. Paget, and dine with Sir Wm. Gull, the Presidents, and Vice-presidents of sections, and distinguished foreigners, and attend the reception in the South Kensington Museum. Fetes, soirees, dinners, and excursions have been arranged for, and the ancient corporation of the city of London extends the hospitality of the city on its usual magnificent scale, placing at the disposal of the Reception Committee two thousand invitations, and issuing an additional one thousand on its own account, for a conversazione in the Guildhall.

TORONTO SCHOOL OF MEDICINE.

We are glad to notice that this well-known medical school has made the most complete arrangements for giving, during the next session, a thoroughly practical and scientific

course of instruction in every department. We quote the following from the announcement which has been recently issued :—

"Since the issue of our last annual announcement important changes have been made which, it is confidently expected, will materially strengthen the Institution, and give increasing effect to the work done in the various departments. Associate Lecturers have been appointed in the principal subjects of the course, who will be prepared to carry on the work in the absence, from sickness or otherwise, of the regular lecturers. The Faculty, in announcing this change, hope that it will commend itself to the friends of the School, as an important step in the interests of intending students.

"Arrangements are in progress for a more complete course of clinical instruction, and it is hoped that, through this, associated with the didactic course, the Faculty will be able to offer advantages of a very superior character to those entering upon medical studies. They will continue to devote their best efforts to the attainment of these ends."

The following appointments have been made, as appear in advertisement in this issue: Dr. W. W. Ogden, to be Adjunct Lecturer on Midwifery; Dr. M. H. Aikins, Adjunct Lecturer on Surgery; Dr. W. Oldright, Adjunct Lecturer on Medical Jurisprudence; Dr. L. McFarlane, Adjunct Lecturer on Anatomy; Dr. George Wright, Adjunct Lecturer on Materia Medica and Therapeutics; Dr. John Ferguson, Assistant Demonstrator of Anatomy; Dr. A. H. Wright, Assistant Secretary.

HOWARD'S METHOD OF ARTIFICIAL RESPIRATION.

We think it advisable at this season to direct attention to the following rules for resuscitating the partially drowned :—

1. *Instantly* turn patient downward, with a large firm roll of clothing under stomach and chest. Place one of his arms under his forehead, so as to keep his mouth off the ground. Press with all your weight two or three times, for four or five seconds each time, upon patient's back, so that the water is pressed out of lungs and stomach, and drains freely out of mouth. Then

2. *Quickly* turn patient, face upward, with roll of clothing under back, just below shoulder blades, and make the head hang back as low as possible. Place patient's hands above his head. Kneel with patient's hips between your knees, and fix your elbows firmly against your hips. Now, grasping lower part of patient's naked chest squeeze his two sides together, pressing *gradually* forward with all your weight, for about three seconds, until your mouth is nearly over mouth of patient; then, with a push, *suddenly* jerk yourself back. Rest about three seconds; then begin again, repeating these bellows-blowing movements with perfect regularity, so that foul air may be pressed out, and pure air be drawn into lungs, about eight or ten times a minute, for at least an hour, or until the patient breathes naturally.

McGILL UNIVERSITY, FACULTY OF MEDICINE, SUMMER SESSION, 1881. Examination for Clinical Prize ($50 Microscope), offered by Dr. Osler. Drs. George Ross and W. Osler, Examiners.

I. Written paper, one and a half hours.

1. A man, aged 40, comes to you complaining of headache, vomiting and dimness of vision; pulse 70, temperature normal; general health has been tolerably good; present illness came on after a few days' indisposition.

State (*a*) your method of procedure in the examination of patient; (*b*) the conditions which might bring about such symptoms, and the points to be attended to in distinguishing between them.

2. How would you proceed to map out the liver dullness? State its normal limits. Mention conditions associated with (1) increase, (2) diminution of its area.

3. Distinguish between the conditions you have met with during the Session, accompanied by a dull percussion note in one infra-scapular region.

4. Sketch the main features of any case of heart disease which you have studied during the Session.—150 marks.

II. A case to diagnose and prepare a written report upon. Condition of fundus oculi and larynx to be given.—One hour. 150 marks.

III. Examination of sputa, vomit, fæces, and urine; chiefly microscopical.—Twenty minutes —50 marks.

Mr. R. J. B. Howard, B.A., was the successful candidate, obtaining 322 out of the possible 350 marks.

ASSOCIATION OF SUPERINTENDENTS OF ASYLUMS.

