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preparation. The reputation of the author as a specialist in this field is too well known to require any notice at our hands.

A PRACTICAL TREATISE ON DISEASES IN CHILDREN, by Eustace Smith, M.D., F.R.C.P. Lond., Physician to the East London Children's Hospital. New York: Wm. Wood & Co. Toronto: Williamson & Co.

The opportunities of the author as well as his reputation as a practitioner, entitle his work to the favorable consideration of the profession on both sides of the Atlantic. The author discusses the whole subject of disease in early life, and deals with it purely from a clinical standpoint. Each subject has been treated very fully, and great care has been bestowed on the sections relating to diagnosis and treatment. Due prominence has also been given to the important subjects of diet and hygiene. Many interesting cases from the author's case-books, by way of illustration, have been introduced into the text. It is the most complete work of the kind in the English language, embracing in 12 parts the following: Acute infectious, non-infectious, diathetic, glandular, nervous, respiratory, circulatory, mouth and throat, digestive, hepatic, genito-urinary, and skin diseases. We commend the work to the Canadian profession.

THE POPULAR SCIENCE MONTHLY for September, 1884. New York: D. Appleton & Co. Fifty cents a number, \$5 a year.

The frontispiece of the September "Popular Science Monthly" is a fine portrait of Professor J. P. Lesley, chief geologist for Pennsylvania, and President of the American Association for the Advancement of Science. Prof. J. P. Cooke's article (Harvard University) on "Scientific Culture: its Spirit, its Aim, and its Methods," is an able exposition of this subject. In "National Health and Work," Sir James Paget strikingly presents an additional reason for sanitary activity in the loss which results to the nation from the sickness and early death of its workers. Among other articles may be mentioned: "Sorghum as a Source of Sugar," "Hygiene for Smokers," "Sun Kinks," "The Problem of Population," "Protection against Lightning," etc. The editor writes on the meetings of the British and American Associations, and discusses a recent article by Bonamy Price, under the heading, "The College Feitch once more."

A MANUAL OF OBSTETRICS, by Ed. L. Partridge, M.D., Prof. of Obstetrics New York Post-graduate Medical School, etc., with sixty illustrations. New York: Wm. Wood & Co. Toronto: Williamson & Co.

This is a very convenient pocket manual, and as such will be found useful by young men commencing practice, for reference in perplexing cases at the bed-side. The author has given a very concise and correct outline of this important subject, and medical students will find it valuable in making readily available their store of knowledge in a professional examination.

MANUAL OF AUSCULTATION, PERCUSSION AND URINALYSIS, ILLUSTRATED. By C. Henri Leonard, M.A., M.D. Detroit: Illustrated Medical Journal Co.

This unpretentious little work contains a complete epitome of the physical signs of the heart, lungs, liver, kidney and spleen in health and disease. The matter is so condensed that a great deal of information is compressed into a very small compass. The illustrations are fairly good and the text clear and explicit. Dr. Leonard is quite an adept at this kind of work, having already published several of like nature, such as "Vest-Pocket Anatomist," "Reference and Dose Book," "Bandaging," "Hair and its Diseases," etc.

THE CARE AND FEEDING OF INFANTS, by Doliber, Goodale & Co., Boston, Mass.

This pamphlet, which deals with the essentials of feeding infants, invalids, etc., will be sent free to any address on application.

VISIONS OF FANCY. A poetical work, by N. M. Baskett, M.D., of Moberly, Mo.
St. Louis, Mo: Commercial Printing Co.

Births, Marriages and Deaths.

At Moorefield, Ont., on the 14th ult., Dr. Henry Mandesley, aged 54 years.

At Arichat, N. S., on the 13th ult., Henry C. Fixott, M.D., M.R.C.S., Eng., aged 64 years.

On the 25th ult., Dr. Edward Morton of Queensville, Ont.

On the 11th ult., Dr. G. A. Kent, of Wallace, N.S.

THE CANADA LANCET.

A MONTHLY JOURNAL OF

MEDICAL AND SURGICAL SCIENCE,
CRITICISM AND NEWS.

VOL. XVII. TORONTO, NOV., 1884. No. 3.

Original Communications.

THE EFFECTS OF TOBACCO.*

BY W. F. COLEMAN, M.D., M.R.C.S., ENG., ST. JOHN, N.B.

Mr. President and Gentlemen,—At our last meeting the President referred to a case of faint cardiac murmur in a very healthy man who smoked a good deal, and questioned as to the possible connection between the tobacco and the murmur. This suggested to me "The Effects of Tobacco" as a subject for this evening's consideration. In regard to one field of observation, I have a very decided view, and am anxious to get the benefit of your experience in a more general field. The universality of puffing and chewing the fragrant weed, and the potency of tobacco as a poison, make the question of the effect of its habitual or remedial use an important one. Tobacco belongs to the family solanaceæ, which embraces such members as hyosciamus, belladonna, stramonium, and curiously enough, the potato. Its important active principles are a colorless liquid alkaloid, called nicotine, a poison "which almost equals hydrocyanic acid in activity" and a camphoraceous volatile oil, nicotianin. By burning tobacco, an empyreumatic oil is produced from the decomposition of some of its constituents, which as found in the pipe of the smoker, is an active poison, and appears to be (Christison says) nicotine attached to a true volatile oil. The proportion of nicotine varies in different sorts of tobacco, and the quantity usually present is by various chemists estimated from 2% to one part in ten thousand. Two or three drops of nicotine or ʒss. of tobacco may cause death. The death of two brothers is reported from the continuous smoking of 17-18 pipes. Pereira gives a case in which twelve drops of an infusion of tobacco given as an enema caused death.

*Read before the New Brunswick Medical Society.

Von Boeck on vegetable poisons, says, "It is from smoking tobacco that nicotine poisoning chiefly arises, the smoke itself containing the nicotine. A great deal of it accumulates on the lower part of the pipes, and the remains of cigars are much more impregnated with it than the parts fresh smoked. Large poisonous doses of tobacco are said to produce syncope, small pulse and labored respiration. In most cases convulsions supervene. The pupils are at first dilated, then contracted. There is prolonged collapse and finally death."

Erb, of Heidelberg, says: Various authors adduce excessive tobacco smoking among the causes of tabes dorsalis. I would here say, in anticipation, if we can prove, as we think possible, that tobacco smoking often produces inflammation and atrophy of the optic nerve, is it not more than probable that it can and does produce myelitis, followed by atrophy of the cord, the admitted pathology of tabes dorsalis. Beau describes eight cases of angina pectoris, in which the attacks ceased when smoking was stopped, and returned when the patients began to smoke. Headland places tobacco under the class neurotics, order inebriants. The observations of Claude Bernard that nicotine at first produces contraction of the arteries, and later on the vessels become distended, agree with the results of the physiological researches of Uspensky, who concludes that nicotine first stimulates then paralyzes the vaso-motor centres.

From personal experience and the literature at my command, I know of no more constant detrimental effect of the abuse of tobacco than impairment of sight, ranging from slight defect to total blindness. The abuse of tobacco is so frequently associated with drinking to excess, that it is questioned by some whether tobacco alone ever produces impaired sight, or whether the tobacco or alcohol is the chief factor. My own opinion is, that tobacco alone is quite able to produce imperfect sight. Dr. Webster, of New York, in an able paper reporting twenty cases of amblyopia from the abuse of alcohol and tobacco, remarks, "That the abuse of alcohol alone, or of alcohol and tobacco combined, may produce impairment of vision, no physician acquainted with the subject will, I think, venture to deny. Some, however, doubt that tobacco alone ever causes impairment

of vision, and indeed it is difficult to demonstrate that it ever does." Now, in looking over Dr. Webster's cases, I find not one in which the patient who used alcohol did not *smoke* to excess. On the other hand two who smoked to excess used so little alcohol that I think even Dr. Webster would not claim it had any share in the effect upon sight, proving, so far as Dr. Webster's cases are concerned, that tobacco alone may impair sight, and that in no case was alcohol the only or even the chief factor in the causation of the amblyopia.

E. g. Case 7, C. McK—, æt. 49. Has smoked 10-15 strong cigars daily for ten years; *occasionally* drinks a glass or two of gin. Vision = $\frac{1}{6}$ each eye. Incipient atrophy of optic nerves.

Case 12, æt. 60. Sight failing over a year. Has smoked a strong pipe most of his waking hours for more than forty years. Has *rarely* tasted liquor. Vision equals $\frac{1}{6}$ each eye. Brick dust atrophy of both optic nerves. Ordered to stop tobacco, and return in a week. *Then* vision in right eye *doubled*, in left eye all but doubled.

McKenzie, one of the worthy fathers of ophthalmology, originally pointed out the effects of tobacco. In 1840 he wrote, "I have already had occasion repeatedly to hint my suspicion that one of the narcotico-acrids, which custom has foolishly introduced into common use, namely tobacco, is a frequent cause of amaurosis." In that pre-ophthalmoscopic day, amaurosis meant obscurity of vision, depending upon a supposed morbid condition of the retina or optic nerve (McKenzie). In the present day, the terms amaurosis and amblyopia give rise to great confusion, from their various application. It would perhaps be best to restrict the term amblyopia to all cases of impaired sight, and amaurosis to cases of absolute blindness, without ophthalmoscopic symptoms. More recently, Wordsworth, Critchett, Hutchinson, &c., have given great attention to the effects of tobacco upon the eye, and believe it gives rise to impaired sight and blindness, with or without ophthalmoscopic signs. Hutchinson, who is probably the best authority on tobacco amaurosis, wrote in 1867 as follows: "The first stage, one which is very transitory, and perhaps often altogether omitted, is one of congestion, during which the optic disc looks too red. Then follows pallor of the outer parts of the nerve disc. During these stages the patient complains of dimness of vision merely. In a later

stage the whole disc has become pale, even to blue milk whiteness, and later still there is advanced atrophy. The stages generally occupy from four months to a year. In many cases the patient becomes at length absolutely blind, but in others the disease having advanced to a certain point, is arrested. There is from first to last no evidence of any disease of any structure in the eyeball, excepting the optic nerve. Almost always both eyes are affected, and progress *pari passu*. Sleepiness, a little giddiness, and a little headache, are usually the only constitutional symptoms which attend it." Three-fourths of his cases recovered. In a personal interview with Mr. Hutchinson at Moorfield, in 1875, he remarked he had come to think the effect of alcohol antagonistic to tobacco, as a cause of amblyopia, unless the alcohol is taken in such excess as to produce degenerative or undermining effects on the constitution. He had seen amblyopia more frequently and more advanced in smokers who abstained from alcohol, than in those who took it. Dr. Berry also holds a similar opinion. He cites two cases of tobacco amblyopia; one a man of seventy, who had been a teetotaler for forty years, and the other a boy of 19, who did not drink. Berry, in common with many others, has remarked the symptoms often gradually disappear on the cessation of smoking, without any other treatment, and frequently without the supply of alcohol being diminished.

Since Hutchinson's description of tobacco amblyopia in '67, he, in common with many others, has examined more systematically the field of vision and color vision, and has found that the diminution in sight is confined to central or direct vision, while usually, eccentric vision remained relatively good, and they have found that color-blindness exists over a portion or the entire extent of the visual field. The color-blindness is for red or green, the red appearing blue, and the green appearing white, gray or yellow. The color-blindness in slight cases of amblyopia requires very careful examination to determine, as it is confined to the central part of the field, particularly within an area stretching from the optic nerve to the macula.

In 37 cases of atrophy of the optic nerve, Hutchinson attributed 30 to the effects of tobacco, and in 36 cases of optic nerve atrophy, Lebr found color-blindness an almost constant symptom, the

perception of color remaining intact in only three. Berry says he has looked out for the symptoms of tobacco amblyopia in women for the last five or six years, and has only met with them in three cases. These three women smoked to excess, but did not drink. Forster cites 20 cases, in a paper on the injurious action of tobacco on vision, each one of the patients being a strong smoker, and only able to see very large type. In 11 of these cases marked improvement was observed when the use of tobacco was given up. I will not detain you by quoting the language in the text-books on diseases of the eye at my command, by authors who express their full belief in tobacco amblyopia and amaurosis, simply stating they are English, Scotch, American, German and French, and among the best authorities. The authors are, McKenzie, Wolfe, Gowers, Wells, Nettleship, Noyes, Williamson, Stellwag, Schweigger, Grunfeld, Mittendorf, Mayer, and De Wecker. The only two authors I have who dissent from the general view are Carter and Lawson, English. Carter quotes a letter from Dr. Dickson, of Constantinople, to the effect that the consumption of tobacco in that city averages 3 lbs. weight per head per month, but that amaurosis is a rare affection there. He quotes also Dr. Hubsch, oculist in Constantinople, who writes, "I have never attributed amaurosis to the abuse of tobacco." Carter adds, "I have obtained the same kind of negative evidence from Egypt and India, and in the face of it I do not attach much importance to the fact that several patients who have suffered from nerve atrophy, have been great smokers. If a patient who consults me on account of nerve atrophy is a smoker, I always advise him to lay aside tobacco. This would be dictated by the duty of leaving nothing undone, and would not represent any personal belief in the necessity of the prohibition." I cannot comprehend why Mr. Carter thinks it his duty to give advice in which he does not believe, unless he thinks the belief of others a stronger reason for his duty than his personal belief, in which case he must hold his own opinion very feebly. Mr. Lawson, one of the surgeons of Moorfield Eye Hospital, thus writes: "I do not remember ever having seen a case in which the loss of sight could be fairly attributed to tobacco only. There was also in addition to the immoderate smoking some other excess, such as intemperance, or undue mental strain with loss of rest."

In looking over my notes of 1824 eye patients who have consulted me since 1877, I find 46 who had partial to total loss of sight accompanied by conditions of the eye similar to those noticed in tobacco amblyopia, viz., either no ophthalmoscopic or otherwise detectable change of the eye, or else hyperæmia, pallor, or atrophy of the optic papilla. These 46 cases may be thus classified: male 33, females 13 (46). Cases referred to smoking alone, 13; tobacco and alcohol, 9; alcohol alone, 0; other causes, 24. Tobacco and alcohol, males 9, females, 0; tobacco, males 13, females 0; other causes, males 10, females 14. Cases in which there was hyperæmia, pallor, or atrophy of the disc: tobacco, 12 male; alcohol and tobacco, 9 male; other causes, 7 male, 11 female. In regard to these figures I would remark that although no case of pure alcoholic amblyopia appears, it is because every one of the drinkers who consulted me was an excessive smoker, a rule, perhaps, with few exceptions, yet I believe amblyopia potatorum is an entity, as is very generally held in Paris. I must admit not having questioned females as to smoking and drinking, as they are so free from such male virtues. Again, in all the cases but one of tobacco or tobacco and alcohol, I noticed changes in the optic disc, as the patients did not consult me in an early stage, when ophthalmoscopic changes are not noticeable. I will briefly refer to four patients who did not take alcohol and had tobacco amblyopia:

J. T., æt. 44, consulted me in Feb. 83, complaining that his sight had been defective for eight months, and he was unable to see more than half a word at a time with either eye, seeing the half on nasal side. Vision is one-half in left and one-third in right eye; outer half of each optic papilla pale. Patient has smoked six pipefuls daily for 15 years past. Advised to take strychnia and stop tobacco. Patient returned in two months, said he had followed advice and sight was all right.

H. O., æt. 21, Dec. 28, '83, said both eyes had gradually failed during the past 15 months, and now he can barely distinguish light. There is advanced atrophy of both optic discs. No symptoms of brain or spinal disease, no history of syphilis, health good. Has for four years past smoked 6-7 pipefuls daily, and chewed one-fifth lb. of tobacco weekly. *Treatment*—Strychnia, hypodermically, m iv. ter die. (grs. iv., ad 3 i.

solution) and increase mj. daily; stop tobacco. Strychnia spasm was not felt till the dose reached m xxv, equal gr. one-fifth, and then only occasionally felt. Vision remained the same after one month's treatment. Feb. 4, '84.—R Strychnia, gr. $\frac{1}{2}$ ter die, by stomach, and gradually increase the dose. Feb. 8th—Apply galvanic electricity to nape of neck and closed lids, three minutes daily to each eye. Feb. 27th—Taking strychnia gr. $\frac{1}{2}$ ter die, by stomach, and feels spasm only occasionally. Vision, each eye increased to $\frac{7}{10}$. April 7th, '84.—Discharged with vision $\frac{7}{10}$, and able to see his way about well. Patient only diminished the amount of his smoking.

