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# The Canada Medical Record

VOL. XX.

MONTREAL, JANUARY, 1892.

No. 4

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## Original Communications.

### SIR JAMES GRANT'S REPLY TO THE TOAST OF THE CANADIAN MEDICAL ASSOCIATION.

*Mr. President and Gentlemen,*—I thank you for the opportunity of making a few observations on the Canadian Medical Association and the various points incidentally allied with our profession in the great march of progress at the present time. The subjects of our medical curriculum and the change to five years of study, as well as the advanced matriculation examination, appear to be very acceptable to the members of the medical profession and the colleges generally. What we now require is one central authority from which degrees in medicine and surgery can be obtained by the passing of a thorough uniform medical examination for the whole Dominion. At present it is not in keeping with the best interests of the profession in Canada to set one province up against the other. This whole subject, if brought under the attention of the proper authorities, will in time be rectified, and thus much good accomplished. By the British North America Act educational matters are under the control of the several provinces. This will require a change so far as our profession is concerned, and sure-

ly what is identical with the dearest interests of our common country will not be refused. It is now twenty-four years since this Medical Association was organized, and during that period its ebb and flow has been more or less spasmodic, and why so, it is difficult to define. This Montreal meeting is certainly most successful, there being quite a large attendance, members being here from the Atlantic and Pacific Provinces, as well as from many intermediate points. The papers read were of a most practical character, and the demonstrations at the hospitals point out in the most undoubted manner that medical science in Canada is keeping pace with that of the outside world. I am confident the President of the Royal College of Surgeons, Mr. Bryant, who is with us to-day, will carry back to England a most favourable impression of our medical schools and our hospitals. Such gatherings as the present cannot fail to be productive of benefit. The intellectual friction resulting from the comingling of ideas and exchanging of sentiments, in the discussion of the various papers brought before the Association, must result in much good to our profession. Attendance at these Association meetings is a duty the members of the medical profession owe to their constituents; by coming here they see the evidence of the pro-

gress being made in the vast collection of medical and surgical appliances, and, in fact, everything that tends to the welfare of the public requiring their assistance in their particular spheres of duty. I feel confident that the sentiments expressed by our worthy President, Dr. Roddick, as to the languishing of our Society are overdrawn—it appear to me that fuller life and vigour is being thrown into the Association—and at the next meeting at Ottawa I hope to see a large increase in the attendance from the various sections of the Dominion. Medical gatherings are now the order of the day. Recently a great congress of Hygiene, numbering some 3,700 members, from all parts of the civilized world, assembled in London. There the most important questions with reference to hygiene and hygienic precautions were discussed in an able and comprehensive manner, and there was one undoubted evidence of advancement which touches very closely the workings of the institutions of our own country, and for that reason I wish to advert to it very briefly—it is the necessity of an alliance of veterinary science and pathology with medical science in order to trace up more closely the intimate relationship that exists between the quadruped species and genus homo. Much good of a practical nature will thus be accomplished tending to advance the welfare of the people. The subject of tuberculous meat, and the spread of consumption from the use of this form of impure food, is certainly worthy of the closest investigation. I trust the day is not far distant when the Government of Canada, like that of Germany, will see the necessity of the establishment of abattoirs presided over by scientific experts, who will test carefully the various descriptions of meat before they are distributed to the public. Thus, undoubtedly, the spread of disease through such channels would be very materially curtailed. Again, the closer association of veterinary science and medicine, if only resulting in the organiza-

tion of a board to watch carefully the cattle trade of England and Canada, would certainly be productive of great benefit to our race. The progress of medical science at the present day is very marked in every department, and to keep abreast with it, the most careful observation and the closest inquiry and study are required, such as we have an opportunity of pursuing in meetings like this of the Canadian Medical Association. Time is an important factor in the accomplishment of everything, and when we trace the grand achievements brought about by that father of medicine, Sydenham, who laboured so vigorously in the 17th century, it should be a source of encouragement to us who are now laboring in the same field of study. We have with us this evening many devoted teachers in the various rôles of our profession, and no position in life stands higher than the noble calling of him who devotes his energy and ability to the imparting of information such as is necessary for the thorough comprehension of the operation of the human system. Many of our old teachers are to-day absent in person, but they are here in spirit. Their influence lives after them, and as the outcome of their life's work we find at the present moment active, able, and energetic professors carrying on the onerous duties connected with our medical institutions. How gratifying it would have been to such men as Campbell and Howard, Fraser and MacCulloch, Bruneau and Hall, to witness the marked progress of our young professors in the hospitals to-day, and certainly they would delight also in the names of such men as Osler and Mills, and that of the able gentleman who now presides over the Canadian Medical Association, Dr. Roddick. The pleasurable emotions of teachers towards their pupils are not characteristic only of the present, but were strongly perceptible in the past amongst the great ones of the earth whose names have descended to us as cherished heirlooms. Voltaire said of Homer he de-

lighted in conning over the genius and ability of his pupil Virgil, and so in like manner Virgil was charmed at the intellectual ability of a spirited youth who was under his tuition. Again, Sir Humphrey Davy had great pride and satisfaction in his associate Faraday, whose investigations in electricity have marked an era of advancement in electrical progress. Thus pupils give unbounded pleasure to their teachers, and the sympathy between them is most marked. Let me say here that the question of hospitalism is intimately allied with the working of the Canadian Medical Association for that reason it is well, in the selection of the place of meeting, to have as large a centre as possible in order to observe the greatest possible amount of clinical study. Montreal, therefore, cannot fail to be very attractive, and when the new hospital, so generously endowed by two Canadian philanthropists, is finally completed and in operation, the facilities here for observation will doubtless be of immense service not only to the meetings of our Association but to those who are fortunate enough to receive instruction at this centre. Hospitalism in Canada is certainly now in the ascendant. When West a short time ago I was pleased to note at Medicine Hat a most charming hospital, built of cut stone, on the banks of the Bow River, equipped with all the modern appliances, and some of the most critical operations in surgery being performed by a graduate of the University of Winnipeg. Is this not a sure evidence of the progress and prosperity of our country such as will be a pleasure to every member of this Association? What a source of pride it must be to our profession to note the advancement of hospitalism generally! Where a few years ago such an institution was scarcely known in China, there are to-day upwards of one hundred and twenty in full operation; and, again, in Tokio, Japan, there is a medical laboratory in which all drugs and patent medicines are carefully analysed and re-

ported upon before their sale in the country is permitted, What an advantage it would be to the Dominion of Canada if this Association could be the medium of the establishment of a laboratory of some description in order to lessen the indiscriminate use of the multifarious quack remedies that are scattered broadcast over our country. In this direction our Association doubtless can accomplish a good deal, and it is to be hoped the day is not far distant when Canada will be up and doing in this respect. It is said that the profession in Canada is very much overcrowded—that the system of education now being introduced will tend not only to advance the interests of its members, but at the same time reduce the numbers of those graduating. There is however, always room in the upper rungs of the ladder of fame, and with the rapid development of the country and the progress that is being made in almost every direction in the great North-West, I feel sure that our young Canadian graduates will have ample scope for years to come for the exercise of their mental powers. The good reputation of Montreal as a medical centre, Montreal as a centre of advanced education, as well as of trade and commerce, is certainly progressive. Its present is only an index to its future, inasmuch as its extending sea-port and shipping, and its rapidly developing connections east and west, cannot fail to make it a chief commercial emporium of the Dominion. Under these circumstances it is most gratifying to observe the progress of intellectual development through its greatly increased scientific and religious institutions. In assembling here, the members of our Canadian Medical Association have not failed to note those facts, inasmuch as the surroundings generally indicate advancement characteristic of the spirit of the age in which we live. In conclusion, let me wish our Society a long and prosperous life, with greatly increased usefulness.

## A CASE OF TRAUMATIC GANGRENE.

A few general notes on a case I had a few weeks ago may be of interest to your readers.

In these days of antiseptic surgery, we seldom, if ever, hear of "Traumatic Gangrene" to say nothing of seeing it and watching the struggles of vigorous young life against the advancing of death as it were inch by inch.

Arthur Lemire, aged 21 years, assistant to the light-keeper at Heath Point, Anticosti, while firing the fog gun, loaded the gun and pulled off three percussion fuses which did not discharge the piece. He concluded to draw the charge, and while pushing the ramrod into the gun for this purpose with his right hand the charge exploded, throwing Lemire down an embankment or slope about 30 feet. When he was picked up it was found that his thumb had been blown off, wrist-joint shattered, both bones of fore-arm broken (lower third) humerus also (middle third). Assistance was immediately wired for, but it was not until after four days had elapsed that he was put on board a schooner and sent here.

He was placed in my charge at 1 a.m.—106 hours after the accident. Absolutely nothing had been done for him and the state of his hand and arm was simply disgusting, the hand a crawling mass of maggots and the arm the seat of rapidly spreading moist gangrene, black as far up as the elbow, the blisters of which had burst in places allowing the putrid-smelling bloody serum to saturate the pillows and flags on which he rested. After a quick examination by the flickering light of the schooner's cabin lamp, I concluded that there might be a bare possibility of saving him by an amputation at the shoulder joint. The œdema which immediately precedes the discoloration or blackened skin in this kind of gangrene occupied the lower fourth of the humerus when I left him to procure assistance in case I decided to operate. I was gone 45 minutes and when I returned

I found the gangrene had spread *over the shoulder* and the man in a state of collapse. We succeeded in reviving him sufficient to remove him to the Hospital where Dr. Williamson and myself did all in our power to relieve his sufferings, which were intense. He died at 10 a.m.—22 hours after the first sign of gangrene appeared in the hand, as I make out from the Captain of the vessel, who *took care* of him on the way over from Anticosti. When he died the gangrenous discoloration had extended in front four inches to left of sternum, over the whole left side of abdomen and partly down the thigh, back about three inches to left of spine and from the neck to the left buttock. I also noted that the chemical changes consequent on the gangrene did not cease at death, the change in process being simply in name—gangrene-putrefaction—and the latter as rapid as the former. He was buried 24 hours after death and 12 hours after death the body was as much decomposed as a corpse which had been left exposed three weeks.

N. C. SMILLIE, M.D.

Gaspé, 28th Oct.

Port Physician.

## Society Proceedings

### MEDICO-CHIRURGICAL SOCIETY OF MONTREAL.

*Stated Meeting, Nov. 6th, 1891.*

F. BULLER, M.D., PRESIDENT, IN THE CHAIR.

*New Members.*—Drs. John McBain, J. E. Molson, R. H. Berwick and J. A. McPhail were elected members.

*Late Perforation in Typhoid Fever.*—Dr. Lafleur exhibited this specimen. The patient had been in the hospital for several weeks under the care of Dr. Molson. He had died with collapse, pain and other symptoms of perforation. At the autopsy there was found abdominal distension and loss of liver dulness. On opening the abdomen there was general purulent peritonitis, the cavity containing a large quantity of lymph and turbid fluid. A perforation was found in the cæcum just below the ileo-cæcal valve. The case was peculiar.

that the ulcerative process was most intense in the large bowel as far down as the rectum. The ileum showed early infiltration of the Peyer's patches. All the ulcers were cleared except two or three in the ileum.

*Hypertrophic Cirrhosis of the Liver.*—Dr. Lafleur exhibited the specimen and gave the following account of the conditions found at the autopsy. The body was intensely jaundiced; there was moderate abdominal distension and emaciation. The liver projected far beyond the normal limits in all directions, the surface was roughened and covered with numerous adhesions, many being organized and traversed by large veins, which were connected with those of the abdominal wall and diaphragm. The organ was rough, uniformly enlarged, of a pale reddish-brown colour, and very firm. The cut section showed here and there prominent bright yellow spots, which were found to correspond to unaltered liver tissue. The rest of the organ was of a grayish-yellow colour and much firmer than the light yellow patches. On microscopic examination there was seen a very general development of fibrous tissue which was not restricted to the periphery of the lobules, but penetrated between the individual liver cells to the centre of the lobule. There was marked atrophy and degeneration of the liver cells. In many places there were collections of small round cells among the strands of fully formed fibrous tissue (probably tuberculous tissue.) It was extremely difficult to make out the lobular arrangement in many sections. No increase in the number of bile ducts could be made out. The case illustrates that variety of cirrhosis called "intercellular" as distinguished from the more common "lobular" cirrhosis. The jaundice was not due to the obstruction of the common duct or any of its larger divisions, as the bile could be easily pressed out. The immediate cause of death was an acute miliary tuberculosis, the lungs, the retro peritoneal glands, which were very large, and spleen being stuffed with minute miliary tubercles. The kidneys also contained them in lesser quantities. There was no meningeal tuberculosis. No old tuberculous focus was discovered to account for the acute infection.

