

Technical and Bibliographic Notes / Notes techniques et bibliographiques

The Institute has attempted to obtain the best original copy available for scanning. Features of this copy which may be bibliographically unique, which may alter any of the images in the reproduction, or which may significantly change the usual method of scanning are checked below.

L'Institut a numérisé le meilleur exemplaire qu'il lui a été possible de se procurer. Les détails de cet exemplaire qui sont peut-être uniques du point de vue bibliographique, qui peuvent modifier une image reproduite, ou qui peuvent exiger une modification dans la méthode normale de numérisation sont indiqués ci-dessous.

- Coloured covers /
Couverture de couleur
- Covers damaged /
Couverture endommagée
- Covers restored and/or laminated /
Couverture restaurée et/ou pelliculée
- Cover title missing /
Le titre de couverture manque
- Coloured maps /
Cartes géographiques en couleur
- Coloured ink (i.e. other than blue or black) /
Encre de couleur (i.e. autre que bleue ou noire)
- Coloured plates and/or illustrations /
Planches et/ou illustrations en couleur
- Bound with other material /
Relié avec d'autres documents
- Only edition available /
Seule édition disponible
- Tight binding may cause shadows or distortion
along interior margin / La reliure serrée peut
causer de l'ombre ou de la distorsion le long de la
marge intérieure.
- Additional comments /
Commentaires supplémentaires:

Continuous pagination.

- Coloured pages / Pages de couleur
- Pages damaged / Pages endommagées
- Pages restored and/or laminated /
Pages restaurées et/ou pelliculées
- Pages discoloured, stained or foxed/
Pages décolorées, tachetées ou piquées
- Pages detached / Pages détachées
- Showthrough / Transparence
- Quality of print varies /
Qualité inégale de l'impression
- Includes supplementary materials /
Comprend du matériel supplémentaire
- Blank leaves added during restorations may
appear within the text. Whenever possible, these
have been omitted from scanning / Il se peut que
certaines pages blanches ajoutées lors d'une
restauration apparaissent dans le texte, mais,
lorsque cela était possible, ces pages n'ont pas
été numérisées.

CANADA

MEDICAL & SURGICAL JOURNAL

JANUARY, 1884.

Original Communications.

FEMORAL HERNIA, RIGHT SIDE.

OPERATION AFTER NEARLY THREE DAYS' DELAY—RECOVERY.

By J. CAMPBELL, M.D.C.M., AND L.R.C.P., EDIN., OF SEAFORTH, ONT.

(Read before the Canada Medical Association, at Kingston, September, 1883.)

Gentlemen,—Thinking the notes of the following case may be of some interest to the members of this Association, I beg leave to present them for your consideration.

I was called at 2 o'clock a.m., on the 24th of Dec., 1882, to see an old lady who said she was suffering from "cramps." The pain was referred to her right groin, and upon examination I discovered a small tumor, which, after some manipulation, I diagnosed to be femoral hernia. As she was suffering severe pain I relieved her with a hypodermic injection, using one of Weyth's pellets of morphia and atropine, which I always carry. I then enquired into the history of the case, and set to work to return the hernia without the aid of chloroform, which I could not procure until daylight without trouble or delay.

The following is the story of the case:—Mrs. T., whose age is 57 years, is a native of Scotland, but has lived 12 years in Seaforth. She has had a rupture of her left side for 12 years, but never had anything wrong with the right side before. She is a heavy, fleshy woman, and upon the previous evening, about 10 o'clock, when going upstairs to bed, she was taken with severe pain in the right side, followed by vomiting, which lasted until relieved four hours afterwards as already stated. The temper-

ature was normal, the pulse slightly accelerated. I tried taxis cautiously, getting the husband to raise the lower part of the body, throwing the weight on her shoulders, a manoeuvre which I had often found succeed, but all was of no avail. I remained with her all night, and at 8 o'clock a.m. Dr. Scott was called in. He also tried the taxis, but failed, and as she was easy, advised delay. Saw her repeatedly during the 26th in company with Dr. S., using injections, taxis and anæsthetics at intervals, as symptoms seemed to require and our judgment would dictate—pulse and temperature all this time remaining normal and the pain and vomiting being allayed by the hypodermic injections which were repeated from time to time.

During the night of the 26th symptoms began to grow more grave, and I prepared for an operation, which I was willing to perform whenever such a course was decided upon. Dr. Scott still counselled delay, and Dr. Gunn, of Brucefield, having called upon me accidentally, I took him in to see our patient. This was about 11 o'clock a.m. The patient was vomiting greenish matter every five or ten minutes, and the temperature which had hitherto been normal, now rose to 101° , while the pulse reached 120. Dr. Gunn was in favor of an immediate operation, and as the friends wished to see Dr. Gounilock, he also was called in and was in favour of operating at once. I had been looking forward to this decision and had everything in readiness. It was, however, decided that when the patient was put under chloroform Drs. Gunn and Gounilock should each try the taxis for the last time, and failing, I would operate without allowing her to recover from the influence of the anæsthetic. The taxis failed, as was expected, and we began the operation. Dr. Gounilock attended to the chloroform, Dr. Scott sponged, and Dr. Gunn assisted me with the instruments. As there was a doubt in the minds of my consultees as to whether it was femoral or inguinal hernia, I consented at their request to make incisions which would suit either case, namely, one parallel to Poupart's ligament and another at right angles to the former, having the neck of the sac under the junction of the two incisions. We made our incisions carefully. There was a large amount of adipose tissue which complicated

matters very much. We used the director as we neared the sac, which, when reached, welled or rolled up clear and shining. We resolved not to open the sac, so passing in the forefinger, which had been carbolised, I found the tense edge of Gimbernaut's ligament well defined. We then passed in the hernia knife with its flat side towards the finger in the usual manner, and turning the cutting edge towards the ligament incised it with a sawing motion, after which we found little difficulty in emptying the sac and returning the bowel, which went back with a gurgling noise. We used antiseptic precautions from first to last, with the exception of the spray. The wound was well sponged out with carbolic lotion and brought together with deep wire sutures, carbolised silk being used to bring the lips in apposition, a piece of lint soaked in carbolic lotion was laid on the wound—a figure of eight bandage put on—an opiate given, and the patient allowed to rest. The bowels moved naturally five hours after the operation; this was the first time since the attack, notwithstanding the injections of warm water, warm olive oil, and other means that had been repeatedly used during the three days she had been under treatment. Everything in short went well until the fourth day, when it was found that a quantity of pus had collected at the lower edge of the wound, the rest having healed by first intention. The temperature which had resumed the normal after the operation now rose to 101° , the pulse to 120, and the patient became restless. The pus was evacuated and the part sponged with carbolic lotion, a good dose of quinine was given and repeated at intervals until the temperature became normal, which was three days afterwards. The wound was kept scrupulously clean, and carbolic dressings used, and the patient made a good recovery. At this stage I regretted that a drainage tube had not been used as I believe this complication might have been prevented. The part of the wound where the pus had formed had to heal slowly by granulation, after which a well-fitting double truss was procured, and the patient resumed her household duties and has done well ever since.

REMARKS.

It may be thought strange that we had so much difficulty in deciding as to whether it was a case of femoral or inguinal hernia

—all my consultants leaning to the belief, to the very last, that it was inguinal hernia—and being only convinced when they felt Gimbernaut's ligament with the finger; but the fact was that I had very great difficulty at arriving at the diagnosis I did, and I certainly had a better chance than any of them, having seen the case from the first, and remaining hours with her. I will give my reasons for arriving at the conclusion I did.

Upon examination, I found a tumour about the size of a small hen's egg, tender to the touch, and below Poupart's ligament. It seemed to be high up for the saphenous opening, and the woman being very fat, it was difficult indeed to diagnose. The tumour was longer in the transverse than in the vertical diameter. The femoral artery could be felt to the outside of the tumour, comparing the position of the tumour when I raised it up with the spine of the pubis, I satisfied myself that it was outside of that prominence (which was, however, very difficult to make out). I could not make out the tendon of the long adductor on account of the fat. There was no impulse upon coughing and the tumour had a soft, doughy feel, as fat would have when compressed by skin and subjacent tissue. Moreover, it was higher up than any femoral hernia we had ever examined. These were the puzzling points in the case. Of course the suddenness of the attack, the severe pain, the complete obstruction of the bowels and the existence of a tumour, all taken together, eliminated everything else but hernia. The only question was—What kind of hernia was it? inguinal or femoral? There were other puzzling factors in the case, such as the following: There never was any impulse upon coughing—there was an absence of the usual elastic feel—the position of the tumour (which had turned up over Poupart's ligament), and last, the length of time that elapsed before urgent symptoms set in, which seemed to point to the fact that the bowel could not have been occluded through its entire diameter. If in connexion with the foregoing we consider the success which attended the operation, after a delay of three days, we must consider it a rather unique case indeed, and worth reporting. I may state that I believe a small piece of omentum must have been included in the stricture, that this was in front of the bowel, and that the gut could not have been occluded throughout its whole diameter.

I believe if any undue force had been used in taxis, we would not have had our patient to-day. We raised the tumour gently, drew it to one side and slightly downwards, and then made moderate pressure as directed, always bearing in mind the direction in which the pressure ought to be exerted. I am not an apostle of force, and would not like to be called upon to operate after repeated and too forcible attempts at reduction had been made.

In conclusion, I would say that I never wavered in my diagnosis as to its being a case of femoral hernia, and only used the incisions I have mentioned at the request of the gentlemen assisting me, knowing that by reflecting back the angles made by my incisions, I could reach the constriction, no matter what kind of hernia it proved to be. I was gratified, however, at finding my diagnosis correct, and the operation successful.

OUR LONDON LETTER.

(From our Special Correspondent.)

LONDON, Dec. 17, 1883.

I happened to be visiting St. George's Hospital recently when a most interesting case was brought on the table by Mr. Timothy Holmes, the well-known surgeon. The patient, a woman of about thirty years, unmarried, first noticed some two years ago a couple of small painful lumps on the radial side of the forearm. They were thought to be connected with the radial nerve and were removed. The pain, however, continued and the hand became contracted, so that Mr. Holmes thought it advisable to amputate at the elbow joint. In a few months the patient returned, complaining of intense pain in the stump. He now excised portions of the median, ulnar, and another nerve (probably the musculo-cutaneous) but with only temporary relief. Now he decided as a *dernier resort* to amputate at the shoulder joint, and this operation I saw him perform. Mr. Holmes feared, however, that the mischief was still more deeply seated, and that even this extreme measure might not be followed by permanent removal of the symptoms.

While sojourning in Glasgow last month I visited the Royal Infirmary on two or three occasions at the invitation of Dr.

McEwen, the famous osteotomist. He kindly afforded me the opportunity of witnessing his operation for knock-knee on two patients, one a boy of ten years, the other a young woman of eighteen.

The condition known as genu valgum or knock-knee is very familiar to every practitioner, although its pathology and treatment perhaps are not always so well understood. Briefly, the deformity is now known to be due to the following changes in connection with the knee joint: In the first place a stretching occurs of the internal lateral ligament, and of the fascia on the inner side of the joint; secondly, on the outer side there is a corresponding shortening of the external lateral ligament, fascia lata, and biceps tendon; and thirdly, on account of the unequal pressure to which the outer condyle and outer tuberosity of the tibia are subjected, these parts become atrophied, while the development of the internal condyle is allowed to go on uninterrupted, and hence the undue prominence which it assumes. All these circumstances, then, combine to cause this deformity. It must not be forgotten, however, that the constitutional condition known as rickets is largely to blame for these changes, and is in fact the primary cause of genu valgum in the vast majority of cases. Thus in large cities such as Glasgow, where the lower classes are ill-fed and ill-housed, and where the parents are notoriously intemperate, nearly every third child one meets in the slums is either bow-legged or knock-kneed. Undoubtedly, however, there are cases where no constitutional defect can be discovered, that is to say, where no evidence is apparent elsewhere in the individual. Here usually one limb only is deformed, and the cause may often be traced to something in the occupation of the person, being compelled perhaps to maintain a constrained position for hours together, the weight of the body coming on one limb.