Nov. 25, '80—J. McK, æt. 31. Sight failing three months. Vision, right or left eye, = $\frac{1}{17}$. Has smoked since 11 years of age, and for three years past 10 pipes a day. Takes a glass or two of whiskey only once in months. Both papillæ hyperæmic. *Treatment*—Stop tobacco, cup temples, take iodide of potassium. Jan. 5, '81—Patient returned; stopped tobacco and gained 12 pounds in weight. Vision has increased from $\frac{1}{17}$ to $\frac{1}{2}$. Outer half of discs now pale. Jan. 20th—White atrophic lines on discs and along vessels, perivascular atrophy; vision the same. Prescribed strychnia.

Oct. 22, '79.—W. S., æt. 21, noticed nine months ago while in school he could not see to read with right eye, and six months ago noticed the same defect in the left, but two weeks later could see to read fairly well. A week later still the eye again failed. With right eye can count fingers at 6" on temporal side only. With left eye, vision is $\frac{1}{41}$ = $\frac{1}{16}$ (Jaeger). Fundus of eye normal, unless there is some engorgement of retinal veins. Patient is anæmic and nervous, but he considers his health pretty good. Has smoked 6-8 pipes a day, from the age of 15, until two years ago, and 3-4 pipes daily since. Diagnosis, tobacco amblyopia. Prescribed strychnia. Discharged after nine days' treatment, with vision of right eye increased 8 times, and doubled in left eye. Continue strychnia by stomach.

Finally, gentlemen, I am prepared to hear you maintain that impaired sight, the use of tobacco, and the wearing of leather boots, for instance, are coincidences, only that and nothing more. The only additional argument in favor of tobacco amblyopia I shall detain you with is, that the quality

of the tobacco and the mode of smoking in Turkey differ so much from the "shag" of England, and the mode of smoking in England and America, as possibly to account for the absence of tobacco amblyopia in Constantinople. Sir Henry Thompson says the ladies of Constantinople smoke fifty cigarettes a day, merely taking a few whiffs from each, and then throwing the cigarette away, and he considers little harm ensues from such smoking. To deny that tobacco produces amblyopia, because a large number of smokers escape, is as rational as to deny that small-pox can reproduce itself, because a large number of the exposed may escape the disease, or to deny that cold or wet can produce rheumatism, because so few of the exposed suffer.

ON TRACHELORRHAPHY—WITH CASES.*

BY DR. SKENE KEITH, EDINBURGH.

(Reported by Dr. H. Aubrey Husband.)

The operation for restoring a torn cervix uteri is not yet generally recognised in the southern part of this country, and some of the so-called Emmet's operations would greatly astonish the great American apostle of clipping and stitching. The few cases he had to relate brought out forcibly the necessity for following up the after history of the patients. He had heard of several cases who were no better some months after the operation, and who were supposed by the operator to have been cured, for example, he knew of a lady who a few months after the operation was no better but rather worse, as she was suffering from constant bloody discharge in addition to her other troubles. This discharge was accounted for by the presence of a wire suture in one lip and want of improvement by complete failure of union, yet it may have been put down as a cure as the patient did not see the operator after the first few weeks.

CASE I.—Mrs. G. had suffered for fifteen years from pain in both groins and from a constant aching in the region of the sacrum since the birth of her only child. The labor had been a natural one. After years of treatment she at last saw Prof. Skene, of Brooklyn, and was advised by him to have the cervix uteri repaired. The cervix was torn on both sides of the os, almost to the vagina,

* Read before the Obstetrical Society of Edinburgh, July 9, 1884.

and there was some, although not very marked, rolling out of the lips. The uterus was of normal size, and was not displaced. Dr. Skene allowed me to perform the operation and assisted me on the 21st December, 1881. Sims' speculum was used to bring the cervix into view in this and the other operations. After passing a sound I fixed on each lip of the cervix a double tenaculum at the spot where the centre of the external os was to be. With Skene's hawk-bill and Emmet's scissors I pared first the left and then the right side of the cervix leaving the central part untouched for the cervical canal. There was little hemorrhage. Three sutures were required on each side and after they had been tied up I passed a sound to be quite sure that the cervical canal was patent. This precaution is not altogether unnecessary, for I have since seen a cervix on which a so-called Emmet's operation had been performed, but where the menstrual discharges after the operation escaped through a small opening at the junction of the cervix with the vagina. There was retention of urine for twenty-four hours, and this was the only trouble the patient had after the operation. The sutures were removed on the seventh day, she sat up on the tenth, and at the end of a fortnight she came to Dr. Skene's office. The union was not as good as it might have been. However, the backache was quite gone, and the pain in the loins was not so bad. I have not heard of her since.

CASE II.—A lady, age 26, was seen by my father in April, 1882. Two years before she had been delivered of a seven month child with forceps, after having been in labor with convulsions for 48 hours. Since then she has suffered from constant backache and leucorrhœa. On examination with the speculum it was seen that the left side of the cervix was torn, and that the tear extended into the mucous membrane of the vagina. The right side was intact. The cavity of the uterus was increased to four inches, and there was no displacement. In May, 1882, I operated in the same way as in the previous case, except that one side only had to be repaired, and that two of the eight silk sutures which were required were entirely in the vaginal wall. After the stitches had been tied the tear measured two and a half inches. The patient had no trouble after the operation. On the ninth day two of the sutures about the centre of the line were found to have cut their way out. Injections

of hot water were given night and morning, and the other silk sutures were left in for two days more. Three weeks after the operation the cervix looked almost as though there had never been anything the matter with it. The uterus now measured two and a half inches. The backache and leucorrhœa had entirely disappeared. This lady kept perfectly well for seventeen months. She was then delivered of a child at term and since has had a slight return of the old trouble. A short time ago my father found that there was a slight tear anterior to the former one.

CASE III.—The patient, age 29, came under notice in March, 1882. She had at that time been suffering for four and a half years, since the birth of her only child, from backache and pain in the left groin. The labor had been a natural one. The backache has steadily increased, and more especially during the last twelve months. The cervix was hard, torn on the left side only. In July I operated. On account of the hardness and hypertrophy of the cervix I had to remove a thick slice of tissue before I was able to turn in the everted edges. The bleeding was rather free at first, but had quite ceased before I introduced the five sutures which were necessary to bring the parts nicely into position. The sutures were taken out on the ninth day, and on the eighteenth the patient went home. The line of union was very good, the backache was gone, and the pain in the left side was somewhat better. In December of same year the patient wrote to say that she had no pain and was cured. She kept well until six months ago, the leucorrhœa appeared accompanied with occasional pain in the side and back. Her doctor told her that she was much better for having had the operation done, so I suppose that the present illness is not due to my opening up of the cicatrix.

CASE IV.—Mrs. H., age 31, suffered from backache, pain in the groin, and leucorrhœa for ten months, since an abortion at about the fourth month. She had been a patient of Mr. Butler Smythe at the Grosvenor Hospital for Women and Children, Westminster, for a number of weeks, and had improved to a certain point, but could not be made to advance further by any of the usual treatment for such cases. When Mr. Smythe asked me to look at the case the cervix was torn on both sides, principally on the left, and the everted edges

were covered by exuberant granulations which bled easily. The uterine cavity measured two and a half inches, and the sound passed backwards with a slight curve. Mr. Smythe asked me to operate and I did so in April, 1883. There was no special difficulty in the operation. I was able to raw the right side with one snip of the hawk bill scissors, as the tear on that side was small and required but one suture; three were put in on the left. Patient suffered from no pain or disturbance after the operation. When she left the hospital the cervix looked beautiful. The leucorrhœa was quite stopped, the backache somewhat better, and the pain in the groin as bad as ever. Now she is perfectly well.

CASE V.—Mrs. M., age 36, has not felt well for years, and since the birth of her last child, seventeen months before I saw her, had suffered from constant backache and leucorrhœa, and frequently from facial neuralgia. On examination, the perineum was found to be partially torn, and what was left of it was lax and soft. There was a considerable rectocele, and this caused great straining at stool. The cervix was low down, large, hard, torn, and the lips were much everted, the posterior being fully twice as thick as the anterior. The uterus was slightly retroverted and the cavity measured three inches. In May, 1883, I pared and brought together the everted lips. There was some difficulty in doing this on account of the difference in the thickness. Six sutures in all were put in. At the same sitting I cured the rectocele by repairing the perineum. Five weeks after the operation the cervix could not have looked better. The patient went to the seaside, and although she came back looking very anæmic and not fully well, there had been no leucorrhœa or face-ache, and the back did not pain her as much as formerly. In December the backache began to get worse, and I found that my patient had become pregnant, and about one-third of the cicatrix in the cervix had given way. She aborted, and I again pared and brought together the everted edges, this time with wire. A week ago the patient wrote to say that she was feeling much better.

CASE VI.—Mrs. L., age 21, was well until after the birth of her second child, four years ago. After getting up she suffered from bearing-down pains, which were relieved by wearing a pessary. Six months ago she was delivered of a boy baby,

with forceps, and remained in bed for five weeks. Since then she has suffered from constant backache and pain in the left groin, and she has a profuse yellow discharge. When I saw the patient last November, the uterus lay low in the pelvis. The cervix was deeply torn on both sides, and there was a great deal of rolling out of the lips. The vagina contained a large amount of glairy mucus. After two months' treatment as an out-patient, during which time the cervix decreased in size the leucorrhœa got less. I thought that the tear would not improve further as it was an irregular one and I therefore operated. On the ninth day the patient felt perfectly well and had no pain. She went home at the end of three weeks, nursed her two children with measles, and her husband, who was also ill, and felt perfectly well for three months. Since then she had profuse discharge with pain in the stomach, and I have heard from Mr. Malcolm, who has been at the Samaritan Free Hospital, that there is considerable suppuration along the lines of the cicatrix on the right side, though the deeper parts appear to be quite firm.

REMARKS.—The operation of Emmet, when properly performed, is certainly of benefit in suitable cases, but I do not believe that it ought to be a very common one, for there are few women who have had a child without having their cervix uteri more or less injured, and most of these injuries do little harm. In my notes of a year's out-patient practice in the Samaritan Free Hospital, I found that I have marked down that there was a well-marked cervical tear in forty-two cases, yet in five only did I recommend operation and two of these five were on account of induration due to excessive application of caustics. Careful application of a mixture of carbolic acid and tincture of iodine with the hot douche and support of the uterus when necessary was found quite sufficient to heal up the other cases. Even in the Women's Hospital, New York, Emmet's operation is not a very common one. In four and a half months of the winter of 1881-2 I saw it performed there 24 times, and I was present at all the operations during that time. Trachelorrhaphy is not a very easy operation, at least, in most of the necessary cases, for in those the tissues of the cervix are much harder than natural. Where it is safe to draw the cervix entirely outside the vulva there would be little difficulty, but as this cannot be done I have found

that the most easy position is to have the cervix at its natural place at the upper part of the vagina, provided always that the patient is placed well in Sims' position and that the speculum is well held. There is far more room here than at any other part of the vagina. In forty cases I have but once seen hemorrhage of any intensity. In the others it either stopped before the stitches were introduced or after they had been brought together. I don't think that it is of importance what kind of sutures are used. In my next case I shall probably use wire for the crown ones, and silk, prepared according to Dr. Skene's method, for the uterus. The needles are of much greater importance. Dr. Emmet used round ones, but I don't find there is any objection to lancet-pointed needles, and certainly they go in much more easily. It is certainly a great comfort to fix into each lip a tenaculum of some sort, then one gets greater command over the cervix, and can keep it steadier than if a loop of thread or any other means be used.

Dr. Wilson congratulated Dr. Keith on his paper, and remarked that, considering the number of cases operated on the other side of the Atlantic, the midwifery must be somewhat rougher there than on this side.

Dr. Berry Hart did not understand the pathology of the cases operated on, and believed that some forms of inflammatory action went on in the parts. He would like to know the conditions Dr. Keith had met with in split cervix. He had seen pelvic cellulitis and other affections following the operation, and had heard many patients complain that they had not been benefited by the operation.

Dr. Milne Chapman had performed the operation with unfavorable results in four cases. He held that the tendency of Nature to heal the rupture in the cervix caused congestion of the part; this leads to a proliferation of epithelium, which prevented healing. In the one successful case a notable result was the diminution in sub-involuted uterus.

Dr. Barbour had seen eight or ten cases; the benefit derived was only in about one-half of the cases. He, however, held that Emmet's operation was based on sound pathology.

Dr. Arnot (Bombay) thanked Dr. Keith for his paper, and was glad to hear a new operation discussed. He held that the proof of the success of the operation depended not so much upon a good

cicatrix, but on the results of a year's experience. How much of the temporary success of the operation depends on the local hemorrhage, relieving congestion, the rest in bed, etc., which accompanied the operation?

Dr. P. A. Young had had no experience of the operation. The operation, he held, received the almost universal assent of the profession. He related a case of chronic split cervix, which was cured by Emmet's operation.

Dr. Brewis recorded five cases treated by Dr. Angus Macdonald, four of which were successful. In the unsuccessful case there was shortening of the broad ligament, which prevented the cervix being drawn down, as was the custom with Dr. Macdonald. There was also some ovaritis. The case at first did well, but on the removal of the sutures it was found that the rent had not been improved. In two cases he had seen severe hemorrhage; he had used a styptic composed of iron, alum, and glycerine, but found the vagina charred, due to the styptic used. This should only be used in hemorrhage due to malignant disease. All cases should be watched by the nurse, as severe hemorrhage may come on in any case.

Dr. Webster mentioned a case in his practice where a severe split cervix had been cured by hot water.

Dr. Keith replied that he once held that the operation should be done far more frequently, but he had since modified that opinion. As to the pathology he had formulated no theory. He had operated more because he thought the cervix was at fault. He thought that the operation, as a rule, should not be done in cases of pelvic cellulitis. Dr. Emmet said that the pelvic cellulitis should be first carefully treated, and then the operation might be carefully done.

THOMSEN'S DISEASE.

TRANSLATION BY J. WORKMAN, M.D., TORONTO.

This is a muscular affection, which has been brought into notice by several German physicians and one or two French within the last few years. It has taken its name from the gentleman who, having himself been the subject of it, in common with a large number of his family stock, throughout five generations, was the first to treat of it with

clearness and precision. No less than thirty-five members of the Thomsen kin were known to have been affected with the disorder. Of thirteen children of his mother, seven were found to present it. Hereditary transmission would therefore seem to underlie this morbid form, and it is by no means improbable that it has not been exclusively confined to Germany and France, though, from its rarity and its apparent triviality, it may have failed to attract particular attention. The writer of this notice believes that he has seen, at least, one distinctly marked case in Canada, within the last two years, and it may be that the perusal of the following notice of an article by Longuet, in a *Revue critique*, in the *Gazette of Military Sanitation*, will lead some of the readers of the LANCET to recall some observances, which at the time of their occurrence wore an anomalous aspect.

The notice above-mentioned is presented in the *Revista Medico-Quirurgica* of Buenos Aires, for May, 1884, of which the following is a translation from the Spanish.

THE DISEASE OF THOMSEN.—In the critical review by Longuet, we have found the following historic details respecting the disease of Thomsen. The subject observed by Leyden was a discharged soldier, who was unable to open his fist when he had shut it; when reading, he was often unable to follow out the lines; the movements of his tongue were impeded; he could not dance or run. In the same year, 1876, Thomsen and Seeligmuller published the first two memoirs on the subject, which were remarkable for their clear and precise conception of the disease. Thomsen, who was not only an observer of the infirmity, but also a sufferer under it, and furnished the first description of it, has given origin to the name by which it is commonly designated in Germany. His own family presented several examples of it, coming down through five generations, in various degrees, and all presenting some form or other of neurotic character. Of thirteen of his mother's children, seven were affected with it. His own children also were affected, though in a mitigated form.

The case recorded by Seeligmuller was that of a recruit, who was a desperation to his drill instructors, because of the slowness and sluggishness of his motions, in spite of his own earnest desire, in the execution of the orders given him. At a later date, Peters, a surgeon major, published his obser-

vations of a soldier, 20 years old, who was affected similarly. At the command, "march," he remained immovable, as if rooted to the ground; afterwards, having moved his arms and legs disordinately, he succeeded in starting, but he vacillated for ten or twelve paces before he could attain free movement. He was absolutely unable to run, and if he persisted in the attempt he fell; his tongue and the maxillary muscles shared in the impotency; he could not raise his arms above the horizontal direction.