In connection with this case Dr. Lafleur exhibited a specimen of the atrophic form of cirrhosis. There had been no history of cirrhosis, but one of obscure lung disease. There was found a chronic bilateral pulmonary tuberculosis upon which had been grafted an acute attack. There was no ascites. The surface of the liver was roughened with small elevations and corresponding depressions. It was softer than the other specimen, and friable. The internal appearance was the same as that on the surface, the elevations corresponding to the lobules and the depressions to the portal spaces. It is an

example of atrophic changes involving the portal circulation, induced probably by a calculous obstruction of the duct, for the common duct and all its branches are enormously dilated. A calculus did probably pass down at some time, as a small one is seen in the gall-bladder, but none in the common duct. The terminal feature in this case was also pulmonary tuberculosis. In the other organs there were no special changes.

Dr. James Stewart said that the man from whom the first specimen was taken was 40 years of age, and had passed the greater part of the last two years in the hospital. The case was of special interest, being the one on which the late Dr. R. L. McDonnell had written his article on "Cirrhosis of the Liver" in the first volume of "International Clinics." The marked feature of the case was the enlargement of the liver and spleen; it was impossible to distinguish between the two, as the splenic dulness merged into the hepatic. There was constant persistent jaundice and absence of effusion into the abdomen. He had had a severe attack of erysipelas and of peripheral neuritis. Two weeks before death he had passed a large quantity of chylous urine, the source of which could not be traced at the autopsy.

*Chronic Myocarditis.*—Dr. Lafleur exhibited the specimen and gave the following notes on the autopsy. There was general arterial sclerosis of the larger and medium sized arteries, which was seen in all the organs. The chief changes were seen in the heart, at the base; there was hypertrophy and dilatation of both ventricles. At the apex of the left ventricle there was great thinning of the wall, and in which two well-marked zones could be distinguished—an outer one, like normal muscle, and an inner one, from which all traces of muscular structure had disappeared. In this situation there was distinct bulging of the apex of the ventricle and a large clot adhered to the endocardium. Microscopically the internal zone is necrotic, all the muscular structure being replaced by a granular amorphous substance. As to the cause, there was no thrombus or embolus of the coronary arteries discovered, but there was probably clogging of some of the minute vessels. Higher up in the ventricle there is a fibroid change, appearing as pearly glistening patches, offering great resistance to the knife and alternating with areas of normal muscle. The valves were competent and showed slight fibroid changes. Thus there was in this case a commencing cardiac aneurism, and had the man lived he would have had a distinct sacculation of the left ventricle.

Dr. Jas. Stewart related the clinical history. The patient had been only two days in the hospital, and the cardiac condition had not been diagnosed. The main clinical features were the constant dyspnoea and the marked difference in the respiratory sounds on the two sides of the chest,

being weak over the left side and exaggerated over the right. It was thought that there was a tumor pressing on the left bronchus. Shortly before death there was a systolic murmur heard at the apex as well as severe pain in the region of the gall-duct. Commenting on the case, Dr. Stewart said that some cases of myocarditis are easily diagnosed, though very often the condition is only discovered at the autopsy. Patients often die with as great suddenness as from hemorrhages into the medulla or from aortic disease.

*Fibroid of the Labium.*—Dr. Lockhart exhibited this specimen which he had removed last April, and which had existed since June, 1890. On examination, the growth was found attached to the left labium minor by a pedicle one and a half inches long and about two millimetres thick. It was removed by Paquelin's cautery.

Dr. Laphorn Smith then read a paper on "A Case of Puerperal Peritonitis Treated by Abdominal Hysterectomy, with Reports of Two Other Cases Treated by Other Methods."

The following very brief and imperfect reports of these cases of puerperal peritonitis, although of very little interest in themselves, may serve as a basis for some practical deductions, and may also, I hope, lead to some healthy discussions and criticisms.

Mrs. C., aged 22, was attended by me six years ago for typhoid fever, which came on during the last months of her first pregnancy. The fever ran a typical course and at the beginning of the third week labour came on, which, owing to her weak condition was tedious, and required the aid of the forceps. There was no change in the temperature however, it continuing at 103° until the end of the third week when it began to fall, and in two or three days reached normal. She made a good recovery. Two years later, I was called to attend her in her second confinement, and found her in a house on Brunswick street which had enjoyed rather a bad reputation for scarlet fever and diphtheria. I was very careful to have everything about her clean, but did not use any injections. There was no laceration of the cervix or perineum, and the placenta came away easily and entire. Her temperature was normal the next morning, and also the following one, but towards the afternoon of the third day I was hurriedly sent for and found her in a very severe rigor. The thermometer registered 105°. I immediately syringed the vagina with plain hot water, and then ran home for a uterine double current catheter which I had shortly before purchased in Berlin, known as the Fritz Bozeman. I also brought some Liquor Potassæ Permanganatis. I then prepared a quart of hot water with one ounce of the Permanganate solution, and allowed it to flow from a high fountain into the uterus. The first few ounces which came away were dirty, and then there was washed out a pale, round

fungous looking mass about three inches wide and half an inch thick, exactly like the colony of fungi commonly called the vinegar plant. After that the water came away clear magenta. At ten o'clock that night the temperature had fallen to 101°, and the next morning it had returned to normal. As a precautionary measure I repeated these injections for several days, but there was no return of fever, no sore throat, and no exhaustion. I should mention I had her ears ringing from cinchonism within five hours of the chill. The injections were repeated night and morning for three days. She made an uneventful recovery. I mention this case because it was the worst of seven similar cases occurring during fourteen years, and among over five hundred confinements, all of which were treated in the same simple way and ended in recovery. The decomposing mass was probably a blood clot, as she had had many afterpains the first day which required two or three 10-grain Dover's powders to relieve. I suppose every practitioner has a case like this occasionally, and saves the patient's life by the same treatment, although such cases, if not treated, would probably go on to puerperal peritonitis and die. But there are cases in which, in spite of the same treatment, the temperature does not go down, the chills are repeated, the belly becomes tympanitic, and in a word, the case proceeds from one of uterine septicaemia to infection of the great peritoneal lymph sac, or general peritonitis. Of such a kind is the following case:

Mrs. J., æt 34, mother of two children, was attended by me three years ago for a miscarriage at the third month, from which she made a good recovery without any rise of temperature. About two years later I was called to see her in her confinement. She was nursed by an elderly maiden sister who was opposed to doctors in general, and to me in particular. She spent four weary hours chiding me for the length of the labour, until at midnight, the os being open, I carefully washed my hands and instruments and proceeded to apply the forceps. This also met with a good deal of obstruction, and the patient herself objected to take any anæsthetic. I tried to apply the forceps without any anæsthetic, but the patient set up such an outcry, in which all the family joined, that I insisted upon having someone to help me. Dr. Reddy kindly responded to my call and administered the A. C. E. mixture, while I easily applied the forceps and delivered. The placenta was expelled by Crede's method. I gave her a drachm of extract of ergot to prevent hemorrhage, and after cleaning her and the bed up I left her comfortable. Next morning (Monday) her temperature was normal and she felt remarkably well. I gave strict orders about changing the soiled bedding and to have the bowels moved on the third day. On Tuesday, Wednesday and Thursday mornings the temperature was still normal, but on

Friday it had risen half a degree. As there was a slight odor to the discharge, I ordered the patient to be syringed night and morning with plain hot water, and the clothes and bedding to be changed again on Saturday morning. To my great annoyance, the patient and nurse informed me that they did not think there was any need of syringing, as they had never done so before and the patient felt well. The thermometer, however, registered a rise of one degree. I gave them all a lecture on the importance of obeying the doctor's orders, and the husband promised to get the syringe. The nurse did not try to use it until Sunday at noon. On Tuesday afternoon the patient was feeling very well, but the temperature was still a degree high. On Monday, the eighth day, I was unable to go to see her in the morning, but about noon, on my return home, I received an urgent call to go there, and on my arrival found that she had had a very severe and prolonged chill which was still going on. Failing to find me at once, they had called on Dr. Devlin who kindly paid her one visit and did what he could to stop the chill. I found the temperature nearly  $105^{\circ}$ , ordered two grains of quinine every two hours until cinchonism was attained. I at once took the douching in hand myself and then it appeared the nurse had been afraid, when syringing the day before, to put the nozzle inside the vulva and had merely squirted it on the outside. As there was by this time a decidedly bad odor, I employed sublimate solution 1-2000 which was greatly in vogue at that time. Although I followed it by two or three syringes full of pure water the first injection was followed by complete anuria, and an obstinate diarrhoea set in which lasted two days. I after that reduced the strength of the injections to 1-4000 and followed them with a more copious flow of plain water. All the injections were intra uterine and repeated twice a day. On Monday night Dr. Reddy met me in consultation and confirmed the diagnosis of peritonitis, and suggested that I should open the abdomen, but I was so disheartened by the constant obstructions of the nurse, and the apathy of the others, that I had not the courage to do so. On Tuesday night they requested me to call Dr. A. A. Brown in consultation, and he suggested that I should curette and wash out with hot water, and this he kindly helped me to do under a little anæsthetic. Nothing came away however, with the curette, although I scraped hard enough to start a little bright oozing. We thoroughly washed out and put an iodoform suppository into the uterus. Before putting the patient back in bed I made a clean sweep of the bedding, and to my mortification discovered under the clean sheets a piece of bad smelling canvas which had been placed on the mattress some time before the confinement. This was removed and fresh clothing was placed on the patient and bed. There was not only no im-

provement from this, but the patient was much worse the next day, temperature and pulse rising to  $105^{\circ}$  and 150 respectively. As the pulse was very weak, I gave her ten minims of digitalis every four hours with very slight benefit. In spite of everything I could do she gradually sank and died on the 19th day after her confinement. No post mortem was allowed. This was my second death in nearly five hundred cases, the first one being due to peritonitis occurring in the 226th one. I might say, that the temperature generally oscillated between  $101^{\circ}$  and  $103^{\circ}$ , except at the beginning and after the curetting. The pulse was always very rapid and wiry. There was little or no pain at any time. The distension was sometimes very great, but seemed to be easily relieved with turpentine stupes, salines, and sometimes turpentine enemata. Quinine, digitalis and brandy were given regularly, and for nourishment she took large quantities of milk and beef tea. No calomel was given. It is very mortifying to have such cases, and still more so to report them, but I believe if this be truthfully done, valuable lessons may be learned which, if applied in similar cases, may save many lives. I felt very much inclined at the time to retire from the case when I experienced such difficulty in having my orders carried out, and indeed one would be quite justified in doing so, and this would probably be the wisest course to follow, although on this point I cannot even now come to a decision. Lawson Tait told us here some years ago, that he never undertakes a case without first being sure that his orders will be obeyed implicitly. On the other hand very few patients do all the doctors tell them.

The second point is, that in any case where the carrying out of your orders is of vital importance, it is better not to trust any one, but to execute them yourself. This case has impressed me so much that I now change the bedding and linen myself at my first visit after the confinement, or at least see it done while I am there.

The custom of delivering women on an operating table as is done at the Preston Retreat, Philadelphia, or on a sofa, as is the custom among the French-Canadians here, and only placing the women in bed after all the flow of water and blood is over is a good one.

One of our most successful physicians has been criticised for taking upon himself the duties of the nurse, and even preparing the lying-in bed with a rubber sheet, etc. But he has probably had some severe lessons such as in this case, which have taught him to trust no one where aseptic midwifery is concerned. Another point worth noticing is the tendency of both nurses and patients to keep the lying-in room darkened and unventilated. It was so in this case, and in nearly every case I have ever had the patient can hardly be seen. As if



the shutters being closed and the blinds down, and the curtains being drawn together were not enough, a thick shawl is generally pinned over all to intercept any straggling rays of light that may be struggling to enter in. Keeping a woman in a badly ventilated and dark room for ten days, plays a considerable part in the great weakness from which many suffer for weeks after a normal confinement. As I have already said, the patient died from peritonitis, but what was the cause? I had not been attending any infectious cases for months before and I carefully washed my hands and instruments and cleaned my nails. May this woman not have had a pyo-salpinx or a virulent ovarian cyst or abscess which burst into the peritoneal cavity while expelling the placenta? It was only since reading Dr. Coe's article in the *American Journal of Obstetrics* that the thought occurred to me, as there was no retained placenta, no decomposing clots, no retained membrane to explain the disease. The uterus when I curetted was completely empty. If I had acted upon Dr. Reddy's suggestion to open the abdomen, I would have at least seen whether there was a ruptured abscess or pus tube, removed it and washed out the peritoneal cavity. On the other hand, if I had found nothing, I could have removed the uterus and appendages after throwing a noose around them and transfixing them with pins. This would not have added in the least to the dangers of an exploratory incision, and although the woman would have lost some organs whose functions she abhorred, it would probably have saved her life. She might none the less have been a good wife and mother.