As to the treatment of knock-knee much can be done in the case of young children by change of air, better diet, the administration of the lime salts in some form, and the application of a suitable support to the limb. Of the last mentioned it will be found that the most useful apparatus consists of a flattened steel bar extending on the outer side of the limb from the hip to the

foot, and attached to the boot. Towards this the knee should be gradually drawn by means of straps properly padded. In very young children, and for a time in all cases, there is no necessity for a hinge opposite the knee, and the limb has consequently to be kept straight, and it is better to treat one at a time when both are affected.

But in practice, and more especially in out-door hospital practice, how imperfectly are these measures carried out. Some of them are absolutely impracticable in the case of poor people. Hence in children under these circumstances the deformity grows with age, and by the time they reach the eighth or tenth year the changes in the joint have become so confirmed that nothing short of operative interference can be of any avail. I took some trouble to examine carefully four cases of knock-knee over a certain age, attending one of the Orthopædic Hospitals which I recently visited, and where the treatment is purely instrumental, but I found in no case (after months of treatment) that decided improvement which would lead one to expect a permanent cure of the deformity.

About seven years ago (it may be longer), Ogston of Aberdeen began the treatment of knock-knee by sawing through the elongated internal condyle subcutaneously, displacing it upwards, and in that way allowing the limb to be straightened. This operation, however, has the great objection that the joint is invaded, and indeed serious consequences have followed its performance. Chiene of Edinburgh modified Ogston's operation by employing a chisel in place of a saw, and breaking off the condyle obliquely down to, but not through, the cartilage, so that the latter was bent but not broken when the limb was brought to the straight position. This method has much to commend it and is still preferred by a few surgeons. But the operation which is now acknowledged by nearly all to be the safest, and to give the most satisfactory and permanent results is that practised Dr. McEwen, of the Royal Infirmary, Glasgow, and which I was afforded the opportunity of seeing that surgeon himself perform. McEwen is a staunch disciple of Lister, and insists upon it that no antiseptic precaution (not excepting the spray) shall be overlooked during

the performance of his operation. He proceeds as follows: The patient being anæsthetized, and the Esmarch bandage applied, the limb is laid over a sand pillow, the inner side of the knee joint being uppermost. The tubercle of the adductor magnus (which by the way can be distinctly felt in any limb not inordinately fat) just above the internal condyle is then carefully made out, and directly over this with a small scalpel, a vertical incision is made reaching to the bone. This incision should be long enough barely to admit a chisel or osteotome about three-quarters to seven-eighths of an inch in breadth. The chisel is passed down, the scalpel acting as a guide, and then turned at right angles to the bone. With the aid of a wooden mallet the osteotome is made to penetrate the bone in two or three directions, but in the same transverse line, until resistance is no longer felt, when it is withdrawn. Now by grasping the leg near the foot and forcibly inverting it, the limb will be found to come to the straight position with a snap. If the operation be properly performed the femur will have been divided transversely above the condyloid portion, and free from the epiphyses. The periosteum on the outer half of the bone will remain *intact* and will be simply stretched when the limb is brought into position. There should be no hemorrhage, beyond a little venous oozing, excepting occasionally when a muscular branch is divided. The wound need not be sutured, but simply covered with protective, and the ordinary antiseptic dressing. The splint used consists of a long external and short posterior piece, a foot rest being attached to the former. The original dressing is left undisturbed for two weeks, excepting of course in the event of hemorrhage, continued pain, or high temperature. At the expiration of six weeks usually the limb is put up in paraffin or plaster of Paris and the patient allowed up on crutches.

Dr. McEwen's results have been so far most gratifying. One of his colleagues, however, has recently had a death from pyæmia after an osteotomy for knock-knee, but the exact cause of the misfortune I could not ascertain. It has been alleged that the deformity returns after this operation and some surgeons oppose it on that account. But in many of these cases of so-called re-

lapse, the fair presumption is that the bone has not been thoroughly divided. I happened the other day to notice in one of the London hospitals a case in point. McEwen's operation was being performed. After a very timid use of the chisel the limb was manipulated with a view to straightening it, but the characteristic "snap" did not follow. However, it was at length made apparently straight, but undoubtedly at the expense of the ligamentous structures. The deformity in that case will of course *relapse*, and the operation will get the discredit.

From Glasgow I went to Edinburgh, where I spent three days, but the only operation I happened to witness was an ovariectomy by the celebrated Keith. There was nothing special in the case beyond the fact that the woman was very weak from a recent pleurisy, and the operation was consequently done rapidly. I find that Dr. Keith uses all the ordinary antiseptic precautions, with the exception of the spray, which he objects to chiefly on account of its chilling effect. He is very fond of the glass drainage tube, and used it in the case in question. In the great majority of his cases he treats the pedicle with the ordinary hot iron, but on this occasion he ligatured with Chinese silk treated precisely in the manner described in my last letter. I saw nothing in his method of operating that was at all singular. The results of this great ovariectomist, however, continue to be as marvellous as ever, notwithstanding the fact that many of his operations are now performed in the Royal Infirmary, where special wards have been set apart for him.

By the way the new Royal Infirmary is a magnificent institution. It is built on the edge of the open space known as the "Meadows," and consists of a number of buildings arranged on the pavillion plan. The medical and surgical wards are under separate roofs, and in fact in different parts of the grounds, so that there is no communication between them. Each ward has its own nurses' room, kitchen, splint room, and surgical apparatus distinct; and, what struck me as very novel, a comfortable room for the dressers and clinical clerks, where convalescent patients are attended to, and where the clerks can work up their cases without risk of being disturbed. Every member of the staff, like-

wise, has a cozy little retiring room in the near neighbourhood of his wards, so that for a wonder they were not quite forgotten by the Management when devising their plans. I may be doing some worthy institution an injustice when I make the statement, but I know of no other hospital where the individual comfort of the staff has ever entered into the calculations. It is to be hoped that the excellent example set by the Management Committee of the Edinburgh Royal Infirmary will not be lost on similar bodies.

Adjoining the Infirmary is the new Medical School in connection with the University. The building is still incomplete in many parts, although the lectures are being delivered now for the first time this winter. No pains are being spared to make it one of the most complete institutions of the kind in the world. Every member of the Faculty has had the planning of his own department, and the consequence is that the arrangements for teaching are simply perfect. For example, the chairs of Physiology and Materia Medica have each in connection with them at least a dozen rooms for laboratory and other purposes in addition to the general lecture rooms. Each professor has his own lecture and retiring rooms, and the former are all intended to seat at least five hundred students. The dissecting room is said to be the largest known, and I should say the most admirably arranged. The building has already cost three hundred thousand pounds, and when the plans for the library and various museums have been worked out, the figure will not fall much short of half a million sterling.

T. G. R.

Hospital Reports.

MEDICAL AND SURGICAL CASES OCCURRING IN THE PRACTICE OF THE
MONTREAL GENERAL HOSPITAL.

CASES OF DYSENTERY—UNDER THE CARE OF DR. OSLER.

During the past five years ending May 1st, there have been very few cases of this disease admitted to hospital, and it does not appear to have been at all prevalent in the city. During this period only 11 were treated, while in the five years previous 77 cases of acute dysentery were admitted. The following cases

illustrate severe types of the disease. Case 1 presented rather anomalous bowel symptoms for dysentery; tenesmus was not a prominent feature, nor were the stools characteristic. Case 2 was admitted in my absence, and was treated by Dr. Molson as dysentery with secondary abscess formation.

CASE I.—*Dysentery—Sloughs in the Colon and Rectum of unusual extent—Death.*

P. C., Italian, aged 35, admitted July 4th, 1883, with fever and abdominal pain. Was a sailor, had come from Glasgow, and about a year ago had had a somewhat similar attack in the East. No satisfactory account of the onset of present illness could be obtained. On admission the temperature was 102°; pulse about 100; face flushed and anxious looking; abdomen tender on pressure, particularly in right side; no diarrhoea. Examination of thoracic organs negative. The case was thought to be possibly one of typhoid fever. Summarized, the course was as follows during the three weeks in hospital: Abdominal pain was a prominent feature, and the general tenderness persisted. The abdomen was moderately full, never greatly distended. There were no spots. Two days after admission diarrhoea set in—four stools. On the 8th, 10th, 12th and 14th he had from six to ten a day. From the 15th to the 21st there were no evacuations; and from the 21st to the 26th, when he died, the diarrhoea was severe. The stools were loose, usually copious, thin, and brownish in color, containing at times mucus in flakes, and on several occasions blood. On the whole, the characters were not those of dysentery, nor did he seem to have severe tenesmus. The spleen was enlarged. There were no special cardiac or pulmonary symptoms. The pulse was weak and rapid, never dicrotic. The face constantly wore an anxious expression, indicative of great suffering. The mind remained clear; no delirium.

Autopsy.—Moderate wasting. Nothing of note in thoracic viscera. In abdomen, the large bowel was injected and looked unusually thick, and was firm to the touch. The general peritoneum was not involved. When slit open, the large intestine presented a picture of the most extensive dysenteric affection.

The cæcum and colon were covered with large, irregular, greyish-white sloughs, ranging in size from a five-cent piece to a half dollar, ragged on the surface, and all of them extending deep into the submucosa, and in some cases to the muscular coat. Scarcely any of them had separated; in fact, there were only two or three small ulcers. The process was most advanced in the cæcum and ascending colon. There were only a few patches in the sigmoid flexure. In the rectum, about three inches from the anus, was a slough of extraordinary size, measuring about three inches in length, an inch and a half in breadth, and fully one inch in thickness, greyish-yellow and necrotic, and beginning to break away at the edges and surface. It extended to the peritoneal coat, which was inflamed and hæmorrhagic. There were no smaller sloughs in the neighborhood.

CASE II.—*Dysentery—Abscess of Liver pointing externally—Death.*

Robert S., aged 43, admitted Sept. 12th with severe diarrhœa. Was in hospital several days in May with *gastritis a potu*. Gave a history of diarrhœa for some time, watery stools; not certain about the presence of blood. No account of tenesmus. Was feverish on admission, pale, pulse weak and irregular, skin moist, and patient looks sinking. Examination of chest negative. In abdomen, there is a soft, fluctuating tumor in the epigastric region, just inside the costal margin, tender on pressure, dull on percussion, and continuous with the liver, which did not seem enlarged. Spleen dulness normal. Abdomen a little full, not tender. The diarrhœa continued on the 13th and 14th, and he became weaker, and died on the 15th, without presenting any additional symptoms. Temperature subnormal after the first day; no sweats; no chills. The treatment consisted of stimulants, with sedative and astringent injections.