The 35th annual meeting of the Association of Medical Superintendents of American Institutions for the Insane, was held in the Rossin House, Toronto, on Tuesday, 14th June, and the three following days, under the Presidency of Dr. John H. Callender, of Nashville, Tenn., the Vice-president, in the unavoidable absence of the President, Dr. Walker. Forty-one members were present, and by the courtesy of the Association a number of local and other gentlemen, and the members of the profession generally in the city were invited to attend. Memoirs of Drs. Isaac Ray, W. S. Chipley, Joseph T. Webb, and Robt. F. Baldwin, deceased members of the Association, were read and entered on the minutes. Papers were read by Dr. Everts on the "American System of Public Provision for the Insane, and Despotism in Lunatic Asylums;" Dr. Joseph Workman on "Some Points in the Management of American Institutions for the Insane" (which we hope to publish soon); Dr. Hughes, on "Cephalic and Spinal Electrization;" Dr. Hurd on "A Plea for Systematic Therapeutical, Statistical, and Clinical Study of Mental Disorders;" Dr. Fauntleroy on "A Case of Extensive Gunshot Injury to Brain without Mental Disorder;" Dr. Barksdale on "A case of Extraordinary Size of Brain and Skull in a Negro;" Dr. Gundry on "Separate Institutions for certain Classes of the Insane;" and a further paper by Dr. Hurd, containing the report of a case with post-mortem examination. Drs. C. Lockhart Robertson, England; A. Motet, Paris, Tamburini, Italy, and F. S. Clouston, Scotland, were elected honorary members. The members visited the chief points of interest in the city and suburbs; were entertained at dinner by the Ontario Superintendents, and the Inspector of Asylums and Prisons, Mr. Langmuir; were received with their ladies at Government House, by Hon. John Beverley and Mrs. Robinson; attended a moonlight excursion on the *Chicora*, given by the Ontario Government; an excursion to Lorne Park, given by the New England Society, and a conversazione in the Normal School building, given by the medical Profession of the city. Many expressions of friendship and confraternity were interchanged, and after numerous valedictory resolutions of gratulation and goodwill the meeting adjourned at half-past 11, on Friday night, to meet again in Cincinnati, Ohio, on 30th May, 1882. Ten years have elapsed since the Association last met within our walls. May the next decade again give them welcome in our midst, and also witness an equal advance in material prosperity and scientific progress with the past!

MEETING OF THE CANADA MEDICAL ASSOCIATION.

All indications point to a successful meeting of this Association at Halifax, on the 3rd of August. The Hon. Dr. Parker, Dr. Lawson, and others of Halifax, have been most assiduous in their endeavours to make every preparation for the reception of those attending, and, in their labours, have received kind assistance from many in the Provinces of Nova Scotia, New Brunswick, and Prince Edward Island; and we feel assured that those from the "far West" in Ontario, as well as those from Quebec, will feel amply repaid for their journey to "the East," although it may be a very long one. We will miss some familiar faces, as a number of the most faithful members, such as Drs. Howard, Osler, Rosebrugh, Grant, and Reeve, will in the same days be acting in the larger sphere of the International Medical Congress, in London.

The Meeting will be held in the Council Chamber of the Government Buildings. The Government of Nova Scotia, kindly appreciating the importance of the gathering, will do the Association the honor of entertaining them at a dinner. It will be a source of great disappointment to many to find that the genial, hospitable, and well-known Vice-president of Nova Scotia, Dr. Parker, will be compelled, by the cruel fates of unavoidable and accidental circumstances, to be absent.

Among the papers promised, we may mention, first, the address of the President, Dr. Canniff. Subject: "Medical Ethics." Paper by Dr. Oldright, of Toronto, on "Local Treat-

ment of Empyema; Dr. Grant, of Ottawa, "The Stomach Pump;" Dr. Osler, of Montreal, "On the Theory of Intra-pleural Râles;" Dr. Bessey, of Montreal, "Vaccination with Calf Lymph;" Dr. Worthington, of Clinton, Ont., "Treatment of Scarlatina Maligna by Cold Water and Ice;" Dr. Fenwick, of Montreal, "Antiseptic Treatment in Ovariotomy and Knee Excisions;" Dr. J. W. Macdonald, Londonderry, N. S., "Water Analysis," and will exhibit a "case containing chemicals and apparatus for the examination of water;" Dr. Stewart, of Brucefield, Ont., "Treatment of Exophthalmic Goitre by Ergot;" Dr. Coleman, of St. John, N. B., "The use of the Ophthalmoscope in the Diagnosis of Brain Disease."

CRUDE PETROLEUM IN PHTHISIS.—Dr. Strothers in the Philadelphia *Medical and Surgical Reporter*, claims good results from the use of crude petroleum in phthisis. He gives it in four-grain doses, in pill or capsule, and finds it superior to cod-liver oil.

NEW YORK PATHOLOGICAL SOCIETY.—Dr George F. Shrady acted for twenty-two years as Secretary of this Society, and at a meeting, held June 22nd, was presented with an elegant silver pitcher and salver, as a "small token of grateful remembrance of his great services."

PERSONALS.—Dr. A. C. Jones, who was last month married to Miss Pickering, of Toronto, has commenced practising in Cumminsville, Ontario.

Dr. Wm. McClure, who was formerly practising in Cumminsville, has removed to Niagara Falls.

Dr. Martin, formerly of Oshawa, is now practising in Toronto, No. 98 Carlton St.

Dr. Edmondson, and Mr. J. T. Duncan, are at present attending St. Thomas' Hospital, London.

Drs. Howitt, Montgomery, and Nicholson sail for London, August 3rd.