Now a word with regard to bichloride of mercury injections. I have used them hundreds of times in the vagina, since for three years, I myself gave one to every woman before applying electricity, and in none of these did I ever have the slightest sign of poisoning. I have only used them in the uterus a few times after confinement, and three times at least, I have had bichloride poisoning. I attribute the difference in effect to the large amount of raw surface at the placental site, and at numerous slight fissures of the cervix, vagina or perineum. I feel satisfied that, while being very dangerous, even when followed by a copious flow of water, they are very little if at all superior to a 1-40 permanganate solution; and I for one shall never use bichloride again after labour.

I now come to a case in which, profiting by my previous experience, I adopted a much more energetic method of treatment, and, I am glad to add, with the most gratifying results.

Mrs. Z., set 35, was attended by me in her first confinement about three years ago. She had always been delicate, and at the end of her first pregnancy was in a wretched general state of health. Her house was dark and in a dirty street, the atmosphere was damp and musty.

She had a strong presentiment that she was going to die. Owing to her age labour was very tedious, so after twenty-four hours she was unable to help herself any more and begged me to relieve her, which I did by applying the forceps at the superior strait, the os being fully dilated. I gave her the A.C.E. mixture and took about half an hour to deliver the head, hoping thereby to save the perineum which was very tough. In spite of this precaution there was a slight tear, necessitating a single stitch as suggested by Dr. Alloway. I gave her vaginal douches of plain water for a few days, and she made a good recovery without any rise of temperature. On the 8th of October of this year she sent for me on account of a severe pain in the right-iliac region. Thinking it might be labor, which was then due, she sent for the midwife who was to attend her. The latter examined her and could detect nothing except marked tenderness in the right side close to the uterus. I found her temperature 102°. Suspecting appendicitis I ordered a saline, and next day the fever and tenderness were gone. I did not see her again until the night of the twelfth, when I was urgently sent for. I found her in a very low condition, being almost senseless and deathly white. She had lost very little blood, but I gave her a drachm of fl. extract of ergot in anticipation of flooding; I also gave her a little stimulant. She rallied somewhat, when the midwife tried during an hour to deliver the placenta by expression and traction on the cord, but without avail. At the end of that time I introduced my two fingers into the uterus with great difficulty and tried to remove the placenta, but found it firmly adherent. By this time the woman was very much exhausted, and complained bitterly of the pain, so I decided to adopt the course recommended by Winkel to wait twelve hours, and if not spontaneously expelled by that time, to give her an anaesthetic and detach it with my hand. I left an ounce of ergot with directions to give her a teaspoonful every four hours for the double purpose of preventing hemorrhage and expelling the contents of the uterus. I gave her a hot injection of plain water, cleaned her up, removing all soiled linen from the bed. I told the midwife to let her sleep so as to gain a little strength for what might be necessary when I returned. As soon as I left the house the midwife began working at the placenta, and by 3 a.m. had removed a considerable portion of it, which she showed me on my arrival at 9 a.m. I did not think that it was all there and, therefore, introduced my hand into the vagina and removed several handfuls more from the uterus, which was still tightly closed. The patient was too weak to stand an anaesthetic, and the introduction of my hand caused her intense pain, so that I could not get my fingers into fundus. I then gave her an intra-uterine douche of permanganate solution until it returned clear, and

these injections were repeated twice a day. She rallied very well for the next thirty six hours, but about forty hours after delivery she took a chill and the temperature went up to 104°. Forty-eight hours after delivery I was suddenly called to see her and found her with her abdomen distended, knees drawn up, face pale and anxious, pulse thready and 140, and she was screaming with pain all over the abdomen. I at once gave her a good dose of Rochelle salts and applied turpentine stupes to the abdomen, and within an hour she was quite free from pain and fell asleep. I felt sure I had a case of peritonitis on hand, but to what was it due? If to a suppurating appendix or a ruptured pus tube, it was plainly my duty to open the abdomen and remove it; if to a septic uterus, to clean it out with the curette. I inclined towards one of the former causes on account of the patient having had a high fever and intense pains in the right iliac region for five days before her confinement; while, if it were due to a septic uterus, it must have been infected some days before her delivery puerperal peritonitis not generally coming on until six to nine days after delivery. The next question for me to decide was, should I curette the uterus or explore the abdomen first? I remembered my experience in a former case in which curetting seemed to render the patient much worse, apparently having opened fresh avenues for the admission of germs into the system; on the other hand what would be the use of curetting if an abscess had broken into the peritoneal cavity? If the patient could have stood the two operations it would be better to curette first, and if this was not followed by improvement, to perform an exploratory abdominal section. Next morning, the 15th, she was a great deal worse, so I placed the matter fairly before the patient and family, and gave them until 3 p.m. to decide whether I should open the abdomen and remove whatever I found to be the cause. At 3 p.m. I returned with Dr. Bruère who also considered the patient's condition critical, and received permission to do whatever I thought best to save the patient's life. I then sent for Dr. Springle who ably assisted me under great difficulties to perform the operation, while Dr. Bruère undertook the very anxious task of administering the anæsthetic. An hour was spent in finding a clergyman and administering the rites of the church, and it was not until a quarter past four that the anæsthetic was begun, and about 4:30 the incision was made. It was a very rainy, dark day, the light was very poor, the room cramped, and the last sutures had to be inserted by the feeble light of a coal oil lamp. Fortunately the distention had been somewhat relieved by the Rochelle salts administered the night before and repeated that morning, so that the intestines only gave us slight trouble. We first inspected the peritoneum and found it free

from lymph or pus, but the intestines were somewhat injected. We then sought for an inflamed appendix with negative results. The uterus and its appendages were very congested, but the latter contained no abscess; neither were there any adhesions any-where. I now felt certain that the seat of the trouble was in the uterus, and, during the next sixty seconds, I had to decide whether I would sew her up and leave her to her fate, or whether I would give her a chance for her life by removing the septic organ. I decided upon the latter course, and lifting out the fundus with a vulsellum and placing the wire of Koeberlé's serre-neud around the uterus about the level of the internal os, taking care to exclude the bladder and intestines and to include the appendages, we tightened up the wire and placed two pins through the uterus above it. A few cuts were made in the uterus, and as they bled I tightened the wire several times until all bleeding was controlled, when I removed the uterus, leaving the stump about the size of a small apple; we then passed about two gallons of very hot water into the peritoneal cavity, paddled it about for a few moments, and syphoned it out. The peritoneum was then dried and the stump drawn down to the lower angle of the wound, which latter was then brought together with silk worm gut sutures placed close together, and which I passed from within outwards by the sense of touch as I could not see. I did not sew the stump peritoneum to the parietal peritoneum, believing as I do that adhesions take place within a few minutes by a simple contact. The stump was not cauterized, but simply buried in boracic acid and covered with boracic gauze; no drainage tube was used. The operation lasted less than an hour, and the patient was returned to bed no worse than before the operation.

I left orders to relieve her if pain should come by the same means as before, namely, by turpentine stupes and salines. Oozing came on soon after, but was easily arrested by a few turns of the screw, which I instructed the attendant how to use. She had only one attack of pain, occurring about day break next morning, which was relieved in a few minutes, and she has been free from pain since. There was a slight tendency to vomit next day, for which I ordered a grain of calomel every hour until the bowels were moved, and which they were towards night. The serre-neud had to be tightened every six hours, until, on the third day, the end of the screw was reached, and I was obliged to put a larger instrument known as Smith's, armed with a stout linen cord, which had been disinfected by boiling, around the short one. As this has happened with every case of hysterectomy, I shall in the future discard Koeberlé's and use Smith's altogether. This was tightened night and morning until the fourteenth day, when the stump came away. The

bowels were moved every day with one grain doses of calomel combined with teaspoonful doses of Rochelle salts repeated every hour, for two, three, and sometimes four hours. On one occasion they had to be repeated six or eight times before they worked, the result being a mild salivation which required a mouth wash of chlorate of potash. The first week I gave a grain of quinine and a grain of digitalis three times a day, as the pulse was so weak and fast, but after that it improved so much that I left it off. The temperature, which had been 105° before the operation, fell to 103° next day, and 101° the day after, and on the day after reached normal, where it has remained ever since. About the end of the first week she began to have a troublesome cough, for which I gave her the compound syrup codeine of the French Pharmacopœia, prepared by Mr. Chivé. This is an elegant preparation and proved very effective. As I had read of a good many cases in which death followed laparotomy, owing to bursting open of the wound from coughing, vomiting, etc., I have not removed the stitches yet, although it is more than three weeks since the operation, and I shall leave them for another week as they are causing no trouble. The patient has a good appetite, eating steaks and chops twice a day, and she is sitting up in bed; she will be out of bed at the end of the fourth week. The hole where the stump was measures one inch in diameter and one inch in width, and is rapidly filling up. Owing to the unpleasant odor from the stump, I tried several times to cut some of it away, but it bled every time until the twelfth day, when it suddenly turned black. No narcotics were given from beginning to end of the treatment, and to this I attribute her freedom from pain. One of the most valuable lessons Mr. Tait has taught us is, that pain after abdominal section is nearly always due to wind, and the administration of morphine only increases this. The breasts were very full, but quickly dried up under inunctions of lead ointment. She was able to pass her water herself from the very first day. Her baby is thriving well on the bottle. A neighbour and a young sister who knew nothing whatever about nursing made excellent nurses, doing no more nor less, than I told them to do. They both remarked this morning that the patient was looking very much better than she did before her confinement. On examining the uterus twenty-four hours after removal, it was found to contain remains of placenta which were so firmly adherent, that they would break sooner than peel off. The inside of the uterus appeared of a dark purple colour, while a semi-purulent liquid could be squeezed out of the sinuses. The walls of the uterus were soft and friable.

From the gratifying result of this case under the most unfavourable circumstance, I feel confident that this method of treating apparently

hopeless cases of puerperal septicæmia has a good future before it, but on the one condition that it be not delayed until the woman is actually dying. Some may say that this was a very radical treatment, but I maintain that it was fully justified by the condition and the disease, which is one of the most fatal. In England and Wales alone there died from puerperal septicæmia, in spite of every other treatment, no less than 1,087 women last year, so that a great many thousands must have died throughout the world. Would not these women have gladly sacrificed their wombs if they could have thereby saved their lives?

Abdominal section for puerperal septicæmia has hitherto had a bad record in Montreal and elsewhere, but the reason seems very clear to me, viz.: That it is of little use to open the abdomen and wash it and then to sew up the wound, without having removed the whole cause of the trouble, namely, the septic uterus, whose walls are saturated with infection, and which no amount of curetting or washing could possibly disinfect. If, when no other cause is found, the removal of the uterus be added to the exploratory incision, I believe the operation will nearly always be followed with success.

Others may object that this woman, although alive and well, has been mutilated, but perhaps the very ones who will say this have themselves mutilated, by the removal of the appendages, many women who were in no danger of their lives, but merely suffered from menstrual pain. The operation which I performed is actually a safer one than simple removal of the normal ovaries, for I did not leave in the abdomen either the cut end of arteries, to furnish secondary or concealed hemorrhage, or ligatures to give rise to abscess. My cut ends of arteries and ligatures were all outside of the peritoneal cavity where they could do no harm, being seen and under constant supervision and control. As for the prospects afterwards, I have two of my patients with fibroid who have had their uterus and appendages removed by abdominal section who are now in good health, such as they never enjoyed since puberty. As for this poor woman, she abhorred and dreaded pregnancy; she is poor, and the two children that she has are as many as she can care for. She will now be able to perform her duties to her husband without the dread with which she has fulfilled them heretofore.

From my very limited experience I would draw the following conclusions:

1. The temperature should be taken every day after every confinement, and on the slightest rise vaginal douches of permanganate solutions should be commenced.

2. If the temperature continues to rise the douches should be made intra-uterine.

3. If there is no improvement at the end of twenty-four hours, scrape out the uterus with

the finger or with the curette and apply strong tincture of iodine and wash out the uterus.

4. If the case proceeds from bad to worse and peritonitis sets in, perform an exploratory incision and if no other evident cause be found, remove the uterus.

*Discussion.*—Dr. Shepherd asked what evidence there was of puerperal peritonitis, and what was found in the uterus after its removal?