Autopsy.—Body fairly nourished. In making the preliminary incision, an abscess cavity was opened in the epigastric region. The right rectus muscle was infiltrated, and the pus had reached the subcutaneous tissue. The abscess was evidently connected with the left lobe of the liver, and was in process of perforation

through the abdominal wall. Below it was bounded by the transverse colon. The general peritoneum was not involved. On removal of the liver, the upper surface of the right lobe looked smooth and natural; towards the suspensory ligament there was a thin layer of lymph. The abscess cavity occupied the region of the organ just below the suspensory ligament, more in the left than in the right lobe, and was about equal in size to the closed fist. The pus was thick and creamy-yellow in color, and mixed with shreds of necrotic liver substance. The walls were rough and sloughy. Anteriorly, the abscess had destroyed the peritoneum and had perforated the abdominal wall, forming the prominent tumor noticed during life. In the centre of the right lobe was a second, smaller abscess, the size of an apple. The portal vein and its branches were normal, with the exception of one branch going to the left lobe, which contained a small mural thrombus. Small bowel not diseased; mesentery normal; veins healthy. The large bowel was extensively involved; cæcum thickened, deeply injected, and the mucosa thickly covered with yellow-brown sloughs. The ascending and transverse colon presented numerous ulcers, from some of which the sloughs had scarcely separated. In the descending colon and sigmoid flexure the process was not so extensive. No changes of importance in other organs.

MEDICAL CASES UNDER THE CARE OF DR. ROSS.

Mitral Regurgitation—Dilated Hypertrophy—Repeated Dropsies and Hydrothorax—Efficient action of Digitalis—Pulmonary Congestion—Death—Autopsy.

W. W., aged 40, a cabman, was admitted to the hospital November 24th, 1883, suffering from obstinate vomiting, shortness of breath, and swollen legs. He had been in the hospital three times previously to the present. The first admission was on the 29th September, 1882; he had then great shortness of breath. This, he stated, had come on very suddenly about a month before. Any slight exertion, or the recumbent position, caused him severe dyspnoea. He had been a heavy drinker, and at date of admission had just got over a spree. Had been

exposed to cold and wet ; had been subject to rheumatic attacks in his left shoulder for three years.

When admitted, the patient's face, feet and eyes were a little swollen and œdematous. There was considerable distension of veins on the left side of neck. Pulsation seen in epigastric region ; no pulsation in mitral area. On palpation, impulse felt over the whole precordial region. Apex beat, on close examination, is felt in 4th interspace, below the nipple. Heart very rapid, and a blowing, systolic murmur is heard, with its maximum intensity just beneath the nipple, and to its outer side, also transmitted beyond the axillary line, and heard faintly at the back, near the spine. There is slight irregularity of the heart's action ; no increase in dulness upwards. At the base the sounds are muffled. Percussion note over lungs, clear in front and behind. Below the 3rd rib, on right side, breathing is feeble. A few moist râles are heard near left axilla, behind. Liver is somewhat enlarged. Pulse rapid, very weak, irregular and intermittent ; no difference in the two sides. Urine, 22 ozs. ; specific gravity, 1012 ; normal color, and contains no albumen. Bowels constipated ; Tr. Digitalis \mathfrak{m} ii ordered every two hours.

Sept. 30th.—Patient a little easier ; breathing not so difficult, but is not able to lie down.

Oct. 2nd.—Not so well. Breathing short, and considerable lividity about hands and chest, also cyanotic in face. Radial pulse almost extinct, although heart's impulse is strong. Very great irregularity of the heart. Some œdema of feet and hands. Tr. Digitalis increased to \mathfrak{m} v every three hours.

Oct. 3rd.—Patient is easier, but dyspnoea still intense, and great lividity of feet and legs. Considerable œdema of feet. Radial pulse scarcely perceptible. Percussion note at right apex is slightly hyper-resonant down to third rib ; below this point it becomes dull. Breathing is exaggerated above third interspace, and below that is very weak ; behind, dull up nearly to spine of scapula. There is diminished fremitus and resonance, and the breathing is scarcely audible over the dull area. Breathing over left lung somewhat exaggerated ; no dulness, except at extreme base, where the breathing is weak. Impossible to count radial pulse. Heart beating 160 per minute.

Oct. 10th.—Patient much easier during past two days; 80 ozs. urine passed in 24 hours. Heart steadier, but still a little irregular; dullness at right side, behind, still present, but over a smaller area. Breathing more distinct. Heart murmur persistent, but not as low as on admission.

Oct. 14th.—Heart still a little irregular, but only beats 68 per minute. Murmur is scarcely audible, having lost blowing quality. Slight shade of dulness at right base, for one inch vertically. Tactile fremitus again present. He is passing 80 ozs. urine. Digitalis diminished to m v thrice daily.

From this time he improved rapidly, all dropsy disappeared, and he was discharged October 19th.

After being discharged he remained idle for a month. At the end of that period he resumed his work as cab driver, and continued driving until two weeks before the 10th February, 1883. He was re-admitted to the hospital on the date mentioned, suffering from shortness of breath, cough, swelling of the feet and legs, and vomiting. He had then been sick for two weeks. He attributed his illness to exposure to cold. The attack began by being chilly while standing on the ice, followed by vomiting and shortness of breath. In three days his legs began to swell. Had a constant desire to vomit. For ten days was unable to lie down. Sense of suffocation does not trouble him while quiet and in the sitting posture. Heart strong, diffuse pulsation over cardiac area but cannot feel the apex beat. Dulness not increased. Action very rapid—over 140 per minute and intermittent. Apex systolic murmur as before. Can hardly distinguish pulse at wrist. Lungs—right base dull, feeble breathing, diminished resonance. Urine contains no albumen.

Feb. 12th.—Since admission patient vomited continuously. Unable to lie down. No change in physical signs. Tr. digitalis m x, spts. chloroform m x, every four hours, also a hypodermic of morphia gr. $\frac{1}{2}$ over stomach.

Feb. 13th.—Vomiting much relieved by the hypodermic and at night patient felt much better. Some vomiting to-day. Pulse better. Dropsy increasing.

Feb. 18th.—Very much better. Vomiting ceased. Colour

good. Sense of suffocation has disappeared. Heart improving. Pulse much better.

Feb. 21st.—Continued improvement. Heart's action stronger and slower. Passing 120 ozs. in 24-hours; no albumen. Dulness at right base, with bubbling râles. Left lung normal.

Feb. 25th.—Dropsy almost gone. Lungs as in last note. Heart irregular, but stronger, not over 100.

Feb. 28th.—Dropsy has disappeared.

March 10th.—Patient going about the ward. Still a little dulness in right base with râles. Heart still irregular and murmur present, though faint. Patient left hospital to-day. Digitalis stopped and Dialysed Iron \mathfrak{m} xv, thrice daily, substituted.

On July 16th, 1883, he was re-admitted with same old complaint of swollen legs and feet, dyspnoea, etc. Systolic mitral murmur, and irregular heart's action as before. Lungs normal. Tr. Digitalis \mathfrak{m} x. given ter die, and he was discharged on the 20th, four days after admission, and much improved.

When last admitted—Nov. 24th—the patient was very restless, frequently changing position, getting up and sitting down every few minutes. Persistent vomiting. Passing very little urine the day before admission, and none whatever to-day. Legs are only slightly swollen, but cold, clammy and blue. Clear note over bladder. Pulse small, weak, and irregular. Systolic mitral murmur. Dulness to upper border of 8th rib in right lung, with feeble breathing over same area. Infusion Digitalis 5 i, spts. Chloroform \mathfrak{m} x, every four hours. Also, 4 ozs. gin.

Nov. 27th.—During night passed seven ounces of urine, and this morning passed eight ounces. It is of a bright reddish color (blood). Heat and nitric acid shows a slight trace of albumen in the urine, which was probably due to the amount of blood present. Had a very restless night. Pulse almost imperceptible.

Nov. 28th.—Feels much easier, can now lie quite still in bed. Slept fairly well last night. Swelling in legs much diminished—feet quite warm. Passed about same quantity of clear normal urine as yesterday—no blood or albumen.

Nov. 29th.—Passed 46 ounces of urine—no albumen. Pulse

rapid and weak. Not much improved. Feels better and rests well.

Dec. 1st.—To-day patient presents a subicteroid appearance and yellowishness of conjunctivæ. Urine not colored.

Dec. 12th.—Passed good quantities of urine till two days ago. Legs swollen again. Spitting up bright blood. Front of chest wet cupped. Expectoration of thickly glairy mucus tinged with blood. The upper lobe of left lung, fine crepitant sounds heard in latter half of inspiration. Sub-icteroid look, cough, and slight hæmoptysis continued, accompanied by great dyspnœa and prostration. Œdema rapidly increased and the legs had to be punctured. He sank and died on the 16th December.

Autopsy.—Large-framed man; general anasarca. A couple of quarts of serum in peritoneum, two or three pints in each pleura, and several ounces in the pericardium. Heart hypertrophied and dilated; thick yellow clots in right chambers. Weight of organ, 610 grammes. Valves normal; aortic segments competent; mitral segments a trifle thickened at edges; no vegetations. Mitral orifice over six inches in circumference; tricuspid orifice nearly seven. The chambers were all dilated, and there was moderate hypertrophy of the walls. Muscle of fair color. Apices of papillary muscles fibroid. Aorta smooth. Coronary arteries not atheromatous. Lungs showed moderate emphysema at anterior margins; general brown induration; a large infarct. at base of right lung. No pleural adhesions. Cyanotic induration of spleen, which was double the normal size. Kidneys slightly enlarged, coarse and hard; three healing infarcts in the left. Catarrh of stomach and bowels. Liver undersized, a little granular in the surface, hard and firm, and in early stage of cirrhosis.

Mitral Disease—Rapid general Dropsy—Complete relief to symptoms from Digitalis.

F. R., aged 48, was admitted 7th December, 1883, suffering from general dropsy and orthopnœa. Health fairly good till early in summer, when some shortness of breath was noticed. About July last had swollen feet at night. Within the last three

weeks the legs had become much swollen, and shortness of breath has been becoming very troublesome. For several days before admission was unable to leave her chair day or night. Has lately coughed a good deal. Ten years ago patient had pneumonia, and a mitral murmur was then noticed. Never had rheumatism. On admission, orthopnoea, labored breathing, moderate cyanosis, and considerable general anasarca. Heart quite tumultuous; a blowing systolic murmur at apex; pulse small, irregular, and intermittent. Both bases of lungs flat on percussion—the right to the level of the scapular angle; the left some distance higher. Breathing feeble generally over these areas, but on the left side, in the upper part of the dull area, the respiration is very distinctly bronchial. Urine, 18 ozs.; specific gravity, 1022; no albumen, no casts. Ordered Potass. Bit. gr. xv, Spts. Chloroform. m x, Infus. Digitalis ʒi ; to be given thrice daily.

No diuretic effect was produced from the 8th to the 12th, on which latter day the amount of urine remained at 18 ozs.; but on the 13th it was 50 ozs.; 14th, 85 ozs.; 15th, 130 ozs.; 17th, 105 ozs., from which date it gradually diminished, but even now (7th Jan., '84), it is as high as 84 ozs. Coincident with the diuresis, the dropsy as rapidly disappeared, and the hydrothorax was completely removed. The pulmonary percussion became normal throughout, and the natural respiration was everywhere heard. The pulse remains small (about 80), and but slightly irregular. The general condition has improved in proportion. Patient is quite cheerful, breathes well, and sleeps soundly in the recumbent posture.

Remarks. — These two cases afford excellent examples of the good results to be obtained from digitalis in the dropsy of heart-failure. In the first case, the apparently desperate condition of the man is hardly realized from the description. On three several occasions he was rescued from a state of extreme danger and great suffering by prompt treatment, and was restored for a considerable time to comparative comfort and activity. The autopsy showed absence of any disease of the valve curtains, but great enlargement of the auriculo-ventricular opening. It is quite probable that, had he been a more carefully-living man,

his life might have been still further prolonged. It will be noticed that in both these cases the kidneys remained, almost throughout, free from any evidences of secondary disease. This fact was utilized in the prognosis of each case, a favorable opinion (for temporary improvement) being based upon this important observation.

Correspondence.