Mr. A. S. Patullo, aged 20, second son of Dr. Patullo, of Brampton, died July 19th.

Book Notices.

The Management of Wounds. By DAVID PRINCE, M. D. Philadelphia: Lindsay & Blakiston.

Twelfth Quarterly Report of the Pennsylvania Board of Agriculture. March, April, May, 1881.—Harrisburg.

Transactions of the American Dermatological Association, with the President's Address. 4th Annual Meeting. Official Report of the Secretary, ARTHUR VAN HARLINGEN, M.D.

Hip Injuries, including Hip-joint Disease and Fracture of the Femoral Neck, Splint for. By DE F. WILLARD, M.D., Lect. Orthopædic Surgery, University of Pennsylvania. (Reprint from *Phil. Med. Times.*

Hip-joint Disease, Death in Early Stage, from Tubercular Meningitis. By DE F. WILLARD, M.D. Microscopical appearances, with cuts. By E. O. SHAKESPEARE, M.D. (Reprint from *Boston Med. and Surg. Jour.*

Contribution to the Correction of Strabismus by the Advancement of the Rectus (with photographs). By A. E. PRINCE, M.D., Jacksonville, Ill. (Reprint from *St. Louis Med. and Surg. Jour.*

The Management of the Perineum during Labour, and the Immediate Treatment of Lacerations, and the Obstetrics and Gynæcology of William Harvey. By F. H. STUART, A.M., M.D. Brooklyn.

The *Ohio Medical Journal* makes its *debut* with the July number, in the room and stead of the *Ohio Medical Recorder*, and as the journal of the Ohio Medical Society whose transactions it will embody. We give it a hearty welcome.

Des Intermittences du Pouls, de la Syncope, et de la Mort Subite dans la Convalescence de la Fièvre Typhoide. Par le DR. LANGLET. (Extrait de *L'Union Médicale et Scientifique du Nord-Est.*) Reims: Chez Deligne, 5 Rue du Cadran, Saint Pierre.

Ether Death. A Personal Experience in Four Cases of Death from Anæsthetics. By JOHN B. ROBERTS, A.M., M.D., Lecturer on Anatomy and Operative Surgery, in Philadelphia School of Anatomy. (Reprint from the *Philadilphia Medical Times.*

The Illustrated Scientific News. The July number of this highly interesting and instructive illustrated periodical has been received, and presents amongst other valuable matter, an illustrated account of the Dobear Telephone, Glass Grinding Machine, Ancient Pottery from Cyprus, Mechanical Larynx, the Remarkable Palmyra Palm, Curious Fishes, the Bursting of a Fly-wheel, etc. The enterprising publishers Messrs. Munn & Co,, 37 Park Row, New York, deserve the support of the profession and the intelligent public generally; and we cordially commend this enterprise which places within the reach of all, this very excellent verbal and pictorial account of many curiosities and inventions of scieutific and general interest, for the moderate sum of $1.50 a year.

Atlas of Gynæcology and Obstetrics. Edited by DR. A. MARTIN, Prof. of Gynæcology, University of Berlin. Containing 475 black, and 37 coloured illustrations from the original designs of the best known names in Obstetric Medicine and Pathological Anatomy, and supplemented by numerous drawings from J. P. Maygrier's Nouvelles Demonstrations D'Accouchements. Cincinnati, O.: A. E. Wilde & Co., Publishers.

The first four numbers of this admirable work have come to hand. The title above cited sufficiently sets forth its character and scope, and the name of Martin, of Berlin, will be a sufficient guarantee of the excellence of the production. Many of the plates will be found to be old and familiar friends, having been adopted from such authors as Beigel, Virchow, Hyatt, Nægele, Schrœder, Rokitansky, Busch, Hueter, Duges, Hodge, Blume, Boivin, Dubois, Hunter, Braune, Moreau, Duncan, Wagner, Kiersch, Cruveilhier, Olshausen, etc. Such a collection can nowhere else be had, and the price demanded is absurdly small. The work is sold only by subscription, and we sincerely trust that a long list may amply repay the enterprise manifested by the Publishers.

Atlas of Skin Diseases. By LOUIS A. DUHRING, M.D., Prof. of Skin Diseases in the Hospital of the University of Pennsylvania, etc. Part IX. Philadelphia: J. B. Lippincott & Co. 1881.

Part IX. of the concluding number of this well-known, and justly much-lauded Atlas of Skin Diseases is now before the public. It comprises two plates of Eczema Rubrum and one each of Pemphigus and Ecthymea. The vocabulary of commendation has been so nearly exhausted in the notices on all hands of the previous numbers of the series, that no meed of praise remains for this final part, other than an iteration of the merits and characteristics of its predecessors, viz.:—truthfulness to life and excellence of mechanical execution. We congratulate the author upon the high standard and sterling worth of the work he has produced; the artists and publishers upon the admirable manner in which their part has been performed and the professional public upon their good fortune in now having, within easy reach, so excellent a portrayal of the most important diseases of the skin, of which, we are sorry to say, so many know so little.