Dr. Alloway said that he regretted not having seen Dr. Smith's second case in consultation, considering that it was known the uterine cavity contained masses of placental tissue in a decomposed condition. He would have counselled thoroughly curetting the cavity before resorting to so extreme a measure as abdominal hysterectomy, which must of necessity have been undertaken under very unfavorable circumstances from the surroundings of the patient. Dr. Smith's description of the condition in which he found the abdominal contents proved to Dr. Alloway's mind that there had been no peritonitis; there had been sepsis without doubt, the starting point and cause of which could have been reached through the vagina and uterine cavity. Dr. Alloway related a case of a similar nature to the one described by Dr. Smith, seen in consultation on the tenth day after confinement. He curetted the uterine cavity with Speigelberg's instrument and packed it with sterilized gauze impregnated with iodoform and boric acid. This dressing was changed every second day during the period of a week; it was then discontinued, there being a continuance of steady normal temperature. The patient is now well. He was recently consultant in another case (the wife of a physician), which was of a much more serious nature. The uterine cavity was curetted and she made a good recovery. He had treated a number of cases of puerperal metritis following labour at full term in the same manner, and had not as yet known death to follow the operation. He thought mortality followed an imperfect operation from want of experience in this particular branch of surgery and from the injection of escharotic fluids after the operation, especially iodine and iodized-phenol. He deprecated the use of the finger in these cases except as a means of diagnosis or exploration. He believed the curette was the proper instrument, but it must be used freely and with skill. He spoke of acute diffuse puerperal peritonitis, and strongly advocated abdominal section and washing out of the cavity with sterilized water. He spoke of gauze drainage in uterine surgery as being far superior to the hollow tube, and thought it should always be used in preference. He regretted that the reader of the paper had not brought the specimen for examination by members of the Society.

Dr. Wm. Gardner, while congratulating Dr. Smith on successfully undertaking such a serious operation under such very unfavour-

able circumstances, agreed with the two former speakers in asking what were the contents of the uterus. In such cases he always used the hand instead of instruments, and by means of the finger explored and scraped away everything. It was the practice recommended by the late Matthews Duncan and others many years ago, and is too often neglected and instruments used instead, which may be a source of danger. In a general way he did not think that hysterectomy would be of any use in acute diffuse puerperal peritonitis, for we have a general septic condition from which recovery cannot take place. Opening the abdomen should be successful if some localized collection of pus or sero-pus, as in a sacculated ovarian abscess or pus tube, was found. He had opened the abdomen twice only; there was general peritonitis, nothing local, nothing definite in the ovaries or tubes; in such cases there might be a limited field for the operation suggested by Dr. Smith, but it should not be done if there was anything in the uterus.

Dr. F. W. Campbell thought that Dr. Smith really should date a large amount of his trouble to leaving the placenta so long in the uterus. It was his custom never to leave the house without having the after-birth away. If he could not express it he would pass up his hand and bring it away, being careful not to leave any portion behind, and his success was invariable. Alluding to the fact that the abdomen had been opened with success in cases of tubercular peritonitis, he pointed out the possibility of a future for the operation when other measures failed. He complimented Dr. Smith on undertaking it, his patient was going to die and he performed a very major operation, and no matter what condition the uterus was in, it must have been the source of infection, as its removal clearly showed.

Dr. Armstrong thought that if he left a woman before the placenta came away he would be responsible for any future trouble. He thought the first thing that Dr. Smith should have done was to have been sure that the uterus did not contain some placenta. He greatly questioned the advisability of the operation.

Dr. McCarthy thought that the septic condition may have proceeded from some placental tissue and that the uterus should have been douched out; he also suggested the syringe that had been used as a source of infection. Speaking on the question as to how long the placenta should be left in the uterus, he said that from what he saw in the hospitals of Munich they do not seem to lay much stress upon the time of its expulsion. In other European hospitals it was found that there is often more hemorrhage when Cr  d  's method of expulsion is used immediately after the birth of the child than if some time be allowed to elapse before resorting to it.

Dr. Smith, in reply, said that he was pleased at the criticism. He had not undertaken the operation hastily or without consideration. He had found a good handful of placenta in the uterus after the removal, but he had not been aware of its presence. He had previously examined and scraped away two or three small handfuls, so he believed that the uterus was empty, and from his experience of case No. 2, where he knew that there was nothing in the uterus and the patient died, he thought that he had one chance to save the patient's life and he took it. He did not wait for diffuse peritonitis, when it would be too late, but operated at the first stage when the uterus was acting as a source of infection.

*Stated Meeting, Nov. 20th, 1891.*

F. BULLER, M.D., PRESIDENT, IN THE CHAIR.

*Fibroma of Uterus.*—Dr. T. F. Robertson (Brockville, Ont.) exhibited the specimen and read the following report:

The patient Mrs. B., aged 40, complained of excessive menstrual discharge, profuse leucorrhœa, great irritability of bladder, neuralgic pains and mental depression.

*History.*—Began menstruating at 15; was always painful and too free. In later life, after any undue exertion, she was liable to have flowing without reference to menstrual period. About a year ago she came under the care of Dr. McGannon (Brockville), when a diagnosis of fibromata of uterus was made. Electricity in the form of galvanism and electro-puncture was used with little or no effect. The symptoms would be relieved for a time under medicinal treatment, but she was progressively becoming emaciated and more anæmic. She was greatly depressed mentally, repeatedly expressing the wish to have something done. It was decided to remove the ovaries and tubes. From the severe symptoms while under observation it was thought considerable difficulty would be encountered. She was operated upon Nov. 14th. The ovaries and tubes were found matted together and bound down by firm adhesions, preventing their removal. Supra-vaginal hysterectomy was decided upon and done according to Hegar's method, the stump being attached in the lower angle of the wound, as shown in the frontispiece to the *New York Medical Record* for Oct. 10th. The patient has gone on without any untoward symptoms.

Was the operation justifiable? I cannot do better than quote from a paper read by Dr. Price of Philadelphia before the section of Gynecology and Obstetrics of the American Medical Association, held at Washington in May last, in which he says: "Another point here to be insisted upon is that the size of the tumour sometimes—nay often—has comparatively little to do with the urgency of the conditions necessitating operation. A moderately large symme-

trical tumour may cause little trouble, because in its growth it has risen uniformly in the pelvis, and its presence is not more irritating than the foetal head. Given, however, a pelvis-bound fibroid, interfering with all the pelvic organs, together with the pelvic circulation, the situation becomes the most urgent possible. The urgency is still further increased if the tumour be not regular, but nodular, containing cysts or excrescences of various degrees of hardness and size. These are the tumours that are anomalous, and can as little be determined without actual exploration as the jungles of Central Africa. They defy exact definition, and the surgeon can promise nothing as to their removal until they are seen and felt. In such cases the removal of the appendages is often impossible, and often more dangerous than the removal of the entire uterus with its appendages."

*Enchondroma of the Ilium.*—Dr. Shepherd brought before the Society the young man whom he had shown at a previous meeting (Oct. 23), and was the subject of a very large enchondroma of the ilium, and which had in the meantime been removed. The operation was found to be much less difficult than had been anticipated. An incision 18 inches long was made over the tumour, which was found to be attached chiefly by a pedicle to the crest of the ilium, and was removed by chiseling. There was a good deal of shock after the operation and a considerable amount of oozing, which necessitated the removal of the dressings and plugging of the wound, but since the patient has made a rapid recovery,

Dr. Lafleur exhibited the tumour and stated that it consisted of pure hyaline cartilage. When fresh it was seen to consist of a structureless basis in which were imbedded cells, arranged in pairs and surrounded by a capsule. In some sections strands of fibrous tissue could be seen running through the matrix. In places the tumour had undergone cystic degeneration, and towards the pedicle there was calcification, but no true osseous tissue could be discovered.

The President asked if a tumour of that size and in that position had ever been removed before.

Dr. Shepherd, in answer, said that almost an identical case was figured in Bryan's *Surgery*.  
*Friedreich's Disease.*—Dr. Jas. Stewart presented a well-marked case of Friedreich's disease or family ataxia. The patient, a young man aged 21, a native of Portage-du-Fort, Que., is one of a family of six, consisting of three sisters, all of whom are similarly affected, and two brothers, who are perfectly well. His mother is alive and well. His father, who died at the age of 50, had some difficulty in walking, but it is very doubtful if he suffered from this disease. The symptoms first appeared at the age of 6, and have recently become more marked. There is ataxia not only of the lower but of the

upper extremities; the muscles of the tongue are also affected, the speech being syllabic; knee-jerks are absent. He has talipes equinovarus and curvature of the spine. There is an absence of nystagmus and other eye symptoms, bladder and sensory symptoms which serves to distinguish this disease from tabes. The disease is due to a lessened or shortened indurance of certain tracks of the spinal cord. The postero-internal columns become degenerated early and very markedly.

Speaking of the occurrence of the disease, Dr. Stewart said that this (including the three sisters) is the one hundred and eightieth that has been reported, by far the larger number being from America. It is also a noticeable fact that a great proportion of the cases reported in America are females.

Dr. Mills cited a comparative case. A bitch had ataxic symptoms of the hind legs, hyperæsthesia, and some weakness of the urinary apparatus. Whether these symptoms were from loss of power or true ataxia it was difficult to determine. She died, and at the autopsy the brain spinal cord were found a good deal injected, but no appearances to account for the symptoms. Ataxia is not very common in dogs, but fairly common in the horse. Dr. Mills also related some comparative cases of tumours. The first, a black and tan terrier, had a large tumour in the mammary gland which proved to be an adenoma, form very common in dogs, and which usually kills them. The second case was a black and tan bitch, aged 14 years. A tumour had been removed from her neck some time ago. Three weeks ago Dr. Mills saw her again; this time he found a large, rapidly-growing tumour low down in the mammary region and weighing one-sixth of the weight of the dog. She failed rapidly and died before an operation could be performed.

*Total Extirpation of a Pregnant Uterus for Cancer of the Cervix.*—Dr. Wm. Gardner exhibited the uterus and ovaries of a pregnant woman, aged 26, and gave the following history of the case:—

L. C. came to the out-patient clinic of the Montreal General Hospital complaining of repeated hemorrhages during the previous ten days. She had borne an illegitimate child several years previous. She had been married a few months, and was now pregnant four months. On examination, there were all the physical signs of pregnancy and unmistakable cancer of the vaginal portion of the cervix, extending to the adjacent roof of the vagina and infiltrating the supra-vaginal portion. The patient was admitted to the gynæcological ward and examined by Drs. Alloway, J. Chalmers Cameron, and Armstrong, who each agreed in the diagnosis and in the propriety of a radical operation. The condition and prospects being explained to the patient, she consented to the operation.

The procedure was as follows: The abdominal wall and vagina were thoroughly washed with soap and warm water, then with peroxide of hydrogen, and finally with 1-1000 sublimate solution. The abdomen was then opened, the uterus turned out, and the broad ligaments tied off outside the ovaries with strong catgut, as low as possible; an Esmarch was firmly applied around the cervix as low as possible, the uterus incised, the foetus extracted, and then the uterus amputated. The cervical canal was then cauterized with Paquelin's cautery. The extirpation of the cervix was effected by tying and cutting the broad ligaments as low as possible; Eastman's grooved staff was then introduced within the vagina and made to project the floor of Douglas' pouch. An incision with a scalpel easily opened the vaginal roof. The subsequent steps of the operation were the tying and separation of the vaginal attachments of the uterus by means of a curved needle held in the jaws of a needle-holder guided by the left index finger, passed through the opening leading to the vagina. The separation of the bladder was easy. Catgut was used for all but the last ligatures, which were strong braided silk. The catgut ligatures were cut short, but those of silk were left long and turned into the vagina. The vaginal vault was loosely closed by three catgut sutures. The operation was completed by washing out the abdominal cavity, the insertion of a drainage-tube and the closure of the abdominal wound as in ordinary ovariectomy, and finally by tamponing the vagina loosely with iodoform gauze. The drainage tube was removed in twenty-four hours. Recovery was smooth and rapid, the patient leaving the hospital in less than four weeks. The operation was done in the Trendelenburg position, which greatly facilitated the numerous manipulations.

Dr. Alloway was associated with Dr. Gardner at the operation, and considered that the most difficult part in the technique was the last, that of the removal of the cervix. Great care had to be taken to escape the bladder while at the same time get as much diseased tissue as possible inside the ligatures. He felt that a more rapid and safe procedure would be to attack the cervix through the vagina.

Dr. Shepherd asked if a microscopic examination of the growth had been made before the operation.

The President asked if it was not strange that a woman in this condition should become pregnant.

Dr. Gardner, in reply, said that no microscopic examination had been made. But it would not have altered his decision even if such an examination had been doubtful, for the clinical features were so well marked. In answer to Dr. Buller, he said that the disease had probably grown very rapidly since impregnation owing to hyperæmia.