Westphal presented to the Medical Society of Berlin two patients, one of whom was a student of medicine and a nephew of Thomsen; he had been affected from his infancy. The symptoms are always the same; the functional anomaly may be presented in any of the muscles of the body. One of Westphal's cases showed that after sneezing, the patient could not again open his eyes without great effort, and when eating he could not always shut his mouth when he desired. The subjects of the affection have an athletic appearance, but their muscular force is only moderate. Westphal thinks there is a special congenital muscular perversion, coupled with an exaggerated muscular development.

Another recruit has recently attracted the attention of the assistant surgeon major Schonfield. This soldier was sent to hospital because, in his exercise, he suddenly fell to the ground, without any apparent cause. After a rest of ten minutes it was impossible for him to resume the march, at the word of command. He moved with great difficulty, and tottered and fell, rising again only with much difficulty. He had to proceed ten or twelve paces before he could move freely. When he sat down for any time, he could hardly rise again; the torpor, at such times, invaded the upper limbs, as the result of violent exercise. The speech was slow and drawing.

Mobins is the latest writer on the subject. He has published in *Schmidt's Jahrbücher* a very complete analytic review, having personally observed a young student of theology, who was a military volunteer, sent in by surgeon major Sane, who appeared to regard the case as a mimic form of the affection. This youth, after severe fatigue, suddenly became subject to cramps in the calves of his legs, and a stiffness of his limbs which left him powerless for many days. His father presented

the same defects, which were exasperated by the fatigues of military service. After a march, all his movements continued difficult for one or two days. Sometimes the loins were invaded, and after musket exercise, his arms, previously free from the trouble, became affected. The contracture is accompanied by a sensation of tumescence in the muscles attacked; but at other times by a sort of trepidation, like that from faradization; if the leg be extended, the whole limb enters into contracture, and remains for a time unable to bend.

A youth of 22, observed by Berger, presented in his exercise a torpor and rigidity which distracted his drill instructors. The French productions on this subject consist merely of the memoir by Ballet and Mare, published under the inspection of Charcot, and supplemented by a recent article of Mare's, who has given the following details of a case under his own observance. The subject, from early age, found that he had special difficulty in making any movement; when he was in class and was ordered to retire, he could not rise. When called into the army, he exhibited, under examination by the council of revision, the infirmity under which he labored; but the military surgeons did not believe in it; he was however set aside for two years, as of feeble constitution, at the close of which he was admitted. When he went to exercise, it was impossible for him to keep step with his comrades, and he had the like difficulty in managing his arms, as in attempting the motions he was seized with his contractures. The surgeon of his regiment declined to admit him as a patient, and he ordered him to the gymnasium to *soften him down*; but in these exercises also he was attacked with the cramps, and when, for example, he went to mount the wooden horse, he was seized in the moment of the effort, with muscular contracture, and he fell violently against the horse. There is no painful feeling in the muscular contraction.

It is not easy to account for this rare and curious infirmity. Does it consist in a lesion of the medulla, situate perhaps in the lateral cords, or is it a simple functional anomaly of the medullary apparatus? Should the affection be localized in the periphery of the nervous system, or in the muscles? All of these have been hypotheses advanced by different authors, but none of them appear satisfactory. Be it as it may, we have deemed it useful to call the attention of our colleagues to a

pathological curiosity which they may perhaps have opportunity to observe. It is well that we should know that a form of nervous disease exists, which consists in *initial transitory muscular spasm, probably hereditary, incurable and independent of any appreciable lesion of the nervous or muscular systems.* Such is the Disease of Thomsen, a designation now accepted both in France and elsewhere.—*La Gaceta de Sanidad Militar.*

THE MODERN OPERATION FOR CATARACT EXTRACTION, WITH CASES.

BY W. TOBIN, F.R.C.S.I., HALIFAX, N. S.

(Read before the Nova Scotia Medical Society).

GENTLEMEN,—I propose bringing before this meeting the notes of some cases of cataract extraction, performed by myself, during the past two years, preceded by a description of the operation.

This operation, in each case, was what is known as the "combined modified linear extraction." It bids fair to become the favorite one with both English and continental surgeons. It consists essentially in an incision confined to corneal tissue, generally made upwards, combined with an iridectomy preceding the opening of the capsule. The instruments required are: a stop speculum—I prefer the one known as the Birmingham pattern,—a fixation forceps, one with a sliding catch being the best—De Wecker's; one of Graefe's narrow bladed knives, about five millimetres in breadth; an iridectomy forceps and scissors and a pricker, to divide the capsule. We may add a hard rubber spatula, also De Wecker's invention, to free the wound from tags of entangled iris or capsule.

The patient's eyes should have been examined, under atropine, some days previous to operation, if possible, and the nature of the cataract and its consistency ascertained; also the condition of the retina as to perception of light. The tension should also be noted and any history of previous inflammatory disease or errors of refraction. The eyelids should be freed, by appropriate treatment, from any pus-producing affection, such as Blepharitis (a frequent cause of flap infection). The steps of the operation are as follows: The patient is placed upon a bed or table with the head slightly raised. An assistant is required to administer chloroform—if an anæsthetic be given it is not

necessary—also to control the patient and to help with the iridectomy. The patient's lids and neighboring parts should be first washed with a disinfecting lotion. The operator's hands and his assistant's, the instruments and the water used, should also be rendered aseptic. It is advisable not to use sponges. A piece of absorbent cotton wool, moistened with boracic acid lotion, which may be discarded when soiled, answers every purpose.

The patient being fully under chloroform, we insert the speculum between the lids and secure it, Seizing a portion of the conjunctiva with our forceps, just below the vertical meridian of the cornea, we draw the globe downwards, and, entering the knife exactly at the sclero-corneal junction, at a point corresponding roughly to the upper margin of the pupil, we pass it slowly and steadily across the anterior chamber on a plane with the iris. Transfixing the opposite point, we carry the blade, with a sawing motion upwards and slightly forwards, making a flap whose summit should reach within a line or so of the corneal border. The assistant now takes the forceps whilst we seize a small portion of the iris and excise it. Resuming the fixation forceps, we pass in the pricker and divide the capsule, making a cross cut, which sometimes brings away a portion of it. Whilst we are doing so, and during the subsequent steps of the operation, the assistant raises and holds suspended over the globe the stop speculum. By pressing on the upper lip of the incision with the spatula and passing a similar instrument from below upwards along the cornea, we start the lens from its bed, and bring it into the lips of the wound, through which it is gently squeezed, perhaps losing some of its cortical matter in transit. The speculum is now withdrawn and the eye closed for a few minutes to allow the chamber to refill. By manipulating the upper lid over the globe surface, we collect the remaining cortical matter in the centre of the pupil, and, reopening the wound, by drawing the eye downwards, cause its escape in the gush of aqueous humor. It now only remains to free our incision from shreds of iris or capsule, with the spatula, to cleanse the globe and sulcus from clots, etc., and to apply the bandage.

I first place upon each eye a piece of lint soaked in boracic acid lotion, then fill up each orbit with layers of cotton wool and tie over all a Moorfield's bandage. This bandage is removed and the

dressings changed twelve hours after the operation, and is changed again twice a day for the first week. If all goes well it may then be discarded for a shade and protective glasses. I look at the operated eye (by oblique light, with a convex lens and a candle) on the second or third day. The patient is allowed to sit up after the first twenty-four hours; and to go out within the first ten days, should the weather permit it. The chief points in this operations as contrasted with the old flap extraction are: 1st, the antiseptic precautions; 2nd, the use of the narrow knife, which gives us great freedom in shaping our flap and allows us to correct a faulty incision even after penetrating the cornea; 3rd, by limiting our wound to the cornea, we get one which heals readily and we avoid a conjunctival flap, which by bleeding, etc., would interfere with the next steps of the operation; 4th, by doing an iridectomy, before opening the capsule, we free the iris from pressure during the escape of the lens, besides getting the undoubted prophylactic benefit of the operation—should we wish to be extra cautious the iridectomy may be done some weeks beforehand. 5th. The operation may be done without an anæsthetic—De Wecker never gives one, having once lost a patient under chloroform. The use of the spatula is also to be noted in cleansing the wound. Here eserine, as a pupil-contractor, may be also of service. Lastly I would draw your attention to our early examination of the wounded eye by non-irritating oblique light, and to the lessened confinement both to bed and to the house of our patient.

I enjoin a few cases illustrative of this method of operating.

CASE I.—Mrs. McC., aged 70, residence, Chester. Double senile cataract, complete in both eyes; a dyspeptic subject. Operated on right eye, assisted by Dr. Farrell. Made usual incision upwards. When about to extract the lens the patient showed signs of chloroform collapse. The operation had to be suspended till she was restored by artificial respiration and subcutaneous injections of brandy and ether. On recovery, the lens (hard, dark and small) came away easily. The eye was cleaned and the bandage adjusted. All went well till the sixth day, the patient then sitting up and using protective glasses. She incautiously removed them and a prolonged exposure to light brought on a sharp attack of iritis, with opacities

in the anterior chamber and vitreous. From this attack she made a tedious recovery. The treatment consisted in hot fomentations of belladonna and inunctions of mercurial ointment and belladonna extract with tonics and sedatives internally. However, in a month she was able to return home. The eye quieted down and the opacities were absorbed. Vision, which had been clear twelve hours after the operation, was restored, and she now sees fairly with the usual glasses.

CASE II.—Miss B., aged 55 years; residence, Halifax. Double senile cataract; complete in right eye, incomplete in left. An anterior synechia, the result of old iritis in the right. Operated upon the eye in Sept., 1883, assisted by Dr. Lawson. The usual corneal incision was made followed by a large iridectomy. The lens was found too large for the wound, which required a slight cut to free it. A portion of capsule adherent to the synechia obstructed the new pupil, but not seriously interfering with vision was allowed to remain. The bandages were removed within a week and recovery with good vision ensued without a bad eye symptom, though she suffered severely from rheumatism. She now sees well at a distance and can read with the usual glasses.

CASE III.—Mrs. C., aged 60; residence, Chester. Double senile cataract; mature in both eyes. Right some years, left one year. Can distinguish light from darkness. Operated on right eye 19th October, 1883, assisted by Surgeon-Major Orwin. Made the usual corneal incision, which in this case, however, was carried too far upwards, involving a conjunctival flap which bridged the incision (remaining uncut), bled freely, and obstructed the operation. In making the iridectomy the lens capsule was ruptured and the lens presented immediately. The conjunctival bridge was divided and the lens extracted; but from the incomplete division of the capsule this membrane had not retracted and occluded the pupil. An attempt was made to extract it with the forceps, but in doing so the posterior capsule was wounded, and there ensued a loss of vitreous. The wound was at once closed, and the eye was tied up with a compressive bandage. This was left unchanged for 48 hours up to which time there was no pain or uneasiness. The wound was then found healed and retained the aqueous. Pain followed, however, the reapplication of the bandage, and decided

iritis followed before the fifth day, shown by contracted pupil, haziness of anterior chamber, dimness of vision and pain over eyebrow. The iritis was treated in the usual way, by atropine instillations, hot fomentations of belladonna and mercurial inunctions, tonics and sedatives internally. In spite of all treatment, however, the pupil became contracted and updrawn, and when she left town, some six weeks afterwards, the eye was still irritable and vision was reduced to the counting of fingers. I have seen her quite lately (six months after the operation). The eye is quiet, the pupil V shaped and updrawn, but part of it is clear of capsule. She can find her way about the house, sees fairly at distance, and with glasses can read the large print of a newspaper. This case shows the troubles which follow a conjunctival flap. It also shows that it is better to leave the capsule behind, trusting to a secondary operation to clear it, rather than risk a loss of vitreous, by trying, injudiciously, to remove it.

CASE IV.—Mr. G., aged 62. Double senile cataract; mature in both eyes. A free liver who had suffered in his time from malaria. Operated on left eye on 21st April, 1884, assisted by Dr. T. Almon. The usual combined operation was done under chloroform, and the lens came away easily, on the end of the pricker. He suffered severely from pain, with great conjunctival inflammation during the first week, which I was at a loss to account for, till I found him considerably the worse for liquor, when visiting him with Dr. Almon, the sixth day after the operation. The eye became acutely inflamed, with chemosis, contracted pupil and dimness of vision. He was treated with solutions of boracic acid and atropine instillations. Stimulants (which had been allowed in moderation from the beginning) were withheld altogether, and a week after he was up and seeing clearly. I had a visit from him to-day (6th July) to fit him with glasses. The pupil is clear, key-hole in shape, and admits of good vision. With + 8 D. he sees well at distance ($V = \frac{2}{3}$ De Wecker's types), with + 14 D. he can read the smallest type in the text book.

CASE V.—Mr. D., aged 55; residence, Newfoundland. Double senile cataract; mature in both eyes, right eye one year, left 8 years. Operated on left on 4th June assisted by Dr. T. Almon. A small, low-placed corneal incision, such as that

recommended by Lubrech—done upwards and confined to the cornea. The lens on presenting was caught by upper section of wound. By pressing this down with the spatula it escaped easily. No other complication attended or followed the operation. On the 3rd day I examined the eye. The wound was healed and the cornea clear. On the 5th the bandages were removed, and a floating shade of black cloth replaced them. On the 8th he was allowed protective glasses and was able to leave the house, with the eye well guarded from light and dust, to take exercise. At the end of the month I fitted him with glasses. With + 8 D. vision= $\frac{2}{3}$ (reads De Wecker No. 7 at distance) with + 12 D. reads clearly newspaper type at 10 inches.

Correspondence.

To the Editor of the CANADA LANCET.

SIR,—The following questions have occurred to me in an hour or two of leisure, and are submitted for consideration, not that they present any new features, for undoubtedly every physician in ordinary practice has mentally asked the same, but to show some prevalent faults and to draw attention to matters pertaining to the welfare of our profession. Besides, it was thought that they would be a departure from the ordinary and monotonous style of medical reading so constantly subjected to our notice.

I. Why are there so many physicians engaged in other employments outside of their profession, who delight in a semi-philanthropic practice to the discouragement of others who endeavor to excel in, and who live solely by their profession?

II. Why are there so many among us who, in consideration of their length of practice, seem to deem it an honor to subscribe to the virtues of "Domestic Medicines," "Every Man his own Doctor," "Household Physician," and similar works?

III. Why is it that now and then a physician in good health, and doing (as he says) a \$3,000 or \$4,000 a year practice, will accept a position which brings in one-half or less of the above?

IV. Why do some Physician-Druggists allow themselves to act as vendors of such remedies as "Sir Jas. Clarke's" and "Lady Huntingdon's"

female pills, which are directed to be used with caution (?) at certain times?

V. Why do ministers of the gospel whom we, as a rule, attend without any pecuniary reward, whenever occasion presents itself at the bedside of one of their flock, interfere with the instructions of the physician, or tell about some similar cases wherein different treatment was beneficially used?

VI. Why is it that among these same reverend gentlemen there exist some who, without admitting any medical knowledge or having pursued medical studies, insult the regular profession with announcements of some specific "croup and diphtheria" compound, life saving pill or compound?

VII. Who is to blame for the ignorance existing among the public in regard to the distinction between patent medicines and well established therapeutical preparations, and where is there a man outside of the fraternity or drug business who understands why we prescribe Syr. Hypophosph. Co. (Fellows) and not "Dandelion Blood Purifier"?

VIII. Do our young physicians go to Europe for extra degrees or extra knowledge?

IX. Are not our nauseous and muddy mixtures advancing the interests of Homeopathy and the patent medicine business?

X. Why as a rule do many of our town and village brethren keep such filthy offices, filthy bottles of all sizes, colors, and shapes (pickle bottles are not uncommonly noticeable), when they know that neatness, cleanliness and order pay well?

"An' then a' doctors' saws and whittles
Of a' dimensions, shapes, an' mettles,
A' kind of boxes, mugs, an' bottles
He's sure to hae;
Their Latin names as fast he rattles
As A. B. C."

XI. Is there a physician of several years' practice who will deny the utility of a series of lectures to a graduating class pertaining to the ordinary duties and obligations of the profession to itself, and the public—and other minor details of a purely practical and business order, which so many of us have learned by sad experience and needless expense?

Yours, etc.,

QUEROR.

September 21st.

Reports of Societies.

HURON MEDICAL ASSOCIATION.

Oct. 7th, 1884.

Dr. Campbell, of Seaforth, presented a case of empyæma, in a boy 15 years of age, on which he had operated, first by aspiration, and after by free incision, removing, on the 29th May, six pints of sweet pus, and on the 12th June following, eight pints of foetid pus, by an incision three inches below the angle of the scapula. This was necessary on account of the distressing dyspnoea. Dr. C. was assisted by Dr. Elliott, of Brucefield. The treatment was, antiseptics locally, and syrup of the iodide of iron and Scott's emulsion constitutionally. Dr. C. also reported a case of puerperal eclampsia at eight months. Labor was induced, and delivery by forceps. The convulsions increased in frequency and violence until one-fourth of a grain of pilocarpine was injected hypodermically the second time, when recovery took place.

