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# THE CANADIAN PRACTITIONER

FORMERLY "THE CANADIAN JOURNAL OF MEDICAL SCIENCE."

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## Original Communications.

### SUPRA-PUBIC LITHOTOMY.\*

BY MR. MARTIN.

The brief space allotted to the consideration and description of the operation in surgical literature, and the disfavour with which it has hitherto been regarded by the great majority of surgeons, combine to force me to make this paper somewhat of a comparison between supra-pubic and perineal lithotomy, rather than a consideration of the former operation alone. So far as I have had opportunity of reading, I have completely failed to discover any sufficient reason why this method of removing stone from the bladder has been rated so low, and kept so much in the background. The only existing cause would seem to be that it has been somewhat a departure from the old orthodox and beaten way, and its adherents have been regarded as heretics. It reminds one of the peasant, who, when taking his grist to the mill, always placed a large stone in one end of the bag and the wheat in the other to balance it across the horse's back. On one occasion, the boy, being sent with the grist, conceived the idea of dividing the wheat and thus dispensing with the heavy stone; but unfortunately for the boy's ingenuity the flour from this particular grist made bad bread, and nothing could dissuade the father from the belief that it was the discarding of the

stone that spoiled the grist. So accidents attending supra-pubic lithotomy, whether resulting from the operation or not, have terrified many of its advocates into abandonment of this method; had the same mischief followed upon any other incision it might have escaped notice and the operation have gone unblamed.

A detailed account of the apparatus major was published in 1524 A. D., by Marianus Sanctus, from whom it took the name of Marian method, a median operation, which supplanted the older "cutting on the gripe;" and about this juncture the high operation or supra-pubic method was attempted by Franco. We read that his patient made a good recovery, but for some reason, not given, he disapproved of this method of operating. In 1717, Dr. James Douglas recommended the supra-pubic operation before the Royal Society, and showed from the anatomy of the parts that it might be performed with safety. However, no surgeon seems to have undertaken it until three years later, when his brother, Mr. John Douglas, performed the operation twice, both patients recovering. Shortly afterwards one of the surgeons in St. Thomas's Hospital operated four times in this way with two deaths and two recoveries. The cause of death in both cases being rupture of the peritoneum, which was so extensive as to allow the intestines to protrude through the opening.

This caused the operation to fall into disrepute, until revived by Cheselden himself,

\* Read before the Toronto School of Medicine Med. Society.

from whose anatomy I copy the following paragraph :—" The next season it being my turn in St. Thomas's, I resumed the high way, and cutting nine with success, it came again into vogue ; after that every lithotomist in both hospitals (St. Bartholomew's and St. Thomas's) practiced it ; but the peritoneum being often cut, or burst (twice in my own practice), though some of these recovered, and sometimes the bladder itself was burst from injecting too much water, which generally proved fatal in a day or two. Another inconvenience attended every operation of this kind, which was, that the urine lying continually in the wound retarded the cure, but then it was never followed by any incontinence of urine. What the success of the several operators was I will not take the liberty to publish, but for my own, exclusive of the two before mentioned, I lost not more than one in seven, which is more than any one else I know of can say. Whereas in the old way, even at Paris, from a fair calculation of above 800 patients, it appears that near two in five died. And though this operation came into universal discredit, I must declare my opinion that it is much better than the old way to which they all returned." Even in Cheselden's time, notice how favourably the results of the supra-pubic method compare with other methods practiced at the same time.

In reading on this subject one cannot fail to notice the gradual decline of the once brilliant operation of lateral lithotomy. True, our ordinary text books still recognize it as the chief method, and give it special prominence and description, but our text books are almost always two or three years behind the best and newest theories of our greatest men.

Sir Henry Thompson states that all patients with stone in the bladder under the age of 13 years are proper subjects for lithotomy, and are not suitable cases for lithotrity. The death rate in these cases being only 1 in 15 or 16 after lithotomy.

He also shows that in ordinary pauper and hospital practice one half of the cases that present themselves are below 13 years of age. This he proves by a careful collection of 1,827 cases, fully one half being under this age. He then goes on to prove that all cases over puberty should with few exceptions be subjected to lithotrity, and brings a whole array of strong and conclusive arguments to show how much safer and more successful lithotrity is in these cases than perineal lithotomy, being an English operator he makes no calculation on the supra-pubic plan. In this way Sir H. Thompson confines the operation of lithotomy to all cases under 13 years, all between 13 and puberty in which lithotrity is counter-indicated and a few exceptional cases over puberty. Now it is obvious that the great mass of these very cases which this distinguished surgeon reserves for lithotomy are much more suitable for the supra-pubic than for the lateral operation. More particularly those under puberty and those over that age in whom large sized calculi exist. Thus we almost dispense with the perineal operation altogether.

Let us make a brief comparison of the anatomy of the regions in which these two operations are performed. In performing the lateral operation the incision is usually made on the left side of the median raphe, commencing half way between the anus and the scrotum to a point midway between the anus and the tuber ischii, and reaching into the neck of the bladder. This incision divides the integument, the superficial fascia, the external hæmorrhoidal vessels and nerves, the posterior fibres of the accelerator urinæ muscle transversus perinei muscle, and artery (in some cases the superficial perineal vessels and nerves) deep perineal fascia, the anterior fibres of the levator ani, part of the compressor urethræ, the membranous and prostatic portions of the urethra and part of the prostate gland. In the supra-pubic an incision three inches long in the median

line above the pubes divides the integument, superficial fascia, deep fascia, and firm structures of the linea alba. In making the lateral incision the greatest exactitude is requisite. If too near the median line there is danger of wounding the bulb of the corpus spongiosum or rectum: if too far from the median line, the pubic artery is endangered as it ascends along the inner border of the pubic arch. In cutting too far forwards there is danger of dividing the artery of the bulb. Carrying the incision too far backwards may result in diffuse inflammation, peritonitis or dangerous urinary infiltration from division of the prostate and the neck of the bladder. Additional and unexpected trouble may arise in this region from an abnormal course of the arteries, notably the artery to the bulb, and the accessory pudic. Moreover the prostatic veins often become much enlarged in advanced life, and when divided give rise to troublesome hæmorrhage and a liability to pyæmia. Impotence, too, occasionally results. The only one of these dangers attending the supra-pubic operation is that of wounding the peritoneum and this can only result from carelessness as I hope to show hereafter.

In examining the coats of the bladder we find the fibres of the middle coat or sphincter vesicæ much more thickly distributed about the neck of the viscus than at the part approached above the pubes, this fact will explain in a measure, the greater frequency with which incontinence follows the lateral operation.

Again the abnormal conditions and diseases of the parts counter-indicating perineal lithotomy are infinitely more formidable than those opposing the supra-pubic operation. For example deep perineum, enlarged prostate, pelvic deformity, encysted, large or misshapen calculi are serious difficulties in the perineal operation, but offer little obstruction to the supra-pubic method, because the operator's finger can easily reach any part of the

interior of the bladder, and by introducing the finger into the rectum, the stone can be directed toward the opening. In many cases the stone can actually be seen through the incision as it lies in the bladder.

Thus, when we consider the structures in the normal state as they are concerned in the two operations, the result is decidedly in favour of the supra-pubic method. In calculating the dangers to which the patient is exposed from injury to the neighbouring parts, we are convinced that the risk is infinitely less when the bladder is opened above the pubes, than in the old way through the perineum; but estimate the various abnormal and diseased conditions under which it is often necessary to operate, surely, nothing but prejudice could prevent a conclusion that it is safer for the patient, and less difficult for the operator to remove the stone by the supra-pubic method.

The usual objections to the "high operation" are (a) the liability to urinary infiltration and (b) peritonitis. But I submit it is not easy to understand how urinary infiltration is more likely to occur, or more injurious if it should occur, in the case of an incision a few lines deep through moderately firm tissue, than in the case of an opening many times as deep and dividing structures infinitely more delicate and spongy, especially when we remember that in the one case the artificial wound is below the level of the natural outlet for the urine, hence it is impossible to prevent the urine from flowing more or less freely over the surfaces of the divided tissues, and in the other, the relative position of the artificial and natural opening is the reverse, and there is actually no necessity for a drop of urine escaping through the incision. If the patient be kept on his back with a soft catheter fastened in the urethra or passed as occasion requires by a careful attendant it will be sufficient to prevent the urine from flowing over the edges of the wound in the bladder. As to

wounding the peritoneum, Dulles states that there is less danger of this accident in the supra-pubic than in the lateral method. A glance at the anatomy of the parts would convince us that nothing but ignorance could cause such a mistake. Holmes says: "The wounding of the peritoneum must be regarded as a failure in anatomical manipulation." When the bladder in the adult is moderately filled, it extends from  $1\frac{1}{2}$  inch to  $2\frac{1}{2}$  inch above the pubes; in males under 20 years of age, and in females it reaches still higher, while in children under 10 years the peritoneum as reflected from the surface of the bladder reaches the anterior abdominal wall two inches below the umbilicus. The tent-like action of the urachus also tends to protect the membrane. In case an unusually large opening into the bladder be required, or the organ be found smaller or lower in the pelvis than usual, the peritoneum may require attention. Should this state of affairs be met with, it is not difficult to reflect the membrane from the upper surface of the bladder, and have it held out of the way by an assistant. But should the peritoneum be accidentally wounded why can it not be as successfully treated as in cases of ovariectomy, &c.? Thus the only two objections stated by the most prejudiced opponents of the supra-pubic method appear to be even more frequent in operations by the lateral method. The complications and sequela of the lateral method are much more important, and not by any means so infrequent as is often supposed. The principal complications are primary and secondary hæmorrhage, incontinence of urine, urinary fistula, recto-vesical fistula and impotence, besides the urinary infiltration and peritonitis already alluded to. Further the nature of the divided parts produces a greater tendency to inflammation and sloughing as well as kidney diseases, erysipelas and pyæmia in the perineal operation. The abundant vascular supply in the perineum as com-

pared with the parts above the pubes is sufficient to explain the greater tendency to hæmorrhage. The wounding of the accelerator urinæ muscle and division of the most important part of the sphincter vesicæ, of course accounts for the incontinence which so often follows the old method. The situation of the wound below the natural outlet as before mentioned, and the consequent continued dribbling of the urine through the opening, lead us to expect urinary fistula as a common result. Recto-vesical fistula is not unfrequently caused by the operator's knife slipping from its guide and entering the rectum, or the bruising and laceration necessary to remove a large or encysted calculus. The position of the incision and the direction of the traction render this accident impossible as a result of supra-pubic lithotomy. Impotence results from division of the seminal and ejaculatory ducts or injury to the vesiculæ seminales and vas deferens. These delicate parts are of course entirely out of danger from the supra-pubic opening. The extreme sensibility of the parts in this region, its excessive nervous supply, its numerous lymphatics and the frequent existence of dilated and unhealthy veins cause the different dangerous constitutional complications already alluded to, such as pyæmia, erysipelas, &c.

There are conditions which render either lithotomy or lateral lithotomy inadvisable if not impossible, as oxalate of lime or mulberry calculi, very large calculi, or those occurring in the presence of stricture of urethra or sacculated bladder, encysted calculi and calculi, associated with irritable bladder or large inflamed prostate. All of these circumstances counter-indicate lithotomy and many of them impose formidable barriers to perineal lithotomy.

According to our best teachers, all calculi less in diameter than an inch to an inch and a half, occurring in healthy bladders of persons over puberty should be

crushed by the lithotrite.—excepting of course the oxalate variety. Sir Henry Thompson and a few others of course go further than this with lithotripsy, but this is sufficient for our purpose, and if we agree to this teaching, we have the lithotrist restricted within those limits which include all calculi in persons under puberty, calculi above the size mentioned and those occurring under the abnormal and diseased conditions above alluded to.

Let us very briefly consider the relative value of the two operations under these several circumstances. We can at once dispose of all large calculi on the side of the supra-pubic method with the consent of all modern lithotomists. The reasons are obvious, Erichsen states that any stone measuring two inches or more in diameter cannot be removed by lateral lithotomy without great injury to the parts. He also shows that the mortality of the lateral operation is five times greater when the calculus weighs more than two or three ounces, and that these very same conditions have little or no influence in increasing the death rate in the supra-pubic method. Dulles has forcibly shown from carefully collected statistics that when the weight of the stone exceeds two ounces the results are directly in favour of the supra-pubic operation. It has been shown that it is much less difficult to manipulate an encysted calculus through an opening above the pubes than through a perineal incision. A strictured urethra or diseased prostate is a serious obstacle to lateral lithotomy, but does not militate materially against the high operation. That the supra-pubic is preferable to the lateral operation in all cases under puberty will, I think, be conceded by all who consider the high position of the bladder at this time of life, together with the liability to complete separation of the neck of the bladder owing to the tender and immature state of the parts, and the greater tendency to induce impotence and sterility at an early age.

I consider it very unjust to the supra-pubic operation to quote statistical comparisons without reference to the age of the patients or the size of the stones as is usually done by the supporters of the other methods, because the very worst cases and these only have hitherto been handed over to the high operation. However we are not afraid of the statistics, even under these conditions. I shall quote a few. Dulles finds that in 2,478 cases operated on by the lateral method, the average age of which was 28 years, 378 proved fatal or one death to 6.55 recoveries. While out of 364 cases averaging in age, 39 years, 103 died, or one out of 3.53 when operated on by the supra-pubic method.

The average weight of the calculi removed by the lateral operation was 7.25 drs.: those by the supra-pubic 32 drs. In the lateral, the average weight of the calculi taken from the patients that recovered was 5.02 drs. In the supra-pubic the average weight in the recoveries was 25.14 drs. Thus we find that the average age of those subjected to the supra-pubic operation is 11 years above that of those treated in the old way, and the weight of the calculi extracted  $4\frac{1}{2}$  times greater. Out of 478 cases operated on in this way only 6 died from peritonitis, and 7 from urinary infiltration. In the same 478 cases, protrusion of the intestines occurred in 13, while 3 only died from this accident. Lizars gives two statistical tables. In the first he found the death rate to be 5 in 40, in the second 19 in 100.