*A Warty Growth of the Anus.*—Dr. James Bell exhibited a photograph of a warty growth surrounding the anus of a young man of 20. It had first appeared five months ago as one small wart. It had increased rapidly, and was limited to the edge of the anus, there being no extension into rectum. Its character it is identical with the growths of venereal warts found on the corona in the male and the labia in the female. Such a condition, in a male and apart from extension from the genital organs, was, in Dr. Bell's experience, unique, and, as far as he could find out, there was no special reason for its appearance. It was removed by the cautery.

*A Case of Umbilical Fecal Fistula in an Infant; Cured by operation.*—Dr. Shepherd read the notes of this case. A male infant, aged three months, had a projection about an inch long at the umbilicus which was red and moist, looking very much like everted mucous membrane. In the centre of this projection there was an opening from which liquid feces escaped, and into which a probe could be easily introduced. The abdomen was opened and the fistula was found to be due to a diverticulum from the ileum (Meckel's diverticulum), which had remained patent in the umbilical cord and had been cut through when the ligature came away a few days after birth. The projecting portion of the bowel was removed and the opening in the intestine closed by a double row of continuous sutures,—the deep row passed through the muscular and mucous coats, and the superficial row through the peritoneal coat only, after the manner of a Lembert suture. The infant made a complete recovery, and when last heard of was well and strong.

*Salpingitis and Pyosalpinx.*—Dr. Armstrong read the following paper on this subject:

My experience with a series of cases of disease of one or both fallopian tubes and sequele has made me think that the treatment of this condition, although plainly indicated by many writers, notably and in the position of a successful pioneer, Mr. Lawson Tait of Birmingham, is not yet fully appreciated by the great mass of general practitioners.

I have nothing original to add to the subject, but I have reason, as you will see, to advocate a treatment of this class of cases quite as radical as that taught by Mr. Lawson Tait. I believe that many women are to-day making the rounds of consulting rooms and being treated by pessaries, glycerine tampons, hot water douches, and local blistering, who are really suffering from salpingitis. I also believe that this treatment is wholly insufficient to cure, and this proved by the fact of their changing one consulting room for another, or returning to the same consultant after a longer or shorter period of only comparative relief and comfort. Trachelorrhaphy has been a great deal, and too often often has been regarded as a sure remedy. It is easy to recognize a lacerated cervix, and also easy to repair it, but it is not so easy to sit in your office three months after and listen to a rehearsal of symptoms similar to the ones complained of before the operation was performed.

Every family physician here has probably one or more ladies among his clientele who have visited some medical centre and had an operation, and still appeal to him for relief from symptoms similar to those complained of before operation. I do not mean to belittle that most useful operation of trachelorrhaphy in properly selected cases, but I draw attention to the necessity of excluding disease of the appendages before advising it.

In this paper I purposely omit all allusion to that larger subject of the etiology of salpingitis and confine myself to two points only, the diagnosis and treatment of salpingitis and pyosalpinx. It is the duty of every one assuming the position of advisor to those suffering from pelvic disease to familiarize himself with the details of a thorough and systematic examination of the pelvic contents, and to persist in the practice of these details until he becomes an adept at it. The palpation of the tubes and ovaries, though not as easy in many women as some would lead us to believe, may yet generally be made to yield valuable information, especially when placed by the side of the subjective and other objective symptoms, and the decision may be the saving or losing of a life.

Noeggerath, William Japp Sinclair and Tait and Virchow, have taught us much of the pathology and prognosis and treatment of these cases. They have taught us that in desquamative salpingitis the ciliated epithelium is destroyed; that the tubes deprived of the cilia which perform the double office of carrying the ovum along towards the uterus and preventing the spermatozoa from passing from the uterus along the tube, are the tubes in which an impregnated ovum may lodge and develop. The timely removal of such tubes would prevent the possibility of the occurrence in the patient from whom they were removed of the results of tubal pregnancy and rupture. They have also taught us that in salpingitis one or both ends of the tube may become occluded, and that constrictions or strictures result. Then between these strictures pus may form, increasing under favorable conditions, distending the tube, thinning its wall, and finally, in percentage of cases, rupture, setting up localized and sometimes general peritonitis of more or less severity. These are the grave disastrous results that may follow a salpingitis, and I will illustrate them by briefly mentioning a few cases. The minor results of salpingitis being pelvic pain and distress, and malnutrition incapacitating the sufferer to a degree for the duties of an ordinary life.

It has been noted by several writers that a history of tubal disease precedes in many cases tubal pregnancy, as in the following cases:

Mrs. L. at 30, began to menstruate at 11 years of age, and from the first suffered from severe premenstrual pain. Her first and only child was born twelve years ago.

Eight years ago she was treated for some weeks for pelvic pain. In April, 1891, when shopping, she was suddenly seized with a very severe pain in the right side of abdomen low down; she fainted and was unable to walk home. After a week's rest in bed she went out again and was once more seized with this same pain. The first seizure was five weeks after the cessation of the last menstrual period. On examination a large doughy mass was distinctly felt in right side of abdomen and pelvis. I removed it through a median incision. It consisted of a large blood clot surrounded by lymph, upon its upper surface lay the right fallopian tube. On the under surface of the tube was a large irregular shaped opening which a cavity in the



tube communicating with the blood clot. Dr. Wyatt Johnston kindly examined the specimen for me and found chorionic villi. Recovery was rapid and perfect.

Mrs. S., a patient of Dr. Allan of this city, who kindly asked me to see her with him, had a history of tubal disease beginning four years ago, and increasing every six or eight months since then, each attack lasting three to six days. When I saw her she had been ill eight days; her pulse was 120°, temperature normal; attack began with severe pain four weeks after last menstrual period. She complained of severe pain in right hypogastric region. A soft fluctuating mass distinctly felt by vagina behind and to the right of the uterus. On opening the abdomen clotted blood welled up. The right tube and ovary were seized, a ligature thrown around them close to the uterus and removed. They presented the appearance showing in the drawing made for me at the time by D-Springle. The chorion is seen lying at the distal end of the tube. After its removal hemorrhage at once ceased.

Recovery was uneventful and without a bad symptom. In the coagula was found fragments of the yolk sac and parts resembling fetal structures.

In other cases the tube becomes constricted at points an sometimes one or both ends occluded, and these cases have a different history.

The first case that I report was very instructive, and complete as the condition was made out at a post mortem examination, and I can't but think that it represents a class of disastrous cases that are not always recognized, because too often the privilege of a post mortem examination is denied us.

On the 10th March, 1887, I confined Mrs. F., at 36. Her labour was easy and rapid, the child was born at 10 a.m. At 4 p.m. I called and found my patient happy and jolly, enquiring how long I wanted to keep her in bed. I had scarcely left the house when she suddenly complained of a most intense pain in the abdomen. She rapidly developed a septic peritonitis, and though I opened and irrigated and examined her abdomen, she died thirty hours after her confinement.

I obtained permission to make an autopsy and then found a small abscess in left fallopian tube which had ruptured, and the escaped pus had undoubtedly set up the fatal peritonitis.

This woman had suffered from an inflammation in the left hypogastrum ten years before. At that time she was ill and under medical care for nearly two years. Her recovery was fair though she never afterwards enjoyed perfect health. She always suffered at her menstrual periods, but recovered sufficiently to become pregnant, probably from the right tube. If her tubes had been removed during her first illness, I think her chances for life would have been greatly increased, and I think probably life is as much desired by the fair sex as by man, and as Dr. J. Price's forcible remarks, women should not be considered altogether as child bearing organisms.

Mrs. D., at 25, was admitted to the Montreal General Hospital on the 8th May, 1891, complaining of severe pain in lower part of abdomen and incessant vomiting. She was confined eight weeks before admission. Her labour was tedious and completed by forceps. She progressed until the third day when she had three chills followed by a temperature of 102° F. and severe abdominal pain. The pain extended through to the back and down the right thigh. She got up on the eleventh day, and again on the twelfth day.

On the thirteenth day she felt a soreness in the right side, and on the following day, the pain continuing in bed that day and the next. On the twenty-third day pain in right side again returned accompanied by vomiting, and a hard lump was felt in right hypogastric region. The history from this date until she was admitted to the hospital was one of pain, chill and profuse sweats. On admission she was pale, anemic and emaciated; eyes sunken, a pained drawn expression of face, she lays on her back with her knees drawn up; temperature, 104; pulse, 140; respiration, 36; heart and lungs normal; urine scanty, specific gravity 1022, acid, no albumen or sugar. On the right side of the abdomen a hard painful tumour was plainly to be felt and seen, extending nearly to the median line. Per vaginam, a bilateral laceration of cervix and a hard mass to right of uterus pushing it over the left. After consulting with the hospital staff I opened the abdomen and found the right tube dilated into a pus sac and surrounded by more than the usual amount of inflammatory lymph. Her recovery was uninterrupted. She left the hospital on the 17th June.

It would be very interesting to learn how many of the cases formerly grouped together as cases of puerperal fever were really suffering from tubal disease, of course not all by any means, but probably a very considerable percentage.

It would almost seem from the history of some of these cases, as if pregnancy and the increased nutritional activity and hyperplasia that take place during that time in the generative organs lighted up old tubal diseases. In the case of Mrs. F., her first illness dates back ten years before her pregnancy. During the last four or six of those years she had been fairly well. Her tube ruptured six hours after confinement.

Another case seems to point in the same direction.

Mrs. B., at 36, confined eight years ago. Recovery unsatisfactory, and accompanied and followed by pelvic pain. Four months ago became pregnant, miscarried, and had a severe attack of pelvic inflammation followed again by imperfect recovery. Became pregnant again in the early part of June last; miscarried in the end of July. Her miscarriage this time was followed by symptoms of acute peritonitis, acute pain, high temperature, and rapid pulse and vomiting. I was called to see her in the middle of the night, and found, in addition to the above mentioned symptoms, a distended abdomen and a great degree of paralysis of the muscular coat of the intestines. On opening the abdomen a large quantity of pus was found in and about the fallopian tube of the right side and septic peritonitis.

Clearly this was a case in which the timely removal of the pus tube could have been undertaken with every prospect of success, and had it been done at the start, it is highly probable that she would now be living and in good health.

One more case and I am done.

Mrs. W., had a history of recurring pelvic inflammation for six years, each attack followed by an imperfect recovery. In July last, her family physician went out of town and left her in my charge, she being at the time suffering from a recurrent attack of pyosalpinx. Unfortunate circumstances prevented my answering numerous urgent messages from this lady until evening. When I arrived there I found evidence of a ruptured tube and consequent beginning of peritonitis. No time was lost in getting instruments, opening the abdomen and cleaning out a quantity of escaped pus, secur-



ing and removing the tube, together with this fibroma of the right ovary. Fortunately here the operation was in time, before the inflammatory process had extended very far, that is, while it was yet localized and before paresis of the intestinal wall had occurred, and the result was all that could be desired.

These cases are primarily in the hands of general practitioners, and I believe it to be the duty of the family physician to thoroughly inform himself of the natural history of this disease, and not to discharge a patient suffering from salpingitis as soon as she can sit up and join her family at dinner, but to watch carefully over her for months and years if necessary, and to keep informed of the condition of the tubes, and thus discharge one of the highest functions of the family physician. And I believe that in recurrent cases of salpingitis, as in recurrent cases of appendicitis, the question of operation is a legitimate one for serious consideration.

*Discussion.*—Dr. W. Gardner agreed with all the reader of the paper had said. The danger of delay in such cases is obvious. He had seen the last case mentioned in consultation, and as her symptoms had improved he advised delay. Those who see many of these cases come across some of which have all the symptoms and physical signs of the disease which recover and remain well for years, while others with exactly the same symptoms do badly. It is a very difficult question to know exactly what to do; and for this reason he sounded a note of warning against the too frequent resort to surgical treatment.

Dr. Alloway spoke of the extreme difficulty of diagnosing salpingitis beforehand, of determining whether the patient has pus-tubes or not. He had operated on cases where the whole pelvis was one matted mass, with hæmatoma or abscess of the ovaries but tubes healthy. In the case of a healthy woman, whose history Dr. Armstrong gives, who, after making a good recovery after confinement, takes suddenly ill and dies from a rupture of a pus-tube, the question arises—When did that pus originate? Is it not possible that it may have originated after impregnation, when the slightest tendency to inflammation might lead to abscess.

Dr. Shephard asked if all these cases originated in gonorrhœa. He was rather startled by Dr. Armstrong's advice to "extirpate the viper when young," for the mortality would be greater if the operation was performed by men not accustomed to it.

Dr. Armstrong, in reply, said that the diagnosis was anything but easy. He makes a complete examination, under ether and taking symptoms that may arise into consideration, a fairly accurate diagnosis may be arrived at. If the condition cannot be determined, an exploratory incision becomes necessary. The question of when does the pus arise? is a very difficult one to answer. The disease may extend over long periods of time under varying conditions. Whenever there is distinct evidence of pus, the sooner it is removed the better.