Drs. Gunn & Elliott presented a case of cirrhosis of the liver in a man 63 years of age. About two months ago he vomited nearly two quarts of blood and has not been well since. The question of cirrhosis was discussed, some thinking that it might be cancer of the stomach. The spleen, on percussion, appeared to be enlarged, and an incurable eczematous eruption covered his chest and face. Drs. G. and E. also showed a case of peculiar nervous hiccough connected with absence of menstruation, which has been in progress about four months, during three of which considerable vomiting was present. The hiccough is constant except when sleeping, and amounts to from 60 to 100 hiccoughs per minute.

Dr. Williams presented a case of blindness of both eyes from congestive amaurosis. The left eye became blind three years ago, and in the last week the other eye became blind in about three days.

Dr. Nichol, Bayfield, read a very interesting report of a case of traumatic tetanus, terminating fatally, produced by a gunshot wound of the thigh. The charge of shot had been in the wound three weeks when he first saw the patient, and tetanus had existed four days without treatment. The probe passed its whole length, and a counter opening was made to facilitate discharge. Any manipula-

tion of the wound at once produced a spasm. He died on the eighth day, twelve days after the tetanus began, and thirty-three days after the accident. Chloral hydrate appeared to be the only remedy that controlled the spasms. The question arose as to whether the charge of shot could not have been extracted and the young man's life saved. At the post mortem the charge was found a little beyond where the probe had reached, and a little perseverance in the early part of the difficulty might have found and extracted the shot by a counter incision.

Dr. Worthington, of Clinton, showed a case of compound fracture of the third metacarpal bone of the right hand, produced by a dull adze, the finger being shortened one-fourth of an inch. A method of extension was devised, and the wound was treated with boracic acid gauze. The wound united by first intention, and the patient suffered no pain from the first.

Some cases of ulceration of the leg were shown after typhoid fever, and a peculiar case of eczematous inflammation of the leg of long standing.

Selected Articles.

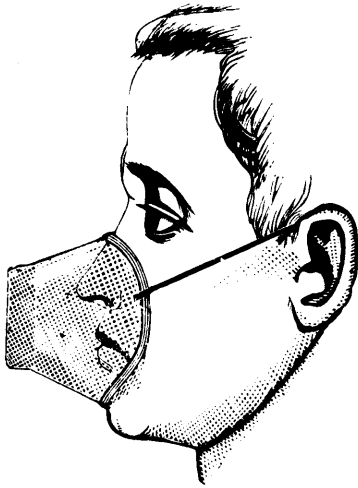
THE YEO RESPIRATOR.

Dr. S. Cohen, M.D., of Philadelphia, gives the following in the *Medical News*, Oct. 11th:—

Continuous inhalation of a volatile medicament by means of an apparatus worn over the nose and mouth—a so-called "*respirator*"—is by no means a novel idea; but the cost and clumsiness of most of the appliances devised for the purpose have until recently prevented this method of treatment from being carried out upon a sufficiently extended scale to afford a reliable test of its efficiency. Dr. I. Burney Yeo, of London, described and figured in the *British Medical Journal*, for July 1, 1882, a respirator constructed of perforated zinc bound with chamois skin, shaped to cover both nose and mouth, which carries a sponge upon which the medicament desired to be inhaled can be dropped, and which is retained in position by means of a pair of elastic loops passed around the ears. The lightness of this appliance, its cheapness, and its cleanliness, commend it as the best device for the purpose yet offered to the profession. Until within a few months it has been impossible to obtain the respirators in this country, and those used in the cases upon which this article is based, were imported. Messrs. Wyeth & Bro., of this city, are now manufacturing them, however, with a slight

change in style suggested by Dr. J. Solis Cohen. This modification consists in placing the sponge within a little cage formed by a fold of zinc in the front of the respirator, instead of retaining it in position by elastic bands.

The material of which the respirator is made being pliable, it can be accurately fitted to the face. The shape being adjusted, the sponge is wetted with hot or boiling water, and the medicament dropped upon it. The respirator is then fastened around the ears, and worn for such period as may be directed by the physician, or practicable for the patient. In many cases, the patient being engaged in his business occupations during the day, will consent to wear the respirator at night only. Some patients can sleep in them, others find it impossible to do so. The following are the substances



recommended by Dr. Yeo for inhalation; creasote, liquefied carbolic acid, spirits of turpentine, eucalyptus oil, terebene, spirits of camphor, solution of tar in rectified spirit, tincture of benzoin, and tincture of iodine. He uses of these five minims, either alone or mixed with an equal quantity of spirits of chloroform. Of course, any drug volatile at ordinary temperatures can be employed, but the list given by Dr. Yeo embraces nearly all which have been found of value in daily practice. I would add to it, however, chloroform, iodide of ethyl, and the alcoholic solutions of thymol and of menthol. Dr. Yeo's principal resort to treatment by the respirator has been in cases of phthisis, in which he has desired to keep up a continuous antiseptic inhalation; and the drug which he has found of the most service is creasote. From this treatment, in conjunction with proper hygienic measures and constitutional medication, he has obtained excellent results, some of which he has reported.

Dr. J. S. Cohen and myself have tested the method during the past two years at the German

Hospital, at the Philadelphia Polyclinic, and in private practice. The cases selected for this purpose number more than one hundred and fifty. While our results do not justify the endorsement of the plan as in any sense curative of phthisis, they have convinced us that much comfort may be afforded to patients past cure; that distressing symptoms may be quickly relieved, and in some instances entirely removed; and that recovery may be aided in cases affording reasonable basis for favorable prognosis. In other diseases of the respiratory organs, there has seemed to be a hastening of the favorable termination in some instances, and a marked degree of relief in others, even in chronic and incurable affections. Without detailing histories of cases the following general results may be recorded:

In Phthisis.—In cases with slight laryngeal involvement, the inhalation of terebene (ten drops, renewed every second or third hour) as continuously as possible during the day, with the addition of chloroform (five drops at bedtime) during the night, has seemed to allay the uncomfortable sensations of dryness and heat in the throat, and to restrain irritative cough. The relief has been particularly marked, and the gratitude of patients correspondingly great in cases in which, prior to the institution of treatment, sleep had been disturbed by violent spells of coughing two or three times during the night. In those cases in which the absence of a hemorrhagic tendency has permitted the use of daily inhalations of compressed air, after the increased coughing and expectoration caused by the loosening of retained and impacted secretions has subsided, there has been almost entire cessation of coughing. At most, in some instances, there has been a "clearing-out" cough on arising in the morning, and in but one or two instances has an unproductive cough remained during the day or night. In dispensary practice, oil of turpentine (twenty drops) has been prescribed instead of the terebene, with almost equally satisfactory results. In some cases, however, especially those in which there has been organic lesion or functional disturbance of the kidneys, terebene and turpentine have caused distressing symptoms referred to the back of the head and to the ears, and apparently due to cerebral congestion. Many patients, even among those whose disease has already proved fatal, have declared that they could not be induced to part with "the little machine." In one case, which I shall at some future time report in full, the patient, a girl of eighteen years, complained that the dose of chloroform (three minims) ordered at bedtime, "smothered her." On increasing the dose to five minims, the unpleasant sensations disappeared, and she fell almost immediately, upon retiring, into a refreshing sleep, undisturbed by the cough that had formerly harassed her throughout the night. While it is only fair to add that in this

case there was a constant and remarkable improvement in every respect under constitutional treatment, yet the relief to cough preceded other favorable changes.

In cases with marked laryngeal disease, the amelioration produced by treatment with the respirator, while decided, has not been so great as in the preceding group of cases. These patients have, as a rule, done better under creasote than under terebene; and where there has been extensive ulceration, eucalyptol seems to have done more good than either of the other drugs. Eucalyptol, however, has been on the whole a very disappointing and unreliable drug, failing utterly in some instances, and as yet, without affording any positive indications as to the conditions in which it is likely to prove of service. Whatever drug has been employed in this group of cases, whether terebene, turpentine, thymol, creasote, or eucalyptol, the best results have been obtained from its admixture with chloroform or with spirits of chloroform; chloroform alone being used at night.

In Bronchitis.—In subacute and in chronic bronchitis, good results have been obtained from the use of the Yeo respirator, worn for an hour or two at a time, during the day and night, with terebene, spirits of turpentine, or tincture of benzoin, as the medicament. In bronchorrhœa and in fetid bronchitis, creasote and carbolic acid have been advantageously employed, either singly or in connection with one of the other remedies. Eucalyptol has been of value in a few cases. Ethyl iodide has given excellent results in cases of profuse bronchorrhœa. Even in a few instances of pulmonary gangrene, the fetor has been controlled by this drug, after failure of other remedies. In most instances, cough has been restrained and expectoration has been diminished in amount and corrected in character; while the subjective relief afforded has often been most gratifying.

In Chronic Laryngitis and Tracheitis.—In cases of chronic laryngitis in which burning or tickling sensations in the throat, or annoying cough, have constituted sources of distress, terebene, creasote, camphor, and tincture of benzoin have proved very useful. Eucalyptol has succeeded where the other remedies have not answered a good purpose; but has not been at all reliable. It must be used, if at all, in small quantity (two or three minims on the sponge at a time) or well diluted. The benefit of inhalation by means of the respirator has been most marked in cases of laryngo-tracheitis characterized by a constant desire to hawk out something that seems to stick in the upper part of the trachea; a purely subjective sensation. In these cases terebene has been chiefly used, but tar has also seemed to be beneficial.

FIBROID TUMORS—DYSMENORRHOEA— RAPID DILATATION.

CLINIC BY DR. GODELL.

GENTLEMEN :—The first case is one which comes for diagnosis. The patient is a colored woman, 45 years of age, who has been married sixteen years, and had seven children, the youngest of which is five years old. She has not seen the menses for over one month. Previous to this they had been coming every two weeks, and were profuse. If she were an unmarried woman, or married and sterile, I should say that she either had a fibroid tumor or a polypus. But as she is a married woman and has children, then I would say, if she were white, that most likely she had carcinoma. On the other hand, she is a colored woman, and I have never yet seen carcinoma of the neck of the womb in a colored woman. We therefore come to the conclusion that she has some growth which causes the bleeding. The diagnosis lies between the rare disease of cancer and fibroid tumor. It is true that the bleeding might be due to fungous vegetations, but usually these do not cause bleeding every two weeks. They produce menorrhagia, with a profuse leucorrhœa between the periods. It might be a malignant growth within the cavity of the womb, but this is rare.

We shall now make the vaginal examination. The womb is decidedly larger than it should be, and on its posterior surface I feel a number of disseminated nodules. This is evidently a case of multiple fibroids. I had expected to find a tumor of some magnitude. The sound gives a measurement of 3.5 inches. I can feel the left ovary, which is hard, enlarged, roughened, and hardened. This is interstitial or parenchymatous degeneration, the result of ovaritis, and is not uncommon. I have never seen but one ovarian tumor in a colored woman, and that was in a mulatto. I can touch without much difficulty the promontory of the sacrum. She states that all the labors were hard, but that instruments were only used in the next to the last labor, and that all her children were very large. I can trace the sacrum all the way from the coccyx to the promontory. When you can touch the promontory of the sacrum with the finger, you may be sure that the pelvis is contracted. The promontory can be reached more readily in those cases in which the perineum is relaxed or torn. In this case the perineum is torn down to the sphincter.

Here is a woman whose womb measures three and a half inches, who has fibroid nodules in the posterior wall of the uterus, and also a laceration of the perineum. This latter, however, is not sufficient to demand the operation. She is not suffering enough to demand the operation. The change of life is coming on, and the nodules are not large

enough to warrant the idea that she is going to lose much blood. There has been an interval of a month since the last period, and perhaps the next may be longer than a month. We shall order for her ten grains of chloride of ammonium, and twenty drops of fluid extract of ergot three times a day. She will return in the course of a month, and report results.

The immunity of the colored race from cancer of the uterus is rather remarkable. Some of the southern physicians say that they have seen cancer in the colored race, but not so commonly as among the white race. They have another form of disease which the whites rarely have, that is keloid disease of the skin. I have seen this a number of times in colored people, but only once in the white race. Colored women are, however very subject to fibroid tumors of the uterus. It is rare to find a fibroid tumor in a white woman before the age of thirty-five years, but in sterile colored women from the age of twenty to thirty-five, they will be found quite frequently. These tumors do not cause death, although a physician who sees a great many of these cases has to operate occasionally. In a case which I saw the other day, I found a fibroid tumor as large as a man's head in an unmarried woman of thirty-nine. She is losing a great deal of blood, it is an anxious question to decide what is best to be done. Her physician states that during the past few months it has been growing rapidly. Now a fibroid tumor which increases rapidly in size may become so large as to interfere with any operation.

In operating for fibroid tumor of the uterus an exploratory incision is made, and if the tumor is found to have a pedicle, this is tied and the tumor removed and the wound closed, just as in the removal of an ovarian tumor; and this ought to be as successful an operation as removal of ovarian tumors. It is, however rare to find a fibroid tumor with a pedicle. They usually spring directly from the womb. When this is the case, the proper plan is to remove the ovaries, which is a simple operation. By so doing, not only is menstruation stopped, but large blood vessels passing to the uterus are ligated, and in this way the blood supply is to a great extent shut off from the tumor, and in the great majority of cases it will diminish greatly in size. I have performed the operation a number of times, and have failed to check the hemorrhage in only one instance, and in this case the tumor proved to be malignant. If the tumor is allowed to become too large, it may render the operation impossible. Two years ago I operated on an enormous fibroid tumor in a white woman of thirty. I had seen her a year previously and had urged the operation, but she preferred to wait. At the time of the operation the tumor filled the abdominal cavity, and must have weighed forty pounds. I had to make the incision from the ensiform cartil.

age to the symphysis in order to get the tumor out of the abdomen. The ovaries were attached to the tumor, and one of them was stretched to a length of six inches. It was a very serious operation, and the girl died in forty-eight hours. I have always regretted that I did not remove the womb in that case, although the result might have been the same. When the tumor is not large, it is possible to get at the ovaries without much difficulty. In these cases the ovaries and Fallopian tubes will as a rule, be found to be diseased. Very often the tubes are cystic. When the ovary is affected it is often a follicular degeneration in which the capsule is thickened and the follicles are enlarged and project from the surface, or else an interstitial degeneration in which the organ is enlarged, roughened, and hardened, cirrhotic in character.

DYSMENORRŒA : RAPID DILATATION.

Here is a patient thirty-one years of age, married and sterile, who has had a great deal of pain since the time of puberty. This has been so bad as to incapacitate her for work, and it has been growing worse and worse. Why should she have pain, and why should it grow worse? If an unmarried woman, or a woman who is married and sterile, comes to you with a history of dysmenorrhœa, what should pass through your mind? That it is a dysmenorrhœa from ante flexion; that it is due to a stenosis caused by the womb bending too sharply towards the front—towards the front because she has never born children, and the natural position is slight ante flexion. This is an exaggerated condition. There are very few exceptions to this rule. Sometimes there is retro flexion. As a rule, you will find ante flexion. The dysmenorrhœa is mechanical, and usually gets worse after marriage. The woman may have been able to get along pretty comfortably before marriage, but afterwards the pain becomes worse and worse. Nature intended that when a woman got married she should become pregnant, and if a married woman does not have children, she nearly always suffers. The pain of dysmenorrhœa, due to stenosis, is usually of that character. It gradually becomes worse until it culminates, and when it reaches the highest point, there is a sudden gush and the pain subsides. Then it begins again and reaches another culmination, which is followed by a gush and relief. The womb is bent. The menstrual blood tries to overcome the bend, but it cannot do so until it has straightened the womb. After the womb is sufficiently distended to remove the bent condition of its neck, there is a sudden gush of fluid followed by relief. The same thing is seen when a rubber tube is bent; the water flows through the tube until it reaches the bent portion, when it is arrested until the force behind becomes sufficient to straighten the bend, and thus overcome the obstruction. The pain is due, not only to distension of the womb, but also

to the efforts of the organ to force the blood out of its cavity. This causes thickening of the endometrium, which in turn tends to increase the difficulty. When a woman suffering with this form of dysmenorrhœa gets married and does not bear children, the congestions arising from sexual intercourse will cause greater thickening and hypertrophy of the lining membrane of the womb, and consequently the cervical canal becomes still more contracted. There is not only thickening of the endometrium, but also hypertrophy of the parenchymatous structure of the womb. Then there is congestion of the ovaries and structural changes following on this congestion. These changes may either result in follicular or interstitial degeneration.