M. Belmas, gives the death rate as 1 in 4.  
Gross, as.....1 in 4  $\frac{8}{13}$ .  
Maund, as .....1 in 8.

So that the statistics are not so alarming as many of the adherents of the older methods would teach us. When the age of the patients, and the size of the calculi are also admitted in the comparison the result is quite favourable to the supra-pubic operation.



I shall read brief notes on a few cases several of which I have seen :

No. 1. Patient a male 65 years of age, very fat and stout, weighing over 300 lbs., had been a hard drinker all his life. Lithotripsy had been attempted and failed. The surgeons he consulted had refused to undertake the perineal operation thinking he must inevitably die if operated on.

The medical man with whom I was staying performed the supra-pubic operation and removed six calculi, the largest measuring over an inch and a quarter in diameter. The patient made a rapid and complete recovery.

No. 2. Male, aged 66, very weak and decrepit, his death had been expected for weeks. For several months his sufferings had been extremely severe. The doctor hesitated about performing the operation while the man was so low, but finally yielded to the most urgent requests of his patient. The interior of the bladder was found to be in a terrible state from inflammation and irritation. One stone of the phosphatic variety was found. Size, an inch and a half in diameter. The wound healed slowly, but completely. The patient died about 3 months after the operation. There was no doubt the operation prolonged his life.

No. 3. Patient, male, aged 67, healthy and in every respect excepting age a favourable case for operation. He had submitted to lithotripsy some years previous, and he came home assured that he had been cured. At the operation twenty-five calculi were removed, the smallest being more than half an inch in diameter. They all presented rounded angles and edges, giving evidence that they had arisen from new deposit upon the irregular fragments of the original calculi which had been reported cured by crushing years before. Recovery was rapid, perfect, and without an untoward symptom.

No. 4. Patient, male, aged 56, strong and healthy. One stone found measuring two inches in diameter. Recovery perfect.

No. 5. Patient, a boy, aged 6, one mulberry calculus an inch in diameter, recovered. Recovery retarded by incessant vomiting. He had entirely recovered within a month.

No. 6. Patient, male, aged 76, very weak and apparently sinking. One stone two inches in diameter removed. Patient appeared to be doing well, but at the end of a week he sank and died. The wound was in a healthy condition and his temperature was never above normal after the operation. His regular medical attendant agreed with the surgeon who operated, that death resulted from causes entirely independent of the operation.

No. 7. Patient, male, aged 64. Two stones removed one two inches in diameter the other an inch and a half. The patient was greatly troubled with urethral rheumatism from retaining the catheter, so much so that finally the instrument was left out altogether and the urine allowed to escape through the wound, until cicatrization took place. Recovery was perfect.

I should say that these cases were not by any means selected, as the surgeon who performed them operated on every patient that presented himself.

#### NEPHROTOMY FOR PYONEPHROSIS.

A. H. WRIGHT, B.A., M.B.

J. P., male, 37, a shoemaker, born in Ireland. Admitted to the hospital, April 27th, 1883. Nothing special in family or previous history. Thinks he never had gonorrhoea although he had two sores on penis twenty years ago.

Since last September has had "trouble with his bladder," frequency of micturition, and pain felt near end of penis. At first the pain was worse before micturition but lately worse at close of the act. Noticed three small blood clots in March in chamber after voiding urine. For a short time in March and April a little blood followed urine occasionally.

The pain is now very severely felt near

end of penis, especially at close of micturition. Passes water four or five times an hour during the day and nearly as frequently at night. Unable to work during last two months.

Ordered, acid benz., sod. bibor., and infus, buchu.

May 3rd, stricture found in bulbo-membranous portion of urethra, admitting Number 1 English catheter, prostate tender per rectum, and slightly swollen. Less pain and frequency of micturition. Blisters applied to perinæum. Examination of urine showed abundance of pus cells, a little albumen—sp. gr. 1012—acid reaction—no casts. Endeavoured after this to dilate stricture by simple dilatation but failed. Then tried continued dilatation commencing with a No. 1 English, which was retained three days and then a No. 2 was used. In twelve days the stricture would only allow the passage of No. 5. Could not find calculus in bladder.

During latter part of May appeared better had less frequency in micturition, but in June was worse again and had occasional increase of temperature.

June 19th.—Passed a Holt's dilator, intending to "rupture" stricture, but as a severer rigor ensued, it was at once withdrawn.

July 12th.—Performed external urethrotomy with a guide, and allowed urine to flow through perinæal opening. The stricture was cut through without any difficulty. The bladder was explored easily but was found to contain no calculus nor abnormal condition of prostate. Bladder apparently slightly contracted.

Pain much relieved by operation and instead of passing urine every 10—30 mins. was able to retain it about two hours; was in good spirits as he thought his condition vastly improved.

In August it was found that pus still passed sometimes by the perinæal opening, sometimes mixed with urine, and occasionally alone, either at commencement or end of micturition. Sometimes urine appeared

quite clear for a day or day and a half, and then a quantity of pus would pass, either alone or with the urine. At one time after an interval of nearly two days about an ounce of pus passed alone. Careful questioning at this time elicited the fact that there was occasional dull pain in right loin, not descending towards groin, apparently worse before the passage of pus. A careful examination on various occasions showed no certain signs of swelling in this region.

Urine examined frequently without discovering anything new. Reaction always acid. Some albumen, probably no more than presence of pus would account for, no casts. During this month (Aug.) the perinæal wound closed up for a few days but again opened and remained so during life. Some urine passing through fistula and some through urethra. Occasionally had chills and increased temperature and attacks of diarrhœa, which were generally easily controlled.

In September he seemed somewhat better and passed less pus; worse again at end of month; had chills, loss of appetite and irregular, sometimes high temperature; slight signs of swelling in right loin suspected.

October 15th.—Percussion showed dullness, limited to a space not greater than a finger-breadth, midway between last rib and crest of ilium. There appeared to be a slight swelling when the two sides were carefully compared. No fluctuation could be made out.

October 18th.—The large needle of aspirator was introduced midway between last rib and ilium, six inches from spine; it passed easily into a good-sized cavity from which seven ounces of pus escaped.

Examination of urine showed no special change; felt rather better after use of aspirator, but in four or five days' diarrhœa returned: evacuations slightly dysenteric in character.

October 23th.—Nephrotomy performed in theatre with antiseptic precautions, in-

cluding the spray; patient under ether which he took badly; ordinary lumbar incision commencing at last rib, three inches from spinous processes, passing downwards and slightly outwards to crest of ilium; passed through portions of latissimus dorsi, and then cut through lumbar fascia and transversalis fascia on a director. Then passed finger past outer edge of quadratus lumborum. The tissue behind kidney (principally fat) was scraped away, mostly with finger, when sac came in view. This was seized with a volsellum forceps and opened freely; about 6 or 7 oz. of pus escaped; the edges of sac were then fastened to integument on each side of superficial incision. There was very little bleeding; no vessels tied.

Patient rallied fairly well and seemed pretty comfortable during evening; stomach was irritable and there was some vomiting during night. On following morning condition about same; unable to take much nourishment. At 11 a. m. commenced to sink and remained very low notwithstanding injection of ether hypodermically and nutrient enemata; died on following day, two days after operation.

Post-mortem examination by Dr. Graham five hours after death; body emaciated; right kidney capsule thickened and adherent to surrounding tissue; numerous adhesions, especially to ascending colon; kidney tissue partially destroyed; no pelvis could be made out; ureter much thickened and lumen very small; left kidney weighed 10 oz.

*Remarks.*—When this patient was first admitted he was treated for cystitis and stricture. The stricture was very obstinate and prevented exploration of bladder. The perinæal blisters were expected to relieve the prostatitis, if any existed. The perinæal section was performed for three purposes: 1st, to cure the stricture; 2nd, to relieve the cystitis; 3rd to explore the bladder. It was very satisfactory for all three purposes, the only drawback being the continuance

of the fistula. It was found quite easy to explore the whole of the interior of the bladder. The exploration showed the bladder to be comparatively healthy. It was not until after this that pyo-nephrosis was suspected, but it was extremely difficult to discover any physical signs of such in the loin. This may be partly understood by an examination of the sac which was composed of the capsule and a very small portion of kidney substance. The sides of the pelvis were to a large extent agglutinated. The sac and its contents occupied the normal position of the kidney and filled but little if any more space than the left kidney which weighed 10 oz. Generally in such cases the pelvis and ureter are largely dilated and form part of the sac, under these conditions the swelling often extends beyond the median line and can be easily detected.

As the other kidney was fairly healthy, and had evidently secreted all the urine for some time, and as the other organs were in pretty good condition, it is quite likely that earlier operative interference would have prolonged the patient's life considerably. It seems likely that the stricture was the origin of the trouble, causing first, cystitis, after which the inflammation extended up the right ureter to the pelvis and substance of kidney.

#### A CASE OF SPASMODIC LARYNGITIS —DEATH.

A. M'PHEDRAN, M.D., TORONTO.

A fatal termination of this very common affection is so rare that the following case will probably prove of sufficient interest to warrant publication.

J. K., æt. 4 years, had been subject to attacks of "croup" from infancy. Following each attack there were hoarseness and other symptoms of a common cold for a day or two. During the last two years relief was always obtained, until this occasion, by recourse to a warm bath, and the administration of emetic doses of alum.

On the 16th of October the child was to all appearances quite well; he had no hoarseness or other signs of cold. Shortly before midnight he was suddenly awakened by an attack of dyspnoea. The parents followed the usual course of treatment, but without relief, though the vomiting was free. The breathing was very stridulous and laboured, and grew steadily worse. Death took place about three hours after the first signs of the attack, without convulsions. I did not see the child till fifteen minutes after death. He was well nourished, and was said to have been otherwise very healthy. An examination of the larynx and thoracic viscera was made eleven hours after death. The venous system and right side of the heart were distended with dark fluid blood. The left ventricle was empty and contracted. The mucous membrane of the larynx, trachea and bronchial tubes was of a livid colour, darker than normal. In the larynx, above the vocal cords, it was perhaps a little thickened. No other morbid change was found.

Judging from the symptoms of this attack and the history of the previous ones, this case was doubtless one of sub-acute laryngeal catarrh, with marked spasm of the adductor muscles of the glottis. Morrell MacKenzie \* thinks that probably spasm acts only as a secondary cause, and that the attack of dyspnoea is primarily due to a collection of inspissated laryngeal secretion deposited on the vocal cords during sleep, when the mouth is often open. The glottis of the child is very narrow, and the gradual accumulation of this secretion soon forms such an impediment to respiration that spasm is excited. If this view is correct, it accounts fully for the efficiency of emetics in this affection. In many cases, however, the dyspnoea is chiefly or wholly due to spasm and when fatal, death is usually due to general convulsions †. In these cases, the most prompt relief would probably be

obtained from the bromides. Given well diluted, after the emetic has operated, they would be quickly absorbed, and their effect soon apparent. For cases of laryngismus stridulous, without laryngitis, Ringer \* recommends cold sponging two or three times a day, and says it scarcely ever fails to modify the attacks and seldom to cure them however severe they may have been. If there be some laryngitis accompanying or causing the laryngismus, the cold sponging requires to be used with caution, lest it increase the inflammatory condition. MacKenzie prefers tepid salt water sponge baths on rising, followed by dry rubbing, warm flannel clothing, and plenty of outdoor exercise, even in coldest weather. Indoor occupations predispose to laryngeal affections. At the London Throat Hospital, catarrh of the larynx is much oftener met with among tailors, shoemakers and other indoor workers, than among policemen, cab-drivers, etc., who are out in all kinds of weather.

In case of death from spasmodic affections of the larynx it is recommended to resort to tracheotomy and artificial respiration, if the case is seen shortly after death. In most cases tracheotomy would not probably be required as, with death, the impediment to the free ingress and egress of air, unless due to an accumulation of mucous, has disappeared.

### VALVULAR ANOMALY BY DEFECT— HEART WITH ONLY TWO AORTIC VALVES.

EDMUND E. KING.

In December last, while dissecting a heart in company with Mr. Hodgetts, we found the aortic orifice guarded by only two semi-lunar valves, one being anterior, the second posterior. The coronary arteries were both given off from in front of the anterior segment. The heart was from a female subject in the dissecting room, and in all other respects was quite normal.

\* Diseases of the Pharynx, Larynx, and Trachea.

† Ringer, Hand-book of Therapeutics, p. 58

## Selections : Medicine.

### PÆDIATRIC MEDICINE.

BY J. B. CASEBEER, M.D.

Many of our most successful practitioners of medicine amongst the *adult* population have made signal failures when called upon to exhibit their skill in the treatment of tender children.

We have often been pained by the remarks dropped from the lips of some physician whom we were endeavouring to regard as sample practitioners, on account of the indifference manifested, and the slight degree of importance attached to their practice among the children, such as, "Well, you may give a few drops of 'paregoric,' or some, 'catnip tea' or most anything of that kind you may find convenient, as we cannot do much for children so young;" or, "Your mothers or 'old women' can treat young children as well as I or any physician can;" or, "I don't like to treat children, it is so unsatisfactory. They cannot tell how they feel and what is the matter with them, and I never can tell what they need."

To my mind, such remarks (and these are but a few imperfect specimens of those somewhat current in our ranks) indicate a lack of knowledge, or a misconception of the true principles of the practice of medicine as applied to the children, which certainly challenges our sincere attention.