*Stated Meeting, December 4th, 1891.*

F. BULLER, M. D., PRESIDENT, IN THE CHAIR.

*New Members.*—Drs. T. F. Robertson of Brockville and J. V. Anglin were elected members.

*Mitral Stenosis.*—Dr. Lafleur exhibited the organs from a case of mitral stenosis, which illustrated, in addition to the cardiac lesion, the various secondary changes. The heart was dilated the cavities being full of soft clots. It was also hypertrophied, the dilatation exceeding the hypertrophy, especially on the left side. The hypertrophy was most noticeable on the walls of the left auricle, the average thickness being four millimetres or three times the normal thickness. Marked changes were seen in the mitral valve, the orifice being reduced to a button-hole opening, which barely admitted the tip of the little finger instead of at least two fingers. On the aortic semilunar valves there was an acute endocarditis engrafted on the old disease; the same was seen, but in a lesser degree, on the pulmonary semilunar valves. The mitral and tricuspid valves showed no signs of recent endocarditis. Right lung contained several typical hemorrhagic infarctions, the rest having a mottled appearance of brownish-red tint, and is an example of brown induration due to the stagnation of the blood in the lungs. In the pulmonary artery there was found an adherent thrombus filling the branches going to the lower lobe. The left lung showed brown induration and typical pressure atrophy; at the root there was distinct evidence of an old infarction, which was decolorized. Histologically there is a large increase of the interlobular connective tissue; it is a typical catarrhal compression of the alveolar cells best known as chronic desquamative pneumonia. The liver showed the changes due to stagnation, the characteristic nutmeg variety. The spleen was not large and dark, as would be expected, probably on account of it being bound down by adhesions.

Dr. Jas. Stewart related the clinical history of the case. The origin of the endocarditis was doubtful. The girl never had suffered from rheumatism, but had had a violent attack of chorea at the age of seven, there being no articular pains as far as she could remember. The physical signs were characteristic of the disease; a rough præ-systolic murmur heard solely in the mitral area, and not propagated in any direction. Before death the physical signs of pulmonary consolidation were very evident.

*Chronic Alcoholic Poisoning.*—Dr. Jas. Stewart brought before the Society a man suffering from a train of very marked mental symptoms, together with certain sensory, motor and reflex symptoms. There had been mental depression for several months with perverted sensations, especially of the extremities. Very fine tremors of the hand and to a slight extent of the

tongue; also an irregularity of the furrows of the brow. There is absolute loss of knee-jerk, and at the time of his entrance to hospital he had been quite ataxic. His history is one of the neuroses and insanity. Ten years ago he was confined in the Longue Pointe Asylum for three or four months on account of insanity in the form of acute mania, with hallucinations of hearing, of being pursued by his friends, and on one occasion made an attempt to injure the attendants. He recovered from this and remained well until last spring, when, after a severe bout of drinking, he again became insane, this time in the form of melancholia unattended with delusion, but accompanied by the other symptoms mentioned.

Referring to the effects of alcohol on the nervous system, Dr. Stewart said that it attacks the two extremes, the cerebral cortex and peripheral nerves, but does not affect the cord to any great extent. The tremor of the hands was due to the motor cortex being depressed, being thus unable to send out lasting impulses. As to the mental symptoms, there may be either mania or melancholia, delusions being frequent with both. Such cases usually recover. The train of mental, sensory, motor and reflex symptoms, as illustrated by this patient, never occur together except in alcoholism.

*A Case of Extensive Tuberculosis amenable to Surgical Treatment.* Dr. Bell showed the patient, a little boy of five years of age, who had been found a waif on the wharf two years ago. He was taken to the Montreal General Hospital, when it was discovered that he was suffering from advanced disease of the left hip-joint, with sinuses covering the thigh almost down to the knee. At the time it was thought that nothing could be done for the child, but with care he gradually gained strength, when Dr. Bell decided to operate. He removed the head, neck and great trochanter of the femur, and scraped away the floor of the acetabulum. The wound suppurated for months, but ultimately healed, when tuberculosis appeared in one of the testicles; this was allowed to go on to suppuration, when it was removed. The child had hardly recovered from this operation when the other testicle became involved and removed. From that time the child has been free from any manifestation of the disease and has rapidly gained strength. He is now able to run about, wearing a thick-soled boot on the affected limb.

*Atrophy of the Stomach.*—Dr. Shepherd exhibited two remarkable specimens found in the dissecting-room. They were both found in adult women who had been inmates of the Longue Pointe Asylum. In the first specimen the stomach was found to be greatly atrophied, being smaller than the intestines, and throughout the length of both stomach and intestine there were seen at intervals constricting bands which greatly narrowed the lumen of the canal.

The second specimen showed great atrophy of the stomach, but no constrictions.

Dr. Shepherd considered the specimens unique. He had never seen or heard of anything like them. He could give no history of the patients, and could offer no explanation as to their cause.

*Diverticulum from the Bladder.*—Dr. Shepherd exhibited another dissecting-room specimen, which was a bladder, from the posterior wall of which protruded a remarkable diverticulum. It consisted of a protusion of the mucous membrane of the bladder through the muscular coat. He could give no history of the case.

Dr. McConnell thought that if the stomach was not used for some time, as is often the case with the insane, the organ would atrophy.

Dr. James Stewart stated that there were several cases on record where the stomach never fulfilled its functions, and that digestion took place in the duodenum, some of the cases having lived a fairly old age.

Dr. Mills did not look upon the case as unique. He knew of a condition, not unlike the specimens, found in a case of human hibernation (which he hoped to report in detail at a later date). From the appearance of the first specimen it looked as if a portion of the stomach had done its work and become slightly distended, while a portion devoid of function formed the constricting bands. It did not explain the condition to say that it is atrophy from lack of use.

Dr. Lafleur regretted that the decomposed condition of the specimen precluded microscopic examination, and drew attention to the fact that the constricted portions were very much thicker than the other parts.

*Vulvo-Vaginal Cyst.*—Dr. Alloway related the case of a young lady who had consulted him four and a half months ago for an enlargement of the left labium majus. This, he thought, was a vulvo-vaginal cyst, though it presented characters unlike those usually found, and did not appear to be just in the proper position. It was oblong in shape, running up the side of the labium to the level of the opening of the meatus, and was soft and fluctuating. At the operation he found no definite cyst-wall, but a jelly-like mass which was not mucus but very like myxomá. This he carefully scraped away, and the edges of the wound being brought together healed by primary union. A few days ago she returned, stating that the growth had recurred. Thinking that it might be a return of the myxoma, Dr. Alloway advised removal, to which the patient consented. A tumour was found, but in a different position to the former one, it being in a line with the posterior vulvar opening. This was removed by careful dissection and was found to be a true retention-cyst of Bartholin's gland. On attempting to pass a bristle through

the duct it was found to be occluded by the cicatrix of the previous operation.

*Hæmatoma of the Fallopian Tubes.*—Dr. Alloway exhibited the specimen, removed from a patient who had been complaining of extreme pelvic pain, menorrhagia and sterility since the time of her marriage six and a half years ago. Commenting on the case, Dr. Alloway said that until quite recently this condition was supposed to occur only in tubal pregnancy, but now it is known that it may be produced by any inflammatory condition or excessive congestion.

*Hæmatoma of the Ovaries.*—Dr. Alloway exhibited two specimens of this condition. The first had been removed from a woman suffering from pelvic pain and menorrhagia. A prominent symptom was nervous tremor, which he attributed to loss of blood and general debility. The appendages were found fixed in a mass which was removed. The ovaries were perfectly riddled with blood cysts. The second specimen was from a woman suffering from menorrhagia and constant pain, and in whom he had diagnosed a myomatous uterus. There was also sub-involution of the tubes.

In all these cases he had used catgut instead of silk for ligatures, and had found no evidence of want of strength.

*Total Extirpation of the Uterus for a Myoma.*—Dr. Wm. Gardner exhibited the specimen of a large myoma on the posterior wall of the uterus from a woman, aged 50, who had been suffering from profuse hemorrhages, having bled almost continuously during the summer. He had diagnosed the tumour several years ago, and its growth had been slow. There was nothing peculiar about the case, but he wished to speak of the method of operation. He had removed every part of the uterus through the abdominal incision by the method explained in detail at the last meeting of the Society. He had used catgut for ligatures, and considered that it had great advantages in pelvic surgery. Silk ligatures may become infected from contact with the drainage, and act as a constant source of irritation until they come away, while catgut holds just as well, and if it should be infected by contact with the drainage-tube it is a small matter as it is so quickly absorbed. He thought that the severe pain so often complained of after the removal of the appendages was due, to a certain extent, to the persistent constriction of the pedicle by the silk ligature.

Dr. Alloway assisted Dr. Gardner, and thought this method would be the one of the future. The operation would be very difficult if the abdominal walls were large and thick. Another disadvantage was the enormous amount of physical endurance required on the part of the operators, for the operation was undoubtedly the most difficult in pelvic surgery, but it offered the great advantage of leaving no sloughing behind.

Dr. Mc Connell did not agree with Dr. Gardner's explanation of pain after the removal of the appendages. He did not think that the constriction of the ligature could last long enough to produce the pain.

*Tumour from Oviduct of a Hen.*—Dr. Mills exhibited the specimen of a caseating tumour about the size of a large turkey's egg which he had removed from the oviduct of a hen. The hen had been out of sorts for several weeks and the tumour had been discovered, the whole process lasting about eight weeks. This apparently rapid growth corresponds with the period of growth and development and the short period of usefulness of a hen's life.

*A Case of Meningitis following Middle Ear Disease.*—Dr. Springale read the history of this case, as follows :

The patient, a female 35 years, gave a history of suppurating disease of the right ear for some years past. More or less acute pains on that side of the head were supposed to be of a neuralgic nature. These are always relieved when discharge took place from the ear. One day in June last the patient began to suffer from pain over the right side of the head, which subsided towards evening, and the patient enjoyed a good night's rest. At three o'clock in the afternoon of the following day she was seized with violent pain in the above situation; this was followed by violent general convulsions, and when the patient was first seen the case presented the characteristics of a most violent attack of meningitis. The condition lasted for twelve hours from the time of onset, and the patient died. At the autopsy, the dura was found to be adherent intimately to the calvarium. A condition of acute meningitis obtained. A perforation measuring 10 mm. from the internal auditory meatus. A further examination of the body was not permitted by circumstances. This is to be regretted, as a soft blowing systolic murmur was to be heard during life over mitral and aortic areas of the heart. This condition was observed in a similar case before this Society, some two years ago, in which some suspicious of ulcerative endocarditis were entertained.

The President said that whenever fatal symptoms have ensued so rapidly on chronic ear disease, death has uniformly resulted from diffuse meningitis. He had never seen the more chronic form. It is quite consistent to assume that there may have been a previous localized meningitis from which the patient recovered. We never know how far a lesion extending from the ear to the cranial cavity has gone or will go. Such a rapid case as this one is rather rarely met with.

## Progress of Science.

### A FEW NOTES ON THE THERAPEUTICS OF COD-LIVER OIL.

By T. Simpson, M.D., Consulting Physician to the Montreal General Hospital, &c.

Perhaps there is no remedy of its class which has been so universally prescribed and used as cod-liver oil. It has been recommended in almost every disease to which flesh is heir, both as an external application and an internal remedy. And this has been going on from time immemorial. The fat of fishes was used as a remedy in the days of Pliny, and for over a hundred years just passed, its steady employment, with scarcely a break, in rheumatism and in disorders having an origin in struma has obtained.

As an evidence of its extended use, I may mention that a middle aged man whom I met on the north shore of Lake Superior thirty-five years ago, informed me that as far back as his memory carried him the fat of certain fishes caught on that coast, and especially the livers, were fed to the emaciated and those suffering from diseases of the chest, accompanied by cough, by the fishermen, who at time were nearly all natives or "half-breeds." I could not discover how far back this plan of treatment extended, or whether or not it had been introduced by the whites. It must, however, be admitted that a knowledge of, and faith in, the virtues of cod-liver oil as a remedy extended far and wide and have existed for ages. It follows also that there must be a solid basis for such opinions.

I have just said that it has been used, at one time or another, in almost all diseases; and whilst on the one hand its more than common use is a direct compliment to its efficacy, on the other hand an injudicious and indiscriminate administration has frequently brought it into undeserved disrepute.

Broadly, it may be said that cod-liver oil is indicated in a very large class of subacute and chronic diseases in which emaciation and debility are prominent, accompanied by, or resulting from mal-assimilation of food or perverted nutrition.