I shall now make a physical examination. The first thing I detect is a virginal cervix. It is not thicker than my little finger. The os is very small. With a little manipulation, I get the sound past the bend and obtain the measurement of three and a quarter inches. This increased length of the womb has been produced by the dysmenorrhœa. I propose to operate for this trouble by forcibly dilating the neck of the womb. The cutting operation is the one usually recommended in the books, but that is a dangerous operation, and is by no means as successful as forcible dilatation. I have notes of one hundred and fifty cases in which I have performed this operation, and there has not been one fatal result, and in but one or two has there been any pelvic inflammation. To show you the result of the operation, let me refer you to a case on which I operated a number of years ago. A clergyman's wife came to me suffering greatly with dysmenorrhœa. She had been married several years, and was sterile. I dilated the canal and heard no more of the case until a few days ago, when I saw her physician who told me that after the operation she had gone home, and the first year had twins and has been having children ever since. I have had a number of such cases, in which pregnancy followed the operation. In the majority of cases, it is not necessary to perform the operation more than once, provided it is done thoroughly under ether. Women often object to taking ether, and want me to do it in my office without ether. I always tell such patients that the operation gives a great deal of pain, has to be repeated frequently, and is very imperfectly performed under such circumstances. I tell them of the man who had a dog of which he was very fond. The dog had a long tail greatly disfiguring him. The tail had to be cut off, but the owner of the dog disliked to give the dog so much pain—he therefore concluded to take off an inch a day until a sufficient length had been removed.

I shall first take this Ellinger's dilator and tunnel my way into the womb. First, introducing the dilator as far as it will go and dilating to that point, then pushing it a little farther, I again dilate, and

in a few minutes the instrument passes the internal os. Sometimes when the os is too small to admit the entrance of the dilator, I enlarge it with the scissors, keeping the blades closed, and using them with a boring motion. As I remove the dilator, you observe that a quantity of thick mucous follows its withdrawal. Whenever this is seen it is an evidence of obstruction. I shall now introduce the larger Wilson's dilator. In buying a dilator of this kind, you should be sure to see that it has these little shoulders on the blades to prevent it from slipping too far into the uterus; for if the blades should come in contact with the fundus of the womb and be separated in that position, there would be risk of producing serious injury. After dilating up to a certain point, I wait a while. In all the cervixes that I have dilated, I have torn only two. One was in a virgin and produced a slight laceration. The other was in a case which had been treated by the application of nitrate of silver until the tissues had been made brittle by the formation of cicatricial tissue. In that case a slight laceration was produced, and the bleeding was free enough to require the application of Monsel's solution. That is the only case in which I found it necessary to apply any styptic. Sometimes I get hold of a very small cervix, one which is really infantile. Under such circumstances I do not expand the instrument to its fullest capacity, for fear that I may tear the cervix. In the majority of cases, however, I dilate to the fullest extent of the instrument. This gives an os through which the finger may be passed to examine the interior of the womb, and in many cases this is better than dilating with sponge tents. There is not the same danger as exists with sponge tents. On the other hand, tents will dilate to a greater extent. After a dilatation of this kind I can often introduce my finger into the womb, although I am not usually able to do so in sterile cases. I have now separated the blades of the dilator to their fullest extent. I shall remove the ether and allow the instrument to remain until the woman begins to flinch. Just before beginning the operation, I introduce a suppository of one grain of the aqueous extract of opium into the rectum, so that by the time the operation is completed the suppository will have dissolved and the opium be absorbed. At first the pain is great, but it soon subsides. Usually two suppositories are all that is required, one being given at the time of operating, the other two hours afterwards. If the pain continues, the opiate must be repeated. If there is much soreness, I have a poultice placed over the abdomen. I always like to keep these patients in bed for forty-eight hours. For the first twenty-four hours I order a light diet, and after that the patient returns to her ordinary food. If the soreness continues, I keep them in bed until it disappears. The woman is now beginning to show evidence of feeling the pain, and I

shall remove the dilator. It is very probable that some of the muscular fibres have been ruptured. I know that some of them have been over-stretched and will never contract as before. There is, as you see, a little oozing of blood, but I shall not attempt to check this, for I consider a little bleeding an advantage, as it tends to prevent the occurrence of inflammation. I have never had severe metritis or peritonitis after this operation. I have, however, seen slight localized inflammation follow it.

You will often be consulted by sterile women who want to have children. It is a mania with them. If a woman wants to have children, she will go through fire and water to become pregnant; and on the other, hand, if she does not want to have children, which I am sorry to say is the crying evil of the day, she will go through fire and water to prevent conception. If a woman wants children, all her friends know of it. Sometimes this operation will enable such a woman to become pregnant. At times, however, the condition has lasted so long that changes in the uterus have been induced which effectually prevent conception. If you are fortunate enough to enable her to have children, she will blazon your name and skill all over the neighborhood. If this operation is done carefully, I can recommend it most confidently. It is much safer and far more successful than the cutting operation, which I am happy to say is now rarely performed. —*Med. and Surg. Reporter.*

WOUNDS OF THE INTESTINE—GROSS.

* * The diagnosis of wounds of the bowel is a matter of primary consideration, as upon its prompt determination the success of our treatment must mainly hinge. The possibility of this will, of course, mainly depend upon the situation in which the bowel is found at the time of the accident. If it has escaped through the wall of the abdomen it will generally be easy to find the injured part by the egress of some of its contents, as *fæces*, mucus, or bile, or all these together; and so also when there is a discharge of some, or all, of these substances through the outer wound, although there be no protrusion of the intestine. The coast in both of these conditions is sufficiently clear; so clear, indeed, that he who runs may read and accurately interpret. But it is altogether different when the abdomen has been pierced with a narrow instrument, as a knife or a dirk, or perforated by a bullet. In such an event the bowel does not protrude, and hence the true nature of the case must be solely a matter of conjecture. All that is positively certain in such event is that there is a wound in the wall of the abdomen. The surgeon, especially if called immediately or soon after the receipt of the injury, must be in doubt whether the weapon has entered the bowel or not. In reflect-

ing upon the subject he recalls the fact that a bullet, a rapier, a sword, or a ramrod has occasionally passed through the abdomen, and, perhaps, even emerged at the opposite side, without in the slightest degree interfering with any of its contents. The records of surgery furnish many such cases.

The two principal signs which must serve to guide us in these uncertain cases are tympanites and a discharge of blood by the anus. The occurrence of tympanites is unquestionably a symptom of great value. Jobert, who was the first to notice it, regards it as the most reliable of all the phenomena when there is no escape of *fæces*, mucus, bile, or other fluid at the abdominal wound, and in this opinion the results of my personal observation fully coincide. The tympanites supervenes at various periods; sometimes almost immediately after the wound in the bowel has been received, and is then always of proportionate diagnostic value; at other times it supervenes very gradually, and in some cases, again, it does not make its appearance under twenty-four, thirty, or thirty-six hours. However this may be, it is always diffused, not circumscribed, and sometimes reaches an enormous height, the belly emitting a hollow, drum-like sound on percussion, and is then always very painful.

Although tympanites is generally present in lesions of this kind, there are cases in which it is entirely absent; as, for example, when the wound in the bowel amounts to a mere puncture, in which the opening is effectually closed by the protrusion of the mucous membrane, thereby preventing all escape of gas into the peritoneal cavity.

A discharge of blood by the anus I regard as a very valuable symptom of the existence of a wound in the bowel. It is especially valuable when it makes its appearance within a short time after the infliction of the external wound, and when it continues, more or less abundantly, for some days afterwards. As the blood is always intermixed with the contents of the bowels, it seldom comes away in a pure state, but is generally of a dark color, and of a grumous consistence.

No useful conclusions can be deduced from the shock and the pain which attend lesions of this character, since both vary greatly in different cases and in different circumstances, some persons suffering very little, while others, owing to the peculiarities of their nervous endowments, experience extreme distress.

In regard to probing wounds of this kind, the universal sentiment of the profession is opposed to it, on the ground that, while it can do no good, it would often be productive of great harm, by disturbing the relation of parts, and thus endangering *fæcal* effusion. I do not think, however, that this rule should apply to the mural wound. Here a probe, properly used, might at least afford useful

information in regard to the direction and extent of the external injury.

In the treatment of wounds of the intestines two leading indications are scrupulously to be kept in view—the prevention of fecal effusion, and occurrence of peritonitis. To secure the first, the only safeguard is efficient suturing of the wound. A case, it is true, occasionally recovers without any precaution of this kind, but this is owing to good luck rather than to good treatment. The question here naturally arises, should all wounds of the bowel, however small, be sutured? Upon this subject there was certainly till recently, if indeed there is not still, some diversity of opinion. Dionis, Palfin, Heister, and Sabatier state that enterrorhaphy is unnecessary when the wound does not exceed the diameter of a goose-quill or a penknife; and views of a similar nature are to be found in other writers, as Sharp, Richerand, Boyer, and Jobert. On the other hand, there are surgeons who are opposed to the return of the bowel into the peritoneal cavity, however small the intestinal wound, without the employment of sutures, lest fecal extravasation should ensue. The great Benjamin Bell, of Edinburgh, writing near the close of the last century, holds, in the midst of the darkness that surrounded him, the following emphatic language: "However small a wound of the intestine may be, it ought always to be secured with ligature; for, although it is alleged by some that we should rather trust to nature for the cure of a small opening than to insert a ligature, to me it appears that the opinion is by no means well founded, inasmuch that I would not leave even the smallest opening, that could admit either *feces* or chyle to pass, without stitching it up. Much danger may ensue from omitting it, and the hazard of the patient cannot be increased by the practice being adopted." This advice of the sagacious Scotchman, so clearly and emphatically enunciated nearly a century ago, is now the universal practice in all cases of wounds of the bowel, however diminutive, based as it is upon the well-ascertained fact that enterrorhaphy, when properly performed, is a harmless operation as compared with the risk of fecal extravasation and the consequent certainty of peritonitis.

Judging from the results of my own observations, I have long been of the opinion that there are only two sutures that should ever be employed in sewing up a wounded bowel. These are the continued and interrupted, with the modifications of the latter by Lembert and Gély. As to Jobert's method, which consists in invaginating the ends of the bowel, when completely cut across, so as to place the two serous surfaces in immediate contact, to facilitate their prompt union, the operation is not only extremely difficult, but very liable, even if successful, to be followed by more or less contraction of the tube at the seat of the injury, thereby

interfering more or less seriously with the transmission of its contents.

The interrupted suture is, as a rule, preferable to the continued, in all wounds of the bowel, whatever their extent or direction, whether they embrace the entire calibre of the tube or only a limited portion, and whether they are circular, oblique, or longitudinal. The operation executed with a long, slender sewing-needle armed with a thin, but strong, well waxed silk thread, is comparatively simple, affords ample security against fecal effusion, and is never followed by injurious contraction of the tube. The sutures should be placed not more than one line and a half, or the eighth of an inch, apart, and the ends, tied in a double knot, should be cut off close, so that in time the sutures may find their way into the bowel and be discharged along with its contents. I deem it very important that each suture should be fully one line from the edge of the wound, and that the needle should be passed deeply through the wall of the bowel instead of embracing its entire thickness—an arrangement which would almost inevitably be followed by more or less puckering, and by the consequent retardation of the cure. The operation of uniting the bowel where the division is complete, will be greatly facilitated if the first suture be inserted at the mesentery and the second immediately opposite. The best, certainly the safest, ligature for suturing a wounded intestine is ordinary sewing *silk*, well waxed, and inserted with a long, sharp sewing-needle. The carbolized catgut ligature is liable to give way prematurely, and should, therefore, be avoided.

In the modification of this suture by Lembert, the object is to invert the edges of the wound so as to bring the two serous surfaces in immediate and firm contact, to establish, as it were, union by the first intention. Great advantage has been claimed for this form of wound, but this is not so apparent when it is remembered that, unless great care be taken in introducing it is liable to be followed by more or less contraction of the tube. In making this suture the needle makes two dips on each side of the wound instead of one, as in the ordinary procedure.

"Gély's suture, which is merely a modification of that of Lembert's, is made with two needles inserted near the angle of the wound, about one line from its edge; they are then carried along the interior of the bowel, parallel with the wound, for the sixth of an inch, when they are brought out precisely at the same level, so as to appear again on the peritoneal surface. The threads are then crossed, the right needle being passed through the puncture made by the left, and conversely, when the ends are firmly tied and cut off close, as in the ordinary operation. The number of sutures varies, of course, according to the extent of the cut. In this way the edges of the wound are thoroughly in-

verted, and consequently all danger of fecal effusion is prevented; the coaptation, in fact, is so accurate as to conceal the ligatures.

The treatment of wounds of bowel by the continued suture has afforded good results in my experiments upon dogs. The chief objection to it is that it leaves the edges of the wound in an uneven, puckered condition, which interferes, perhaps, somewhat with rapid union. This, however, may be prevented in great degree, if not wholly, by the employment of a double thread, after the fashion of the glover, although I do not consider this at all essential to success. Of the seventeen experiments performed with a single ligature, not one terminated fatally. The wounds in two of the cases were transverse, oblique in three, and longitudinal in twelve. The wound in one of the latter was six inches in length. The dog, a large, old one, was killed on the twentieth day, when every trace of suture had disappeared, with the full restoration of the calibre of the tube. I must not omit to state that in all these experiments the sutures were passed through the fibrous tunic of the bowel, or, in other words, outside the mucous membrane. We have here, then, also a very valuable suture for sewing up wounds of the intestines, especially well adapted to the treatment of longitudinal and oblique wounds; not so well, I think, to the treatment of transverse ones as the interrupted.

The suturing of the wound having been completed, and any foreign substance that may be present removed, the bowel is restored to its natural situation, followed by the omentum, in the event of its prolapse. It is hardly necessary to say that the protruded structures should be treated in the most gentle manner; any wiping that may be required should be performed with the softest cloth, and all firmly adherent matter should be picked off with the forceps. Generally speaking, the best way of cleaning the parts is to make free use of the syringe, charged with warm water. The operation may be completed with a one to one thousand solution of corrosive sublimate. The return of the bowel will be materially facilitated by the use of a little olive oil. If any serious obstacle offer, it must be surmounted with the probe-pointed bistoury, or by puncture of the tube, if it depend upon the presence of gas. The wound in the wall of the abdomen should be closed in the same manner as in ovariectomy, the sutures being carried through the peritoneum so as to protect the parts effectually against hernial protrusion, a thing never to be lost sight of after such lesions.

The question arises here, What should be the conduct of the surgeon when the bowel is wounded, but not prolapsed, owing to the small size of the mural opening? I do not think I can answer this question better to-day than I did forty years ago, when we knew comparatively little of abdominal

surgery, and when the most visionary enthusiast could not have dreamed of half the triumphs that have since awaited it. The case in question is a suppositious one, and is thus stated: "A man, after having indulged in a hearty repast, receives a penetrating wound in the abdomen from the thrust of a dirk or knife; the bowel is pierced, or it may be, nearly divided, and there is a copious discharge of fecal matter, both externally and into the peritoneal cavity, as is evinced in the latter event by the excruciating pain, the gastric oppression, and the collapsed condition of the sufferer. Here the most prompt and decisive measures must be resorted to, or the person will perish from peritoneal inflammation, with as much certainty as if his skull had been fractured and a portion of his brain had been let out. It will not do for the surgeon to fold his arms, and look upon the scene as an idle and disinterested spectator. Far otherwise; he has a duty to perform, and that duty consists in dilating the external wound, if it be not already sufficiently large, in hooking up the injured bowel, and in closing the solution of continuity with the requisite number of stitches, at the same time that the effused matter is carefully removed with tepid water and a soft sponge. All wiping must, of course, be carefully avoided, as this would add much to the risk of peritonitis.