Zoological Atlas, (including comparative anatomy), illustrating a series of Typical Forms, Representing the Chief Divisions of Animal Life by Drawings of Specimens and Dissections, with practical Directions and explanatory Text. By Dr. McAlpine, F.C.S., Lecturer on Biology and Natural History, Edinburgh. Imperial quarto., Full bound cloth, in two parts. Vertebrate, 24 full-coloured plates. Invertebrate, 16 ditto. Edinburgh: W. & A. K. Johnston.

We are in receipt of the first part of this excellent atlas, dealing with the anatomy of the vertebrata, and comprising 5 plates illustrating the anatomy of the skate, 4 of the cod, 1 of the salamander, 3 of the tortoise, 4 of the pigeon, and 7 of the rabbit. The drawings are very well executed throughout, and the colouring good; the whole conveying an excellent idea of the parts and forms depicted. An explanatory text facing each plate and clearly indicating and describing the parts portrayed, of course greatly enhances their value to the student, as do also the accompanying practical directions. We unhesitatingly recommend the work to all who are commencing the study of zoology.

Anatomical Studies upon Brains of Criminals. By MORIZ BENEDIKT, Professor at Vienna. Translated from the German by E. P. Fowler, M.D. New York: Wm. Wood & Co., 1881.

The object of this work, published in Germany some three or four years ago, is to show that "the cerebral constitution of criminals exhibits mainly deficiency—deficient gyrus development—and a consequent excess of fissures, which obviously are fundamental defects." And this being generalized throughout, the brain substance does not admit of compensation by vicarious functioning. The introduction sets forth by means of figures and verbal description the normal character of the cerebral convolutions and fissures, and contrasts therewith the appearances presented by brain specimens from criminals. Then follows the record of twenty-two observations of criminals convicted of different offences, together with reproductions (by means of photo-engravings which are more permanent and durable than the photographs in the original) of the brain surfaces and sections. Four sections devoted to a recapitulation of the facts brought out by the observations, together with deductions, complete the work. Speaking generally, the book may be described as a really valuable "contribution to anthropology, medicine, jurisprudence, and psychology," and having been prepared for the information of lay as well as professional readers, by the avoidance, as far as possible, of technicalities, it may justly be expected to exercise a wide influence in the community. Dr. Fowler deserves the thanks of all interested for his very excellent translation.

An Introduction to Pathology and Morbid Anatomy. By T. Henry Green, M.D., Lond., Lecturer on Pathology and Morbid Anatomy at Charing Cross Hospital Medical School. Fourth American, from the fifth Revised and Englarged English Edition with 138 fine engravings. Philadelphia: H. C. Lea, Son, & Co., 1881.

This very excellent hand-book of Pathology needs no commendation at the hands of the reviewer, its great merits and advantages for the student being already so widely known. In this latest edition we observe certain changes in the chapters on Nutrition Arrested, and Nutrition Increased, designed to bring the text up to the latest advances in our knowledge in this department. Psammorna is here classed amongst the Fibromata, and not as heretofore with the Sarcomata. We miss, however all notice of Cylindroma, Some slight changes in the text on Inflammation, and an addition treating of the terminations of this process have been introduced. A newer definition of Septicæmia has been adopted, and Koch's contributions duly acknowledged. The chapter on Leukæmia has been re-written and much improved. The distinction between Fibrinous and Croupous Inflammations is not recognized or maintained in this edition. The croupous and diphtheritic processes are regarded as one; and a better description of them given than in the previous editions. Some slight alterations have been introduced in the account of Cirrosis of the Liver, and Hypertrophic Cirrosis more fully recognized, but not yet sufficiently admitted as a distinct affection to meet the views of certain French Pathologists. All the good things that have been said and written of previous editions apply with added force to this, and we know not how to recommend the book too highly to all students and to those practitioners who have not a recent edition, and who care to know the why and wherefore of those processes which fall under their daily observation.

It has been announced that the following is to be the *personnel* of the new Medical School in London, Ont., connected with the Western University:—Dean and Prof. of Surgery, Dr. Moore, sen.; Medicine, Dr. Fraser; Midwifery, Dr. Moore, jun.; Diagnosis and Therapeutics, Dr. Stevenson; Jurisprudence, Dr. Jones; Nervous and Mental Diseases, Dr. Bucke; Sanitary Science, Dr. Fenwick; Clinical Surgery, Dr. Niven; Clinical Medicine, Dr. Arnott; Anatomy, Dr. Waugh; Physiology, Dr. Eccles; Histology and Etiology, Dr. Moorehouse; Botany, Dr. Burgess; Mat. Med., Mr. William Saunders, the well-known druggist; and Chemistry, Prof. Bowman. We have heard one of the oldest members of the oldest school in Ontario express the opinion that the separation of Mat. Med. and Therapeutics, and the allotment of the former to a practical druggist, was most excellent feature in the management.

Meetings of Medical Societies.

ONTARIO MEDICAL ASSOCIATION.

(*Concluded from page 232.*)

AFTERNOON SESSION.

The President took the chair at 2 o'clock.