In various forms of tuberculosis, including those of the skin, and notably lupus, in rachitis, in tardy ossification of the bones and growth of the teeth in children, often accompanied by tumid liver and abdomen, in softening of the bones in adults, in a variety of skin diseases, notably psoriasis, occurring, in children and young women ill-nourished or emaciated, or tainted by scrofula or syphilis, it is indicated. I have known it, when judiciously administered remove most extensive psoriasis, after the failure of the usual remedies, including arsenic and chrysophanic acid.

As a purely local application, I am satisfied that it does not possess any property which would compensate for the uncleanly and malodorous practice; nevertheless cases occasionally, though rarely occur, in which it is advisable, failing other means, to attempt its introduction into the system by inunction. It is, however, a most unsatisfactory method.

In chronic arthritis, and in the chronic and scarcely inflammatory musculo-fibrous rheumatism of the aged and debilitated, accompanied by rigidity of the muscles and stiffness of the joints, the medicine is indicated, and will often procure decided relief of pain and more or less relaxation of the muscles and joints.

But it is as a remedial agent in the treatment of pulmonary consumption and certain chronic bronchial ailments—especially such as are attended by copious muco-purulent expectoration—that cod-liver oil has acquired its reputation, and although its beneficial action is doubtless owing chiefly to its nutrient qualities, still it possesses others in addition. It has been found that bland and wholesome oils—olive and others—admirably adapted for fat food, when readily assimilated, increase the weight and strength of the patient. But cod-liver oil does this and more; it promotes assimilation, lessens waste of tissues, often restores appetite, and diminishes cough and expectoration. It favours the expulsion of tuberculous matter, as well as lessens the tendency to its formation. In short, in favorable cases, when the stomach is in fair working condition, it ameliorates all the symptoms and in some cases restores health. Unfortunately these latter are decidedly few in number, especially among persons inheriting the tuberculous diathesis; nevertheless many persons live for years in comparative comfort, owing chiefly to the persistent and judicious use of the oil. The disease is not cured, but held in check.

It has been charged with the production of hæmoptysis by enriching the blood and increasing the number of red corpuscles, in this way inducing local hyperæmia in parts adjacent to tuberculous deposit, but as hæmoptysis frequently occurs in phthisis where no medication has been used—is often the first symptom of its presence—I am not disposed to attach much importance to the charge. Its use, however, should be suspended during hæmoptysis or the supervention of any acute intra-thoracic inflammation. Its whole action on the economy is what may be called altero-nutritive, and whilst it cannot be pretended that it has any direct and local effect on the bacilli of tubercle, it may under favourable circumstances render their bedding and feeding ground untenable.

Its marked alterative action and influence on digestion over other fats is accounted for by the presence of bile constituents and other substances, chiefly bromine, iodine, iron, and phos-

phorus in a certain combination. There are said to be also one or two "peculiar principles." Doubtless the oil suffers from over "purification," some of its important constituents being eliminated during the process.

Unfortunately the taste and odour of cod-liver oil are most unpleasant, even to the exciting of nausea in many persons. In others unaffected in this way, the stomach rebels, consequently various plans have been devised to conceal these objectionable qualities, and without altering the chemical constitution, to present the oil in a more acceptable form. With this end in view, numberless mixtures, emulsions and extracts of various flavours, strengths and compositions have been offered to the public. Among these preparations is an excellent one manufactured by the Davis & Lawrence Company of Montreal, called the "D. & L. Emulsion of Cod Liver Oil, with Hypophosphites of Lime and Soda," which I have used freely for the past two years owing to its agreeable appearance, not unpleasant taste, and evident therapeutic qualities. It has the colour and consistence of thick cream, and, I am creditably informed, contains 50 per cent. of Norway oil, well broken up in glycerine and mucilage; in addition there are six grains each of the hypophosphites of lime and soda to the ounce. Most children take it without trouble, and anyone who has the management of children will understand what a boon this is to both patient and nurse. I have used it in cases where the pure oil for some valid reason could not be borne, and it is especially indicated in such diseases of the bones as have been mentioned, and in certain neuroses with emaciation, the result of excessive brain work, worry or specific taint. The presence of the hypophosphites adds no doubt to its potency in these latter diseases.

As has been already pointed out, cod-liver oil is not only an efficient remedy, but in a degree an admirable food, and advantage is taken of this fact to use it largely as a preventative. Children and young people without active disease, but having so-called delicate lungs, whether acquired or inherited, who in this northern and changeable climate are subject, during sudden alternations of temperature and moisture, to bronchial and catarrhal troubles, and to that insidious and alarming complaint, common croup, are saved many an attack and permanently benefitted by its judicious use during the cold seasons of the year, but more particularly, perhaps, during the autumn and early spring. I am in the habit of ordering for delicate children, referred to above, from a teaspoon to a dessertspoonful of the "D. & L. Emulsion" each night at bedtime, and keep this up, with occasional intermissions of a day or two, for months.

As regards the administration of cod-liver oil—this alternative food—in individual cases, I

shall say that the same experience, judgment and watchfulness on the part of the physician are necessary in this plan of treatment as in any other rational mode. The same regard to accessories, environment, and to the idiosyncrasies of the patient.

In closing these few notes—which, it is needless to say, do not contain anything new in the proper meaning of the word, or any attempt at completeness on the part of the writer—it may not be amiss, in these days of "new remedies" and fancy ephemeral theories so captivitating to the young and enthusiastic, and, for that matter, to many of the older members of the profession, to suggest that we should pause for a moment now and then—but by no means stand still—and turn our attention backwards to old and tried friends, to remember how often they have stood us in good stead, and although they have not the gloss and insinuating flavour of the new remedies, with which it is attempted to supplant them, they are yet sturdy helpmates, whose usefulness is neither to be despised nor belittled.

#### TREATMENT OF FURUNCULOSIS.

Dr. Veiel, says that since the investigations of Garre, Lowenberg, Lannelougue and Bockhardt have shown that furuncles are caused by the entrance of pyogenic bacteria into the openings of the sebaceous and sweat glands, the treatment of furunculosis may be summarized under the four following heads: (1) The destruction of the pyogenic bacteria in the tissue before they have caused necrosis. (2) When necrosis had already taken place, to eliminate the dead tissue, together with the contained bacteria as quickly as possible. (3) To sterilize the pus from open furuncles, so that it will not give rise to other boils in the surrounding region. (4) To place the whole organism in such a condition of health as to resist any new infection. The first of the requirements can seldom be fulfilled, for at the time when there are any symptoms of redness, swelling, etc., on the skin the necrosis is already so far advanced as to be past all hope of recovery. It is therefore best to go on to the second indication for treatment, viz, to aid in the elimination of the diseased mass, and for this purpose there is nothing either so quick in its action or so sure in its results as warm poultices. It is true that the pyogenic bacteria adherent to the under side of the poultice may infect the skin. This may be obviated by painting a 1 per cent. bichloride solution on the poultice, or if the skin is to tender a 4 per cent aqueous solution of boracic acid. Each time the poultices are renewed the skin ought to be cleaned with absorbent cotton soaked in either of these solutions. At night the furuncle should be covered by one of Unna's carbolic acid mercurial plasters. Unfortunately, however, this plaster, as well as the zinc gutta percha plaster, very often causes a

dermatitis, which prepares the skin for a fresh invasion of bacteria, and for this reason it is better to use a paste composed of

Oxide of Zinc

Vaseline

Boracic Acid

āā. ʒss.

gr. xx—M

S.—To be spread thickly on lint and held in place with American sticking plaster.

Indolent furuncles had better be opened with the knife. Pressing out the furuncles at too early a stage is very detrimental, for it does not shorten the healing process, and it only presses the infective material out into the surrounding tissues, and causes the patient a great deal of unnecessary pain. In order to disinfect the skin the foregoing paste may be rubbed in over the entire body, or the patient may receive sublimate baths. Beside these therapeutic measures, the greatest cleanliness must be observed. If the skin itches, the nails must be cut short. Undergarments and bed linen must be frequently changed, and the clothes thoroughly disinfected. The fourth indication is met by a good diet. If anemic, the patient may be given iron. Diabetics must receive appropriate treatment. No other internal treatment has given any satisfaction, neither arsenic nor the much praised sulphide of calcium have given good results, either in furunculosis, impetigo, acne or sycois. Purgatives are decidedly detrimental.—*Monatshefte f. Prakt. Dermatologie, Occidental Med. Times.*

#### WHAT I HAVE LEARNED TO UNLEARN IN GYNECOLOGY.

Under this caption Dr. Wm. Goodell gives his experiences. He had learned that the climacteric is not responsible for most of the ills of motherhood, and especially, for menorrhagia, as popularly taught; that uterine hemorrhages, indeed, and other uterine discharges, can rarely be traced to the climacteric as a cause in itself; that the so-called "critical discharges" and "change of life" are misnomers which, too often, lead to indolent diagnosis and slovenly therapeutics. He has learned that operations, if time be precious, need not be deferred on account of menstruation. The menstrual period is the best time, in fact, to curette for fungous vegetations. The only operations which offer serious objection at this period are those upon the uterus itself, and because of its increased vascularity and danger of hemorrhage. He has learned that antelexion and antiversion in themselves—without narrowing of the canal—are not necessarily pathological; that pessaries for these conditions, except occasionally a stem pessary for stenosis, are rarely useful; that irritable bladder is generally the result of nerve exhaustion, a lack of brain control, and not of pressure of an antelexed fundus. He has long abandoned the idea that

the parturient woman must be swathed like a mummy and be kept as immovable. He finds no objection to her turning from side to side, sitting up, and even getting up to use the commode, if she feels like it. He does not believe that mammary abscess comes from "caked" or over-distended breast, but from cracked nipples; that uterine catarrhal secretions are any greater drain than those from the nose, or that they require heroic treatment; that cellulitis is at the bottom of most female ailments, and that the hot water douche is its cure-all. He believes that the latter has even caused ovaritis, salpingitis and periuterine inflammation, and that the supposed cellulitis and exudations are usually tubal and ovarian lesions. The hardest task of all was to learn that uterine symptoms are not always present in uterine disease, or that when present, they necessarily come from uterine disease. They are nerve symptoms. Nerve-strain or nerve-exhaustion comes largely from the frets, the griefs, the worries, the cares and cares of life, and their symptoms simulate uterine disorders, and are almost uniformly attributed to them. The tricky nerves, when underfed or overworked, or out of discipline, billet themselves upon some maimed organ, and hold high revel there. Thus, a woman hitherto in perfect health, though having an adherent or dislocated ovary, a torn cervix, a narrow cervical canal, a slight displacement, has her nervous system unstrung and at once there are set up vesical, uterine and ovarian symptoms. Dr. Goodell sums up his gynecological creed: "I believe that the physician who recognizes the complexity of woman's nervous organization and appreciates its tyranny will touch her well-being at more points, and with a keener perception of its wants, than the one who holds the opinion that woman is woman because she has a womb."—*Medical News.*

#### HOW TO PREVENT SCARLATINA.

Dr. J. Lewis Smith refers to the important facts regarding the propagation of this disease. It is contagious from the first day of its occurrence, continues so during desquamation, is probably propagated by ear discharge if disinfectants be not used. Its area of contagion is limited—but a few feet; on the other hand the tenacity of its poison is remarkable, adhering to persons and things, and thus being carried by physicians, nurses, visitors, clothing that has been stowed away a length of time, letters, library books, and also, being retained in the hangings, furniture, and wall paper of rooms, etc. The gases generated by burning sulphur are proved to be not efficient, although Dr. Squibb suggests that it is because they are used in too dry a state. The sulphur should be burned in a room with boiling water. Chlorine generated by the action of sul-

phuric acid on a mixture of common salt and black oxide of manganese is probably more efficient. But Dr. Smith asserts that methods for purifying rooms in which scarlet fever and diphtheria patients were confined can only be successful if preventive measures be employed during the continuance of the case. These consist in the use of disinfectants in the sick room, or upon the patient from the beginning of the disease. Isolation and disinfection are the measures to be relied upon. The floor and walls of the rooms should be bare; none but doctor and nurse should enter it; all books, toys, etc., used by the patient should afterwards be burned; soiled clothing should be thoroughly disinfected; thorough ventilation secured; the air purified by vaporizing, in broad dish over a gas or oil stove, two tablespoonfuls of the following mixture: carbolic acid,  $\bar{3}$ i.; ol. eucalyptus,  $\bar{3}$ i.; spts. turpentine,  $\bar{3}$ vi; the vaporizing to be continued uninterruptedly. The body should be anointed every three hours with carbolic acid,  $\bar{z}$ i.; ol. eucalyptus  $\bar{z}$ i; olive oil,  $\bar{z}$ vii. To the pharynx a solution of corrosive sublimate, two grains to a pint of water, may be applied as gargle or spray every two hours. It may also be injected into the nostrils. Articles of clothing should be disinfected. Physicians should be especially careful to preserve their clothing from contamination, and to cleanse themselves thoroughly before visiting other patients. They should impress upon the family the importance of careful disinfection of the room on the termination of the case. In addition to the ordinary measures it is advised to rub the walls of the apartment with slices of fresh bread which gather up microbes, and to wash, whitewash or kalsomine the walls, ceiling or floor with a solution of corrosive sublimate — *Archives of Pediatrics.*