It is a loud cry for *reform* or *re-education*. To my mind, the diseases of children speak a plain language, and require as direct remedies to control them, and are as emphatic in their demands as are those of the adult; and when we admit that untutored women or good nurses can judge of the requirements of sick children, and can treat them as well as the educated physician, then I feel that we ought to be honest enough to admit that the same is true in all classes of the sick. To my mind, paregoric, rhubarb, and chamomile are appropriate remedies, when indicated, alike to the child and the adult, and when not indicated would be as much out of place in the one as the other.

The natural language of the child is the true and untarnished expression of facts; while that of the adult, tainted by the prejudice of their own opinions, freighted with the imperfect use of an imperfect language to express their imperfect thoughts, must

be taken with a great deal of allowance, and very much of it must be often entirely excluded when making up a diagnosis.

If the intelligent physician will but open his eyes and his ears, his little patient will unconsciously tell him how he feels and what is the deviation from the health standard. If he will but study cause and effect, he will find the indications for treatment just as plainly marked out as in his older patient, that may be very fluent in reciting his pains and aches. The physician practicing rational medicine, and who is governed in his treatment by the indications of each individual case, and strives to meet only the indications that do exist, needs to be versed in the laws and natural language of disease, the laws, and standard of health, the true nature and effect of the remedies used, both physiological and toxic; and if he can read these correctly and apply them with judgment, it matters not whether he finds his patient in Maine, Georgia, Pennsylvania, Ohio, Indiana, or California, the same symptoms call for the same remedies, and in the different ages of the patients the same language is to be read, the same indications to be met in the same way; and thus the same skill and judgment is called for, and the man who is really a good physician, and applies the same good common sense in his practice, can do so in one State or age as well as another.

While we believe the above is true, we believe also that the converse is only partially true; for we may, in our treatment of the vigorous adult, fail to skillfully meet the leading indications with their appropriate remedies, yet if we are not too excessive in the use of our misused remedies, our patient, with his strong vitality, may get well in spite of us, but in the tender age of our infantile patient a misplaced remedy might be fatal in its consequences.

We are, therefore, forced to the conclusion that the diseased children ought to be placed in the care of the *best physicians*, and, if the uneducated women and nurses are to be given work because of their kindness of heart and their good nursing, or even for their experimental knowledge, certainly let it be given them in the realm of the adults, where a neglect or a misapplied remedy is far less harmful.

And now, in conclusion, let me ask my fellow-labourers in our beloved profession, in the interest of our own honour and useful-

ness; in the interest of the dear children we are called to administer unto, and in the interest of the anxious and earnest students seeking to know the geography of the whole field of medicine—I say in the interest of all these, let us endeavour to appreciate and teach the true relation existing between the child and the adult; the sprout and the full-grown tree, and forever divorce this branch of our practice from the unnatural relation heretofore forcibly maintained between it and gynaecology and obstetrics. And let us wake up to the realization of the fact that there is more real science in the proper practice of medicine among the children, where we read the nature, expression and influence of disease by the physical signs and rational symptoms, unaided by the verbal language of our patient; and also, that the treatment of children calls for the best efforts of the most scientific and skilful of our ranks, and that any indifference to or inclination to shift responsibility of their treatment, is only an evidence of our weakness in this direction, and our non-appreciation of and unwillingness to perform our whole duty.—*Jnl. Am. Med. Association.*

TREATMENT OF MIGRAINE.—William A. Hammond, in the *N. Y. Medical Journal*, divides migraine into two forms, the angio-spastic and the angio-paralytic. The first is the result of a spasm of the blood vessels, producing a state of anæmia of the parts supplied by them. The chief symptoms of this form are dilatation of the pupil of the affected side, sinking of the eyeball in its socket, face and ear pale and cold, temporal artery contracted, lowering of temperature, pressure on the carotid of the side affected increases the pain, on the opposite carotid diminishes the pain. As the paroxysm passes off, as the vessels distend, and the temperature rises, there is profuse perspiration, and an increased excretion of urine. In the other, the symptoms are almost the exact opposite of those in the spastic form. Sometimes the conditions alternate, or they may both exist at the same time on opposite sides. The indications for treatment are in the spastic form to relax the spasm and augment the quantity of blood in the head, in the paralytic form, the vessels want toning, and the blood in the brain is to be lessened in quantity. In the spastic form galvanism is of service

in the treatment of the paroxysm. One pole over the sympathetic is the neck, and the other over the solar plexus, and a current from fifteen cells allowed to pass for three minutes. A hypodermic of one quarter grain of morphia, followed every fifteen minutes, by a pill containing a drop of a one per cent. solution of glonoin. In the intervals, between the paroxysms, the glonoin should be steadily administered, and also the bromides. In the paralytic form, galvanism will sometimes cut short the attack, cold to the nape of the neck, compression of the carotid in the affected side with Corning's instrument sometimes acts like a charm. Thirty or forty grains of guarana or ten grains of caffeine or even strong coffee or tea will cut short an attack, or better still a large dose, 100 grains of sodic bromide. In the intervals, bromides, ergot, and strychnine should be given. Dr. Allan McLane Hamilton (*ibid*) regards migraine as much a vascular as a nervous disease. He looks upon it as due to an epileptic dyscrasia. The treatment consists in improving the general health by the hypophosphites, cod liver oil and iron. A constant vascular balance must be insured by the exhibition of digitalis, nitro-glycerine, or convallaria. For the relief of the paroxysm, large and repeated doses of ammonia, as 20 grains of the muriate in Vichy water every hour until three or four doses be taken, will usually break up an attack. At the congestion stage, ammonia bromide, with cannabis indica. If there is any periodicity in the occurrence of the headaches, and they have a certain regularity in expression, we are warranted in using the bromides as in epilepsy. Dr. Alfred L. Carroll (*ibid*) acknowledges that in cases of migraine, arising from eye-strain, the wearing of proper glasses is sufficient for a cure, that in others, gynaecological treatment is necessary, in others, the extraction of carious teeth, and in others, of malarious origin, the exhibition of anti-periodics, as quinine and arsenic. In the so-called idiopathic cases, the long-continued use of cannabis indica, in small doses (one-third to one-half grain of the extract), gives better results than any other single remedy.

CATCHING COLD.—There has always been more or less of mystery connected with the disorder popularly called "a cold." Dr. C. E. Page (*Pop. Sci. Monthly*), observing that

all classes of people have colds from the slightest causes to-day, and are utterly unable to account for the attack; may next month be severely exposed and chilled and yet produce no symptom of this disorder: that infants who are fed every hour or two are peculiarly subject to acute attacks; and that the influence of the "influenza wave" prevails more severely in summer than during the steady cold of winter, goes on to say, while the disease under consideration is no respecter of persons, but is as universal as the dietetic habits of the people are uniform, there is one class, viz., vegetarians, who are very much less subject to it. Individuals, indeed, there are, living still more abstemiously, and paying proper regard to the ventilation of their dwellings, who never have a cold: the "wave" never touches even the hem of their garments. Members of this class, however, upon resuming their former practices as to diet, returning to the "mixed" diet and three meals a day, also resume the habit of "catching cold." He says that personally though a life-long sufferer from the disease in various forms, he now finds it impossible to excite any of the "well known symptoms," so long as he lives upon a frugal diet, chiefly cereals and fruit, served plainly, nominally two meals a day, ready to skip a meal whenever the symptoms of indigestion warn him of having carried the pleasures of the table a trifle beyond the needs of the organism.

In his efforts to "catch cold" he has made experiments upon himself, which most people would consider suicidal. He has walked in low shoes in snow and slush until shoes and socks were saturated, sat for an hour in this condition and going to bed without warming his feet; irregularly changing his clothing, sleeping in a direct draught, rising from bed on a cold rainy morning, sitting naked for an hour writing, then putting on shirt and trousers only, the shirt almost saturated with rain and the trousers quite damp from hanging by the window. He has done these and similar things repeatedly without catching cold. On the other hand, changing the nature of his experiments, he returned to his indiscriminate diet, the universal mixed diet of the people, and expending his efforts in the avoidance of exposure and draughts, he found no difficulty in accumulating a cold, within a reasonable length of time, the time depend-

ing upon the degree of over indulgence as to frequency and amount.

In every instance he banished the cold by entirely abstaining from food for a time; he has never known this remedy to fail (if applied at the very onset) in breaking up a cold in twenty-four to forty-eight hours. On the first appearance of the symptoms of a common cold, skipping a single meal, when two meals a day are taken, and two meals in a three-mealer, will suffice when the following meals are very moderate. Out-door exercise is desirable.

He concludes that the disease manifested by the symptoms which indicate that a cold has been caught, is a *filth disease*, arises largely from indigestion (*surfeit fever*), and forms the basis or is in fact the *first stage of all* the so-called filth diseases. Whatever interferes with digestion or depuration, or depraves the vital organism in any manner, produces an impure condition of the body, and a continuance of these habits must inevitably result in periodical or occasional "eruptions." Among the causes of this impure bodily condition are, impure air, excess in diet, impure food. Our houses, public and private, are insufficiently ventilated; we are starving for oxygen, and without sufficient oxygen the best of food will cause indigestion. The "fresh air idiot" seldom catches cold. People may live in unventilated rooms, yet have plenty of exercise, but they seldom practice voluntary restriction as to food. People of this class are great sufferers from colds. Impure air, although a prevailing source of disease, is not absolutely essential in provoking this disorder; an unwholesome diet alone being sufficient. Mankind are by nature, or at least from custom, prone to over-indulgence in diet. Excess in diet is a relative phase, the quantity of food must be proportionate to the amount of labour performed, the degree of cold endured, and the amount of oxygen taken into the blood. It must also relate to the present physical condition of the individual. Nature's preventive and curative agents may be summed up thus:—Pure air, appropriate food, exercise, skin cleanliness, with proper ventilation of the surface of the body, *i. e.*, through the use of non-sweltering garments, supplemented by rational exposure of the entire surface of the body to the air, by means of air baths, sunshine in the home, and "sunshine in the heart." With these, and only

these, all curable cases will go on to certain recovery. Without these no medication will avail.

**PATHOLOGY AND TREATMENT OF SOME FORMS OF HEADACHE.**—At a meeting of the Medical Society of Islington, recently, a very interesting communication was read by Dr. T. Lauder Brunton, F. R. S., on this subject, of which the main points were as follows: (*The Lancet*): Headache is usually the product of two factors—local irritation and general condition. The chief local causes are decayed teeth and abnormalities of the eye, although disease of the ear and nose, inflammation of the throat, and local irritation of the pericranium, or of the skull in rheumatism and syphilis, are not to be forgotten. Decayed teeth may give rise to temporal or occipital headache when the molars are affected, and also, I think, frontal when the incisors are decayed. The chief abnormal conditions of the eye are strain from reading, or working with imperfect light, or for too long a time, myopia, hypermetropia, astigmatism, and inequality of vision between the two eyes. Besides these, I think that alterations in the circulation and intraocular pressure are frequently produced by bile or poisonous substances circulating in the blood, and that probably also a rheumatic condition affecting either the eye itself or the muscles which move it is a not uncommon source of headache. Where both eyes are equally affected the headache is usually frontal, but when one eye is more affected than the other the headache appears either in the form of brow ache or megrim. In treating any case of headache, therefore, the first thing to do is to see whether the teeth are sound and the eyes normal. If any thing is found wrong with either the teeth or the eyes, the defect should be at once corrected. The throat, ears, and nose should also be examined, to see if any source of irritation is present there, and the surface of the scalp tested by pressure for rheumatic or syphilitic inflammation. The locality of headache is probably determined chiefly by the local source of irritation, but this differs according to the general condition. Thus frontal headache with constipation is usually relieved by purgatives; frontal headache just above the eyebrows without constipation is relieved by acid; and a similar headache situated higher up at the commencement of the hairy

scalp is relieved by alkalies. Vertical headache is usually associated with anemia, and is relieved by iron. The more or less continuous headache of syphilis is usually best relieved by iodide of potassium, but in order to gain relief the dose must sometimes be much larger than that usually given, and may range from five grains up to thirty grains for a dose. Similar quantities of iodide of potassium are usually sufficient to cure the rheumatic headache.—*Louis. Med. News.*

**VARIATIONS OF THE URINARY CHLORIDES.**—No one will deny that a more frequent examination of the constituents of the urine might lead to the acquisition of fresh knowledge. Even in our public clinical institutions the systematic estimation of the most important urinary constituent is not regularly carried out. A complete clinical account of the changes in the urine which attend the active stages of the rachitic process would probably be attended with important additions to medical science. Indeed, the same may be said of most acute diseases. In ordinary medical attainments perhaps the only piece of information with regard to the chlorides of the urine consists in the knowledge of the fact that there is a remarkable diminution of this ingredient in acute pneumonia. M. Burot has done well to draw attention to this unexplored field of clinical medicine. He has devised a simple apparatus for the purpose of estimating the chlorides. A small flask is furnished at its inferior extremity with an ampulla capable of holding just one cubic centimetre of urine. A pipette is obtained gauged in tenths of a cubic centimetre. Another little flask containing a solution of argentic nitrate, is used from which the pipette may suck up some of its contents by means of a ball of caoutchouc. A cubic centimetre of urine is first treated with a solution of potassic chromate. The solution of nitrate of silver of known strength is then dropped in by means of the pipette. The whole of the chlorides in the urine have been obtained as soon as the *casé au lait* precipitate of chromate of silver appears. M. Burot found that the normal amount of chlorides in the urine was eleven grammes for every litre, consisting of ten grammes of chloride of sodium and one of chloride of calcium. In tuberculosis it was estimated that seventeen to eighteen grammes of



chlorides per litre were discharged. But a diminution of the chlorides is of greater import, especially in acute affections. In pneumonia, when the temperature is much raised, the fall in chlorides is considerable. This diminution was not noted in bronchopneumonia. But in the pneumonia of typhoid fever at the onset of death the chlorides completely vanished.—*Lancet*.—*N. Y. Med. Jul.*

**LOW RECTAL TEMPERATURE IN APOPLEXY FROM RUPTURE OF A LARGE CEREBRAL ANEURYSM.**—Dr. Charlton Bastian related to the Clinical Society (*Lond. Lancet*), a case of rupture of a large aneurysm in the right corpus striatum, with intra-ventricular hæmorrhage and extreme lowering of rectal temperature. The rectal temperature was 94°.5, 94°.6 and just after death, 95°. At the post-mortem a large effusion of blood was found at the base of the brain, beneath the arachnoid, extending from the optic commissure over the pons, medulla, and hinder part of the cerebellum. The lateral ventricles were greatly distended with blood clot. The superficial portion of the right corpus striatum was found to be much torn and shreddy. At the bottom of the space thus formed a large aneurysm was found about the size of a chestnut, three-quarters of an inch in diameter. Dr. Bastian said he did not know of any recorded case of apoplexy in which the rectal temperature had fallen so low as 94°.4, and in which it remained so near to this point for a period of three hours. In only two of Bourneville's cases did it ever sink so low as 96°. The prognostic value of such a sign is great. He had also been unable to discover the record of any case in which so large an aneurysm has been found imbedded within the substance of the brain, and formed upon one of its smaller vessels. It is rare even to find one so large situated upon the basilar or middle cerebral artery. Yet this large aneurysm was evidently formed upon one of the small arteries that come off directly from the first part of the middle cerebral and enter the nucleus lenticularis.