Dr. Campbell stated that he had a resolution to propose, and in introducing it referred in eloquent terms to the fact that no gentleman of their profession wished to profit by the afflictions of others. Their object was two-fold, viz., the prevention as well as the cure of disease, and the former was of as much importance to the public as the latter. If the school teachers would impart instruction in hygiene and the laws of health these laws would become better known, and the result be a decrease in the death rate. Some years ago, in speaking before the North Huron Teachers' Association, he had stated it as his opinion that there were too many "ologies," and he believed so still. There are many diseases that can be prevented far more readily than cured, and one of these is phthisis. The proper ventilation of schools, especially in the rural districts, is greatly neglected, and thus the seeds of consumption are sown. He expressed it as his opinion that if a little book on the subject of hygiene were introduced into our schools a great improvement in the general health of the community would be the ultimate result, and if drainage were better understood, cases of typhoid would be less frequent, and this subject could be incorporated in the text-book he had just mentioned. He then read the following resolution, moved by Dr. Campbell, seconded by Dr. Worthington, "That in view of the very widespread ignorance among the masses of the people of the simple laws of health, and of the sickness which frequently arises from this ignorance, this association is unanimously of opinion that if the subject of hygiene with some of the essential elements of physiology were substituted in the Public Schools for one or more of the much less essential subjects now commonly taught, and were made compulsory and taught in the Public Schools throughout this province, so soon as pupils arrived at an age at which they could comprehend the same, it would tend in no small degree to prevent sickness, and to promote the wellbeing of the people of this province; and that the following be a special committee to urge upon the Minister of Education the desirability of an early change being made in the schools in this behalf." The names of the gentlemen forming the committee to be Drs. G. Wright, J. Fulton, Canniff, the mover and seconder.

In rising to second the resolution, Dr. Worthington said it was now some years since any book on hygiene had been taught in our schools, and agreed with the mover that if this subject were taught in our schools, the ultimate result would be a marked improvement in the general health. He had great pleasure in seconding the motion.

Dr. Bowlby, of Berlin, said that teachers, unless educated to it, could not give the necessary instruction.

Dr. Curry thought there were too many subjects for study in schools. They had too much overwork, and this was as bad as too little ventilation. He knew several cases where health had been injured by overtaxing the intellect, and thought that the Association should give this subject their attention. It would be better for the children, their parents, and every one else.

Dr. Oldright said that in some schools they had shortened the hours, but cut out the recess in the morning, and if there was anything that assisted the children it was that morning recess. He thought the trouble was not so much in sending children to school when, as some imagined, they were too young, but in giving them too much to do when they got there. The only idea some teachers seemed to have on the subject of ventilation was that when a school-room became too warm all they had to do was to throw open the doors and windows, and this in winter time was anything but pleasant for the scholars.

Dr. McDonald and others also endorsed the remarks of the previous speakers.

The President before putting the resolution made some remarks of an interesting character. Last year he read three papers on the subject of brain overwork, and expects to read another before the Teachers' Association before long.

He gave it as his opinion that the rate of consumption among teachers is three times greater than the members of other professions, and the same might be said of insanity. With regard to the suggested text-book, he thought if introduced it would only be one more added to the long list of subjects now taught in our schools.

Dr. McGregor moved, seconded by Dr. Macdonald, that the resolution be referred to the Committee on Public Health, to report on at the next annual meeting. Carried.

A resolution by Dr. Sloan, to the effect that when the meeting of the Dominion Medical Association was held in a convenient locality in Ontario the meeting of this Association be united or merged in theirs, was, after some discussion, withdrawn.

Dr. Powell, of Edgar, then read notes of a case of diastasis of the upper ends of the tibiæ presenting casts and photographs of the deformity.

This was followed by a paper by Dr. Yeomans, of Mount Forest, on empyema, after the reading of which Dr. Oldright, of Toronto, showed two cases in which he had practised intermittent drainage and irrigation on a special plan which he described, and a general discussion was elicited, in which Drs. Oldright, Fulton, and Ross, sen., of Toronto, Malloch, of Hamilton, and Bowlby, of Berlin, participated.

Dr. Stewart, of Brucefield, contributed a paper on the use of coto bark, in the night sweats of phthisis.

An intermission of ten minutes ensued, at the end of which, the Nominating Committee presented their report, and the following gentlemen were unanimously elected as officers for the ensuing year, viz. :—President, Dr. Covernton; vice-Presidents, 1st, Dr. Mullin, Hamilton; 2nd, Dr. Yeomans, Mount Forest; 3rd, Dr. Hamilton, Port Hope; and 4th, Dr. Irwin, Kingston; Secretary, Dr. White; Treasurer, Dr. Graham, both of Toronto. The various Committees are the same as this year.

Dr. Oldright then read a paper on the "Disposal of Sewer Gas" (see p. 199), illustrating it by means of diagrams and models. Dr. Playter made some remarks upon the subject, which we were unable to catch; and several queries were put and replied to.