THE OTTAWA "HOUSE OF BETHLEHEM."

(From our Special Correspondent.)

The "House of Bethlehem" of Ottawa, under the care of the Grey Nuns, has lately been receiving a great deal of attention. This charity is a sort of branch of the House of Mercy Lying-in Hospital, and is almost solely devoted to receiving infants born in the hospital. Since its establishment in 1879, the rumors concerning its high death-rate and the care of the inmates have not reflected to the credit of the institution. The City Council recently decided to investigate the matter, and the City Health Officer was directed to prepare a report, five other physicians being appointed to act with him. The report of this committee was well deliberated and prepared with care. They considered that the objects of the charity were unattained, and recommended that, in its present state, it should be discontinued. The following are the conclusions arrived at as to the cause of the deaths :

1st, The want of nourishment from the mother.

2nd, The low state of vitality and oftentimes diseased condition of many of the infants received.

3rd, The location of said institution, in our estimation, not being the most suitable to serve the purpose of the delicate task undertaken, in the great majority of cases of death, we are convinced, has been derangement of the digestive functions, or complications brought about by disorders of that part of the system.

4th, Though exonerating the ladies in charge of this institution from all blame, believing that they, to the best of their ability, did all that lay in their power to best serve the interest of humanity, we are of opinion, however, that the system itself

is impracticable and faulty, being productive of negative results, so far as attaining the chief object in view, the saving of the infant's life; therefore we would recommend that the House of Bethlehem, as a foundling institution, be closed, and that no children be received there under the present system of dry nursing.

After careful consideration, and as the result of practical experience, we are of opinion that, in order to effect a greater saving of life, it is necessary that the child be nourished at the breast, this method embracing the only certain means of lessening infant mortality.

To this report was appended a second by the attending physicians, reviewing their experience in their official capacity, and also blaming the system of dry-nursing for the mortality. They conclude as follows:

“ We succeeded in saving all the children who had the good fortune of being nursed by their mothers for at least the first two or three months of their existence; the two weeks of maternal feeding required of late by the Local Government always proved to be utterly insufficient. The endeavors that we, as well as the sisters, have made to diminish this great mortality, brought us to the conclusion that wet nursing is the only means of obtaining this result and of saving the lives of infants in cities.”

The mortality has been—

1879-80	79½ per cent.
1880-81	81 “
1881-82	97 “
1882-83	89 “

In consequence of the above report, the City Council passed a resolution that the institution should be discontinued, and word was sent that no more infants were to be received.

Following upon this, the Grand Jury of the County Court, in their presentment, stated that among the public charities visited were the “ House of Mercy Lying-in Hospital ” and the “ House of Bethlehem,” both of which were disapproved of. The former they considered, by aiding women to hide their shame, only encouraged the evil; the latter they advised should be closed, as follows:

“This awful mortality, we were informed, arose mainly from the separation of the children from their mothers, and we cannot urge too strongly upon the proper authorities the urgent necessity for immediate interference by the Government, or, if necessary, by the Legislature, to prevent the countenance of this loss of infant life.”

The latest phase of the controversy is a letter in an evening daily paper, presenting the views of a “Catholic Clergyman.” It defends the institution on account of the lives saved that would otherwise, he states, be sacrificed, and states that as long as the legal requirements are complied with, they are fulfilling their duty, and can only be prevented by the Local Government. As the Government inspector has annually reported against it, the Government can hardly fail to act when it is brought to their notice. Any further aid from the county or city they cannot now expect.

Reviews and Notices of Books.

A Practical Treatise on Materia Medica and Therapeutics.—By ROBERTS BARTHOLOW, M.A., M.D., LL.D., Professor of Materia Medica and General Therapeutics in Jefferson Medical College, of Philadelphia. Fifth edition, revised and enlarged. New York: D. Appleton & Co.

The fifth edition of this deservedly popular work on Therapeutics contains many very important additions. There is a short but well written chapter on the use of electricity in medicine. Preference is rightly given to the Siemens-Halsken element as being the most suitable for the work of the physician. This form of battery is very durable, and the current generated from it is smooth and uniform. It is much cheaper also than the batteries made on this side of the Atlantic and in England. If medical batteries could be obtained as cheap and as good in this country as in Germany, the profession would soon take up the subject of Electro-Therapeutics. Practitioners cannot much longer afford to neglect the use of such an all-important means of diagnosis and treatment.

Dr. Bartholow gives a clear description of the polar method of

investigation. His remarks on electro-diagnosis, and especially on Erbe's "degeneration reaction" are good.

An account is given—necessarily superficial—of the different diseased conditions that are benefited by the rational use of the *galvanic* and *induced* currents.

The importance of using the galvanometer is insisted upon, but no description is given of Edelmann's instrument, which is the most trustworthy of all.

In the section dealing with the motor depressants we have a very good account of the latest information concerning such agents as curara, nitro-glycerine, muscarine, and quebracho. The pharmacology of these drugs is very fully considered. In no other work in the English language can the same information be found.

The aim of the author to bring his work thoroughly abreast of the times is further evidenced by the fact of the presence of full articles on convallaria, resorcin, chinoline, etc. Hydrotherapy, metallotherapy, and the pneumatic treatment of diseases of the chest all receive more or less attention. Atropine is recommended as a physiological antidote to carbolic acid. Dr. Bartholow says he is indebted to Dr. Post of New York for this observation. The latter administered atropine in a case of carbolic acid poisoning where there was marked contraction of the pupils and failing circulation. The result was successful. Similar success is reported from other quarters, it is said. Dr. Bartholow instituted a number of experiments on animals, and as a result of these he considers it as proved that there is a real physiological antagonism between these two agents. If this should prove to be true, it will be a very valuable discovery, for although we possess in sulphate of soda a chemical antidote, its action is too slow in the very acute cases of poisoning to save the patient. We can confidently recommend this work as being an able exposition of the present state of pharmacology and therapeutics.

The Medical Student's Manual of Chemistry.—

By R. A. WITTHAUS, A.M., M.D., Professor of Chemistry and Toxicology in the University of Buffalo, and in the University of Vermont, &c. New York: W. Wood & Co.

The scope of this work is best gained by the following state-

ment made by the author in his preface :—" In the preparation of this manual, the Author has striven to produce a work which should contain as much as possible of those portions of special chemistry which are of direct interest to the Medical Practitioner and at the same time to exclude so far as possible, without detriment to a proper understanding of the subject, those portions which are of a purely technological interest. The descriptions of processes of manufacture are therefore made very brief, while chemical physiology and chemistry of hygiene, therapeutics and toxicology have been dwelt upon."

The book has been well and carefully prepared, and can be safely recommended to the notice of all students in this branch of medical education.

The Treatment of Wounds, its Principles and Practice, General and Special.—By LEWIS J. PILCHER, A.M., M.D., Member of the New York Surgical Society. With one hundred and sixteen engravings. New York : Wm. Wood & Co.

The above is one of the best practical works which have been added to the list of ' Wood's Library.' Its author is well known as a thoughtful surgeon, and one who has contributed many articles of value to the current American literature. The all-important subject of wound-treatment is considered in a really scientific and impartial manner. Dr. Pilcher never advises the slavish following of the methods of any one man, but rather the carrying out of the management of injured parts by strict reference to our knowledge of the natural processes of cure and the means we possess for advancing these. Careful attention is of course given to the discussion of the relation of micro-organisms to wound-disturbances and the closely related subject of asepsis and antiseptics. The third section, dealing with wounds of special regions, abounds with practical hints, and furnishes a complete repertory of special dressings. We had much pleasure in the perusal of several of these chapters, and congratulate the author upon the successful manner in which he has succeeded in bringing his subject-matter together.

The International Encyclopedia of Surgery—A Systematic Treatise on the Theory and Practice of Surgery. By Authors of various Nations. Edited by JOHN ASHURST, Jr., M.D., Professor of Clinical Surgery in the University of Pennsylvania. Illustrated with chromo-lithographs and woodcuts. In six volumes. Vol. III. New York: Wm. Wood & Co.

The third volume of this truly great work has now been for some time in the hands of the subscribers. It fully sustains the high reputation of the two former, and the encomiums passed upon them. The admirable articles contained in each one deserve a much more extended notice than we are able to give them here. Several of the most interesting departments of Surgery are discussed in the present volume, as may be judged of from the following list.—Injuries and Diseases of the Muscles, Tendons, and Fasciæ, by P. S. Connor, M.D. Injuries and Surgical Diseases of the Lymphatics, by Edward Bellamy, F.R.C.S. Injuries of Bloodvessels, by John A. Liddell, A.M., M.D. Surgical Diseases of the Vascular System, by John A. Wyeth, M.D. Aneurism, by Richard Barwell, F.R.C.S. Injuries and Diseases of the Nerves, by M. Nicaise, M.D. Injuries of Joints, by Edward Anderson, M.D., LL.D.

Anatomy, Descriptive and Surgical.—By HENRY GRAY, F.R.S., F.R.C.S., &c., with an Introduction on General Anatomy and Development, by T. HOLMES, M.A., Cantab., Surgeon to St. George's Hospital. The drawings by H. V. CARTER, M.D., with additional drawings in later editions. Edited by T. PICKERING PICK, Examiner in Anatomy, Royal College of Surgeons of England. A new American from the tenth English edition, to which is added "Landmarks, Medical and Surgical," by LUTHER HOLDEN, F.R.C.S., with additions by WILLIAM W. KEEN, M.D. Philadelphia: Henry C. Lea's, Son & Co.; Montreal: Dawson Bros.

This still remains the great standard text-book of Anatomy. The present edition is, in many respects, an improvement upon its predecessors. The added text and new drawings are decidedly advantageous, and add still more to that which, even without them, seemed to be well-nigh complete. Luther Holden's

"Landmarks" have been since their publication well received as a practical aid to the study of Medical and Surgical Anatomy. Their introduction here, along with "Gray's Anatomy" proper, does not increase the size of the volume beyond reasonable limits, and yet presents it in a place where it most appropriately belongs.

Books and Pamphlets Received.

TYPHOID FEVER IN VICTORIA. By James W. Barrett, M.B., Ch. B. Section I. George Robertson, Melbourne.

ASIATIC CHOLERA: Being a Report on an Outbreak of Epidemic Cholera in 1876 at a camp near Murree in India. By Charles Moore Jessop, M.R.C.P. London: H. K. Lewis.

INDEX TO THE TRANSACTIONS OF THE AMERICAN MEDICAL ASSOCIATION. Vols. I.-XXXIII. Prepared by Wm. B. Atkinson, M.D. Philadelphia, W. Fell & Co.

ELEMENTS OF PRACTICAL MEDICINE. By Alfred H. Carter, M.D., London. Second edition. London: H. K. Lewis.

PRINCIPLES OF THEORETICAL CHEMISTRY: With special reference to the Constitution of Chemical Compounds. By Ira Bensen, Professor of Chemistry, Johns-Hopkins University. Second edition, thoroughly revised and enlarged. Philadelphia: Henry C. Lea's Son & Co. Montreal: Dawson Brothers.

SURGICAL APPLIED ANATOMY. By Frederick Treves, F.R.C.S. Illustrated with 61 engravings. Philadelphia: Henry C. Lea's Son & Co. Montreal. Dawson Bros.

ELEMENTS OF SURGICAL PATHOLOGY. By Augustus J. Pepper, M.S., M.B., Lond., F.R.C.S., Eng. Illustrated with 81 engravings. Philadelphia: Henry C. Lea's Son & Co. Montreal: Dawson Bros.