**HYDROCEPHALIC CRIES.**—M. Daremberg reports a case of tubercular meningitis in which the frightful hydrocephalic cries ceased suddenly after a sub-cutaneous injection of chloroform. This happened three times. After the irritating fluid got under the skin,

the hydrocephalic cries, *i.e.*, the concomitant spasm of the laryngeal and expiratory muscles ceased. A very curious point was that the convulsions which disappeared in one place reappeared in another. The clamour was extinguished, and the arms took on rhythmical movements without the knowledge of the patient. The injections were made in different regions.—*Le Prog. Méd.*

**CONGENITAL ABSENCE OF THE GALL-BLADDER.**—M.M. Rambault and Schachmann presented to the Anatomical Society of Paris the liver from a general paralytic, dead in the service of M. Falret at Bicêtre.

From the 1st of January, 1882, until death no biliary manifestations had been noted. Lately he had suffered from many congestive attacks in one of which he died. The autopsy showed the liver comparatively small. The gall-bladder was absent, from its under surface the cystic fossa was replaced by a narrow and shallow groove. The choledoch canal in its entire length presented no opening for the cystic duct. The hepatic canal was normal, numerous sections through the liver discovered no vestiges of a rudimentary bladder, nor one of the central bladders which have been found. It cannot have been a case of pathological atrophy, for there exists not the slightest trace of it. It is simply then a case of agenesis of the gall-bladder.—*Le Prog. Méd.*

**IS THE LUNG IMPERMEABLE TO AIR?** EWALD AND ROBERT.—The authors found in dogs and rabbits after insufflations of air in the trachea made with a pressure below that made by the respiratory muscles, an exit of air through the walls of the alveoli and the trachea. The air passed first of all into the subcutaneous cellular tissue of the neck. (The emphysema of whooping cough might be thus explained). By the alveoli the air would first pass partly into the pleural cavity and partly into the vessels, and they had never been able to find the slightest tearing of the pulmonary tissue. These experiments would explain the rare cases of essential pneumo-thorax. The authors admit the possibility of a man voluntarily by mechanical pressure pressing a quantity of air into the vascular system and pleura, sufficient to cause death. This might account for those cases of suicide by voluntary suffocation.—*Lyon Méd.*

**THE TREATMENT OF LICHEN RUBER.**—The following is the method now adopted by many German dermatologists, and which was introduced by P. G. Unna. In an article by Bockhart, on the management of this obstinate disease, he speaks of the Unna treatment as being a genuine therapeutic triumph.

The affected parts are rubbed twice daily with the following ointment :

Ung. Diachyli.....	500
Acid. Carbolic.....	20
Hydrarg. Perchlor.....	1

The time required in treatment varied from eight days to three weeks. In the event of the mouth becoming sore, it was healed with chlorate of potash, and the teeth kept thoroughly clean. Finally the skin is rubbed with sp. saponis kalinis and oil. Occasionally tar and white precipitate ointments were used to complete the cure. *Monat F. P. Dermatol.*

**SULPHURIC ACID IN INFANTICIDE.**—M. Regnard at the *Société de Biologie (Gaz. des Hôpitaux)* pointed out the use of sulphuric acid in destroying animals dead of infectious diseases. The quantity of acid required is about twice the weight of the body. M. Regnard thinks that this means of destroying a fetus born at term would be taken up by infanticides; a small quantity of sulphuric acid, about three quarts, being sufficient. The fetus in twelve hours disappears entirely, the acid turning black; the acid could then be got rid of by pouring it down a water-closet where it would form chemical compounds with the ammoniacal products of the drain, and all trace of acid and fetus lost. He advised that greater restrictions should be placed upon the sale of this acid.

**ZONA.**—All authors agree that spontaneous zona does not recur. This law is as formal as that of the non-recurrence of the eruptive fevers. This is explained by the fact that the disease has created a peculiar modality of the organism, that it has withdrawn from the blood mass a special principle whose presence or absence is opposed by the renewed development of the same morbid germ.—*L'Un. Méd.*

Dr. Althaus says that the exaggeration of tendon reflexes in the parietic side of the body is indicative of structural disease of

the nervous centres, while in hysteria, these reflexes may be normal, increased or diminished, but are equal in symmetrical parts of the body.—*Lond. Lancet.*

**MIXTURE FOR PERTUSSIS:—**

R Ammonii vel. Potassii Bromidi.	ʒ i.
Ext. Lippie Mex. fl.....	gtt. xxx.
Syr. Belladonnæ.....	ʒ i.
Syr. Digitalis .....	
Syr. Valerianæ .....	āā ʒ iii.
Aq-Lauro-Cerasi .....	ad. ʒ iii.
	M.

Sig.—ʒ ss. to ʒ i. daily, gradually increased.—*R. M. in N. O. Med. and Surg. Jnl.*

**SALICYLIC ACID PASTE IN ECZEMA:—**

R Acidi Salicylici ...	grs. x.
Petroleol .....	ʒ iv.
Pulv. Zinci Oxidi...	
Pulv. Amyli.....	āā ʒ ij. M

Rub into a smooth paste.—*Van Harlingen, Phil. Med. Times.*

**PRURIGO.**—Dr. O. Lassar reports considerable success in the treatment of prurigo by the internal use of infusion of jaborandi; and the protracted use of tar water baths and the free inunction of salicyl-vaseline.—*Wien. Med. Woch.*

**Surgery.**

**WIRE SUTURES IN FRACTURED PATELLA.**

At a recent meeting of the Medical Society of London, M. Lister read a paper (*Lond. Lancet*) on wire suture of the patella. The operative procedure is simply to make a longitudinal incision over the joint; remove all clot or fibrous material, freshen the ends of the bones in old cases, drill a hole through each fragment and pass a heavy wire suture through the holes, twist and then hammer the ends down upon the bone; provide suitable drainage; dress antiseptically, put up in an immovable apparatus. He thought recent cases the most favourable and the most proper for the operation, although old cases of ununited fracture did well. The strict observance of the antiseptic method converts serious risk into complete safety. The surgeon was then not only justified but bound to give to his patient the benefit of the operation. He first men-

tioned three cases of successful suture of the olecranon, and then detailed seven cases upon which he had operated for fractured patella, successfully; six of the patients he was able to show to the society. They were all markedly successful. Five of these cases were of recent fracture and two of ununited fractures. In one case separation of the fragments occurred from passive motion too vigorously made at too early a period, and a second operation was performed upon the case successfully; osseous union was obtained in all; the limbs were kept in the fixed dressings for about eight weeks.

In the discussion of the subject M. Bryant admitted the excellence of the principles of M. Lister's treatment but disagreed with him in regard to the cases to which the treatment was applicable. He thought the results generally obtained from the ordinary treatment of fractured patella were so good that it would not be justifiable to operate in recent cases. Only in old cases when the limb was useless or its use seriously impaired would he consider it right to operate. M. Bryant then criticised some of M. Lister's expressions. He wished to know what was meant by "morally certain." He did not believe any one was justified in saying that all septic influences could be excluded, and complete safety be secured. The anti-septic method was powerless against visceral complications. He thought expressions such as those used by M. Lister capable of producing excessive over-confidence in the minds of his disciples and juniors.

Messrs. Adams, Gant, Henry Morris, and many others agreed with Mr. Bryant, and objected to the operation. M. Lister, in reply, repeated his statements, and insisted on the strict observance of the antiseptic method. He did not agree that the ordinary results of the treatment of fractured patella were so good as some of the gentlemen had asserted. He said the question of any operative procedure was a large question dependent on many factors. But as for himself he persisted in saying that he regarded the operation as simple and without risk so long as antiseptic principles were strictly adhered to. He had brought the subject before the society with the object of showing what could be done more than with advocating its employment under all circumstances.

At the Paris Société de Chirurgie (*L'Union*

*Med.*) the same subject was under discussion at very nearly the same time. M. Chauvel brought forward a report upon a case of M. Beauregard of osseous suture in transverse fracture of the patella. His case was of two months' duration. Approximation of the fragments was impossible. Arthrotomy was performed and immediate suture. The lower fragment was so small that the wire was passed beneath it. Two months afterwards the patient walked well and seemed cured. The case was then presented to the society, which thought the results not altogether successful. M. Chauvel admitted that the operation appeared to be indicated, but did not consider the result obtained by M. Beauregard as encouraging.

M. Chauvel had gathered 43 cases, 4 being anterior to 1877, when the antiseptic method came into practice; 38 of these cases were sub-cutaneous, and 3 compound. In 25 the fracture was recent. He concludes from the study of these cases that a single suture is generally sufficient, wire is the best material for the suture, and is best left in place; drainage is indispensable; the strict antiseptic method absolutely necessary, and that the limb should be placed in an immovable apparatus from which it should not be taken until the end of the first month. The results of the operation are often dangerous. In 33 observations there were 28 good and 5 bad results. Atrophy and weakness of the limb after operation is the rule, fibrous union usual and osseous consolidation the exception. He concludes then that in old cases with functional impotence of the limb the operation is useful, and ought to be tried. In recent cases he hesitates to decide. He says that people do not die from a fractured patella, but they may die from arthrotomy, and therefore the operation should be restricted in recent cases to those in which the coaptation of the fragments is absolutely-impossible by other means. M. Lucas-Championnière does not coincide with M. Chauvel's conclusions. He quoted M. Lister's seven cases, and said that in his opinion the operation was good, provided one was very sure of his antiseptic method. M. Pozzi had performed the operation in one case with results that bade fair to be good. But accidental circumstances prevented the complete success of the operation. He was disposed to try it again.

M. Richelot viewed the question as to its operative value and to its clinical value. He does not admit that separation of the fragments is the sole cause of the functional difficulty which may supervene. Some patients with a wide separation walk well, while others with no separation walk with difficulty. He considers the difficulty to be largely due to atrophy of the triceps. In his mind he has no doubt that those patients who walk well have a normal triceps, and he is convinced that in certain cases a cure could be obtained as well by electrification of the triceps as by coaptation of the fragments. Therefore, before proceeding to the operation, it is well to examine the triceps, and if it is atrophied, try electricity.

M. Gillette agrees with M. Richelot, and considers osseous consolidation not the sole element to be considered; often indeed a fibrous is better than a bony union. He would reserve the operation only for compound fractures or for old cases with locomotor troubles insurmountable by ordinary means.

M. Verneuil is of the same opinion. If I had the misfortune, said he, on leaving this place to break my patella, should M. Lister himself propose to open my knee and practice osseous suture, I should vigorously decline the proposition. As he endeavours to follow the golden rule, he absolutely condemns immediate arthrotoomy. He considers the results obtained by treatment with the plaster splint, etc., sufficiently good, and therefore protests against the introduction of the operation into current surgery.

M. Forget agrees with Verneuil; he said that even Malgaigne's hooks had been abandoned as too dangerous, and yet now mortal operations were proposed for cases which in themselves were without danger to the patients. M. Chauvel said that there were cases in which electrification of the paralysed triceps was altogether insufficient, and in which the patients walked so badly that the operation was justified.

The *Medical News* says that suturing the fractured patella was done more than fifty years ago by Dr. John Rhea-Barton in Philadelphia, by McClellan in 1838, by Cooper of San Francisco in 1861, by Logan of Sacramento in 1864.

But amongst the modern school must, unfortunately, be included a large section

to whom it may well be feared the publication of the new method of treatment for fractured patella and similar operations is not unfraught with danger. These are they who have enthusiastically accepted the new faith, but make poor professors, because they have not mastered the details of its practical application. It is such men as these who bring discredit upon antiseptic surgery, and to whom, at the present time especially, a word of warning may not inaptly be given—namely, that until they have had sufficient experience to justify them in feeling perfectly confident that they can prevent the entrance of putrefaction into a wound, there is no manner of justification for them in undertaking an operation (which, if not properly carried out, involves serious risk to limb and life) for such a condition as fractured patella, for which a fair and indeed a good treatment is at hand involving no risk whatever. It may be hoped that when the principles of antiseptic surgery are more widely accepted and universally taught, it will be considered on all hands a disgrace for a surgeon to have putrefaction in a wound of his own making through unbroken skin (except in certain positions). But this cannot be said to be the case yet; and until any one feels that if he were to wire a patella it would not only be a disgrace, but a practical impossibility for putrefaction to occur in the wound, I am sure that all well-wishers of the new faith will join in appealing to him to let the operation alone. Still more, perhaps, is the warning needed by those who look upon the whole thing in the loosest possible way, who talk gaily about the "spray-and-gauze treatment," and who make use of one or both as a sort of fetish, under whose guidance they proceed with a light heart to court, as it were, disaster. In the name of humanity, let such confine their experiments with antiseptic surgery to necessary operations. I have been horrified to see finger-tips and instruments just shot through an antiseptic solution, the unshaved axilla scarcely cleaned in the most perfunctory way, before the removal of a breast; or a sponge wiped freely over outlying unpurified portions of skin, perhaps even that of the perineum itself, and then dabbed upon the wound as the grand finale to an operation performed "under the strictest antiseptic precautions."