It is a rule with all educated surgeons to do the work which they are called upon to perform in as complete and thorough a manner as possible, and nowhere is this precept of greater importance than in the treatment of wounds of the intestines. A case recently reported by Professor O. K. Roberts, of Louisville, Ky., will aid me in illustrating my meaning. A man was cut in the abdomen with a pocket-knife; the wound was three inches long; the bowel protruded, and was pierced at two points, one opening being of the size of a common lead-pencil, the other of a pea. The knife in its passage had stripped off the serous membrane over a space of one inch by one quarter. There were two slits in the mesentery, each one inch in length; and the patient had lost much blood. The mural wound was closed by sutures which embraced only the skin and superficial fascia. None of the bleeding vessels had been secured, and active bleeding was still going on from three points in one of the wounds in the mesentery, the other being occupied by a clot. It was in this condition that the man was found by Dr. Roberts, shortly after his wounds had been dressed by another surgeon. Satisfied at a glance that the case had not been properly managed, Dr. Roberts reopened the mural wound, secured the bleeding vessel with carbolized catgut ligatures, stitched the opening in the gut more thoroughly, washed out the peritoneal cavity with hot carbolized water, and closed the abdominal wound with deep sutures, completing the dressing by inserting a drainage-tube in the lower angle of

the wound. Under this treatment, with proper subsequent care, the man made a rapid recovery. Had the dressing originally applied been allowed to remain, death would have been inevitable; either from hemorrhage, peritonitis, or peritonitis and septicæmia. The case affords a happy exemplification of hasty, careless, slovenly surgery, on the one hand, and of thoughtful, wide-awake, scientific surgery on the other.

The therapeutics after all such lesions is sufficiently simple. The great point is to prevent peritonitis, or to combat it, if it takes place. The posture should be such as to relax thoroughly the abdominal muscles. The bowels should be locked up with opium, to prevent peristaltic action, and nothing but iced water or pounded ice, aided, if there be much gastric distress, by a small allowance of dry champagne, should be permitted during the first three or four days. Oppression from gas should be relieved with injections of turpentine and asafetida. Peritonitis should be met with leeching, followed by vesication with cantharidal collodion, and full doses of opium; venesection will be proper when the patient is young and robust. A laxative of castor oil, or of sulphate of magnesium, may be given at the end of five or six days, if there be marked suffering from tympanites. The urine should be drawn off during the first few days, with the catheter.

I have, thus far, said nothing of gunshot wounds of the intestines. Such wounds are generally of a very serious nature, and are, therefore, liable to be followed by the worst consequences. In the first place, they are nearly always concealed wounds, from the fact that there is no prolapse of the bowel; secondly, such wounds are commonly multiple, as in one of my own cases, in which there were as many as eight perforations—two in the ileum, two in the jejunum, two in the duodenum, and two in the arch of the colon; thirdly, there is always more or less copious effusion of fecal matter; fourthly, great shock, to say nothing of hemorrhage, which nearly always attends; and, lastly, most patients who survive the more immediate effects of such injuries are almost certain to succumb to peritonitis. The only rational treatment in such cases is to expose at once, or with the least possible delay, the peritoneal cavity, to stitch up, or excise, the wounded bowel, and, lastly, to clear away all extraneous matter. Excision of the tube is imperatively demanded when the wound is very large, severely contused, or very ragged. Nothing short of this would answer under such desperate circumstances; and even then no sensible surgeon would venture to pronounce a favourable prognosis.—*Med. News.*

INFANT DIGESTION.

In the July number of the "Archives of Pædiatrics," Dr. H. R. Bigelow, of Washington, says: "The question of infant growth is one of assimilation. Assimilation of food will depend upon the integrity of the digestive function. The digestive system of the new-born is not formulated at once, but develops in logical ratio with the expansion of other parts of the body. Its measure is the requirement necessitated by the elaboration of tissue. Tissue-growth is a slow process, demanding special nourishment, and varied at each advance in age. The necessities of the child, both chemical and physiological, are not those of the adult, because each is adjusted with great exactness to the immediate environment. The excess of non-nitrogenous matter, which is an essential to adult life, is pernicious to the well-being of the infant. Muscles, when at work, consume principally hydrocarbonaceous aliments, and not albumenoid substances. In the infant there is no muscular exertion, and hence it draws more largely for its development upon the nitrogenous substances than upon the hydrocarbons. At birth the alimentary tract is short, the cæcum being very small and the masticatory organs are absent. Bidder says that the ptyalin appears only with the cutting of the first tooth. Reasoning from analogy, it is not improbable that the pancreatic and intestinal ferments are also inoperative until about the eighth month. Nature is not a spendthrift, and she would not call into useless action any function not demanded by the necessities of her own handicraft. With the eruption of the teeth a new era begins. Mastication presupposes increased development. Increase of development calls for increase of nourishment, and increase with variety in nourishment sets up new digestive processes, in which the ptyalin and other ferments play an important part.

"The alimentary tract of the infant is exceedingly susceptible, so the nursing women have to be very careful in their diet. Now, if this tract is so impressionable as to feel any departure from a standard diet in the mother, how much more seriously will it suffer in the administration directly of unwholesome cow's milk—not unwholesome, perhaps, in the light of general use, but unwholesome for the limited infantile digestion. It may have an *acid* reaction, or it may have come from a cow in *heat*, or it may be tainted with certain vegetable substances obnoxious to the child. The natural food of the baby is its mother's milk.

"An intelligent study of human milk will lead up to a more just comprehension of the demands of infant digestion, and to a more perfect knowledge of a physician's duty in prescribing for such cases as are, unfortunately, deprived of the mother's breast. It would be a valueless encumbering of space, and an expenditure of time without profit,

PROF. PARVIN favors the employment of anæsthetics during the use of the forceps.

to cite one half the analyses that are matters of record. It best subserves the present purpose to view the main constituents of human milk in their relation to certain physiological principles. It is to be noticed first, that woman's milk has an *alkaline* reaction, which persists for an indefinite period, and a specific gravity of about 1.0317. It contains water largely in excess (89.20 in 100 parts) milk-sugar, nitrogenous matter, fat, and salines. The albumenoids will vary in different women so largely that we can not affirm that any analysis is infallible. A fair average percentage would probably be about 4.84. The milk-sugar (6.987) is much greater than in cow's milk (4.92). These figures are only approximately correct. No two samples yield the same results. This variability in the composition of women's milk, if not pathological, is a wise dispensation of nature to provide for the exigencies of each month of advancing age. Thus the function of the milk-sugar as a heat-producer is kept constantly in mind, while the absolute rate of nutrition may vary within wide limits, because the bodily heat must be preserved at all hazard. In fat, women's milk exceeds that of the cow, but falls far below it in albumenoids. The ash, or mineral constituent of milk, is chiefly concerned in metamorphosis. The basic phosphate of sodium is invariably found in the blood while the acid phosphate of potash is the chief constituent of the juice of the flesh, Phosphate of lime is intimately incorporated with the nitrogenous constituent principles. It is very generally admitted that the carbohydrates lead on to fat-production, through the co-operation of the nitrogenous and saline elements. Nitrogenous elements themselves, when in excess, may also serve as a source of fat. Nitrogenous matters do not, probably, undergo complete oxidation within the body; a portion of them is eliminated as urea. Fatty compounds are of higher value as force-producers, because they contain a quantity of hydrogen as well as of carbon free of oxidation. Pavy says that the value of nitrogenous compounds as force-producers depends upon the amount of unoxidized oxidizable elementary matter they contain. In human milk the percentage of nitrogenous matter to carbohydrates is about 1.45. About one fourth part of its casein is coagulable by acid. The *alkaline reaction* is *highly valuable*, since it serves to convert the *casein* into *soluble albumenoids* and soluble carbohydrates, which are great heat-producers. Writing upon this subject, Kuss says: 'It is generally admitted (Moleschott, Voit) that an adult consumes 320 grammes of carbon and 21 grammes of nitrogen, or in other words, 130 grammes of albumenoid elements, and 488 grammes of hydrocarbons and fats (fats 84, hydrocarbons 404); it follows that, in this case, the normal proportion in a mixed diet, of nitrogenous to non-nitrogenous aliments, is 1 to 3.7, while in milk, as well as in the egg, the proportion is 1

to 3, or even 1 to 2; in other words, the quantity of albumenates (nitrogen) is much larger, and of hydrocarbons (carbon) much smaller. This fact may be easily explained by referring to the part played by the hydrocarbons in regard to the production of force—muscular force especially. The adult draws his forces from the combustion of non-nitrogenous substances, the albumenates scarcely serving for this purpose. On the other hand, when the organism is in course of development, the nitrogenous substances are indispensable to the growth of the different tissues. It is therefore easy to see how mistaken is the common practice of condemning children to a diet containing a large quantity of starch and scarcely any nitrogen.'

'Women's milk contains no starch. It may be conceded that, in the adult, the ptyalin may continue its action in the stomach; that particles of unconverted starch may be transformed by the pancreatic and intestinal juices. In the infant this rule cannot apply. The baby does not secrete ptyalin until the sixth or eighth month, *neither do the other juices, of pancreas and intestine, have any transforming power whatever before that period.* It is sheer ignorance to assert small particles of starch can do no harm, since they undergo transformation in the intestine, when the truth is that they not only act as irritants, but pass out of the bowels unchanged. The attenuant of woman's milk is an important factor, of which we have little absolute knowledge. It is chiefly in consideration of this point that *cow's milk can not ever be safely substituted for that of the mother.* Before it can be satisfactorily approximated to this great food of nature it must be radically transformed by some chemical process, which science has not yet developed. The addition of water to cow's milk will reduce the percentage of albumenoids into harmonious relationship with human milk, but it does not suffice to change the characteristics of the clot. To use starch as an attenuant is, of course, radically wrong.

'In view of these facts, it becomes a matter of the utmost interest to establish some definite principles of treatment, in cases where the mother is unable for any reason to nourish her child properly and sufficiently. There is no known process, chemical or mechanical, by which cow's milk alone can subserve this purpose. Up to six months of age, at least, the baby needs just those equivalents found within the mother's breasts—nothing more and nothing less. The compound must be *alkaline* in reaction; it must contain *no cane sugar* (because cane-sugar must be first converted into grape-sugar before it can be assimilated; cane-sugar is frequently subjected to a kind of acetous fermentation, producing excess of acids in the infant stomach so that bodily heat will diminish and disorders of respiration and circulation will follow), and *no starch*. It must be rich in heat-producers, although, as I have said before, the amount of albumenoids

may vary greatly. Position has something to do with digestion. In some bad cases it will be found that, if the infant be placed in the usual position of a nursing child in its mother's arms, it will assimilate its food, when artificially fed, much more readily. In the nursing child a by no means inconsiderable amount of heat is derived from the mother's body. An artificially fed infant is deprived of this, so that there should be some compensatory action in its food. There have been many attempts made to overcome this difficulty, and our journals have been full of discussions upon the matter. It may be said that no artificially prepared food that does not meet in all these requirements will be of permanent value in infantile therapeutics. What is needed is something rich in carbohydrates, with a proper admixture of albuminoids, salts, and moisture, free from starch and alkaline in reaction."

Dr. Bigelow gives notes of three cases of disease in infants, with disturbed digestion or assimilation, in which great benefit attended the use of Mellin's food. "I satisfied myself," he says, "by personal analysis of the constituents of the preparation, and found that it contained the principles which it seemed to me nature demanded, in exact combination, and more satisfactorily and more cheaply prepared than I could compound upon my own prescription."

EPILEPSY TREATED WITH HYDROBROMATE OF CONIA.

BY R. NORRIS WOLFENDEN, B.A., M.B. CANTAB.

Being frequently disappointed in the action of potassium bromide in the treatment of epilepsy, I have lately been trying a remedy which I believe has not previously been used for this complaint. If the result is not quite so favorable as I might have expected, it is at any rate sufficiently good to warrant further trial, and I venture to place on record the notes of seven cases, in the hope that it may lead to further observations. We have all experienced the failure of potassium bromide until poured in in such quantity that often a condition of bromism is established. The unsightly blotches thus produced are a source of annoyance, especially to the better class of patients, to whom personal appearance is a matter of concern. The following is a summary of my notes.

CASE 1. A., girl, æt. eight: ill for two years, with epileptiform seizures consisting of sudden flexions of the fore-arm (right), and a momentary vacantness of look; latterly the attacks had become more severe, culminating in loss of consciousness. Hydrobromate of conia, in doses of half a grain three times a day, was prescribed. During the first week she had six slight "fits" The dose was

then increased to $\frac{5}{8}$ of a grain, and during the succeeding week she had no attack. The medicine was continued for four weeks, during which time she had no fits at all, and slept better. The drug was then discontinued for some weeks, when she returned for further treatment. During its administration this patient complained of constant frontal headache.

CASE 2. B., male, æt. 22: suffered from true epileptic fits, with typical aura, convulsions, unconsciousness, and great headache afterwards. One and a half grains hydrobromate of conia was ordered twice a day; during the week, this patient had nine fits. One and five-eighths grains was given twice daily for a week. During this time the patient had four bad fits. He was now, at his own request, put under potassium bromide, 3 j doses, three times a day, which kept them under.

CASE 3. C., female, æt. 34: had been ill for four years, with one or more fits every week, typically epileptic. While taking potassium bromide they were kept under. I ordered one grain of hydrobromate of conia twice a day to commence with. For a week she was better, with only one slight attack. The dose was increased to $1\frac{1}{4}$ grains, and during the next fortnight she had one slight fit. She was then ordered back to bromide.

CASE 4. D., girl, æt. 7: has seven or eight fits a week, of a typical epileptic character. She has frequently right-sided convulsions, the right arm being suddenly flexed. Sometimes these culminate in a real fit, with insensibility and rigidity. The child is an imbecile. As while under 3 j doses of bromide, the child still had frequent fits, I ordered $\frac{1}{4}$ grain of hydrobromate of conia three times a day. For the first week she had five fits (all occurring the day after the medicine was changed). For the second week there were seven fits. The drug was increased to $\frac{1}{2}$ grain three times daily. For a fortnight she was absolutely free from fits, and then had seven. The drug was continued for some weeks, but she still had fits occurring at irregular intervals, which were refractory both to conia and potassium bromide.

CASE 5. E., female, æt. 27: has typical epileptic fits which continue under 3 j doses of potassium bromide. I administered $\frac{1}{2}$ grain of hydrobromate of conia three times a day. During the next week she had no fits and stated that she felt better, but with frequent headache. For a month while under this treatment she had no fit, but complained of more frequent headache, in consequence of which I returned to bromide.

CASE 6. F., male æt. 18: would have three fits a day, and then go for a week without. They were typically epileptic fits. While under large doses of bromide they were kept under, but not until an unsightly bromide rash was established, which was troublesome to the patient. For the first week, while taking one grain hydrobromate of conia twice daily,

he had three fits. For a fortnight longer while under this treatment he had two fits. During the whole three weeks he therefore had five typical epileptic fits. As he stated that the drug made him feel giddy and weak, I returned at his own request to bromide, which so long as he was entirely under its influence in large doses seemed to ward off his attack. This young man was of weak intellect.

CASE 7. G., female, æt. 15 : suffered from true epilepsy, dilated pupils; her optic discs were congested. She had not menstruated and had phthisical symptoms (cough, hæmoptysis, sweating). Half grain doses of hydrobromate of conia were ordered three times a day. During three weeks she had no fit, which she stated was the longest time she had ever been without. I then lost sight of her.

The conclusions I draw from the treatment of these seven cases are—that the drug is undoubtedly serviceable in certain cases, and those in which it fails are cases of convulsions depending possibly on some gross lesion of the brain (Cases 4 and 6). The slighter cases (*e. g.* Cases 1 and 7) were distinctly benefitted by it.

The drawbacks to the use of the drug appear in the complaints of headache, and where in large doses, of giddiness lasting for an hour after taking it, with sometimes a suffusion and congestion of the conjunctivæ. In the doses in which I have given it, there has not been noticed any cardiac or respiratory alteration. It is said that the dose of this drug must not exceed $4\frac{1}{2}$ grains in 24 hours, commencing with $1\frac{1}{2}$ grains. In my experience a child of eight bore $1\frac{7}{8}$ grains with only headache; a child of 7 took $1\frac{1}{2}$ grains per diem, without any complaint: $2\frac{1}{2}$ grains per diem, were taken by a female without complaint: one adult man took $3\frac{1}{4}$ grains with impunity. In one case two grains per diem caused sickness, headache, giddiness, and "weakness" in a man of 18. One and a half to two grains appears to be followed frequently by headache. I think the drug deserves further trial. Combined with constant application of the continuous current, I have successfully treated with it a case of hemichorea. In this disease however, it would be rash to speculate whether the drug, the galvanism, or the time was the most effectual in the cure.—*Practitioner*, June.

THE TREATMENT OF DIABETES MELLITUS.