It was then moved by Dr. Carney, seconded by Dr. Stewart and carried unanimously, that the thanks of the Association be tendered to Dr. O'Reilly, of the Toronto General Hospital, for his kindness in throwing it open for the inspection of the members, and expressing their gratification with the general appearance of comfort and cleanliness that pervades the whole institution.

Dr. George Wright then presented the report of the Audit Committee. It stated that the accounts had been examined and were correct, and recommended that the Secretary, Dr. White, be recouped for the preliminary expenses incurred by him in connection with the association. The report was adopted.

The following gentlemen were then appointed delegates to attend the meetings of the British Medical Association and the International Medical Congress, viz. :—Drs. W. Roseburgh, Hamilton, R. A. Reeve, and W. B. Geikie, of Toronto.

The meeting then adjourned until seven o'clock.

EVENING SESSION.

The President took the chair at 7.30, and after calling the meeting to order, a resolution was moved by Dr. Oldright, to the effect that in view of the action taken by the medical members of the Ontario Legislature at the last Session, for the purpose of collecting and disseminating information on sanitary matters amongst the inhabitants of this province, and believing that it would be a valuable means of promoting so important an object, therefore be it resolved, that this Association cordially and unanimously endorse the action taken by the medical members of the Legislature, and trust that they will urge as strongly as possible upon the Government during the recess and at the the next meeting of the House the desirability of early legislation which shall make provision for the formation of a Provincial or Central Board of Health, similar to those now long in operation in a number of the neighbouring States, and in many countries of Europe. Carried.

It was moved by Dr. Winstanley, seconded by Dr. Temple, and carried unanimously, that

the sum of $75 be granted to the Secretary as an annual honorarium.

A paper on the treatment of asthma, was then read by Dr. McKelcan, in the discussion of which many members took part. See page 203.

A paper by Dr. Ryerson, of Toronto, was taken as read in the unavoidable absence of the author.

Dr. Playter called the attention of the meeting to the circular he had just issued to the profession on the subject of phthisis.

Dr. Geikie gave notice that the by-law dealing with the reading of papers be made to provide that no member of the Association shall at any one Annual meeting read more than a single paper, or bring forward more than one subject for discussion.

Votes of thanks were then tendered to Dr. Workman, the retiring President, the various railroad companies, etc., and the meeting adjourned about nine o'clock, to meet in Toronto, on June 1st, 1882.

[We hope to publish the papers and discussions from time to time during the year, and direct attention to the three published in our last issue. ED.]

NEWCASTLE AND TRENT MEDICAL ASSOCIATION.

The Medical Association of this district held its regular meeting at the St. Lawrence Hall, Campbellford, on 8th June. The President, Dr. Burritt, occupied the chair. After reading and adopting the minutes of last meeting, Dr. Byam, Campbellford, presented a patient with

HEMIPLEGIA.

An intemperate farmer, aged 35, who was otherwise well and had been in town the previous evening, four weeks ago, felt a numbness over left side, which deepened to complete one-sided palsy, during the day. No known injury although there may have been such. There was no impairment of consciousness at first nor since. He had aphasia for the first five days. The mouth was drawn. He protruded the tongue to the left side. The pupils were equal and not dilated. No ptosis. The left armpit was for the first three days one degree hotter than the right, which was normal. He has dysphagia, which is rather on the increase. He complains that he cannot readily hawk mucus from the throat. There is no cough and no pain. The heart is normal. He has gradually improved under treatment until he can now almost walk alone. The leg has improved most. A discussion arose as to its origin especially whether embolic or apoplectic. The latter opinion prevailed.

SCIATICA.

Dr. Byam also presented a man aged 30, who had marked pain in the sciatic region for about eight years and who had been under his treatment for ten months. The treatment had been very various. Results so far were not the most encouraging. He is never free from pain although almost so at times. After a turn of improvement the old pain would return violently and suddenly. The motions of the hip joint are perfect but the pelvis of the side affected is tilted up so as to give the appearance that the limb of that side is shortened. There is a double curve in the spine which is not tender, and this curvature gives the trunk a distorted look when walking which is managed with difficulty. When almost free from pain he walks perfectly, and all deformity disappears to re-appear with recurrence of pain. His sister is similarly affected on the other side, but neither of these have much or any pain. Their common father is undoubtedly rheumatic. The actual cautery has been well applied over sciatic on two different occasions without relief. The pain is worse at night and is then in the region of the great trochanter. He requires an anodyne twice a day by the hypodermic method. Ether has also been injected. In the ensuing discussion suggestions were made of ammonia baths, nerve stretching, chloroform injections, alkalies and colchicum. Alkalies had been given a fair trial already.

FLOATING KIDNEY.

A case of the above was stated by Dr. Byam. The case is still living. The rational and physical signs taken together led to the diagnosis and no other was suggested.

FATAL HEPATIC COLIC.