—*Lancet*.

From these observations the following may be formulated:—1. The chief cause of non-osseous union of the patella in cases of transverse fractures is the interposition of fibrous and aponeurotic structures between the fractured surfaces. 2. If osseous union be desired in transverse fractures of the patella, it is requisite, in the first instance, to elevate all the tissues which lie over the fractured surfaces, and which prevent them from coming into intimate contact. 3. From the ease in which the two fragments, in many instances, may be maintained in position, it is probable that osseous union could be obtained without suturing, provided these soft tissues were first elevated. Practically, however, suturing the patella ought to be adopted, as it is the easiest and surest way of securing accurate apposition and adds no risk to the operation. 4. The operation of elevating the soft structures between the fragments and of suturing the bone ought to be undertaken within the first forty-eight hours from the time of injury. 5. In order to lengthen a muscle, a series of V-shaped incisions made into its substance in a transverse row will effect the purpose, while not diminishing its strength as transverse incisions do.—(*Ibid.*)

**SURGICAL DISEASES OF THE KIDNEY.**—At the annual meeting of the British Medical Association, Mr. Clement Lucas said that the credit of having awakened a new interest in renal diseases, and of having, by experiment on the lower animals, made sure of his ground, was due to the late Professor Simon, of Heidelberg, who in 1869 successfully performed nephrectomy for the cure of a fistula of the ureter following ovariectomy. Since then, extirpation of the kidney has been performed upwards of a hundred times. The operation of nephrotomy has been much more frequently undertaken, and the removal of a stone from the kidney, which used only to be attempted when a sinus or tumour existed, has been several times successfully performed before the kidney has suffered any severe damage.

In casting a glance over diseases of the kidney to determine which might admit of surgical treatment, it is necessary to exclude at once all such diseases as attack equally the two organs: hence the various degenerations included under the name of Bright's

disease and lardaceous disease must ever remain outside the province of renal surgery. On the other hand, conditions which disturb the functions of one organ only, for the most part, admit of relief by operation.

*Painful moving or floating kidney*, being only a mechanical disturbance, admits of relief only by mechanical means. Simple exploration and replacement through an incision in the loin would probably be found sufficient in the majority of cases for the cure of this condition,—the adhesion resulting serving to retain the organ in position. Stitching of the capsule to the parietes, or, as it is termed, nephrorraphy, is a somewhat serious, but still simple, undertaking. In eight cases in which it has been performed the patients all recovered and were relieved. There might still be cases where intense suffering was experienced, and where the other means had failed, which would suggest nephrectomy. Martin, of Berlin, had, in six cases, removed floating kidneys through the peritoneum, and four of these recovered.

*Hydronephrosis* should be first aspirated, then cut down upon and drained through the loin, the cyst-wall being stitched to the parietes. Finally, should the fistula fail to close, the remains of the kidney might be removed through the loin.

In women these tumors had been often mistaken for ovarian tumors, and had been operated upon as such. Being movable, and not forming adhesions till late, some might advocate ventral nephrectomy for these cases before drainage; but such treatment would entail more risk than the method advocated. Abdominal nephrectomy for hydronephrosis will, however, show better results than nephrectomy generally.

*Large isolated cysts of the kidney* having no communication with the pelvis are rare. They should be aspirated and afterwards drained through the loin.

*Hydatids of the kidney*, also rare, have a tendency to discharge themselves through the pelvis. When forming tumours, they may generally be cured by aspiration or syphon tapping.

*Pyonephrosis*, when unilateral, falls under renal surgery. The double pyelitis, with suppuration and distention, which commonly resulted from stricture and enlarged prostate, the author said was inappropriately named "surgical kidney." He suggested

the term *reflex pyelitis* as better expressing this condition. Reflex pyelitis, when one-sided, is due to some obstruction in the ureter, and then often gives rise to a large pyonephrosis. Other causes of unilateral pyonephrosis are calculus and strumous pyelitis. After speaking of the diagnosis, and stating that these tumours are more adherent and gave rise to more pain and constitutional disturbance than hydronephrosis, he said that nephrectomy for pyonephrosis had been performed twenty-eight times, and of these seventeen recovered and eleven died; but it was most worthy of notice that among these twenty-eight cases six had previously discharged their contents through a fistula in the loin, and all these recovered. Hence, he argued, it is better to drain a pyonephrosis before performing nephrectomy.

*Neoplasms* of the kidney can only be treated by nephrectomy, and if this be performed early there might be a good chance of permanent benefit. Generally they are too large to be removed except through the peritoneum; but of five cases removed through the loin, four recovered. Out of sixteen removed by ventral incision, ten died and six recovered.

*Calculus of the kidney* offers an excellent field for surgical interference, but the difficulty is to make sure of the diagnosis. Many cases of supposed calculus turn out to be strumous kidneys. Two cases were related in which the kidney was explored and even deeply punctured, but no ill result or rise of temperature followed, and the wounds healed primarily. Several cases of nephro-lithotomy were recorded in the Clinical Society's Transactions, and two cases had been performed successfully at Guy's Hospital during the present year. When the kidney is much dilated and damaged it would be a question whether it might not be better to remove it.

After briefly alluding to *injuries to the kidney*, which, though not included under the title of the paper, might suggest nephrectomy, the author proceeded to speak of some details in operating. Here recommended for the lumbar operation a combination of two incisions, which he had employed as giving the most room,—viz., an oblique incision higher than the colotomy incision, within about half an inch of the last rib and parallel with it, and a vertical incision on the outer margin of the quadratus lum-

borum, extending from the upper edge of the last rib to the iliac crest. For the transperitoneal operation Langenbuch's incision external to the rectus muscle was to be preferred to the median incision, as it enables the operator better to reach the kidney through the outer layer of mesocolon.

In conclusion, he urged that antiseptic exploration of the kidney through the loin is a simple and not at all a dangerous operation, which may be undertaken without anxiety in any case where calculus is suspected; that it is generally wiser to tap and drain fluid tumours of the kidney before proceeding to remove the diseased organ; that when nephrectomy is decided upon, the extraperitoneal operation through the loin should always be chosen for any tumour it is possible to withdraw through the limited space at disposal; finally, if this course be adopted, the transperitoneal operation will be reserved for large solid tumours, and perhaps some floating kidneys.—*British Medical Journal*.—*Phil. Med. Times*.

RISKS ATTENDING CATHETERISM IN CASES OF LONG-STANDING RETENTION OF URINE.—In commenting upon Sir Andrew Clark's remarks on catheter fever, Sir Henry Thompson writes to the *Lancet* (October 27th) as follows:—

The risk sometimes incurred by elderly men in commencing the use of the catheter, accurately appreciated by Sir A. Clark at the Clinical Society, and well described and commented on in your leading article, is a subject of great importance. It is, however, by no means unrecognized by surgeons, and has long been one of much interest to myself; so that I have made it a special topic for remarks and caution in my clinical lectures. I have so often observed the danger in certain cases associated with a resort to catheterism, although rendered absolutely necessary to relieve chronic retention of urine, that I have advised the greatest care and special management for them. But the dangerous and fatal results are rare as compared with the great number of elderly men who are compelled to depend for relief on the catheter, and who derive the greatest advantage and comfort from its daily use. For a case never becomes advanced and dangerous in regard of retained urine, unless the retention has

been long overlooked or neglected, and when advice to empty the bladder in an early stage has unhappily not been given. If employed at that early stage, before the urinary organs have suffered damage from retention persisting perhaps through many months or even years, no fatal or dangerous "fever" will be met with. It is the *neglect of timely catheterism*, and not the employment of a catheter, which is the real occasion of the fatal issue, which now and then occurs under the circumstances described.

The first surgeon to point out the occurrence of this particular form of "fever" was Sir B. Brodie, in his lectures; and I beg you will allow me to cite an extract from my last edition, referring to his views, describing the symptoms, and indicating the method which I have adopted to diminish the risks which should mostly be expected, and always be provided for, when a pint or more of urine habitually remains in the bladder, despite the patient's efforts to relieve himself. The passage is as follows:—

"I revert to a fact, already alluded to, which is one of considerable importance, that although the urine may have been quite clear before the catheter was employed, yet in some instances, after its habitual use has been continued for a short period, the secretion becomes cloudy, and the patient is feverish and unwell. A stage of constitutional derangement, more or less marked, has sometimes to be passed by those persons who, having long experienced difficulty suddenly change from their usual mode of micturition to the artificial one. It requires some judgment, as I already pointed out to decide when this change should be made but having made it, the phenomena described occur in a few exceptional instances; and this fact you should be aware of, and you should watch the result of the daily catheterism. Sir Benjamin Brodie was the first to remark it, and in his valuable lectures called attention to the circumstances that patients might even sometimes gradually succumb with symptoms of low or irritative fever a few weeks after beginning to use the catheter. Bearing this in mind, our mode of proceeding may be advantageously modified in relation to those patients whose amount of residual urine is large. It is then undesirable to empty the bladder completely on every occasion of catheterism during the first few days. If the patient has been in the habit

of retaining perhaps a pint of urine, or even more, after he has made water, it is a serious change for the bladder to be suddenly and completely emptied two or three times a day; the organs soon become irritable, urine is charged with pus, and the patient loses appetite, becomes feverish, and there is sometimes considerable danger to life. The rule under such circumstances is to proceed cautiously. Instead of removing the entire quantity, leave some urine behind; and thus a compromise is made between the exigencies arising in this condition of the bladder, and the usually absolute rule that it should be emptied. Draw off half or only two-thirds of a pint; you will thus relieve the organ partially, and in the course of a week or sooner, you may gradually accomplish the entire emptying of the bladder, and all will probably go well. And it conduces greatly to success to permit no outdoor movement to such a patient, but confine him to his room, in a warm temperature, if the weather be cold, or even to his bed, for a few days. The probationary period, while the use of the catheter has to be learned, and the onset of chronic cystitis with constitutional disturbance is to be feared, is more safely passed if *absolute rest and quiet* are accepted as necessary conditions by the patient. It is only within the last few years that I have pursued this course, and I cannot speak too highly of the results. Nevertheless, very rarely, notwithstanding every precaution, you will find a case in which during this process the tongue grows slowly more red, dry, and contracted; the powers of life gradually fail, the senses become impaired and the patient sinks. You will always find in such cases, if an autopsy is made, old-standing pyelitis, with dilatation and marked degeneration of the renal structure, and you will know that in no circumstance could the patient have long survived" (p. 57).

The lesson to be learned—and it is an important one—is this. When the bladder of an elderly man fails to empty itself, let him learn to use a soft catheter without much delay:—thus life with comfort may often be maintained to its natural term. Neglect the catheter until chronic disease of the organs is established, and a catastrophe may then be hastened by the use of the instrument. Scores of men whom I know in this town, between sixty and eighty years

of age, still active, mature in mind, and more than ever serviceable to their fellows, owe their existence entirely to habitual catheterism.—*Med. News.*

**AN OCULAR POLYPUUS.** S. POLLAK, M.D., OF ST. LOUIS.—A lady of 74 years presented herself with a "bleeding eye." Blood was oozing from beneath the upper lid constantly when the lids were open. The eye was perfectly sound, vision good, except when obscured by the blood. The upper lid was somewhat conical, and of a light bluish tint. On evert-ing it, the conjunctiva was found perfectly smooth, but on pressure, directly on the superior orbital margin, a racemose, painless tumour was extruded from the sulcus, of the size, shape, and color of a Lawton blackberry, which was bleeding profusely on the lightest touch. It was very brittle and friable, and could have been crushed with ease. It was difficult to determine the nature of it. Was it benign or malignant? Was it an angiectasia, an erectile tumour, or a polypus? I am inclined to think it was the last. Though a very confined space for a polyp to emanate from and to grow, yet the mucous membrane everywhere is the habitat of polypi, and the upper sulcus of the eye is well adapted for its origin, although not for its development. It had to be removed at once, and it was promptly effected. With a curette the edges of the tumour were raised; they were found flattened against the conjunctiva, but not attached to it. A pedicle of about a centimeter was reached and readily twisted off with the forceps. Bleeding stopped at once. The levator palpebræ superioris being freed from the impediment of the tumour, resumed its function. This result was entirely satisfactory. No recurrence of bleeding. The wound was nearly cicatrized the next day. The polypoid tumour is carefully preserved, and will be accurately examined with the microscope.—*Am. Med. Ass. Jnl.*

**TUBERCLE BACILLI IN LUPUS.**—J. Doutrelepont (*Monat. für Prakt. Dermat.*) states that he has examined seven cases of Lupus for the bacilli, and with positive results in each. He took a nodule from the ulcer, hardened it in absolute alcohol, made sections with a microtome, stained these after Koch's method, and mounted them in Canada balsam.