In the *Col. and Clin. Record* Aug. 84. Dr. Flint Jr. gives the following summary of treatment. He says:—"The more I study the cases of diabetes that have come under my observation, especially those that are now under treatment, in connection with the writings of those who have faithfully followed the dietetic plan, notably Bouchardat and

Cantani, the more thoroughly I am convinced that the prognosis in a recent and uncomplicated case of this disease in an adult is invariably favorable, provided, always, that the proper measures of treatment be rigidly enforced. In the hope of convincing the profession that this statement is reliable, I shall at the risk of what may appear to be needless repetition, give a summary of treatment, with brief statements of the progress of cases that I am now actually observing.

At the outset, patients should be impressed with the fact that they are suffering from a grave disorder, and that everything depends upon their full co-operation in the treatment, which treatment is essentially dietetic. The diet table should be carefully studied, and the diet regulated and carried out absolutely. In case a rigid anti-diabetic diet does not promptly influence the glycosuria, it may be well to subject the patient to an absolute fast for twenty-four hours and follow this with anti-diabetic regimen. This rather harsh measure is suggested by Cantani. I shall not hesitate to employ it in cases in which it may seem to be required, although no such case has yet come under my observation. Systematic daily muscular exercise should be enforced. A moderate system of training on the plan adopted by athletes is most useful; and this, if continued, will do much to render a cure permanent after a return to the normal diet.

The return to a normal diet should be gradual, and during this time the urine should be frequently examined, the rigid diet being resumed at the first reappearance of sugar in the urine; but all alcoholic excesses, the immoderate use of sweet fruits, and any use of sugar, should be interdicted at all times. A patient who has once had diabetes is always liable to a return of the disorder. He must lead a thoroughly careful, hygienic, and temperate life. In the words of Bouchardat, "you will not be cured except on the condition that you never believe yourself to be cured."

While I believe that the physician is justified in encouraging patients to expect relief, and even cure, in recent, uncomplicated cases, the diet is all important, and its regulation cannot be expected to be perfect without professional aid in its enforcement. A diabetic is never safe from a return of his disease, even when he believes himself to be cured; and under no circumstances should he pass more than a few weeks without an examination of the urine.

The arsenite of bromide, or Clemen's solution, appears to be useful. It consists of arsenious acid and bromine dissolved in water and glycerine in such manner that two drops represent the 24th. part of a grain of arsenite of bromine. We may begin with 3 drops three times daily in a little water immediately after eating, gradually increasing the dose to 5 drops. This may be continued for weeks and months without producing any unfavor-

able effects; but the administration of this remedy does not supply the place of the dietetic treatment, which should be enforced in all cases. Cantani recommends lactic acid "lemonade" 1 to 2 drachms to the pint of water and flavored. A rigid diet should be continued for two months, at least, even in the mildest cases of the disease. It may be necessary, in certain cases, to continue it for a longer period, even twelve or more months. There is probably no such disease as intermittent diabetes. In some instances glycosuria occurs during the season of sweet fruits, when they are indulged in excessively, and disappears when the diet is changed; but these are mild cases of diabetes, excluding those in which a transient glycosuria follows the inhalation of irritating vapors, the taking of anæsthetics, etc. Robust or corpulent persons are more tolerant of the disease than those who are feeble or spare, and the glycosuria yields, in such cases, more readily to treatment.

Diabetes occurs at all ages. Bouchardat mentions a case in an infant of 3 years, although the disease is rare before the age of 12. The most unfavorable cases are those which occur before the age of puberty. An adult male presents the most favorable conditions for cure. In old persons, when the disease is of long standing, the dietetic treatment will secure practical immunity from nearly all the distressing symptoms, although the glycosuria may not be entirely removed. A study of any of the diet-papers recommended will make it evident that those who are able to follow the required regimen, without regard to the cost of articles of food, present much more favorable conditions, as regards the prospect of cure, than persons in straightened or indigent circumstances. Diabetes, however, occurs in all classes, and is by no means a rare disease. A hospital devoted to such cases, where the dietetic treatment could be strictly carried out, would be a boon to the rich and poor alike."

ANEURISM CURED BY DIGITAL COMPRESSION IN SIX HOURS AND A QUARTER.

In the *Brit. Med. Journal*, Arthur E. J. Baker, F.R.C.S., Eng., of University College, reports the following interesting case:

J. D., aged 36, was admitted into University College Hospital, under my care, on August 29th, 1883, suffering from an aneurism of the right popliteal artery. For this he had been already carefully treated, by M. Gandy, of Norwood, with a Skey's tourniquet, applied almost continuously for five weeks. This compression had had no effect upon the tumour. The patient was a particularly healthy, fresh-looking, cheerful man, whose personal and family-history were excellent, and

showed no evidence of constitutional disease of any kind. He had always been a gardener, working for the last eleven years in a very hilly garden, and doing all the work (which was very heavy) himself. This overstrain appears to have been the only exciting cause for the aneurism in this case. The appearance of the tumour dated from eight weeks before admission, when he first noticed pulsation in the ham. He was unaware of any special strain or other cause for it, and it gave him at the time no pain. Its size had remained the same since first observed. On admission, the swelling was of flattened oval shape, about two inches in diameter; it was tense and elastic, and pulsated strongly. It was seated exactly opposite the middle of the knee-joint, and was slightly red on the surface, having a distended vein on its outer side. There was aching pain on flexing the leg, but none when the limb was at rest in extension; some tenderness on pressure on the tumour was complained of, but none in the thigh or leg. Pressure on the superficial femoral artery arrested all pulsation in the sac.

Instrumental compression having failed, and the man being extremely anxious that something radical should be done, I ligatured the superficial femoral artery in Scarpa's triangle on September 6th, 1883. The operation was done in the usual way under spray, and the vessel was tied with a twisted silk ligature well carbolised, which was cut short and left in the wound. The first ligature broke in drawing the second half of the knot; the next piece of silk bore the strain well, and was placed a quarter of an inch above the first spot chosen. The pulsation in the aneurism was now found to be completely controlled, and no pulsation was felt in it until about five hours later, when it was just perceptible. The tumour gradually shrank, while over it a small artery could be easily felt. The wound healed, without any trouble of any kind, by first intention throughout, the ligature showing no signs of coming away. The patient left hospital on October 1st, looking and feeling very well. At this time there was no pulsation to be felt in the tibial arteries, and no discomfort or pain anywhere. In this condition the patient remained at home until the second week in January, 1884, (about four months). He then noticed a return of pulsation in the right popliteal space, with pain in the knee as this gradually increased. A week later he came up to see me, when I found the aneurism almost, if not quite, as large as before the ligature of the femoral artery, although the latter, below the seat of ligation, was now pulseless, as were also the tibials. Above the ligature the vessel pulsated strongly. Pressure on the common femoral, below Poupart's ligament, completely controlled the expansile stroke in the aneurism, and from this there could be no doubt that it was fed by branches of the profunda, which had been

presumably enlarged during the five weeks of instrumental compression of the common femoral, which had preceded ligature. Of course here there could be no question of the ligature having dissolved away, as it was of strong silk, and the vessel was still pulseless below its seat; moreover, pressure on the femoral at this spot did not affect the aneurism, whereas pressure above the profunda did so at once.

I now determined to try digital compression, and, on the readmission of the patient on January 26th, he was put upon a somewhat restricted diet for two days, being confined to bed, and smartly purged. The effect of this treatment in lowering the arterial tension was most marked, and to it, no doubt, some of the good result may be attributed. Then, on the 28th, having a number of most willing volunteers from among the students, I commenced digital pressure of the common femoral at 10:50 A.M. This was carried out with the same attention to details referred to in my former case, and, at 5.15 P.M., all pulsation in the aneurism had ceased finally. Compression was still continued until 8 P.M., and then stopped. The temperature of the limb remained lower than the other for some time, but all discomfort and pain was soon gone. The patient returned home cured on February 5th. Since then, I have seen him several times; there has been no return of the aneurism, which has shrunk up to small size. The pulsation in the tibials is still absent. The man is now engaged in his gardening work as before, without any pain or trouble from his former ailment.

EARLY SYMPTOMS OF CANCER— HUTCHINSON.

As Emeritus Professor, Professor of Clinical Surgery Mr. Hutchinson is now delivering his second annual course of lectures at the London Hospital. This course was instituted last year on the occasion of Mr. Hutchinson's retirement from the acting surgical staff, when he was appointed consulting surgeon. It was considered desirable to retain him as a teacher in connection with the Medical College, so he was made Emeritus Professor, and undertook to deliver six lectures annually on some subject connected with surgery.

The lectures for the present year are perhaps a greater success than those given last summer, and being wholly delivered extempore appeal more directly to the minds of the auditors. It goes without saying that Mr. Hutchinson gives no mere summary of ordinary text-book opinions, but lays before his hearers, in plain and unmistakable terms, the results of his own clinical experience.

On Wednesday, July 2nd, a good audience assembled to hear the lecture on "The Early Recognition of Cancer." The term "cancer" was used

in its clinical sense and as including sarcoma, and not in its limited anatomical sense applying solely to carcinomatous growths. The importance of its early recognition was obvious. Mr. Hutchinson said that before the actual presence of cancer was what might be termed the pre cancerous stage, and this was essentially a condition manifested by signs of local inflammation. An interesting case was narrated in support of this view. It was that of an old gentleman whom Mr. Hutchinson saw in consultation some years ago. One testicle had enlarged and was slowly increasing in size. The surgeons who saw the case agreed that it was probably not malignant and recommended non-interference. It continued to grow, however, and was at last removed solely by request of the patient, who had all along been anxious about it lest it should be cancerous. It was examined microscopically and was found to be simply in a condition of inflammatory hyperplasia, and no signs whatever of malignancy were discoverable. The patient recovered from the operation, no further trouble manifested itself, and his medical attendants came to the conclusion that his testicle had been unnecessarily removed. Two years elapsed. The remaining testicle then began to enlarge in the same way in which the other had done. Remembering the result of the previous operation, the surgeons strongly advised the patient against operation. As before, it continued to enlarge until finally it reached a considerable size. At last even the surgeon began to be alarmed and the patient's anxiety was extreme. The testicle was at last removed at the urgent request of the patient. It was examined and proved to contain a well marked sarcomatous growth. The inference was that the one first removed would, if allowed to remain, have also acquired a sarcomatous structure, and that the inflammatory hyperplasia found was a condition leading up to that of actual malignancy.

Eczema of the nipple preceding cancer was an illustration. Mr. Hutchinson remarked that cancer attacked parts that were functionally dead, as the breast in women late in life. Among animals it attacked the cat, the dog, and the horse, but not the sheep. The two former animals led a lazy life and were allowed to drag out their existence to old age. Sheep were usually killed before they were old enough to develop cancer.

The practical conclusion Mr. Hutchinson drew from his view was to treat as cancer all those cases where you suspected it—to adopt active measures at once and not wait for more decided symptoms until it might be too late.—*Med. Record.*

Oliver Wendell Holmes says that the great secret of success in every form of quackery is hope kept alive in the patient; while the too fatal gift of science is a prognosis of despair.

THE CANADA LANCET.

A Monthly Journal of Medical and Surgical Science
Criticism and News.

Communications solicited on all Medical and Scientific subjects, and also Reports of Cases occurring in practice. Advertisements inserted on the most liberal terms. All Letters and Communications to be addressed to the "Editor Canada Lancet," Toronto.

AGENTS.—DAWSON BROS., Montreal; J. & A. McMILLAN, St. John, N.B.; GRO. STREET & Co., 30 Cornhill, London, Eng.; M. H. MAHLER, 23 Rue Richer, Paris.

TORONTO, NOVEMBER, 1884.

The LANCET has the largest circulation of any Medical Journal in Canada, comprising four-fifths of the entire Medical Profession.

MEDICAL SCHOOL OPENINGS.

The first of October is generally considered a red-letter day among medical students and professors in medical colleges in Canada and Europe. In many medical colleges both at home and abroad, it is customary to begin the work of the session with an introductory lecture on some general or special topic. In some the practice has been discontinued, and in others revived after a period of suspense. The beginning of the present session has been no exception to the general rule. Our exchanges bring us brief reports of the medical school openings in the mother-land, and the festivities which accompanied them in the form of hospital dinners and conversaciones. Some of these were on a grand scale of magnificence, and were the means of bringing together in friendly intercourse, old class-mates, fellow students, and professors. St. Bartholomew's, Guy's, St. Thomas', St. Mary's, King's, London, etc., vied with each other in the character and success of their respective festivities, and the friends and patrons of each turned out in force to do honor to the occasion. Although in Canada we have not yet inaugurated the festive part of the programme, we have not lagged behind in the "feast of reason." The introductory lecture is now a constant feature in all the medical schools in Canada, and in its general scope and character will compare favorably with those of a similar character in older and more favored countries.

The introductory lecture of the course in Trinity Medical College, Toronto, was delivered by Prof. Geikie, Dean of the Faculty. After welcoming the assembled class, he referred to the large graduating class of last year and the honor they had done the school and themselves by their successful examinations at home and abroad. Their example was held up as a model, and a like success was confidently predicted for all who would bring diligence and perseverance to bear upon their studies. The lecturer chose as his main subject, the history of the origin of medicine amongst the Egyptians, Jews, Greeks, and Romans, passing down through the centuries to our own times. He dwelt upon many medical superstitions, especially those connected with amulets and charms. He closed with a strong appeal to those present to prosecute their studies with that zeal and thoroughness which alone would lead to distinction during their college career, and throughout their entire subsequent professional life. He also earnestly cautioned them against giving way to any temptations to idleness or vice. They were urged to be very careful in the choice of their companions, and especially to steer clear of any who have the misfortune to rank amongst either the idle or the vicious.

At the Toronto School of Medicine the opening lecture was delivered by Dr. George Wright, who, after welcoming the students and referring to the success of the school, gave some timely advice to those about to enter the profession. He alluded to the interesting character of the study of medicine to the enquiring mind. The whole domain of nature, animate and inanimate, came under their observation in some way or other. They were now laying the foundation in professional work which was either to make or mar their success through life. He was a firm believer in the doctrine that each one had special adaptabilities, and the more accurately these could be gauged the more likely would be the success. He cautioned them against the tendency to be content with purely theoretical knowledge, and advised them to utilize all the advantages within their reach for the practical study of disease in all its varied phases. He deprecated any slipshod preparation in so important a profession and condemned the three years' course system. Brief addresses were also delivered by Drs. Workman, Thorburn and Richardson.

The opening lecture of the Royal College of

Physicians and Surgeons, Kingston, was delivered by Dr. Fife Fowler, Dean of the Faculty. He referred to the many successful students who had been educated in the College and who now occupy positions of honor and usefulness. Genius, accompanied by energy and application, could accomplish wonderful results; but the careful, plodding, persevering student often in the end succeeded in obtaining what the restless, fitful men of talent failed in accomplishing. He then referred to the motives which impel men in the race of life: that while some are urged on by envy, the love of success, or the love of money, the highest motive was the knowing and the doing of one's duty. Life should be viewed with exalted and purified minds, and the moral nature should be matured and elevated. The necessity of bed-side observation was strongly emphasized. The importance of being honest in thought, word, and deed, and the usefulness of acquiring business habits was referred to. He also dwelt on the importance of having such moral qualities as decision, courage, self-reliance, and individuality, and although their paths would not all be paved with daisies, he advised them to be of good cheer and arm themselves with prudence, fortitude and truth.

At the opening of the medical department of the Western University, London, Dr. J. M. Fraser delivered the introductory lecture. He referred to the good conduct and success of the students of the classes in previous years, and to the gratifying results of their efforts in the local examinations as well as at those of the Ontario Medical Council. He next referred to the responsibilities the medical student assumed on entering the profession, whose aims were to alleviate human suffering and prolong life. The responsibilities at the bedside of the sick and the suffering were of the gravest description, and required the highest cultivation and preparation, nicety of perception, calmness of judgment and an utter avoidance of self-seeking propensities or arrogance. He pointed out many of the solemn and sacred duties which the physician owes to his patient, or to the families of those with whom he comes in professional relation, and showed how necessary on his part was the exercise of kindness and sympathy. He pointed out the high aims before the student of medicine, noted the difficulties and obstacles to be overcome, indicated the vastness of the fields of medical science as yet unex-

plored or only partially understood, and expressed the hope that among those who, in the future, will be eminent in the profession and benefactors of the race, might be graduates of the Western University.

The opening lecture of McGill Medical College, Montreal, was delivered by Dr. Penhallow, Prof. of Botany in the University. The subject treated upon was "the relative position which the teaching of botany holds in the various schools in this country and the United States." The lecturer dealt with the question in an able and comprehensive manner, and was listened to with marked attention. Space does not permit our giving a digest. The prospects of the school for the present session are good, upwards of seventy new students having registered up to the 15th ult.