EPITOME OF SKIN DISEASES, WITH FORMULÆ, FOR STUDENTS AND PRACTITIONERS. By the late Tilbury Fox, M.D., F.R.C.P., and T. Colcott Fox, M.B., M.R.C.P. Third American edition, revised and with additions by T. Colcott Fox, B.A., M.B. Philadelphia: Henry C. Lea's Son & Co. Montreal: Dawson Brothers.

A TREATISE ON BRIGHT'S DISEASE OF THE KIDNEYS: Its Pathology, Diagnosis and Treatment. With chapters on the Anatomy of the Kidney, Albuminuria, and the Urinary Secretion. By H. B. Millard, M.D., A.M. With numerous original illustrations. New York: Wm. Wood & Co.

THE MEDICAL RECORD VISITING LIST, OR PHYSICIAN'S DIARY FOR 1884. New York: Wm. Wood & Co.

A TREATISE ON SYPHILIS IN NEW-BORN CHILDREN AND INFANTS AT THE BREAST. By P. Diday. Translated by G. Whittley, M.D. With notes and an appendix by F. R. Sturgis, M.D. New York: Wm. Wood & Co.

CLINICAL CHEMISTRY. By Charles Henry Ralfe, M.A., M.D., Cantab. Philadelphia: Henry C. Lea's Son & Co.

THE DISSECTOR'S MANUAL. By W. Bruce-Clarke, M.A., M.B., F.R.C.S., Eng., and Charles Barrett Lockwood, F.R.C.S. Philadelphia: Henry C. Lea's Son & Co.

ON THE PATHOLOGY AND TREATMENT OF GONORRHEEA. By J. L. Milton. Fifth edition. London: Henry Renshaw.

Society Proceedings.

MEDICO-CHIRURGICAL SOCIETY OF MONTREAL.

Stated Meeting, Nov. 23rd, 1883.

T. A. RODGER, M.D., PRESIDENT, IN THE CHAIR

Uterine Fibroid.—DR. GARDNER exhibited a number of fragments, making up a fibrous polypus he had removed from the uterus of a patient sent to him by Prof. Geo. Ross. The patient, aged 48, unmarried, presented no evidence of ever having been pregnant, is very fat, and very anæmic. Gave a history of frequent hemorrhages and watery discharge for a few years, with little or no pelvic pain. On examination, the ostium vaginæ was narrow and rigid; vagina distended to the extent of the pelvic cavity by a tumor of very firm, somewhat elastic, consistence, and uneven surface, about the size of a child's head. The tumor could be partially rotated. Diagnosis from inversion could not be made by the sound, as it could not be passed around the tumor. Under ether, the fundus uteri could be indistinctly outlined through the thick abdominal wall. After incision of the perineum and orifice of the vagina, a running noose of strong twine was slipped over the tumor and drawn tight around the pedicle. A vulsellum forceps was then fixed on the tumor, and successive portions removed until at last a large portion—the residue of the growth—came away in the forceps. Very little blood was lost during the operation. The pedicle was found to be attached to the anterior wall of the uterus, above the internal os. It was trimmed off, and touched with Churchill's tincture of iodine. The uterus measured three inches in depth. The vagina was tamponed with alum cotton with iodoform—not because of actual hemorrhage, but as a precautionary measure. The patient recovered without a bad symptom. There was no pain worth mentioning, and the temperature never rose above 99.5°F. Microscopic sections made by Dr. Wilkins shewed it to be mainly fibrous in structure. In parts, smooth muscle fibres were to be seen.

DR. TRENHOLME said that the diagnosis of a polypoid tumor occupying the vagina is usually not very difficult to make out.

The mobility of the tumor in this case, and the absence of vesical complication, together with the solid character of the growth, rendered it specially easy to diagnose. As to treatment, he (Dr. T.) had seen a case some time ago where the lady declined any operation, and in which he had simply twisted the tumor round a couple of times, and this cut off its blood supply. A short time afterwards the growth came away by sloughing, and the patient made a perfect recovery. In this case a similar mode of treatment would have been most likely followed with the same success without any operation whatever.

DR. GEO. ROSS said this case ought to be a warning against treating menorrhagia without making an examination. This patient was blanched and weak, and had been treated by several physicians, who never had made any examination of the pelvic organs.

DR. GARDNER also shewed the *Uterus* of a woman aged 60, who died last August. The patient, referred by Dr. Roddick, was first seen at the University Dispensary for Women on 30th January last. Unmarried; no signs of pregnancy. Menses ceased seven years ago. Health always good until a year ago. At that time she had a bloody discharge from the vagina, lasting a week; six months later a similar discharge, lasting three days; three months afterwards a recurrence of the discharge, which has continued to a slight extent ever since. It is pale, and free from clots. Intermittent hypogastric pain prevailed. On examination, abdomen flaccid, a few lineæ albicantes; cutaneous aspect of perineum slightly lacerated; vagina very narrow and atrophied, slight pale bloody discharge escaping. Bimanual examination reveals distinct enlargement and decided firmness of uterus; it is mobile. Cervix small, admitting with difficulty an Emmet's silver probe the size of an ordinary surgical probe; this entered four inches, causing free bleeding. The diagnosis then made was intra-uterine malignant growth. A month later patient returned for treatment. She was put to bed. The os was incised bilaterally, as no laminaria tent fine enough for introduction could be got. Successive tents were then introduced, until the finger could be inserted within the uterine cavity. A soft, easily broken down growth was at once detected. The sharp curette

was used freely, and a large quantity of brain-like substance removed. Hemorrhage was free, but soon arrested by Churchill's solution of iodine and plugging. The result was undoubted but temporary relief. After the pain and slight fever following the operation had subsided, symptoms returned, and in about two months later, after labor-like pains for a few days, a portion of the recurrent growth was found projecting through the now dilated orifice. The curette being again used, a much larger quantity of the same substance than at the first operation was removed. Decided, but temporary, relief again followed. After this she lived four months, suffering much from pain, fetid, but not bloody, discharge, diarrhoea, rigors, high fever and perspiration. Death took place from exhaustion. At the autopsy, made by Dr. Osler, the uterus is described as being enlarged eight times its normal size; it fluctuates, and is soft. Examined from the vaginal os, it presents a ragged, sloughy-looking mass projecting from the upper and left side. On section, the entire inner surface is involved in an extensive sarcomatous growth which has sloughed on the surface, and presents dark shreddy, soft, disintegrating portions. The margin of the os is free, with the exception of one spot, at which the portion already noted projects. In places the growth is an inch thick. At one spot of the posterior wall the growth has perforated. Ovaries and broad ligaments unaffected. A secondary deposit was found on one pleura. During life, an elevated spot the size of a ten-cent piece existed on the anterior vaginal wall; this had the same histological character as the growth in the uterus. Microscopic sections of the substance removed from the uterus during life showed the structure to be numerous small, round cells, with very scanty stroma.

DR. GARDNER said that in some quarters the treatment adopted might be considered as open to criticism. The most favorable cases for extirpation of the uterus were those of sarcoma. Freund's operation by abdominal section he considered absolutely unjustifiable. If the uterus is ever to be extirpated, it should be done by the vagina, after Schröder's method. The great size of the uterus, and the narrow vagina, rendered the case unfavorable

even for this method. He quite agreed with Dr. Reeves Jackson of Chicago in the views he put forth at the meeting in September of the American Gynecological Society in Philadelphia. Dr. Jackson believed that extirpation of the uterus, instead of saving life, had destroyed many years of life.

DR. TRENHOLME remarked that if ever we were warranted in extirpation of the uterus, this was such a case. The uterus, though large, was free, and could readily have been brought down and removed. However, the fact of Dr. Osler finding secondary cancer deposits in the lungs shows that perhaps it was as well not to have attempted it. The smallness of the vagina, in his (Dr. T.'s) opinion, did not preclude the operation if otherwise desirable. In cases of midwifery, cases are now and again reported where the whole vagina has been torn up to Douglass's fossa, and yet the patients made good recoveries. Where necessary, we could divide the vagina and complete the operation.

DR. OSLER exhibited a heart showing ulcerative endocarditis, and remarked that we have had exhibited at our Society the two kinds—one, quickly fatal, with typhoid symptoms; the other, more chronic. The case was diagnosed ulcerative endocarditis by Dr. Wilkins. The patient had also acute pneumonia. The heart showed old sclerotic valves with deposit of lime salts. One of the chordæ tendineæ was ulcerated across. The cavities were dilated, and the left side hypertrophied. The spleen was also enlarged, and had numerous infarcts through it.

Case of Puerperal Eclampsia.—DR A. L. SMITH read a paper on this case. He saw his patient about the seventh month, who complained of pains in her head, back, and lower part of abdomen; said she felt silly, and saw things upside down. Micturition painful and frequent, but urine scanty in amount, high colored, and loaded with albumen. Feet and eyelids swollen. A few hours later, was sent for, as she had taken a fit. Used a mixture of alcohol, chloroform and ether as an anæsthetic; this arrested the clonic spasms, but unconsciousness remained, broken only by recurring seizures till evening, when a consultation with a senior *confrère* was sought, and twenty leeches to the temples

recommended. As the last leech fell off, consciousness returned, and she steadily regained her usual health. She was kept in bed on a strictly milk diet for several weeks, during which time the albumen decreased rapidly. Four weeks later Dr. Smith delivered her of a dead foetus, much decomposed. She made a perfect recovery. Dr. Smith lays his success to the bleeding and rigorous milk diet, as recommended by Dr. Donkin, whom he quoted at some length.

DR. GARDNER said that the efficacy of hypodermic injections of morphia or Liq. Battley was extraordinary in these cases. He had used it frequently with very satisfactory results, even where convulsions came on weeks before labor.

DR. ROSS said the question of bleeding was divided. His own experience went against it. Only once saw good results follow, and that time the patient was a small, weak woman. He had several times seen strong plethoric women bled without any benefit. Has found chloral, given early, very useful, but morphia more reliable, and recommended hot air baths.

DR. TRENHOLME said the pulse was a good indicator to bleed or not. If strong and bounding in a full-blooded person, believed bleeding to be the best treatment. If convulsions came on some time before full time, then an opiate would be good. If at full time, and os dilatable, give chloroform and deliver. He agreed with Dr. Smith's treatment of his case as regards the form of bleeding and milk diet.

DR. GARDNER spoke highly of hot air baths in these cases.

DR. RODGER said he had treated a good many cases of puerperal convulsions. Used to bleed if the person was strong, but of late, in all cases, uses hypodermics of morphia. Chloroform or ether have not given satisfaction, nor has he seen the good effects from chloral and bromide of potassium which others speak of. Some time ago had a patient six months pregnant, with 75 per cent. of albumen in her urine, who had a convulsion. He gave her a hypodermic of half a grain of morphia, repeating it in six hours. She had no more seizures till three weeks after. Again he used the morphia, which stopped them for two weeks more, when pains came on, and she was delivered of a dead foetus.

Stated Meeting, Dec. 14th, 1883.

DR. RODGER, PRESIDENT, IN THE CHAIR.