**LUXATION IN ACUTE RHEUMATISM.**—M. Verneuil, at the Société de Chirurgie, made a report, based upon seven cases of luxation, of a similar nature. A subject, young or old, has an attack of rheumatism, which poly-articular at first, is quickly limited to one or two joints. One of these placed in a vicious situation is suddenly luxated at the tenth or fifteenth day of the disease, and at this moment the pains, until then severe, suddenly ceased. The luxation is reduced without difficulty, the limb immobilised, and recovery is only a question of time. Of the seven cases, five were iliac luxations of the hip, and two luxations of the knee backwards. The pathogeny of these luxations has been attributed to hyarthrosis of the joint. M. Verneuil cannot accept this as he never succeeded in diagnosing an acute hyarthrosis of the hip, and on the two knee cases there was certainly no hyarthrosis. He believes the cause to lie in the neighbouring muscles. A muscular group being paralyzed, as often occurs in articular inflammations, the opposite group enter in action and a vicious position being assumed, gives the proper direction and force, and the luxation is produced. The reduction is always easy, but they are as easily reproduced, unless the limb is confined in a retentive apparatus. M. Reclus has met with and published five cases of these luxations. Quite lately he has met with two, one in the ankle, the other of the knee, in a child suffering from infantile paralysis.

**SYPHILIS IN ANIMALS.**—Dr. L. Letnick and Prof. Reinhardt, of Odessa, have conducted a series of experiments on dogs and pigs with a view to determine whether this disease can be communicated from man to these animals. The material used for inoculation was taken from genuine hard chancres by excision. Portions of these chancres were placed beneath the skin, and the wound protected by gutta percha paper. In no case was syphilis developed. They then made a culture preparation of the chancre in gelatine and Liebig's extract. This was placed under the microscope, and found to contain abundance of the micrococci seen in syphilitic sores. From these trials, however, there was no syphilis. One of the dogs died of septicæmia. From their observations they conclude that syphilis can not be given to animals.—*Wien. Med. Wochen.*



**RESORCIN AND CHINOLINE SALICYLATE IN OTORRHOEA.**—Chas. H. Burnett, M.D. in *Phil. Med. Times*, has used powdered resorcin, pure or mixed with boric acid, one part to seven of the latter, with great success in chronic purulent otitis media. After cleaning the discharging ear, the powder is blown in, or the mucous cavity may be swabbed with a piece of cotton twisted on a holder and dipped in a pasty solution of resorcin. Chinoline is an energetic bacteria poison, its best known salts are the tartrate and salicylate; the latter is colourless and amorphous. It is blown into the auditory canal; it is a detergent and disinfectant powder; if the skin is ulcerated the undiluted powder caused pain; hence a one in eight mixture with boric acid, was satisfactorily substituted. It is a prompt destroyer of the aspergillus. The mucous membrane becomes blanched under the use of these drugs; the odour of decomposing pus lessened or removed, and the secretions cease.

**ANTI-SYPHILITIC LOTION—MARTINEAU:—**

R Hydrate Chloral..... ʒ iiss.  
Tincture of Eucalyptus ... ʒ iiss.  
Distilled water ..... 0 ij.

Dissolve. To be used as a lotion morning and evening in syphilides of the vulva.—*L'Un. Méd.*

**TREATMENT OF OBSTINATE MASTURBATION AND NOCTURNAL POLLUTION.**—Dr. Haynes (*Boston Med. and Surg. Jnl.*) has successfully performed in these cases, not castration, which his patients nearly always refused, but resection of a portion of the vas deferens.—*L'Un. Méd. du Canada.*

**Midwifery.**

**THE PREVENTION AND TREATMENT OF PUERPERAL FEVER.\***

BY T. GAILLARD THOMAS, M.D., NEW YORK.

*Prophylactic Measures.*—1. In all midwifery cases, whether in hospital or private practice, the floor and ceiling of the room in which the woman is to be confined should be thoroughly washed with a ten per cent. solution of carbolic acid, or a bichloride of mercury solution, one to one thousand. The bedstead and the mattress should be sponged with the same solution. All cur-

tains and upholstering should be dispensed with.

2. The nurses and physician should take care that all their clothing is free from exposure to the effluvia of septic infection, and if there has been any exposure all the clothing should be changed and the body should be thoroughly sponged with a saturated solution of boracic acid.

3. As labour sets in the nurse should thoroughly wash her hands with soap and water, removing the dirt from under the nails, administer an antiseptic vaginal injection, repeat it every four hours during labour, and keep a napkin wrung out of the same antiseptic solution over the genitals until the birth of the child.

4. Both doctor and nurse should wash their hands thoroughly with soap and water, and scrape the nails, and afterwards soak their hands for several minutes in a solution of bichloride of mercury (1 to 1,000).

5. The third stage of labour should be efficiently produced, all portions of placenta should be removed, and ergot administered in moderate doses three times a day, to be kept up for at least one week, to secure complete expulsion of the clots and closure of the uterine vessels.

6. The doctor should take nothing for granted, but at the conclusion of labour should carefully examine the vulva of the patient. If there is any rupture of the perineum it should be closed at once by suture, and if slight lacerations are found they should be dried thoroughly with a cloth, and equal parts of a saturated solution of carbolic acid and persulphate of iron applied, and again the surface dried with a cloth and painted over with gutta-percha collodion.

7. Within six or eight hours after the termination of labour, syringe out the vagina with an antiseptic solution, and introduce a suppository of cocoa butter containing from three to five grains of iodoform.

8. The vaginal injections should be repeated every eight hours. But in all cases of difficult labour, and in those in which instruments have been employed, they should be administered twice as often, and kept up at least for ten days. The nurse must wash and disinfect her hands before every approach to the genital tract of the woman.

9. Employ a new gum elastic catheter which has been thoroughly immersed in an

\* Abstract of paper read before the New York Academy of Medicine, December, 1883.

antiseptic fluid each time the bladder is evacuated, rather than trust the nurse to cleanse an old silver catheter.

10. The physician must inform himself by personal observation as to the competency of the nurse with regard to the use of the catheter, the administration of the vaginal injections, and the introduction of the suppositories.

It might be objected that so many details with reference to the lying-in woman are unnecessary, because of the enormous preponderance of cases in which complete recovery ensues without such treatment, and that to introduce them savors of the performance of some grave surgical operation. So much the more did Dr. Thomas urge them on this very ground, because he believed that the woman who is to bring forth should be treated as though she is to go through a capital operation.

At this point Dr. Thomas made a strong protest against the use of intra-uterine injections as a prophylactic resource, except after very severe operations in the uterine cavity, which rendered the occurrence of septicæmia almost certain.

But suppose that despite all these precautions the poison has entered, what are the most reliable means for checking the advance of the septic disorder? He did not believe there is any specific disease-germ which gives rise to puerperal septicæmia. It is probably the same cause which gives rise to septicæmia in the stump after an amputation, or after a wound with compound fracture, or in the lacerated tract after gunshot wound.

A portion of retained placenta or membranes does not give rise to true puerperal septicæmia, but rather to a toxæmia. If the mere presence of decaying material would produce septicæmia without the agency of a specific disease-germ, the disease would develop in healthy country localities.

As soon as the patient is stricken by the poison, certain morbid phenomena develop themselves, such as chill, high temperature, pelvic pain, mental disturbance, headache, pain in the back, and sometimes, though not commonly, nausea and vomiting.

*Treatment for the Cure.*—*First.*—As soon as the diagnosis is determined upon, all pain and nervous perturbation should be allayed by a hypodermic injection of mor-

phine, unless there is some special idiosyn-

crasy in regard to opium, and throughout the attack, whether suffering in mind or body, the hypodermic use of morphine should be repeated sufficiently often to allay it. In this particular case the drug should be used hypodermically, and special care should be taken to use a clean syringe, dipping the needle before its use into a solution of bichloride of mercury (1 to 1,000), which will prevent the formation of abscess.

*Second.*—Being relieved of pain, spread an India-rubber cloth over the edge of the bed, making it fall into a tub of water rendered antiseptic by the use of carbolic acid (two and one-half per cent.), or bichloride of mercury (1 to 2,000). Then move the patient very gently across the bed, place a pillow under the head, allow each foot to rest upon the side of the tub, and cover with blankets. Then introduce either a Chamberlain glass tube or a Lyman metallic tube, very carefully guided by the index finger, passing it up to the very fundus of the uterus, attach a Davidson syringe, and throw a stream of water with gentle force against the lining membrane of the organ. If there is any suspicion that there remain attached portions of placenta or membranes, they should be carefully removed, using the finger-nails as a curette, as advised by Dr. Wilson, of Baltimore.

There are dangers attending the administration of these injections: first, the entrance of air into the uterine sinuses; second, the production of hæmorrhage; third, the danger of forcing fluid directly into the general circulation through the injection tube into the mouth of the sinuses; fourth, convulsions and violent pain, which produce a sudden and baneful influence upon the nervous system, and fifth, the passage of fluid into the peritoneal cavity through the Fallopian tube. All of these may to a very great extent be avoided by careful attention to details. By the use of a large tube, with water not less than 100° F., and using only a moderate degree of force, proceeding gently, cautiously, and slowly, these dangers can be avoided. The tube should not be allowed to fill the os internum or externum completely. If after the use of the injections it is found that the cervical canal hugs the tube too closely, it should be dilated before further injections are practised, and this may be done by the use of either the hard rubber or Barnes' dilators. If hæmorrhage occurs, persulphate

of iron should be added to the antiseptic solution and ergot administered.

The frequency of the administration of the intra uterine injection should be varied greatly with individual cases. In moderate cases, where the temperature falls readily, only once in five hours may be all that will be required, while in other cases they may be required every three hours, and in bad cases they may be administered as often as every hour. These injections should be administered by the physician always, and should be carried up to the fundus uteri, and every precaution exercised concerning detail. Dr. Thomas favoured the intermittent stream. For a number of years he entertained the idea that the continuous flow was most desirable, but on that point he had changed his opinion entirely. Continuous irrigation he regarded as a delusion and a snare. For vaginal irrigation it is an excellent method; nevertheless, in severe cases he preferred to employ continuous irrigation and use the intermittent stream every three hours rather than exhaust the patient by the use of injections as often as seemed desirable. At all events, that plan is best which best cleanses the parturient canal.

*Third.*—Control the temperature by the use of Townsend's rubber-tube coil, placed over the entire abdomen, from the ensiform cartilage to the symphysis pubis, with ice-water flowing through it. In his service at the Woman's Hospital this means of controlling the temperature is as commonly and freely used as are gargles for diseases of the throat, and thus far no ill-effects had been produced, either in the way of chilliness or by the development of complicating diseases, such as pneumonia, pleurisy, etc. Formerly he relied upon Kibbee's cot for the same purpose, but had found the coil much more convenient.

*Fourth.*—Keep the nervous system under the influence of quinine, fifteen grains night and morning, or Warburg's tincture administered in capsule, according to the recommendation of Dr. John T. Metcalf, or by the use of salicylate of soda.

*Fifth.*—The diet should consist of fluid food, and the staple article should be milk, but animal broths may be alternated with it.

*Sixth.*—Efficient and abundant assistants. Two nurses are necessary, one for night and the other for day, and at least one extra

physician as an assistant, in order to carry out this method of treatment effectually.

In regard to the antiseptic substances used, they have been thymol, boracic acid, salicylic acid, carbolic acid, and bichloride of mercury. The last two are the best, and the bichloride seems to be about to supersede the carbolic acid, and for intra-uterine injections it should be used in the strength or 1 to 2,000.—*Med. Record.*

#### THE PREVENTION OF MAMMARY ABSCESS.—

Dr. Richard Wood expresses the "firm belief based upon an experience of ten or twelve years, that no breast during lactation would ever suppurate if proper preventive treatment could be adopted early enough." His plan is, in the first place, to watch closely for premonitory signs of trouble in the mammæ. These are: first, pain and soreness about one of the nipples. This warning must never be disregarded. A glass shield, with a tube and an India-rubber nipple for the infant, should be put in use at once, and local applications of glycerite of tannin should be made frequently. If the mother continues to suffer in spite of these measures, the child must not be allowed to nurse from the affected breast. These means will probably be sufficient, if there is no localized induration, redness, or tenderness in the substance of the breast itself. If, however, such a condition exists, no time should be lost before active treatment is begun. If shivering has occurred, it may already be too late. To insure success, the case must be taken in hand the same day the pain and hardness are first noticed. A piece of lint, doubled four times, and ample enough to cover the tender part of the breast easily, is to be soaked in one ounce of belladonna liniment. This is to be laid on and covered with gutta-percha tissue, and the whole "bandaged up carefully with three bandages, each six yards in length." A five-grain pill of calomel and the following mixture are to be prescribed internally:

R Tincturæ bel. adonnæ,     ̄ ij;  
magnesi sulphatis,       ̄ iss;  
spiritus chloroformi,     ̄ ij;  
aquam destillatam     ad ̄ vj.

M. Sig. Two tablespoonfuls every 3 hours.

In very delicate women the effect of the medicine must be carefully watched. If the bowels act more than four or five times, it must be stopped, but resumed again on

the following day. The belladonna, however, should not be stopped unless the head, tongue, throat, or pulse makes it necessary. The second day the dressing should be resumed and reapplied as before, after the lint has been soaked in more belladonna liniment. The breast must be well supported by carrying the bandages around the neck and shoulder every time. The hardness and inflammation should yield in about three days. After that period a few more dressings on alternate days may be required. Meat and all stimulating beverages should be interdicted from the outset. For the first day, the less the patient eats the better. "At the same time the nurse should have instructions not to be afraid to give brandy, if there should be signs of fainting from the violent action of the aperient."