Dr. Ruttan, Napanee, presented one large and two small calculi obtained from the following case. Each had rough excrescences. The large was of ovoid shape, its long diameter about five-eighths inch, and shorter two-fifths inch. Mr. H., druggist, aged 40, had been so well that he had never consulted any medical man for eleven years, when present illness began. While in his shop he has often been seen to stop, apply the hand to the right side, while his face was contorted as if in pain which would apparently soon subside. His appetite was good and his general health fair. Between New Year's and the middle of June, he had four or five attacks of hepatic colic. He had a moderate attack on the morning of the first day of his last illness, but went down town, and had an unusally severe one that evening. The pain being referred to the region of liver and back. Vomiting occurred freely but the egesta did not contain bile. Anodynes gave him perfect relief. The first decided relief to pain followed the swallowing of half a teaspoonful of chloroform in water. The matter vomited later, contained bile. He was apparently much better the following day, due to gangrene as was shown *post mortem*. His illness was of only four days' duration. It is believed that a large gallstone obstructed the common duct in the earlier days of illness which sometime before death had escaped into intestines and so allowed of vomiting of bilious matter. Such stone was not found; but the intestines were not searched with care. A calculus was found in the cystic duct and many from the size of a pin's head upward were found in the gall bladder. Nearly the whole duodenum and under surface of liver but especially the liver tissue around the common duct were gangrenous. In such cases Dr. R. would rely on opium, hot baths, chloroform. Dr. Burritt would bleed. He had seen prompt relief from venesection in several cases.

GALL STONES.

Dr. Hamilton, Port Hope, presented three specimens of gall-stones from three cases. One of them was obtained *post mortem*. The other two were from cases still living. One was the size of a small pigeon's egg of stony hardness and glistening structure. The patient had died of a disease not at all or very remotely connected with the calculus. A second was the size of a small pea as hard and as pearly white as a tooth. The third was mahogany-coloured, weighed 35 grains, of light density, and presented five facets. A discussion as to their frequency of occurrence and significance ensued.

OBSTETRICS.

Dr. Bogart, Campbellford, gave details of a case in which there was a double placenta but only one child. There was a single cord which branched, a branch going to each placenta separately. One branch was eight inches long, the other three. He thought care should be exercised in removing the placenta and that such a condition be not overlooked as it might otherwise prove fatal.

Dr. Bell, Peterborough, reported a case in which a midwife had imprudently torn the cord across. Rapid bleeding ensued. Before a doctor could be sent for and brought, eleven miles, the woman was so bloodless as to live only a few minutes after his arrival.

Dr. Burritt reported a consultation case of delivery at full term in which the attending physician is confident no placenta was ever expelled. The membranes seemed certainly to be retained and considerable placental matter was adherent over the usual breadth of surface. There was hour-glass contraction. There was no hemorrhage at all. The child was living. He advised non-interference. A fetid discharge followed for six weeks. The recovery was good.

Dr. Richards, Warkworth, verbally reported a case of apoplexy with stertorous breathing and profound coma.

Dr. Pettigrew, Campbellford, reported a case of congenital absence of brain.

Dr. Ruttan, Napanee, reported a cure of bifid spine by operation, giving particulars of his mode of proceeding. The patient has grown up to sturdy and robust manhood.

Dr. Sinclair, Hastings, reported a case in practice.

Dr. Byam, Campbellford, promised to open a discussion on "leucorrhœa" at next meeting, and Dr. Burritt to give history of a case of uterine hydatid.

The Association then adjourned to meet at Napanee, in October.

HURON MEDICAL ASSOCIATION.

The regular quarterly meeting of the Huron Medical Association was held in Exeter, on July 5th. Dr. Sloan of Blyth, President, in the chair.

The following members were present: Drs. Sloan, Holmes, Hyndman, Worthington, Gillies, Williams, Irvine, Graham, Campbell, Hurlburt, and Stewart.

Dr. Hyndman exhibited the following cases:

I. A case of extensive necrosis of the femur, in a lad aged 14.

II. A case of necrosis of the humerus, with anchylosis of the right elbow joint, and osseous union of the heads of the ulna and radius, in a boy aged 15.

III. A case of probable disease of the upper cervical spine, in a child aged two years.

IV. A case of long standing contraction and induration of the left lung, in a girl aged 14 years.

Dr. Irving, of Kirkton, showed a very well marked example of infiltrating carcinoma of the right breast, in a woman aged 45.

Dr. Sloan exhibited a young man whose pleural cavity he recently opened for the treatment of an empyema. The operation was performed with strict antiseptic precautions (Listerism.) When he first came under Dr. Sloan's care he had been ill for several weeks and had spat up large quantities of pus, which was due (according to his previous medical attendant in Michigan) to the pus in the pleural cavity finding its way into the lung texture. He soon ceased to spit up pus, and when first seen by Dr. Sloan there was physical evidence of the presence of a large quantity of fluid in the right pleural cavity. The temperature varied from 102 to 103, the pulse was constantly elevated, and the respiration quickened. The introduction of an aspirator needle confirmed what was suspected—an empyæma. Under the spray, Dr. Sloan made a free incision and gave exit to about a pint of sweet-smelling pus. Only three dressings were required. The man increased in weight 40 lbs., and is at present in excellent health.