Syphilitic Caries of inner table of skull.—Great thickening of Calvaria—Compression and Deformity of Brain.—Dr. OSLER exhibited the skull-cap and brain—The patient, a woman aged 35, had been in hospital many times during last six years with various symptoms of constitutional syphilis. Was not under regular constitutional treatment in the intervals. At one time had necrosis of right tibia. In November, 1882, was admitted with a small open sore in right parietal bone through which dead bone could be felt, and a probe passed far in between the bare bone and dura mater, towards the vertex. Symptoms chiefly debility and severe right unilateral headaches. Was in hospital several times within last year, and amyloid disease of kidney was made out. During her last illness, as on the previous occasions, her intellect was clear, and although within a few days of her death she was dull and very irritable, it was probably due to the severe pains in her head and her increasing weakness. Never had any signs of local brain disease. The headaches were very severe at night. The external surface of the skull cap was smooth, and on the right side, close to the coronal suture, was a small sinus through which a Bowman's probe could be passed. On removing the calvaria, which was moderately thickened in the supraorbital regions, a quantity of thick pus escaped. The dura mater was thickened and strongly adherent posteriorly. The internal surface was smooth and did not present any adhesions. As shewn in the specimen, the disease is confined to the contiguous surfaces of skull and dura over the frontal and part of the parietal regions. The inner aspect of the bone in these parts is rough and carious, having an eroded, worm-eaten appearance, and covered with granulations; and towards the parietal bone, firm, solid, fibrous masses unite it to the dura. The upper half of the frontal and the greater part of the parietal bones are thickened, measuring from two to three centimetres, and are exceedingly dense. The outer surface of the dura-mater shews numerous soft granulations springing from

solid fibrous tissue. The falx in its anterior half is thickened, and the longitudinal sinus is in this part obliterated. The brain shewed no trace of coarse disease; the arachnoid was a little opaque, but the pia-mater was normal. The hemispheres were curiously deformed from the pressure to which they had been subjected by the thickened bone and dura, and the pus between them. They are wedge-shaped, the base is at the occipital bones, where the greatest vertical height is eight centimetres, and the apex is at the orbital margin of the frontal lobes, where the height only two-and-a-half centimetres. This curious deformity has been brought about slowly, and illustrates the degree of pressure to which the brain may be subjected, so long as it is applied gradually.

DR. HENRY HOWARD referred to the remarkable absence of cerebral symptoms in such extreme compression.

DR. OSLER also exhibited a skull from the museum of McGill College, with syphilitic destruction of the entire right parietal and part of the frontal bones, with caries also of the inner table.

Epithelioma of Tongue—Excision—Erysipelas—Circumscribed Gangrene of Lung—Perforation of branch of Pulmonary Artery.—DR. SHEPHERD narrated the case and showed the specimen: Thos. W., aged 42, a strong, healthy man, came to the Montreal General Hospital in January, 1883, suffering from epithelioma of the tongue; this being near the tip, only a portion of the tongue (right half) was removed with the scissors by Dr. Fenwick. Two months ago he noticed that the growth was returning, and at the time of his re-admission into hospital, under Dr. Shepherd, early in November, it was increasing rapidly. He then had an epitheliomatous ulceration of the part of the tongue that remained, and also of the right tonsil and left anterior pillar of fauces; the floor of the mouth was infiltrated and hard. It was decided to remove the whole tongue. This was done on November 10th. Dr. Shepherd first ligatured the lingual artery of each side by a curved incision reaching from the front of the angle of the jaw to the hyoid bone, and up towards the symphysis. After ligaturing the linguals, the tongue was removed by scissors with very little trouble and no hemorrhage, after Mr. White-

head's method. The right tonsil (or part of it) and the anterior pillar of fauces were removed also by scissors. After the operation the patient rallied well, and was fed for two days by nutrient enemata, the mouth being rinsed out frequently with a solution of Condy's fluid. For five days the man did well; there was no fetor from the mouth, the wound was granulating nicely, and the incisions made for tying the lingual were healing by first intention, when, on Nov. 15th, erysipelas appeared on the nose and rapidly spread over face, neck and head. Temperature rose to 103° - 104° , and pulse became rapid (120) and weak. The erysipelas then spread over the chest, and the mouth now became sloughy; fetid breath was first noticed on Nov. 27th, at which time a slight cough developed, and some bronchitis, which was looked upon as septic. No rigors or sweatings had occurred. From this time patient became gradually weaker and weaker, in spite of the stimulating treatment, and died suddenly on December 2nd from hæmorrhage. Dr. Shepherd remarked that at the time of the operation several cases of erysipelas had been admitted into the hospital from outside. With regard to the operation, he felt perfectly satisfied with it, the previous ligaturing of the linguals greatly facilitating the removal of the tongue by scissors, as all fear of hæmorrhage was removed, and the scissors left a clean, instead of a bruised, surface, as is seen after the use of the *écraseur*. The method of operating had nothing whatever to do with the fatal result.

At the autopsy the wound looked in process of healing, and the cancerous masses had been removed. The linguals presented thrombi at the site of ligature. There was a small pocket of pus beneath the left sterno-mastoid. The trachea and bronchi were filled with blood. The right lung presented four areas of circumscribed gangrene, the left two, each about the size of small apples. Placing the lung under water and blowing water through the pulmonary artery, bubbles escaped from one of the gangrenous regions close to the root of the lung. Dissection proved, as the specimen shows, that the hæmorrhage came from a small branch of one of the main divisions of the artery, which had been opened in the necrotic process.

DR. R. P. HOWARD spoke of the frequency with which gangrene of the lungs followed operations on the tongue and neck.

DR. GEO. ROSS mentioned having had a case of Cancer of the œsophagus in Hospital last winter which proved fatal from gangrene of the lung.

Sarcoma of Lumbar Glands; Perforation of the Colon; Persistent Hemorrhage.—DR. SHEPHERD presented the specimen and gave the following notes: Man, aged forty-five, large, strongly built, weighing over two hundred and fifty pounds, sent for him on July 23rd, and stated that he had been seized in the night with severe pain in the back and abdomen. The temperature was 103° , pulse, 120; tongue coated; great tenderness of abdomen, with fulness in left iliac region; no vomiting; bowels had been opened several times during the night. In the evening he was worse. Temperature, 104° ; pulse, 120; great abdominal distension with tenderness. On the 25th the temperature was normal, but the abdominal symptoms persisted, and there were diarrhœa and frequent vomiting. On the 29th he had a severe rigor, with temperature of 104° , and profuse sweating; tympanites and pain, with evidences of peritonitis. In a day or two he had another rigor, with severe vomiting and diarrhœa, and great abdominal distention. Dr. Ross saw the patient in consultation, and the conclusion arrived at was, that there was local suppuration deep in the iliac region. His condition at this time was very bad; pulse weak; vomiting incessant. With champagne and careful feeding the vomiting was checked, and he began to improve slowly, until in the early part of September he was able to move about the room. There was still fulness on deep pressure in the iliac fossa, but the thick layer of fat prevented a satisfactory examination.

About September 10th he began to pass a small quantity of blood—bright red—with the stools, and this increased until the daily amount was often as much as half a pint, and he became very anæmic. In the month of October he again took to bed; had severe rigors with high temperature and sweats, about every other day. At this time a tumor was made out in the hypogastric region, deep in the abdomen, fixed, solid, and not

tender on pressure. Rectal examination negative. The loss of blood continued, and he got much weaker, and death took place on November 20th, after a profuse hemorrhage. The tumor had increased in size, and a week before death it seemed about the size of a child's head, and firmly fixed in the hypogastric region. The autopsy showed matting together of the coils of intestine with old peritoneal adhesions, particularly near the pelvis. The tumor was in front and a little to the left of the lumbar spine, and the sigmoid flexure was firmly united to it. The mass was readily turned out, and dissection revealed an extensive perforation of the bowel, as the specimen shows, and exposure of soft sloughing masses of the tumor. The wall of the colon was defective in an area two and a half by one and a half inches. The growth was a sarcoma of the retroperitoneal lymph glands. There were no secondary tumors, and nothing of note in the viscera. The persistent hemorrhage for over two months, had evidently come from the vessels of the exposed and sloughing part of the tumor. The repeated rigors were difficult of explanation; there evidently had been peritonitis, but whether local suppuration had occurred was not so clear, possibly it had in the process of perforation of the bowel.

DR. GEO. ROSS remarked that he had seen the case several times, and it had offered considerable difficulty in the way of diagnosis. The amount of abdominal fat prevented a satisfactory examination, and the fulness in the iliac region was thought to be possibly a focus of suppuration. Later on, when the hemorrhage occurred, and a more evident tumor could be felt, the diagnosis was made of malignant growth, and from the situation and size, probably retroperitoneal and involving the bowel.

DR. HOWARD said that from the same symptoms he would have diagnosed as did Drs. Shepherd and Ross. He congratulated them on having located the tumor so exactly.

Small Tumor on Nerve: Intense Brachial Neuralgia; Removal.—DR. SHEPHERD presented a microscopic section of a small tumor the size of a bean, which he had removed from a man's arm for painful neuralgia. The patient, a thin, nervous man; stoker by occupation, was admitted to hospital complaining

of severe pain in the left arm—so bad that he could get but little rest at night. His appearance was that of a man suffering intensely. The pain was more severe at times, and was situated at the insertion of the deltoid, and from there ran down the back of the arm to the elbow. He also had numbness along the ulnar nerve. Just below the posterior fold of the axilla, internal to the brachial artery, a small nodule the size of a bean was felt, which on pressure caused agonizing pain. Dr. Bell admitted the case as one of neuroma. Dr. Shepherd had removed the growth, which was found connected with a small nerve, and closely united with the cellular tissue at the back of the artery. The man has had no pain since the removal, three days ago. The section of the tumor showed a fibrous capsule, and a small, angular-celled growth inside.

A report on the nature of the tumor was requested for the next meeting.

Early Symptoms of Tabes dorsalis.—DR. STEWART exhibited a man, aged 33, clerk, whose only complaint was of dimness of vision. He first noticed failure of his sight ten weeks ago. Three weeks after, he consulted Dr. Buller, who diagnosed the case as one of Tabes dorsalis. Twelve years ago he saw double for a week. In the year 1879, he recollects seeing double for about three days. With the exception of these two occasions, and a few days during which he was sick from measles, he has always enjoyed excellent health. He never had syphilis. The family history is unimportant. Three years ago he worked for several months in a very damp cellar.

Present state:—There is permanent contraction of the right pupil (myosis). There is loss of reflex contraction of the pupil (Argyll Robertson symptom). Both pupils readily contract on accommodation. In addition to the loss of reflex contraction, he has also undoubted loss of reflex dilatation of the pupils. There is well marked atrophy of both discs. The patellar reflex is absent in both legs. This is the only symptom characteristic of Tabes dorsalis present, with the exception of the eye symptoms. There are no lightning pains, no paresis of the bladder or rectum, no ataxia, no delayed, lost or perverted sensations.

The skin reflexes are present. Notwithstanding the absence of some of the prominent symptoms, there can be no doubt whatever about the nature of the case. It is an undoubted case of *Tabes dorsalis* in its pre-ataxic stage. The case is a good example of what is now generally conceded, viz., that *Tabes dorsalis* is essentially a disease of the sensory tracts. Three of the most prominent symptoms are failure of the normal reflexes. There is (1) loss of the reflex contraction of the pupils; (2) loss of reflex dilatation of the pupils; (3) loss of the patellar reflexes.

Treatment.—During the last seven weeks the patient has been treated with the *faradic brush* three times weekly, after the manner recommended by Rumpf of Bonn.

In reply to questions asked by members, Dr. Stewart said that his patient probably contracted the disease while working in the damp cellar three years ago. The patient was slightly worse now than when he commenced the faradic brush treatment.

Dr. BULLER here remarked that one eye was a little better, the other rather worse, than when first seen. The patient consulted him on account of failing vision. He found his sight much impaired. R. E. V., 20/100; L. E., 20/70, with great concentric limitation of the visual fields. The field for colors was constricted in a similar manner, but there was no central scotoma. The optic nerves presented the usual appearance of progressive atrophy from spinal sclerosis. The condition of the eyes, together with the absence of patellar reflex, seemed to warrant the diagnosis of *Locomotor Ataxia*.

Dr. OSLER asked if the very early symptoms were preataxic, as it was well known that the eye symptoms often preceded for a long time lightning pains, etc.