This treatment [which Dr. Wood appears, from the sentence just quoted, to recognize as heroic] has proved successful in his hands even in cases in which this most painful and distressing affection had been allowed to go without proper attention for two or three days. It would be well for physicians to caution women whom they attend in confinement, or their attendants, that the first indication of trouble in a nipple or breast is a warning that should be promptly attended to. To regard it, as so many women do, as one of the little things which are too trivial to need the attention of the physician is to invite an experience which, of those ills that do not actually threaten life, is about as serious as a woman can undergo.—*N. Y. Med. Jnl.*

**PESSARIES.**—Undoubtedly a woman wearing a pessary should not be sent away ignorant of its presence, and without any directions. She should therefore be informed that such an instrument has been inserted, and she should be given certain directions. Thus, it is advisable at once to tell her that it is well to wash out the vagina once or twice a day with simple water, which will prevent secretions from accumulating, decomposing, and causing an unpleasant smell (which in some cases is bad enough to suggest the presence of cancer); she should also be told that soreness, itching, or profuse discharge indicates that the pessary should be seen to, and, generally, that it should not be worn without being seen to three or four times a year. It is also usually advisable that the doctor should satisfy himself in a

week or so that the pessary is doing good, and doing no harm, and then, having once started the treatment, the patient should be left to test its efficacy. Now this test implies the removal of some symptoms or symptom, which may justly be attributed to some former morbid condition, and it also implies the locomotion of the patient. Generally speaking, a patient lying down is better without a pessary, whatever displacement is present; thus it is rare for even complete proclivata not to reduce itself, or become much smaller, when the patient lies down, and the symptoms of partial descent, which (if there are any symptoms at all) will include almost certainly a sense of weight and dragging pain in one or other iliac fossa, will disappear, or become greatly diminished, in the recumbent position. A pain which is better when the patient is standing and worse when she is lying should be regarded with suspicion if supposed to be due to descent or displacement: it is probably nothing of the kind. Thus it is to relieve pains increased by standing that pessaries are most generally useful. If this is not effected, the uterus may be unquestionably in the "normal" position, but the pessary is useless, and, if useless, injurious. Thus, the proper use of pessaries is first, in most cases, after the insertion of the pessary, to get the patient on her legs; secondly, to satisfy oneself in a few days that it is doing good and is doing no harm; but as soon as both these objects are attained, to send the patient away to test the treatment, with the above directions. It should not be the task of months to fit a woman with a pessary, any more than with a truss. The following are *not* instances of the proper use of pessaries. To keep the patient in bed for long periods wearing a pessary; to see her every day, every other day, twice a week, for weeks, months, or years. Perhaps such visits are not made to the patient, but to the pessary. However that may be, it is not the pessary, but the patient, who has to pay. What should we say of a surgeon who called for months to see a patient to whom he had given a wooden leg or a truss, and who kept him in bed for long periods; or of an oculist who had fitted a patient with spectacles, and saw him every day for several months, whether the spectacles seemed to suit him or not? It is true that the pessary is a truss in the dark, but that is no reason why the management of a

nessary should be a deed of darkness. Recent investigations have shown that the whole question of displacements has to be reconsidered. It cannot be too widely or too dogmatically stated that prolonged treatment by pessaries, such as we have described, is quite inadmissible and unnecessary; and if unnecessary, injurious not only to the patient—*i.e.*, to her *morale* as well as her purse,—but also, in the best sense, to the practitioner; and if to the patient and practitioner, then to the public and the profession. It should also be realised that a pessary is a mere form of truss, and that its operations, though removed from the general view, are not occult. Ill-treatment bids fair to bring this useful form of truss into disrepute, and we are daily expecting to meet the practitioner whose sensitiveness is such that he shrinks from a cure whose name he has learnt to mistrust and dislike; but we feel bound to say we have not come across him yet.—*Lond. Lancet.*

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THE  
**Canadian Practitioner,**  
(FORMERLY JOURNAL OF MEDICAL SCIENCE.)

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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, JANUARY, 1884.

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HAPPY NEW YEAR.

We congratulate ourselves upon our advancement to the ninth volume. It is our desire to press forward in the race set before us, and aided by our friends and subscribers we expect to win the prize of our high calling. Asking only a continuance of their friendly support we wish for them all, A HAPPY NEW YEAR.

DIDACTIC LECTURES IN MEDICAL SCHOOLS.

At the recent Medical School dinners in Toronto, several allusions were made to the present arrangements in the schools regarding lectures. It is well known that two

courses of lectures are required in nearly all the subjects. The students, almost without exception, consider this regulation not only useless but an actual drawback, and have protested against the custom on many occasions.

We attach a great deal of importance to didactic lectures when delivered by men who have a thorough knowledge of their subjects, and at the same time endeavour to teach rather than to lecture; but it seems rather remarkable in these days that students should be compelled to listen to the same lectures twice. In former times when medical books were few and expensive, and students had to depend principally on their notes taken from their lectures, it is easy to see why a double course was demanded; but in modern times when many subjects are added to the course, and much more laboratory and hospital work are required, and while medical text books are numerous, excellent, and cheap, it is hard to see any necessity for the maintenance of the regulation.

We understand that a committee of the Ontario Medical Council is at the present time considering this question and we hope that as a consequence a change will be made in its curriculum. One course of didactic lectures is sufficient in such subjects as Surgery, Medicine, Midwifery, Jurisprudence, Physiology, Materia Medica, and Chemistry, while two courses are all important in such a subject as Anatomy. This would leave the students no time for idling, but would give them more time for their practical work in the laboratories, dissecting rooms, and hospitals. Such a programme would correspond pretty closely with that in the University of London, England, and has in Canada been adopted by the University of Toronto.

An important consideration for the school then, would be the question of fees, but they could regulate that as they pleased without losing any of their revenue. They could charge a double sum for the one course.

while they made the second free but not compulsory.

### UNIVERSITY CLUB.

Early in December last a meeting of University graduates was convened at the hall of the College of Physicians and Surgeons. The object of the meeting was to obtain the views of University men upon the advisability of establishing a club for social purposes, where University men could meet and discuss matters in connection with their universities, and it was thought that some centre around which University matters would revolve could be formed, of interest to the graduates sufficient to command their presence and support.

The meeting was not numerously attended nor was there an overwhelming amount of enthusiasm manifested. In view of the agitated condition of University matters now absorbing the attention of University men, questions, which might possibly eventuate in a continuance of the old unfortunate heated prejudices, and in the formation of future perhaps more bitter feelings of dislike and animosity, it was deemed inopportune to push the question of the establishment of a club at the present time. A committee was however struck with power to add to their number to investigate what resources they could depend upon for its support and inauguration in case it was once established. This committee was made as representative as possible of the Universities of Canada. They held a meeting on December 20th, but no definite conclusions could be arrived at, and they adjourned to meet again.

### TORONTO HOSPITAL CLINICS.

The extra clinics given this session on diseases of the skin by Dr. Graham and diseases of women by Dr. Temple have been well attended and highly appreciated. Dr. Uzziel Ogden will conduct the women's clinic for the remaining half of the session. The regular out-door, in-door, and bedside clinics go on as usual.

### THE TORONTO SCHOOL OF MEDICINE MEDICAL SOCIETY.

The first meeting of this Society in January will be an open one. An attractive programme is promised.

The State Boards of Health are agitating for the formation of a section in the American Medical Association to be devoted to the work of Boards of Health—or for the formation of a separate organization, in order that the everyday work of such Boards may be more fully and profitably discussed. Advantage is to be taken of the meeting of the American Medical Association in Washington in May, 1884, for the furtherance of this object. Committees have already been appointed, Drs. H. B. Baker and McCormack to confer with the State Boards to secure their co-operation; and Drs. Reeves of West Virginia, Chamberlain of Connecticut, and Stephen Smith of New York, on organization—to report at the meeting in May. It is thought that by this means sanitary progress will be quickened and rendered more thorough and efficient, and that concerted action without reference to State lines and borders will materially aid in the solution of the vexed question, of quarantine, inspection, disinfection and other international sanitary questions.

An over-zealous friend inserted in the columns of the *West-End Gazette* a prominent advertisement of Dr. Bryce. From the letter written to his friend by Dr. Bryce, which we had an opportunity of perusing, we imagine the indiscretion will not occur a second time.

The teaching of physiology in Paris, is not received with that amount of fervour and enthusiasm it meets with in Germany and Austria, *Le Progrès Médical* says that of 6,000 medical students, only six attend the physiological lectures, and that while the professor is greeted with a crowded theatre, his assistant lecturers and tutors have nearly empty benches.

The London correspondent of the *St. Louis Courier of Medicine* was astonished to find only five or six students, in addition to the assistants present, to see Lister operate on the occasion of his first appearance after his recent trip to the Continent.

The *International Review of Medical and Surgical Technics* has just been organized and its first number appears this month. It is under the joint editorship of Drs. Jos. H. Warren, Chas. Everett Warren, and W. Everett Smith; and is published at Boston, 51 Union Park. It is a quarterly and intends to confine its attention to new instruments, appliances, and methods of operation, the devices and methods of the preparation and administration of drugs; a department devoted to the synoptical review of books, and a department of notes and queries. The promises are fair and if thoroughly carried out, will beneficially fill a gap in medical literature. We welcome it to our exchange list and wish it abundant success.

The *American Druggist*, is the title by which our old and reliable friend, *New Remedies*, is to appear in 1884. In an entirely new dress, with double the amount of matter and half the previous subscription—it will be the wonder of the age. We wish it and its enterprising publishers all success and a prosperously Happy New Year.

#### OBITUARY.

##### DR. ARCHIBALD ALEXANDER RIDDEL.

It is undoubtedly difficult to write the obituary of one whom we have but little known, yet strange as it may to some appear, it is far more difficult to write that of one whom we have known long and intimately. Of the dead we are instructed to say only that which is good, but only the dead are faultless. Shakespeare has told us "the web of our life is of a mingled yarn." That such it was in Dr. Riddel's case, his warmest friends well knew, but perhaps few webs of life have had more golden threads in their woof. He was a man of sterling honesty, unswerving truthfulness, and unflinching courage, ever "too fond of the right to pursue the expedient." He never desired the friendship of the false, and therefore he never sought it. That his estimate of his fellow men should be always correct, would have demanded infallibility. That he

ever had the courage of his opinions, none who knew him well will question. Perhaps his most salient characteristic was that of enduring negation. No organization in which he took part could ever fall into torpidity. As a civic alderman, as a member of three medical associations, and of the Canadian Institute, he exhibited superior judgment and laudable zeal. He was one of the founders of the present Toronto Medical Society, and so long as his health permitted, he took an active part in its proceedings, and contributed some valuable papers. He was the ablest coroner that ever filled that office in Toronto, if not in all Canada. Few men could write more vigorously or more tersely, and very few have read more diligently or more widely. By his assiduity and perseverance he acquired a fair knowledge of the Spanish, French, Italian, Portuguese and German languages, and until within three weeks of his death he did not relinquish these studies.

But few of the citizens of Toronto have ever known, and fewer, alas! have justly appreciated the services rendered by Dr. Riddel in his capacity of physician to the Small-pox Hospital. The writer of these lines was cognizant of acts of Samaritan philanthropy and unostentatious abnegation, there performed by him, which might give him rank among the noblest benefactors of humanity. But his good deeds our city fathers wrote in water, and poor Riddel had more milk than brass in his frail organism.

An old friend of Dr. Riddel, at the funeral, said to the writer, "There lies a man who was understood by very few." Truer words were never spoken. After almost two score years of close acquaintance, I might well have said the like. For one good quality I can give him ample praise; he never failed to tell me of my faults, and he never enlarged my self-esteem by extolling my good qualities.

To chronicle his merits as a good husband, a loving father, and a liberal family head, would be to intrude upon the sacred precincts of domestic life. Suffice it to say, it was here the greatest beauty of his life shone, and long will it be enshrined in the hearts of his surviving children. It is very pleasing to know that by his industry, good judgment, and frugality, he was enabled to make a suitable bequest to each of his four daughters.

#### Meetings of Medical Societies.

##### TORONTO MEDICAL SOCIETY.

Regular meeting, November 8th, 1883.  
The President, Dr. Graham, in the chair.  
Dr. W. H. Aikins, Pickering, and Hearn, elected members.

Dr. Ryerson being absent, Dr. Workman read a translation from the Italian of a valuable paper on the Localization of Cerebral Functions. After discussion on the paper, cases in practice were called for.

Dr. Covernton spoke of the great benefit he had derived from the use of Croton Chloral in cases of Facial Neuralgia.

Dr. Carson fully endorsed the remarks on the value of this drug and also spoke highly of Gelseminum, which, however, had the disadvantage of producing partial intoxication.

Dr. Cameron recommended the Ammonio Sulphate of Copper.

The President nominated Drs. Sheard, Krauss, and W. H. Aikins, as a Microscopical Committee. He also gave notice of motion to alter the by-laws, so that weekly meetings may be held.

Dr. Covertton gave notice of motion, relative to the reduction of the annual fee from \$3 to \$2.

Dr. Carson promised to read at a future meeting a paper upon Abortion.

The meeting then adjourned.

#### NOVEMBER 22nd.

The President, Dr. Graham, in the chair. The minutes read and approved.

Dr. Cassidy read the notes of a case of Abscess of the Brain. J. G., æt 33, admitted to the General Hospital, October 23rd, 1883, with two cuts over left upper part of frontal bone. He was conscious when seen the following day by Dr. Cassidy, but could not explain how he had received the injuries, having been drunk at the time. It appeared that he had fallen and struck his head against a crockery spittoon. For ten or twelve days matters progressed satisfactorily, then he began to complain of severe headache, which, in spite of treatment, gradually increased. November 17, patient was in a stupor, the sphincters paralysed, the temperature normal. November 18th, quite unconscious; it was decided to trephine over the seat of injury. This was done, no depressed bone was found, nor blood, nor pus, but the brain bulged a little through the opening; suspecting fluid the needle of a large hypodermic syringe was passed into the arachnoid, with negative results. Nothing further was done, Dr. O'Reilly advising against it. The patient remained unconscious and died the same day.