Drs. Stewart and Hurlburt showed the following cases:

I. A child, aged 19 months, who has lost, in a great measure, the motor power of all extremities. The little patient is unable to stand or even to sit. There is a marked tremor in all muscles brought into action. This tremor is absent when the muscles are at rest. There is also marked loss of the muscular sense. The disease is now of four months' standing, and made its appearance slowly. There has been no elevation of temperature and the child has gained in flesh during the last two months. There are fits of explosive and ceaseless crying. The child had been walking for a period of three months previous to the loss of power.

II. A man, aged 37, who has stenosis of the tricuspid orifice, and disease of the left heart also. When first seen, six weeks ago, he wished to get relief from a severe headache which was constantly troubling him. This headache was much severer when he lay down. So much was this the case that he had to pass many nights sitting on a chair. He has never been what is commonly called a strong man. He, however, never felt or showed any symptoms of his present trouble, until about five or six years ago.

Present state.—There is distinct bulging of the cardiac region, and a præsystolic thrill is felt when the hand is laid over these parts. The transverse cardiac dullness reaches (on a line with the fourth rib) from three quarters of an inch beyond the right border of the sternum, to 4 inches to the left—a distance of 6¼ inches. The vertical dullness extends from the fourth rib downwards. A præsystolic murmur (having its maximum intensity over the sternum on a level with the fourth rib) is heard, and a systolic murmur loudest in the mitral area is also heard. The heart's apex is displaced downwards and outwards. There is great fullness of the veins of the face, head, and extremities. There is distinct jugular pulsation. There is great fullness of the retinal veins and the discs are good examples of "choked discs." The pupils are firmly contracted, and resist the mydriatic influence of atrophine to a considerable extent. The atropine, however, quickly paralyzes the accommodation.

There is no œdema of the extremities, and the urine is free from albumen. The pulse is

generally about 60, and regular. Tracings taken from the radial and jugular were shown. For the last three weeks he has been taking full doses of Calabar Bean, with the object of relieving the full veins, and headache caused thereby. It was, however, found not to act so beneficially as Digitalis which was previously prescribed.

III. A case of *Splenic Leucocythæmia.* The patient, a man, aged 47, had intermittent fever for nine months, sixteen years ago, in Tennessee. Three years ago he felt weak and had palpitation of the heart. It was only ten months ago that he first noticed "a lump" in his left side. It rapidly increased in size until six weeks ago, since which it has diminished somewhat.

During the months of April and May of the present year, he has had daily attacks of chills, fever, and sweating. When first seen (1st June), his temperature was constantly elevated (100° to 101°.)

Present state.—The spleen extends from the sixth rib to within two inches of the ilium in the mamillary line, a distance of 7½ inches. In a transverse direction from one inch to the right of the umbilicus to within four inches of the spinal column, a distance of 11½ inches, there is no abdominal pain or tenderness. The liver extends two finger breadths below the ribs.

There is no enlargement of any of the lymphatic glands, nor is there any tenderness of any of the bones. Blood: 2,500,000 red cells in a c.m.m., and 147,000 white, being a proportion of 1 : 17. The red cells vary in size considerably, as also do the white. Many of the latter are very granular, and a good deal of free granular matter is to be seen.

He sleeps well. The appetite is good and the bowels are regular. Only on one occasion has he had epistaxis. There is a considerable amount of œdema of the lower extremities. About six weeks ago he commenced taking arsenic and quinine. There is no elevation of temperature now, and he has gained ten pounds in weight. The spleen has also diminished in size, but there is no improvement in the state of the blood.

Dr. Stewart and Hurlburt showed also the following microscopical preparations:—

I. Spleen and liver from a case of leucocythæmia.

II. Spleen from intermittent fever.

III. Melanæmia of the brain.

IV. Simple hyperæmia of the brain.

V. Tuberculosis of the pericardium.

Miscellaneous.

The Cincinnati *Lancet and Clinic* explains how this is thus: "Oh! Bliss! What Bliss is this? Is this Cundurango Bliss? Yes, this is Cundurango Bliss. How did Cundurango Bliss come to this? About like this: When the President fell he turned immediately to Bliss, and oblivious at once of the extreme agony he felt, suppressing at the same time the shock of the peritoneal wound, he exclaimed, 'Bliss, my boy, you have known me from my boyhood. Bliss, take care of me.' And this is how Bliss came to this. The report that peritonitis has been averted and granulation of the wound promoted by the administration of this Bliss's cundurango, lacks confirmation. As to precisely what is being done for the President we are as yet in blissful ignorance. But when ignorance is bliss 'tis folly to be wise."—*Mich. Med. News.*

CONUNDRUM.—Why did only four members of the Ontario Medical Council vote against Dr. Bray's "inexpensive method" of licensing a Homœopathist, instead of "admitting him to registration in the usual way—by undergoing the usual examinations?" Everybody gives it up.

Births, Marriages, and Deaths.

BIRTH.

At Stouffville, on July 17th, the wife of W. J. Wilson, M.D., of a daughter, still born.

DEATH.

At Brampton, July 19th, James Alexander, second son of Dr. Patullo, aged 20 years.