Up to the time of writing we have had no official reports from Bishop's Medical College, Montreal, or the Winnipeg Medical College, but have learned indirectly that their prospects for the present session are very good, the attendance being greater than last year.

The opening of the Women's Medical College here and in Kingston also took place on the 1st ult. The following extract from the address delivered by Dr. Alice McGillivray, at Kingston, may be taken as representing the sentiments of those who favor women entering the arena of medicine: Ladies, whatever your motive in undertaking this serious responsibility, whether it be from a desire to earn a livelihood or to provide against future contingencies, or from a realization of the many existent ills among those of our own sex, who shrink from seeking relief elsewhere, or in response to the appeal from the multitude of our suffering sisters in India, who are permitted to die unattended, we know each one of you will strive to achieve a high place as a student, to preserve all good grace becoming a lady, and in future to distinguish yourselves as much by your womanly dignity of character and goodness of heart as by your skill in the profession.

The number of those entering the profession seems to be ever on the increase. This year especially there would appear to be a much greater number than in previous years. McGill College, as before stated, has upwards of 70 freshmen. In the Kingston School the freshman class is larger than usual. The Toronto School of Medicine has

a goodly number. The number of freshmen in Trinity Medical School this session mounts above 100, the entire class numbering about 250. Abernethy's exclamation may well be reiterated: God bless you, gentlemen! What is to become of you all!

THE QUEBEC LUNATIC ASYLUMS.

Grave complaints have been made from time to time for several years past by well-informed persons regarding the management or rather mismanagement of the asylums in the sister Province of Quebec. Dr. Hack Tuke, the well known alienist, who accompanied the British Association to Canada, availed himself of the opportunity to visit the asylums in Ontario and Quebec. The report of his visits to the Quebec Asylums was forwarded to the Hon. the Provincial Secretary, and has been made public. It is in truth a formidable indictment of the general management and moral treatment of the unfortunate insane in that Province. In regard to the cleanliness and order in the principal parts of the asylums there is much to commend; but in the upper stories and the refractory wards he finds "a skeleton in every closet." The wards are poorly lighted and ventilated, and almost destitute of any provision for the comfort of the inmates. One ward in the Longue Point Asylum, Montreal, he characterizes as a "chamber of horrors." In the corresponding portion of the building on the female side matters were no better—"a veritable pandemonium." Many were restrained by various mechanical appliances—muffs, manacles and straps—who should have been governed by moral restraint alone. They were closely huddled together and the atmosphere was stifling in the extreme. In the fourth story were the idiots and imbeciles, removed from all humanizing influence, treatment or education. The condition of the patients confined in the gallery, roof and basement, was beyond adequate description. In contrasting the condition of the asylums in Quebec with those in Ontario he says:—"The astonishment which I experienced in witnessing this relic of barbarism in the Province of Quebec is still further increased when I see such excellent institutions as the lunatic asylums of the adjoining Province of Ontario. I am certain that if it were possible to transfer the worst patients now in the asylum at Montreal to

these institutions, they would be freed from their galling fetters and restraint chains. They would quit their cells also, and, in very many instances, be usefully occupied where they are now restrained, with the result that in not a few cases perfect recovery to health would follow. 'Look on this picture and on that,' were words constantly in my mind after visiting the institutions of the two Provinces."

In discussing the cause of this lamentable state of affairs, he says, it is due entirely to the contract or farming system. This, it cannot be too often repeated, is the essential root of the evil, and unless speedily abolished will bear bitter fruit. In the conclusion of his report Dr. Tuke advises the Government to undertake the responsibility of providing the necessary accommodation and treatment of the insane poor, appoint resident medical superintendents with full authority, a competent board of management and efficient inspectors, and then the asylums would become institutions of which they would be proud instead of institutions of which they are now heartily ashamed.

ANOTHER MALPRACTICE SUIT.

At the recent assizes in this city an action was brought by a patient named McClure against Dr. Grant, of Woodbridge. The plaintiff had the misfortune to receive a severe fracture of the leg from a kick in a drunken brawl. Dr. Grant was called in and treated the fracture by means of a fracture box, first applying a bandage to the limb. About the ninth day dry gangrene began to appear in the great toe. Dr. Stevenson, of Kleinburg, was called in consultation, and both he and Dr. Grant examined the bandage and came to the conclusion that whatever might be the cause of the gangrene, it was not due to the bandage. On the following day, Dr. Savage, of Thistleton, visited the patient in the absence of Dr. Grant, removed the bandage, and gave the plaintiff to understand that it was the cause of the gangrene. The gangrene then spread to the remaining toes and dorsum of the foot. After the line of demarcation formed, the anterior part of the foot was amputated by Dr. Savage, who had taken charge of the case, assisted by Dr. Heggie, of Brampton. In a few months afterwards the ankle-joint began to suppurate, and a second am-

putation was performed above the joint. The fractured bones and amputated foot were produced in court. There was fracture of the lower end of both bones, the fracture of the tibia being comminuted and extending into the joint, and the astragalus was fractured horizontally. The principal evidence for the plaintiff besides himself, was Dr. Savage, who was positive that the whole difficulty arose from the tightness of the bandage applied to the limb. Dr. Heggie at first thought the gangrene was due to the bandage, but said it might be due to other causes. Dr. Bull's evidence favored the defendant. For the defence, the evidence of Dr. Grant, and Dr. Stevenson went to show that every care had been exercised and that the bandage was not too tight at any time. Expert testimony, consisting of the evidence of Dr. Sullivan, of Kingston, Drs. H. H. Wright, Fulton, Bethune and others, of Toronto, was also brought forward, which went to prove that the accident itself was of sufficient severity to produce the gangrene, by injuring the anterior tibial artery, and that it could not have been caused by the bandage, inasmuch as the sole of the foot was not affected, and the gangrene was of the dry, instead of the moist variety. The judge, who was unable to comprehend the bearing of the expert evidence in the case, charged against the defendant, and the jury brought in a verdict for the plaintiff with \$750 damages. The case will be appealed. Comment on the unmanly and unprofessional conduct of Dr. Savage in this case is wholly unnecessary.

QUEBEC MEDICAL BOARD.

The semi-annual meeting of the Quebec Medical Board was held in Quebec on the 24th of Sept. under the presidency of Dr. C. E. Lemieux. There was a full attendance of members present. After the reading of the minutes a resolution of condolence was passed on motion of Drs. Guay and Belleau, respecting the death of Dr. J. E. Landry, a member of the Board. The report of the examiners for the preliminary examination was read and adopted. Of 34 candidates 19 were admitted. The Treasurer, Dr. E. P. Lachapelle then read his report, which showed that \$5,322 had been raised during the past year, and after paying all expenses there was a balance of \$1,579 on hand. It also stat-

ed that the balance on hand was being continually diminished and suggested that means should be taken either to increase the income or lessen the expenditure, and a committee was appointed to enquire into the matter. The report of the detective showed that several actions had been instituted against illegal practitioners which were still pending in the courts. Dr. R. P. Howard, presented the report of the committee to enquire into the charges brought against the professors of Victoria College by Dr. Lachapelle, of having furnished copies of the questions to their students prior to the professional examination last spring. The consideration of the report was postponed until the next meeting. Notice of motion was given that at the next session of the Provincial Parliament a petition be presented praying for an amendment to clause 3, chap. iv. of the statutes and by-laws of the College of Physicians and Surgeons of Quebec, and that the words, "without examination" be replaced by the following, viz.: "after examination," the said examination to be upon the following subjects: medicine, surgical anatomy, descriptive anatomy, surgery, obstetrics, and materia medica.

The following gentlemen received the license of the college—Drs. P. Coote, M. R. G. Matte, E. Pelletier, E. Larue, E. Gosselin, J. A. Milette, A. Morin, F. S. Caron, E. Duval, C. N. Valin, M. T. Brennan, O. Berthiaume, F. H. Daigneault, W. Fournier, H. Leduc, J. O. A. Beaupré, H. Gauthier, R. Migneault, A. Richard, H. Brosseau, J. O. Stewart, A. Stewart, C. E. Cameron, J. A. Hutchison, and B. F. W. Hurdman.

ACTION FOR SLANDER.—This was an action brought by Dr. Hunter, at the recent assizes in this city, against Dr. Freel, both of whom reside in the village of Stouffville, Ont. Dr. Hunter attended a woman in her confinement. The labor was natural and the placenta came away without any trouble. On the fourth day afterwards she had a chill which was followed by an attack of pelvic cellulitis from which she died. Dr. Hunter complained that Dr. Freel, who had been called in the day before the woman died, stated to the friends of deceased that he (Dr. Hunter) had left a portion of the placenta in the uterus, which was the cause of the woman's death. This statement was also made to several parties in the village, and hence

the action. For the defence Dr. Freel called witnesses to prove that Dr. Hunter himself stated that he was afraid a portion of the placenta had been left in the uterus, and that the friends of the deceased mentioned this to Dr. Freel. His reply was "if Dr. Hunter left a portion of the placenta in the uterus it would account for the woman's condition," and this was essentially the statement he had made to other parties in the village. Dr. Hunter and his witnesses on the other hand testified that the statement was to the effect that if he (Dr. H.) had been obliged to remove the placenta a portion might have been left and caused trouble, but under the circumstances he could not account for her condition. A large number of witnesses, lay and medical were examined on both sides, and the trial occupied three days. In his charge to the jury the judge explained that any expression of opinion by Dr. Freel to the friends was privileged, but statements made to parties outside adverse to Dr. Hunter, or with a view to injure him constituted slander. The jury found a verdict for the plaintiff and \$50 damages.

APPOINTMENTS.—Dr. T. W. Mills has been appointed Prof. of Physiology and General Pathology in McGill Medical College, *vice* Prof. Osler; Dr. Wilkins, Professor of Practical Histology, and Dr. Sutherland Professor of Morbid Anatomy.

Drs. P. R. Inches, St. John, N.B. and J. H. McCollum, Toronto, have been appointed medical examiners under the Civil Service Act.

CORONER.—Dr. D. D. W. Harrington, of Halifax, has been appointed coroner for the City and County of Halifax.

ACKNOWLEDGMENTS.—The Chairman of the Ontario Board of Health desires to acknowledge with thanks contributions to their reference library of hygiene from the following publishers:—D. Appleton & Co., New York; A. E. Wilde & Co., Cincinnati; Henry C. Lea's Son & Co., Philadelphia; Jansen, McClurg & Co., Chicago; G. P. Putnam's Sons, New York; Houghton, Mifflin & Co., Boston; Harper & Bros., New York; Geo. S. Davis, Detroit.

AMERICAN PUBLIC HEALTH ASSOCIATION.—The 12th annual session of this association was held in St. Louis, Mo., on the 11th of October and three

following days, under the presidency of Dr. A. C. Ghion. About 150 members were present. A large number of interesting papers on sanitary questions were read and discussed. Dr. C. W. Coverton, President of the Ontario Board of Health, and Dr. Bryce, Secretary, were present as delegates from Canada.

MEDICAL COUNCIL ELECTIONS.—Dr. Allison, of Bowmanville, will again be a candidate for election to the Council for the Territorial Division of King's and Queen's. He has been a most able and faithful representative and we hope to see him re-elected. We know that the interests of the profession and the Council are very dear to him, and are in hopes that he will, some of these days, grant the institution a liberal endowment.

MONTREAL MEDICO-CHIRURGICAL SOCIETY.—The following have been elected officers of this Society:—President, Dr. Roddick; 1st Vice do., Dr. Alloway; 2nd Vice do., Dr. Trenholme; Treasurer, Dr. Molson; Secretary, Dr. Gurd; Librarian, Dr. Reed; Council, Drs. G. Ross, Kennedy and Rodger; Publication, Drs. Cameron, Ross, Bell and Kennedy.

REMOVALS.—Dr. Coleman, of St. John, N.B., has removed to Baltimore, U.S., to practice his profession. He carries with him the hearty good wishes of his Canadian confreres.—Dr. Atherton, of Fredericton, N.B., has removed to this city. We welcome him to our midst and wish him every measure of success and prosperity.

TRIPLE VALERIANATE.—Dr. Goodell recommends the following in the treatment of certain nervous diseases in females:

R Quinæ Valerian.
Ferri " "
Zinci " aa grs. xx.—M.
Ft. pil. No. xx.

Sig. One three times a day.

PRESENTATION.—Dr. Aiken, of Weston, Ont., who is removing to California, on the occasion of his departure, was presented with an illuminated address, accompanied with a silver tea service for Mrs. Aiken, by his numerous friends in the village and neighbourhood.

THE NEW LOCAL ANÆSTHETIC.—The new local anæsthetic, cocaine hydrochlorate, recently discovered in Germany, is giving most astonishing and satisfactory results in the hands of specialists, as reported in the *N. Y. Medical Record*. Drs. Noyes, Agnew, Moore and Minor all speak in enthusiastic terms of its value. A few drops of a two per cent. solution is dropped in the eye three or four times at intervals during a period of fifteen minutes. The effect is to produce such profound local anæsthesia as to permit of operations, such as division of the recti muscles, being done without the patient complaining or showing any signs of pain. The new remedy is the reigning sensation in New York among specialists.

STAMP CANCELLATION.—We learn from the *Daily Star* that Dr. Griffin, of Montreal, has invented an instrument for cancelling postage stamps. It is stated that the loss to the governments of Canada and the United States through inefficient stamp cancellation, ranges from \$10,000 to \$50,000 respectively. The instrument will be tested in the Montreal post office, and if found satisfactory will be adopted generally. The instrument cuts a piece out of the stamp, but does not go through the envelope.

THE BRITISH CHOLERA COMMISSION.—The Commission, of which Dr. Klein is the principal, are busily prosecuting the work in Bombay, and have made experiments with the microbes which led them to doubt the infectious nature of Koch's cholera microbe. Dr. Klein has shown his contempt for the microbe theory by swallowing a number of so-called cholera bacilli without any ill-effects.

COMPLIMENTARY DINNER.—The medical profession of Montreal gave a complimentary dinner to Dr. Osler prior to his departure for Philadelphia. The chair was taken by Dr. R. P. Howard, and about fifty members were present, all of whom united in wishing their guest abundant success and prosperity in his new sphere of labor.

MUNIFICENT DONATION.—A donation of half a million dollars has been given to the College of Physicians and Surgeons, New York, by Wm. H. Vanderbilt. This is an example of generous and public-spirited liberality which is worthy of the highest commendation. It is to be hoped that it is only the beginning of good things in store.

Books and Pamphlets.

THE LAND OF BURNS, and other Pen and Ink Portraits. By J. Campbell, M.D., Seaforth, Ont.

This interesting work by Dr. Campbell will be issued from the press in a few weeks, and the profession will, we are sure, be pleased to patronize it. The subject is an inviting one, and the author is quite competent to make it entertaining. We bespeak for the author and the work the kind consideration and patronage of the profession in Canada.

HOOPER'S PHYSICIAN'S VADE MECUM; with an Outline of General Pathology, Therapeutics and Hygiene. 10th edition. Revised by William Augustus Guy, M.B., Cantab, and John Harley, M.D., London, F.L.S. New York: Wm. Wood & Co.

The original work of Dr. Hooper, published as far back as 1823, has been such a great favourite with the profession, that every few years the proprietors of the original copyright have placed it in the hands of successive editors, by whom it has been brought down to the present level of the various subjects treated on. The work, as now presented to the profession, may be recommended as a useful reference to all items of information in clinical medicine, to both student and practitioner. Both volumes are largely illustrated by wood engravings, and an extensive collection of formulæ, preceded by classified lists of the British Pharmacopœia, with their doses, is added.

MATERIA MEDICA AND THERAPEUTICS. By Mitchell Bruce, M.A., M.D., London. Philadelphia: H. C. Lea's Son & Co.

This hand book is one of the very best of an excellent series. It is new, condensed and eminently practical in its character. It is divided into three parts: I. The inorganic. II. The organic materia medica. III. General therapeutics. This book, small in size, but large in the amount of information it contains, is sure to have a large sale.

Births, Marriages and Deaths.

On the 15th ult., J. E. Brouse, M.D., of Brockville, Ont., to Amelia Mary, only daughter of P. L. Allen, Esq., of Hamilton, Ont.

On the 28th ult., the beloved wife of Dr. J. Fulton, editor of the CANADA LANCET, Toronto, aged 40 years.

On the 1st ult., Dr. J. A. Aikman, of Ingersoll, Ont.

On the 21st ult., Dr. J. S. Diamond, of Toronto, aged 45 years.