Autopsy by Dr. Sheard, November 19. An oval fracture about the size of a five cent piece was found where the blow had been received, it was not depressed. On cutting into the brain substance an abscess containing curdy pus was found in the left frontal lobe about 1½ inches in length. This was the only lesion discovered.

Dr. Cassidy remarked upon the length of time between the occurrence of the accident and the development of untoward symptoms, viz., eighteen days. He also urged the advisability of exploring the brain substance in similar cases. The pulse was slow and full, sixty to the minute, the power of speech was retained, there had been no rigors.

Dr. Oldright had dressed the wound before sending the patient to the Hospital. The cut was as clean as though made by a sharp instrument. He asked after the condition of the pupils.

Dr. Cassidy replied that the pupils were equal and responded to light, there was slight contraction.

Dr. Graham showed a girl, æt 11, with a peculiar form of epilepsy, he had carefully sought for sources of irritation, he had found pin worms in the rectum and vagina, but their removal had not improved the condition of the patient.

Dr. Duncan presented for Dr. Cameron, the following specimens.

I. A finger, which had been removed from a demented woman, æt. 70, for supposed malignant growth thereon. The specimen was referred to the microscopical committee for examination and report.

II. A brain from a woman, æt. 40; married 22 years, had several children, one miscarriage in early days of wedded life, children healthy, husband healthy; previous personal history discloses no ill health. Thin, spare woman, not grey nor bald; marked capillary ectasia in skin of nose; no other external evidence of disease or degeneration. Eye-sight has deteriorated in last two or three years; never suffered from ear-trouble; not subject to headaches. Pulse on admission hard, incompressible—high pressure. Three weeks ago the patient having been in her usual supposed good health was suddenly seized, while engaged in housework, with pain in the right side and back of head and neck. Shortly afterwards an epileptiform convulsion came on accompanied and followed by unconsciousness which persisted for several hours. When consciousness returned, complaint was made of pain in right side of head and back of head and neck, and incoercible vomiting for 48 hours. Dr. R. H. Robinson, who saw her at that time, found deviation of the tongue to the right on protrusion. Patient's condition then somewhat improved, but in ten days another convulsion accompanied with similar phenomena occurred. Improvement seemed to follow brisk purgation. Five days later she was admitted to hospital. She was then cyanosed and unconscious. Pupils contracted, equal, responding to the stimulus of light; slight passive divergence of eyeballs.



Respirations quick and shallow, no puffing of cheeks or lips on respiration; pulse hard incompressible over 100. Muscular tonicity of right side normal; *partial* left brachial monoplegia. Skin reflexes slightly diminished; tendon reflexes also slightly diminished, certainly not exaggerated. Potass bromide, aloes and asafœtida, administered; could swallow solid bolus better than liquids. Next day—consciousness returned, bowels had acted, passed urine, asked for utensil; could answer questions rationally; complained of pain in right side of head and back of head and neck and also in back; could move all four limbs; grasp of left hand weaker than right; legs manifested an irresistible tendency to fall out of left side of bed, had to be pinned in. Urine laden with urates, no albumen; tongue protruded straight. Next day, felt somewhat better, pain in head and neck persists. Ophthalmoscopic examination, kindly made by Dr. Reeve, entirely negative.

Next day, still felt somewhat better; head rotated markedly to the right, any attempt to straighten it is painful. Other symptoms same as before. No marked localized tenderness in scalp. No valvular cardiac lesions. Temperature 101° F. Aneurysm thought to be excluded; tumour likewise, syphilitic gummata likewise, embolism probably, hæmorrhage not likely from age, and site of lesion; thrombosis of right lateral sinus with effusion and pachymeningitis leaned to, but diagnosis not made.

Next day, no change, quite rational.

Next day, coma, cyanosis, rapid pulse and breathing, death.

Autopsy 6 or 8 hours after death. There was a thin layer of blood beneath the pia mater on the right side dipping between the convolutions, and an extensive extravasation, columnar in shape, about half inch in diameter extending through the brain substance from about half inch from the cortex obliquely to the base, about two inches posterior to the sylvian fissure. Heart concentrically hypertrophied, no valvular lesions. Lungs somewhat emphysematous. Liver healthy, kidneys small, capsules adherent, cortex granular.

Dr. Adam Wright presented the kidney from a case of pyo-nephrosis with the history (see page 6.)

Dr. Cassidy remarked upon the similarity of a case which came under his observation. He agreed with Dr. Wright that

earlier operative interference would have prolonged life.

After some miscellaneous business the Society adjourned.

### Book Notices.

*The Electro-Osteotome.* By M. Josiah Roberts, M.D., New York. (Reprint from *The Medical Record*.)

*Description of a Revolving Astigmatic Disk.* By Chas. A. Oliver, M.D. (Reprint from *Medical News*.)

*Invitation and Programme for a Sanitary Convention in the City of Ionia, Michigan.* A. W. Dodge, Secretary.

*Explanatory Announcement.* Minnesota State Board of Medical Examiners. P. H. Millard, M.D., Secretary.

*Observations on Sponge Grafting.* By Ed. Borek, A.M., M.D., of St. Louis. (Reprint from *Weekly Medical Review*.)

*Announcement of the Hospital College of Medicine. Session 1884.* Louisville, Ky. Wm. H. Bolling, M.D., Dean.

*Health and Meteorological Bulletins.* Issued by Provincial Board of Health of Ontario. P. H. Bryce, M.A., M.D., Sec.

*Health Mortuary and Meteorological Bulletins.* Issued by the Michigan State Board of Health. Henry B. Baker, M.D., Lansing, Sec.

*Index to the Transactions of the American Medical Association.* Vols. I.—XXXIII. Prepared by Wm. B. Atkinson, M.D., Permanent Secretary.

*The Increase of Insanity in the United States. Its Causes and Sources.* By Foster Pratt, M.D., of Kalamazoo, Mich. (Read before Am. Pub. Health Association, Detroit, Nov., 1883.)

*Forty-first Report to Legislature of Massachusetts, relating to the Registry and Return of Births, Marriages and Deaths for year ending Dec. 31st, 1882, with Report on Libels for Divorce for years 1879 to 1882, inclusive,* with Editorial remarks by Frank Wells, M.D., Boston.

*The Medical Record Visiting List, or Physician's Diary for 1884.* New York: Wm. Wood & Co.

This excellent Visiting List will be found, by all who use it, convenient and handy. The usual matter for the use of the busy practitioner will be found well selected, and concisely put.

*A Treatise on Bright's Disease of the Kidneys; its Pathology, Diagnosis and Treatment*, with Chapters on the Anatomy of the Kidney, Albuminuria, and the Urinary Secretion. By Henry B. Millard, M.D., A.M. With numerous original illustrations. New York: Wm. Wood & Co., 1883.

The author states that this work is the result of the experience of nearly twenty-six years' practice, and of the laboratory work of several years. The illustrations, twenty-four in number, are all drawn by himself except seven, and four of these were drawn for him from his own preparations. Three only being borrowed from other authors. He does not consider the term Bright's Disease exact, and in the book employs the word Nephritis. The book is divided into two parts. The first consisting of twenty chapters in which are successively considered the Anatomy of the Kidney, its Physiology and its Pathology. The second part, composed of five chapters, is devoted to the treatment of the various forms of nephritis.

In his description of the epithelia of the kidney, we recognize a disciple of Heitzmann, his illustrations of the varieties of epithelia demonstrate vividly the reticulated structure of the protoplasmic formations. He proceeds to show that this reticulum is the living matter of the cell. He remarks upon and demonstrates the rodlike structure of the epithelium which, he affirms, is formed by this reticulated matter, and that consequently these rods are in close relation with the process of secretion. He asserts that the structureless membrane of the urinary tubules is lined by flat endothelia which in nephritis become enlarged. His description of the sources of the urinary secretion is very clear. In fact throughout the book he displays a remarkably lucidity which adds greatly to the pleasure and profit derived from a perusal of his work.

In discoursing upon the tests for albumin in the urine (our author makes a distinction between albumen and albumin, the latter representing the proximate principle, the former the white of the egg), he accords great accuracy and delicacy to the Brine test of Roberts, of Manchester; and this, by-the-by, is the solitary mention of Roberts' name or allusion to his work on the kidney that occurs. In naming the

possible sources of error in using the picric acid test he does not mention the precipitate formed in the urine of those who are taking the cinchona alkaloids by that reagent.

In the chapter upon casts, he asserts his belief that casts are never found in normal conditions of the kidney. He also gives a good description of the differences between the mucous hyaline casts, drawn principally from Tyson. He says that casts are invariably an albuminous exudate into the tubules; and in chapter XI. he gives an interesting account of their formation.

He considers that all forms of Nephritis may be comprised in three varieties:— I. Croupous; II. Interstitial; III. Suppurative. The Croupous and Interstitial he regards as identical in character, and says that they always co-exist.

His chapters upon treatment are very good and full. In acute nephritis he places a high value upon the chlorides of mercury; in interstitial nephritis using the subchloride, and in croupous the corrosive sublimate. Of this latter he uses very small doses of about 1/1000 of a grain, and of calomel 1/10 to 1/20 grain every two or three hours. Diuretics, he finds very useful and often indispensable; they act variously, and sometimes disappointingly.

We have derived great pleasure from the perusal of this work, a pleasure enhanced by the readable type and excellent quality of the paper upon which it is printed. We heartily recommend it to the public.

*Insanity in its Medico-Legal Relations.* By T. R. Buckham, A.M., M.D. Philadelphia: J. B. Lippincott & Co.

This book is printed on strong paper, and the type, which is set in leaded lines, is invitingly clear. It might be styled a very useful, and indeed much needed publication, could we only hope that it would be calmly read by those who stand most in need of information on the very important questions discussed in its pages; but that any author who appends to his name the ominous letters, A.M., M.D., should expect that the gentlemen of the long robe will condescend to learn from him how ignorant they are of the real nature of insanity, or to discover how utterly absurd, and alternately contradictory, have been the rulings of judges, and how gladiatorily horrible or heinous have been the conflicts of prosecutors and defenders, seems to us little short of the dominance of an insane delusion in

the author himself, which some ill-natured readers might say best qualifies him to deal with his subject; for, is it not known as a melancholy, if not an admonitory fact, that many eminent medical men have died of the very diseases which they had made their life-long studies, and on which they have left treatises of imperishable merit?

But before pronouncing on Dr. Buckham's mental status the reader will do well to weigh carefully some of his more startling utterances. Here is one: "There cannot," says Dr. B., "be two criteria of insanity, a legal and a medical, the one contradictory of the other and both be correct. That which is false in science, cannot be true in law; and that cannot be health in law, which is disease in fact."

Certainly, there cannot be two criteria. There is, in fact, only one criterion, and that is the criterion of the man in the black cap, who lucidly (*lucens a non lucendo*) from the seat of doom, defines insanity, and sends to the gallows whom he deems sane, despite the remonstrances of all the Buckhams in creation. Science, forsooth! Is not law the science of sciences; is it not the hub of the harmonies, the gem of the consistencies, the touchstone of wisdom? Has not might always been right, and is not the judge mightier far than the entire conclave of scribbling doctors who have lived among the insane, and studied insanity in the concrete, so long that their own brains have become muddled and utterly unfit for any reasoning process? "That which is false in science cannot be true in law!" What rubbish! Is it not true that many lunatics have been hanged? Have they not hanged according to law? This is fact, and is not fact truth?

But we may be told judges have differed in their deliverances. Well, what of that? Do doctors, do parsons, do politicians never differ; and has not a very able poet told us that—

"All discord is but harmony, not understood."

Any one who is desirous of learning the harmony of judges in their rulings on the obscure question of mental sanity will find both instruction and amusement in the perusal of Dr. Buckham's appendix. Since the days of "Cobbett's gridiron," nothing half so ludicrous as this miscellany has appeared in print. Perhaps this part of the book, just like the postscript of a lady's letter, is the best of it. We must commend

it to every unfortunate chopfallen alienistic expert, who has passed under the frowns of the bench, or the sneers of the bar. Its carminative effect will be stronger than a double dose of chloral; but let him not dream that the oracles of law will stoop to the study of the "Medico-Legal Relations of Insanity." He might as well request Jack Smith to come down from horse-back and see how awkward a rider he is. Judges can ride as they please, and override all the medical legists that cross their path; nay, indeed, they may ride facing either the head or the tail of their steeds, and what is even more funny, they ride down one another. If anybody questions these facts, let him buy Dr. Buckham's book. If he rises from it without wondering at the wisdom of law he must be a rare specimen of modern mentality.

### Personal.

It is said that Professor Lister has been offered, and accepted a baronetcy.

THOMAS BEATTY, Esq., died suddenly of heart disease on Dec. 26th at Lambton Mills.

DR. J. E. WHITE, of this city, has been made a director in the Acadian Science Association for his labours and researches in entomology.

DR. G. B. SMITH, of Wilton Avenue, was elected Recording Secretary of the Toronto Medical Society at its last meeting, Dr. Duncan having resigned.

DR. H. E. BUCHAN has been appointed Assistant Superintendent of the Asylum of the Insane at Toronto, vice Dr. Lett, who has taken charge of the Homewood Retreat.

MR. JOHN HERALD has been elected President of the Alma Mater Society, after an exciting election, in which the students of the Women's Medical College exercised their suffrage.

THE EXAMINERS in Medicine at Trinity University, for the year 1884, have been appointed:—Medicine, Dr. Alex. Davidson; Medical Jurisprudence and Sanitary Science, Dr. Allen Baines. The other examiners are the Professors and Lecturers on their respective subjects in the Trinity Medical School.

### Birth.

MACHELL—At Owen Sound, Nov. 17th, the wife of Dr. A. G. Machell, of a daughter.  
BALDWIN—On 13th December, the wife of Dr. H. G. Baldwin, of a son.