Dr. R. P. HOWARD said that one of the first cases diagnosed in Montreal was one of his patients, who came to him suffering with transient strabismus, his walk was slightly axatic, but there were then no pains, he lived 15 or 16 years, and died in Europe last year. He had myosis.

Dr. HENRY HOWARD remarked that he has had several cases under observation where impotency was the first symptom.

DR. OSLER, the past summer, had a patient under his care who had been troubled with double vision, and severe headache for four or five years. He went to London and consulted Dr. Broadbent, who diagnosed and treated him for cerebral syphilis. He got perfectly well, but two years ago Tabes began to develop, and now he is in the third stage of Locomotor Ataxia.

DR. ROSS said a patient came under his care yesterday in the Hospital, who had had the gait symptoms for two years, but till lately had had no eye symptoms at all. At present he is remarkably ataxic, has loss of patellar reflex, no lightning pains. Dr. Ross had asked Dr. Buller to examine this patient.

DR. BULLER remarked that the hospital patient with ataxic symptoms, sent to him by Dr. Ross for examination yesterday, had no loss of vision. His optic nerves, however, did not present a healthy appearance. They were somewhat swollen, and the margins decidedly indistinct, perhaps presenting the condition described by Dr. Gowers as gelatinous infiltration. The bulk of the papilla had a hyperæmic appearance, whilst the temporal side was in part rather unusually pale. On the whole, I think the condition was such as we usually meet with in persons whose vision is beginning to suffer from excessive use of tobacco and alcohol. With regard to the atrophy of the optic nerves met with in Locomotor Ataxia, Dr. Gowers has made the observation that when this condition comes on early in the course of the disease, that is, during the first or pre-ataxic stage, the resulting loss of vision is more rapid and more complete than when occurring as a later symptom; this observation coincides with my own experience of such cases. When atrophy of the optic nerve occurs early it must, I think, often be a matter of doubt as to whether the trouble is of spinal origin at all. I know of several cases in which atrophy of the nerves has led to complete blindness, which has now lasted for one, two, or three years without the development of any fresh spinal symptoms, though there has all along been absence of knee-jerk, yet all of these cases have been regarded as commencing Locomotor Ataxia by the very highest authorities on the subject, both in Europe and America.

DR. R. P. HOWARD said he had three cases of Locomotor

Ataxia at present. In two, there is great contraction of the pupils—one a gentleman, the other a lady. The gentleman has myosis of both eyes, but greater in one. In the third case the pupils differ, there is good vision in one eye. Dr. Howard remarked that a contracted pupil should make one look out for Tabes. There is great frequency of pulse in one gentleman and in the lady. The gentleman took Hyoscinamin for a long time under Dr. Seguin, with but little effect. Dr. Howard said a late theory was that this disease was caused by functional excess of a sensory nerve, and that sexual excess was said to lead to it. Dr. Howard also remarked that out of many cases which he has seen, one only suffered from gastric crisis. Had used the electric brush in the case of the lady with the result of restoring feeling in some parts of the skin, otherwise no improvement followed.

DR. HENRY HOWARD had used the electric brush for anæsthesia with good effect where there was absence of motor paralysis.

Lawson Tait's Operation.—DR. ARMSTRONG exhibited the ovaries and tubes removed by him a couple of days previous from a lady, aged 22, who had suffered for three years from pelvic pain. She had menstruation for fourteen days for the past year, suffering much each time; this quite unfitted her for work, and made life miserable. Both ovaries were prolapsed. Patient doing well. The ovaries were both a good deal enlarged.

OTTAWA MEDICO-CHIRURGICAL SOCIETY.

The regular meeting of this Society was held on Friday, the 30th of November. Present: Dr. Robillard, President; and Drs. J. A. Grant, H. P. Wright, S. Wright, Prevost, Horsey, Powell, Grant, Jr., Malloch and Small.

Dr. Playter was introduced by the President, and unanimously elected a member.

DR. PREVOST communicated the results of some experiments with "*Jequirity*," a new drug recommended for the treatment of granular lid, exhibiting some samples of the drug. It is especially indicated in cases of trachoma, where pannus is a marked symptom. Eight beans are placed in 4 ozs. of cold water, and 4 ozs. hot water added. The granulations are painted

with the solution, and the patient told to wash the lids every day, allowing a small amount to penetrate beneath the lids. It acts as an irritant, causing œdema and purulent discharge in some cases. When these acute symptoms subside, the eye is found to be free from the troublesome disease. He had used it in several cases with success ; so had Dr. Robillard.

DR. POWELL read a paper on "*Typhoid Fever : its Complications and Sequelæ.*"

A vote of thanks was accorded the reader, who was complimented upon the thoroughness and originality displayed in its preparation.

The discussion that followed was confined to "high temperature."

DR. H. P. WRIGHT agreed with Dr. Powell that a continuous moderately high temperature was more serious than a temperature very high, but of short duration. He cited cases in point that had terminated fatally.

DR. POWELL believed baths would prove of service in such cases, on account of their effect on the nervous system.

DR. PREVOST had frequently taken the temperature of patients before and after sponging, without detecting any decrease of temperature. Believed that too much attention was given to treating the symptoms ; if the fever was properly treated on general principles, the temperature would soon moderate.

DR. MALLOCH said the use of febrifuges had always proved very unsatisfactory in lowering temperature. Had no faith in quinine, as its action was of very short duration.

DR. S. WRIGHT, in all his cases, gave 5-grain doses of quinine every three hours, and has always kept the temperature down to 100° or 101°. Some patients cannot bear the drug. In the patients where head symptoms follow, a lessening of the dose overcame the difficulty. He reported a case where 40 grains had been given daily for three weeks. During the first week only had cerebral effects been noticed.

The discussion of the other complications was adjourned to the next meeting.

DR. GRANT, Jr., exhibited a *Brain* containing a small solid tumor pressing on the upper portion of the ascending frontal convolution on the right side. A report of the case was promised for a future meeting.

Extracts from British and Foreign Journals.

Unless otherwise stated the translations are made specially for this Journal.

The Prevention and Treatment of Chilblains.—I doubt whether it can be correctly said that chilblains are local congestions. With the exception of the very mildest and slightest cases, if even these can be excepted, there has always seemed to me to be something more than congestion. The classical signs of inflammation, *rubor et tumor, cum calore et dolore*, are all present; indeed, a chilblain, in its first or so-called erythematous stage, presents a remarkably good illustration of a simple dermatitis. If neglected at this period, a blain rather rapidly forms, and, under the slightest friction, quickly gives place to a very tender superficial ulcer; this ulcer is surrounded by skin which is acutely inflamed and tender. It is this combination of a superficial and very vascular ulcer, with extensive underlying and surrounding inflammation of the skin, which is most characteristic of the later stage of chilblain. The gentlest touch on the diseased finger gives pain; and the dread excited by the fear of a blow or rough handling may render the sufferer so miserably nervous, as to lead him to seek to escape from games and outdoor amusements, and so to avoid the means best tending towards prevention. Boys are very merciless to each other; and I believe the best and quickest treatment, when a case has reached such a stage, is to put the boy on the sick-list for a day or two, and apply continuous poultices until the surrounding inflammation has gone down, and we have to deal only with the ulcer, which will quickly heal under favourable conditions. Occasionally, beneath the blain, or even before it has appeared, a limited sphacelus, involving the whole thickness of the true skin, occurs; after this becomes detached, a deep ulcer, with sharply cut edges, is left, but without any marked amount of surrounding inflammation. This ulcer is much less painful than the condition above referred to, and heals slowly, but without any difficulty, though it leaves, of course, an ugly scar. It is the first or so-called erythematous stage that is most amenable to treatment. My experience quite agrees with the

statement that counter-irritants are no good. An exception might, perhaps, be made with regard to iodine, which seems to act, however, more as an astringent, and perhaps, by hardening the outer layers of the epidermis, may cause some pressure on the deeper layers of the cutis. Collodion is worse than useless; after drying, or even in the process of drying, it splits and cracks in various directions, and in each crack in the collodion a crack in the skin is liable to occur. Careful packing with cotton-wool, is the most trustworthy treatment. A little calamine lotion, applied first, and allowed to dry, will help to allay the distressing itching.

It may be remarked that chilblains are especially apt to occur when the weather is both damp and cold. As a boy, I have often gone through a fortnight's frost with no chilblains, or the very slightest; whereas, as soon as the thaw has set in, my hands have at once become covered with numerous chilblains. The explanation of this is to be found in the fact that, in a thaw, the air is heavily charged with moisture, so that it is impossible to keep either boots or gloves dry, and the bared hand must be always moist. The evaporation which, under these conditions, is always going on, must necessarily keep the temperature of the parts continuously, for extended periods, below the normal. My experience is that, probably for the same reason, it is a mistake to wash the hands in tepid water; and warm water is not to be recommended. I was early led by my own sensations to prefer very hot water. To plunge the hands in hot water, and then to raise the temperature still further by the addition of fresh quantities of still hotter water, certainly allays the irritation, diminishes the size of already existing chilblains, and, I believe, also aids in preventing the occurrence of fresh ones. The action of "hot water" is, as its recent use as a hæmostatic has proved, essentially different from the action of "warm water." Further, I believe that the use of "hot water" for washing the hands is beneficial, because they can be dried more rapidly and surely than when tepid or warm water has been used. In the case of children subject to chilblains, I should, therefore recommend woollen stockings and armlets (reaching to the axilla); the use

of very hot water for washing hands and feet, and rapid drying with a dry absorbent towel; and, finally, the exercise of the greatest care in seeing that boots and gloves are dried before use. To dry the boots, whether apparently wet or not, the soles should be exposed to the fire, and cautiously approached to it until thoroughly warmed through. The constitutional condition which underlies the pathology of chilblains is, no doubt, benefited by the use of tonic remedies, such as iron-phosphate; but not, I believe, by cod-liver oil or high feeding.—*Dr. Dawson Williams, in British Medical Journal.*

Rapid Absorption of a Pleuritic Effusion by Treatment with Common Salt, and Cutting off Liquids.—

John C. came under my observation on August 1st, 1882. He was then suffering from a well-marked pleurisy, *i.e.*, pain, catching breathing, and a cry at the end of inspiration. He sat up in bed and held his hand against his side, complaining bitterly of the pain. A bandage was put firmly round the thorax, with much and rapid relief, and he was ordered absolute rest, a liquid diet, and some opium. On August 2nd he was evidently much relieved, and his respiration was more uniform, deeper and attended with less pain. On August 3rd I was hastily sent for, and, on my arrival, I found my patient in great and urgent distress. His lips were livid, his nostrils were smoky, his eyes were prominent, and his nails blue. He had cold-clamminess of hands and brow, and he was breathing fifty-one times in a minute. The pulse was barely appreciable at his wrist. The heart was pushed over to the right. I told him of his great danger, and urged him to permit me to draw off the fluid. This he flatly refused to allow me to do, saying that a friend of his was tapped, and died one hour afterwards. This was at 11 a.m. I put him under the following conditions. He was to take every hour one tea-spoonful of common salt, dissolved in a wine-glassful of tepid water. I produced sweating by a hot wet flannel and a piece of waterproof sheeting, and I gave him two ounces of the common black draught at once, and stopped all fluids. At 1 p.m. he said: "I can get my wind now," and he had most markedly improved in every way. He looked less

livid. His respiration had dropped down to 48. At 9 p.m. he looked cheerful. The lividity had almost disappeared. He could lie on either side, and get well down in the bed.