#### THE BRIGHT'S DISEASE OF PREGNANCY.

Dr. James Tyson refers to several important points in relation to this subject. (1) That the prime agency in its production is the irritating effects upon the renal cells of some toxic substance in the blood, probably represented by some combined excrementitious substance from the mother and fetus. (2). That the child plays an important part, is shown from the fact that the evil does not arise until the later months of pregnancy, when it has attained some size and disappears upon the death of the child, though it be not expelled. Pressure upon the renal vessels is believed to have much less influence in the production of the disease than was formerly held, although in the latter months it may aggravate an existing nephritis, or cause some albuminuria. Acute nephritis of pregnancy is more serious than acute nephritis from any other cause, while uremia is the dangerous symptom which is responsible for the fact; so much so, that if this danger be escaped the

prognosis becomes quite favorable, even more so than in acute nephritis from other causes. Convulsions occur in one-fourth of all cases, and about 30 per cent. of the eclamptic cases die, Dr. Tyson believes that this high mortality can be diminished, and relies upon the induction of premature labor for the accomplishment of this result. If serious symptoms from Bright's disease have occurred in one pregnancy, premature labor should be induced in subsequent pregnancies whenever albuminuria appears. In those having Bright's disease before marriage, the premature labor is advised whenever increased albuminuria appear or convulsions threaten. If albuminuria persist after labor, even though the patient passed through her labor safely; it may be well to shorten pregnancy in subsequent cases. No rule can be laid down as to when premature labor is to be brought about; it may generally be delayed until after viability, but large albuminuria, dropsy, intense headache and scanty urine call for immediate action. These symptoms occurring in those married late in life are more serious and need earlier attention.—*Medical Record.*

#### THE KNEE REFLEX IN EPILEPSY.

Dr. Vasilieff, though not first to notice the fact that epileptic attacks exercise changes on the knee-tendon reflex, has made a slight addition to our knowledge on the subject by a series of experimental investigations, carried on in the laboratory with the help of Marey's chronograph and Bekhtereff's reflexograph, the subject being dogs thrown into epileptic convulsions by electrization of the cerebral cortex. In the tonic period of the attack it was found to be impossible to excite the reflex, owing to the rigid state of all the muscles; in the succeeding clonic stage, however, the phenomenon was well marked. After a violent fit, accompanied by loss of consciousness, the tendon reflex was usually either entirely absent or very deficient in strength, the change occurring within a few seconds at latest after the clonic spasms had ceased. The length of time during which the reflex was absent varied from one to twelve minutes, and it did not regain its normal force for a good while, in some cases not for half an hour or more. Sometimes, however, after it had become normal, a temporary increase in the force of the reflex was observed. It has been noticed by Dr. S. N. Danillo, too, that the knee reflex was absent in dogs in which epileptiform fits had been produced by absinthe. Dr. Vasilieff thinks that these observations may be of value in diagnosing true from spurious epileptic attacks. His paper, as well as those of Prof. Bekhtereff and Dr. Danillo, dealing with the subject of the knee reflex, are published in the *Vrach—London Lancet.*



## THE CANADA MEDICAL RECORD.

PUBLISHED MONTHLY.

Subscription Price, \$2.00 per annum in advance. Single Copies, 20 cts.

## EDITORS:

A. LAPHORN SMITH, B.A., M.D., M.R.C.S., Eng., F.O.S., London  
F. WAYLAND CAMPBELL, M.A., M.D., L.R.C.P., London.

ASSISTANT EDITOR

ROLLO CAMPBELL, C.M., M.D.

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All letters on professional subjects, books for review and exchanges should be addressed to the Editor, P.O. Drawer 1933 Montreal.

Writers of original communications desiring reprints can have them at a trifling cost, by notifying THE HERALD Co. immediately on the acceptance of their article by the Editor.

MONTREAL, JANUARY, 1891.

THE CANADA MEDICAL RECORD  
APPRECIATED.

The following cheering words are from Dr. Buchanan of St. Lawrence, New York State: "There is no more welcome visitor each month than the CANADA MEDICAL RECORD. There is not one number that does not repay the cost of the RECORD for the whole year. I have received information in some that has been very valuable to me." Our correspondent also approves of our efforts to raise the standard of medical education to a five years' course. We would be very pleased if more of our subscribers would send us a few words of encouragement and also report some of their cases, many of which would be of the greatest interest not only to us but to our many readers. We shall not be satisfied until we shall have developed a correspondence department in which practitioners may exchange their experiences especially in their daily work. We again repeat an invitation therefore to our readers to drop us a line for publication on matters of general interest to the profession, which will find a welcome place in our columns.

## NEWS ITEMS.

THE INTER-CONTINENTAL (OR PAN)  
AMERICAN MEDICAL CONGRESS.

In July last Dr. James F. W. Ross, of Toronto, was appointed the Executive Committee-man for British North America.

Foreign Executive Committee-men are expected to organize the profession in their respective countries in the interest of the Congress. They are asked to

- (1) Nominate one vice-president for the Congress.
- (2) Nominate one secretary for each section of the Congress.
- (3) Appoint auxiliary committee-men in local medical societies, or in considerable towns and cities where no medical societies exist.

Dr. Ross, we are pleased to state, has his district, from the Atlantic to the Pacific, well in hand. Many of the selections have been made, and when the list is completed the names will be published. Dr. J. Graham, of Toronto, has been nominated for a vice-president, and he, with several others, has assisted Dr. Ross in making the Ontario selections. Drs. F. J. Shepherd and Lachapelle, of Montreal, and Ahern, of Quebec, have given valuable assistance in the Quebec selections; and Dr. Muir, of Truro, Nova Scotia, has done similar work for the Maritime Provinces. These auxiliaries are nominated for the purpose of creating an interest in the Congress among the members of the profession in each city, town, or district. To them will be sent all the official literature printed from time to time by the Committee on Permanent Organization. In his letter to those nominated Dr. Ross says: "I have endeavoured to secure progressive practitioners of good standing in the profession. The congress will be composed of members of the medical profession living in the 'western hemisphere.' It is the first time that Canadians have been asked to take an official part in any American congress of medical men."

Professor Pepper, of Philadelphia, has been elected president of the Congress, and he has never yet done anything by halves. Under his leadership, the Pan-American Congress will be a great scientific union of professional brethren—each of them a link in a chain extending from pole to pole.

This will be the first Pan-American Congress, but its success will no doubt necessitate other similar meetings in the near future. The meeting will be held in the year of the Columbian Exhibition, 1893. Washington has been selected as the place of meeting, and the time appointed is the first Tuesday in October.—*The Canadian Practitioner.*



## ALVARENGA PRIZE OF THE COLLEGE OF PHYSICIANS OF PHILADELPHIA.

The College of Physicians of Philadelphia announces that the next award of the Alvarenga Prize, being the income for one year of the bequest of the late Senor Alvarenga, and amounting to about one hundred and eighty dollars, will be made on July 14, 1892. Essays intended for competition may be upon any subject in Medicine, and must be received by the Secretary of the college on or before May 1, 1892. It is a condition of competition that the successful essay or a copy of it shall remain in possession of the College.

CHARLES W. DULLES,  
Secretary.

The Drevet Manufacturing Company have removed their factory from 10 West 4th Street, to 28 Prince Street, New York City.

## BOOK NOTICES.

THE THERAPEUTIC GAZETTE with January, 1892, begins the sixteenth year of its publication, under the editorial management of Hobart Amory Hare, M. D., George E. de Schweinitz, M. D., and Edward Martin, M. D.

INTRODUCTION TO THE ANTISEPTIC TREATMENT OF WOUNDS, According to the Method in use at Professor Billroth's Clinic, Vienna, arranged for Students and Physicians. Translated with the author's permission, from the German of Dr. Victor R. v. Hacker, Assistant in the Clinic Billroth; Professor in Surgery; Surgeon to the Allgemeines Poliklinik and the Erzherzogin-Spital in Wein, by Surgeon-Captain C. R. Kilgely, M. B., Army Medical Staff. London: Percival & Co., 1891. Price Two Shillings.

SAUNDER'S QUESTION COMPENDS, No. 21. Essentials of Nervous Diseases and Insanity: their Symptoms and Treatment. A manual for students and practitioners. By John C. Shaw, M.D., Clinical Professor of Diseases of the Mind and Nervous system, Long Island College Hospital Medical School; Consulting Neurologist to St. Catherine's Hospital, and Long Island College Hospital; formerly Medical Superintendent King's County Insane Asylum. Forty-eight original illustrations, mostly selected from the Author's private practice. Philadelphia, W. B. Saunders, 913 Walnut Street, 1892.

THE PHYSICIAN'S VISITING LIST (Lindsay & Blakiston's) FOR 1892. Forty-first year of its publication. Philadelphia: P. Blakiston, Son & Co. (successors to Lindsay & Blakiston) 1012 Walnut Street.

This always popular Visiting List presents one or more new features for the coming year. There is a short account, compiled by Dr. Geo. M. Gould, of the diagnosis and treatment of the simpler superficial diseases of the eye. A table showing the characteristic characters of the urine in the various forms of Bright's disease may prove of value when more important sources of information are not

handy. The publishers deserve credit for their efforts, year after year, in bringing out a list which fulfils such a useful purpose.

J. B. Flint & Co., New York, have in press, and ready early in the current year the following books: A COMPLETE SYSTEM OF GYNÆCOLOGY AND OBSTETRICS, with 869 new illustrations based upon translations from the French of Pozzi, Auvard, and others, revised by Chas. Jewett, M. D., bound in leather or half morocco, \$8.00.

FLINT'S CONDENSED COMPLETE ENCYCLOPEDIA OF MEDICINE AND SURGERY. Arranged upon a new system, and embodying the various methods of treatment employed by eminent practitioners. The most valuable and complete work of this nature ever published. The result of a year's labor of a large corps of writers. Leather or half morocco, two volumes, \$8.00 per volume. The above works sold by subscription.

Also in press, ready March 1st, the "Electro-Therapeutics of Gynaecology," by Augustin H. Goelet, M.D. Cloth bound, \$2.50.

SYPHILIS IN ANCIENT AND PREHISTORIC TIMES. By Dr. Fred. Buret, Paris. Translated from the French with notes by A. H. Ohmann-Dumesnil, M.D., 12 mo., pp. 226. Philadelphia and London: F. A. Davis. 1891. St. Louis: J. H. Chambers & Co., 914 Locust St. Price \$1.25.

The scientific effort of the physician has been directed towards the evolution of a system of treatment by which the ravages and ulterior results of syphilis might be controlled. Fortunately for humanity, this has not been in vain.

The primordial origin of syphilis has been a matter for dispute, for lo! these many years, the majority of syphilographers considering the epidemic of 1491 as its starting point. From this time syphilis has been variously designated, *morbue gallicus*, the Neapolitan disease, the disease of the Germans, of the Poles, of the Spaniards, of the Turks, the disease of the holy man Job, of St. Sementius, of St. Mevius, of St. Roch; and last, but not least, the American Disease. The author has been stimulated by the premise suggested by Philippe Albert, that "to write the history of syphilis is, so to speak, to trace that of humanity." In accord therewith, "the volume is entirely devoted to the proofs of the existence of syphilis from the creation of the world to the Middle Ages." And further, "to eliminate numerous so-called proofs, which prove nothing," and to carefully study the archives of antiquity from prehistoric man and *Nuei King* (a medical treatise edited \* \* \* by the Emperor Hoangty, of China, who lived 3637 B. C.) to "syphilis in Rome under the Cæsars."

To prove that "syphilis dates from the creation of man" is a task from which most of us would shrink. The author attempts this, and we must admit, has not only presented a very readable book, but one filled with much substantial information, if not absolutely convincing proof. A few pages are devoted to the nature, character and treatment of syphilis.

The translator, our colleague, Dr. Ohmann-Dumesnil, has fulfilled his task admirably, and is to be congratulated for his faithful adherence to the original text, and for his effort to present such an admirable historical sketch to English readers. We bespeak abundant endorsements for the effort.—J. L. B.