On August 4th, on entering the room, I could not have detected any embarrassment of breathing, and all his subjective symptoms had disappeared. There was comparative dulness of the left base, but the air could be heard entering the lung. I now gave one drachm of common salt twice a day, and two ounces of the brandy-mixture of the *Pharmacopœia* every four hours, together with some oysters, an anchovy and Digby chick, or a piece of salted bacon. He did not complain much of the thirst, said his "mouth was dry," and his tongue looked red and glazed. From this time there is practically nothing to say, my patient never had a return of his symptoms, and he was up and out of doors in a week. It is barely necessary to comment upon the *rationale* of the treatment adopted in this case, and my only object in bringing it forward is to see whether like results will follow in the experience of other similar cases, or in any effusion which takes place into a serous cavity. The salt, I believe, increased the density of the blood; the blood became thirsty, if I may so express it, and drank up the pleuritic effusion in a manner to me singularly rapid and striking. Doubtless the sweating and purging aided me very much; but purging and sweating will not remove serous effusions with precision.—*Dr. Robinson, in British Medical Journal.*

Carbolic Acid as a Local Anæsthetic and Mouth-Wash.—Dr. Squibb says: Carbolic acid and other phenols with which it is associated are all very effective local anæsthetics, and this therapeutic relation is far too much overlooked or neglected. A paper by Dr. J. H. Bill, of the United States army, published in the *American Journ. of Med. Sciences* for 1870, page 573, first drew attention strongly to this point, and every one who has handled the acid much has amply confirmed Dr. Bill's experience, and yet the matter has been but imperfectly followed up. Even its application to the pain of burns, erysipelas, and other superficial affections, though often insisted upon, is not generally adopted, and when adopted

it is rarely in the best way. The writer knows from personal experience, and from extensive practice in his laboratory where burns and scalds are not unfrequent, that a solution containing from one-half to 1 per cent. applied by means of thin cloths, frequently renewed, will relieve the pain of burns within ten minutes; and the relief will be permanent if the application be continued during the twenty-four or forty-eight hours of primary irritation. Under such dressing the burns, if superficial, will not suppurate, and if deeper, the suppuration will be greatly diminished and modified. If the solution be applied too strong, it will at first increase the pain for a very short time; but the after-effects are less favourable, as the irritation of too much of the acid increases the tendency to suppuration. A simple rule for guidance is that the renewal of the application should not cause smarting or renewal of the pain. The anæsthetic effect upon the acute suffering of burns and scalds is very remarkable. A 5 per cent. solution of the liquefied acid is a very convenient preparation to keep in readiness for making the more dilute solutions needed for burns, erysipelas, &c., and for such uses as protecting hypodermic solutions. One-twentieth of such a solution is quite sufficient to prevent the growth of micro-organisms in any preparation which needs protecting. It is simply to be added in making up the preparation to the required measure. A piece of paper moistened with a few drops of such a solution and kept in extract-pots, &c., will prevent the growth of mould. Such a solution diluted so as to be not stronger than 1 per cent., nor weaker than about one-half per cent., makes an excellent tooth and mouth wash for use in the morning. Habitually used, it in some degree checks the deposition of "tartar" on the teeth, keeps the tooth-brush sweet and clean, and there is nothing that leaves the mucous surfaces in so clean and pleasant a condition for the first meal of the day. A bottle of the 5 per cent. solution may be placed upon the washstand, and a couple of teaspoonfuls poured into the mug, diluted with four or five times as much water, stirred with the tooth-brush and then used upon the brush; the mouth being finally rinsed out with the remainder of the solution. This is a very good habit, which has

been followed by the writer and many others for many years with advantage. (*Ephemeris*, May, 1883.)

The Ill-doings of Flies.—Dr. B. Grassi, of Rovellasca, reports, in a recent number of the *Gazetta de gli Ospitalia*, some investigations he has been making on the above subject. He has convinced himself that the common house-fly is a dreadful enemy of the human race as of all living things in general. Wherever any infectious product is present, for instance, the sputa of phthisical patients, or dejecta from the intestinal tract, swarms of flies are to be seen, which soil themselves with the offensive material, and then crawl about over our food. The writer placed a plate containing a large mass of the ova of a human parasite (*Trichocephalus*) upon a table in his laboratory, which was situated at the distance of about thirty feet from the kitchen. Sheets of white paper were placed in various parts of the kitchen, and in the course of a few hours the dejecta of flies were observable on the paper. Upon examination of these with the microscope, they were found to contain some of the ova of the parasite. Dr. Grassi then killed some of the flies, and found an enormous mass of feces containing more of the ova. On another occasion he minced some segments of tape-worm that had been preserved in spirit, and put them into water, so that a mass of ovæ were suspended in it. In half an hour he succeeded in finding the ova of the parasite in the abdominal contents of the flies, and also in the spontaneously deposited dejecta. In like manner it could be proved that flies that had alighted on moldy cream harbored the spores of *oidium lactis*. It is useless to comfort one's self with the thought that these germs die in the intestines of the flies. Even if the intestinal juice does act upon them, and it is not proved that it does in the case of bacteria, some would almost certainly escape destruction. In any case, moreover, the legs and proboscis would still serve as carriers of the infection. He proposes that attempts shall be made to introduce the same disease among them in the spring time that already causes such devastation in the autumn.

Removal of the Thyroid Gland.—Extirpation of the enlarged thyroid gland has been of late years frequently practised, and, on the whole, good results have been obtained, thanks chiefly to the antiseptic system of dressing. Amongst the more important recent writers on this subject may be mentioned Professor J. L. and Dr. A. Reverdin, who have published in the *Revue Médicale de la Suisse Romande* (1883, Nos. 4, 5, and 6) an account of twenty-two extirpations of goitre performed by them on twenty-one patients, twelve of whom were women. These cases are interesting, not only on account of the good results obtained, but also, and chiefly perhaps, because Messrs. Reverdin were able to examine their patients several years after the operation, and then discovered certain remarkable alterations of the general health, which will be mentioned below, and which had, it seems, escaped the attention of other operators. The following is a brief account of Messrs. Reverdin's paper. The size of the tumors varied from that of a hen's egg to that of an adult's head. Most of the tumours were parenchymatous, with or without cysts, and occupied more or less exactly the middle line; one sent a prolongation downwards behind the sternum. In seventeen cases, total extirpation was performed; once an enucleation was done, while the remaining were cases of partial extirpation. Of the twenty-two operations, two only were followed by death, which was caused, in one case, by dyspnoea and convulsions, and, in the other, by lobular pneumonia. On an average, the patients remained only sixteen days in the hospital after the operation, and, in ten cases, union by first intention was obtained.

Amongst the accidents which may accompany or follow the operation, Messrs. Reverdin mention hemorrhage, which is best prevented by securing the thyroid arteries as soon as possible; secondary hæmorrhage occurred in two cases. Dyspnoea was sometimes present before the operation, and in several cases prevented the administration of chloroform. The same complication, and also dysphonia, aphonia, and dysphagia, were often noticed after the operation, but generally disappeared after a short time. In three cases, tonic convulsions of the upper

extremities appeared after the operation ; in one of these cases (mentioned above), they were accompanied by a severe attack of suffocation, and soon followed by death. In five patients, three of whom were men, a remarkable alteration of the general health showed itself some months after the extirpation of the thyroid gland. There were at first weakness and coldness of the limbs, then loss of appetite, slowness of speech, diminution of the progressive anæmia, accompanied, in two cases, by a peculiar œdema, most marked in the face, and very analagous to that which occurs in myxœdema. These symptoms partially disappeared after about three years. They seem to show themselves only after total extirpation, and are produced, according to Messrs. Reverdin, by a lesion of vaso-motor nerves, and by a mucoid infiltration of certain tissues, in consequence of the removal of the thyroid gland. These serious consequences, which have a remarkable analogy with cretinism on the one hand, and myxœdema on the other, must be taken into consideration in the prognosis. Nevertheless, extirpation (or, if possible, enucleation) ought to be performed, according to Messrs. Reverdin, when there are symptoms of imminent danger, such as attacks of suffocation, and also in cases of retrosternal or rapidly growing goître, when the ordinary treatment has proved useless.—*British Medical Journal*.

The Conversion of Malignant Tumors into Innocent Growths.—Prof. V. Nussbaum, in a clinical lecture recently delivered in Munich (*Wien. Med. Zeit.*, June 3, 1883—*Boston Med. and Surg. Jour.*, Oct. 25th), expressed the belief that he had discovered a procedure for the positive cure of cancer by restraining the proliferation of the tissue elements of the disease. It appears to him that a total interruption of all peripheral sources of nutrition is the means best adapted to secure this result. He accomplishes this object by the use of the thermo-cautery, with which instrument a deep channel is made quite around the malignant growth, thus cutting off entirely the supply of blood and other nutritive fluids from the surrounding tissues. The small vessels which ascend into the tumor from the parts beneath are sufficient to preserve

its vitality, so that gangrene does not occur. He thinks the thermo-cautery far preferable to the ligature, and that it possesses many advantages over the knife. He regards the hot iron and the various chemical caustics worthy of more extensive employment in the domain of malignant growths than they have ever enjoyed. Prof. Nussbaum doubts not that this circumscribing a cancerous growth, thus cutting off every channel of peripheral nutrition, has a brilliant future, especially in those desperate cases in which death is imminent from hemorrhage. In his experience, this method of cutting off the peripheral blood supply has afforded such astonishing results that he recommends this procedure to the attention and practice of all those having occasion to treat a case adapted to its employment.

Curious Malposition of a Tooth.—

In a recent number of the *Lancet*, Dr. Gopaul Chunder Roy relates the case of a Hindoo lad, aged 14 years, who presented himself for treatment at the Soree Charitable Dispensary, for what he considered to be a tumour growing within the nasal cavity. He noticed a foul smell in his breath about four months before, attended with catarrh and sometimes a bloody discharge from the left nostril. For the previous two months the growth had been observed to occupy the left cavity, where it seemed to be attached to its wall at its upper part, its free end was looking downward in the shape of a truncated cone. Arrangements were made for plugging the posterior nares, in the event of uncontrollable hæmorrhage, the tumor was seized with dressing forceps and extracted. It proved to be a tooth of the shape of a canine. There was very little bleeding after extraction, and this was stopped by alum lotion. The free extremity was covered with enamel, which stopped short at its junction with the root. The root was deeply imbedded in the side and upper part of the antrum. The boy had got his set of permanent teeth, with the incisors and canines entire on either side. There was no deformity of the jaw and no swelling or cystic formation. It was clearly a case of extra-follicular development and eruption of a tooth in a wrong place, the peculiarity being that while in reported cases of like nature the crown of the tooth shows itself

at the floor of the nasal cavity from below upward, in the present instance, by some freak of nature, the dental follicle was transposed, and the eruption was from above downward. The tooth has been sent to the Royal College of Surgeons' Museum.

The Differential Diagnosis of Tic Douloureux and Dental Neuralgia.—Magitot, of Paris, some time ago expressed the opinion that these two varieties of prosopalgia were clearly distinguishable by their symptoms alone. Tic douloureux he would define as an affection of the cutaneous branches of the trigeminus, occurring in paroxysms of an intermittent and spasmodic character which are provoked by the slightest contact or movement; while neuralgia originating in the teeth is increased or diminished by forces acting upon the oral cavity, such as the pressure of foreign bodies, atmospheric air, heat, cold, certain drugs, etc., none of which exert any influence in the case of tic. This view is controverted by Dr. Th. Walzberg, in the *Centralblatt für Chirurgie* November 10, 1885. He maintains that there is nothing specially characteristic in the symptoms of either complaint, and proposes to divide the facial neuralgias into two classes, viz: those whose causes can, and those whose causes can not, be determined—the latter answering to the tic douloureux of Magitot. He adduces in confirmation three cases of prosopalgia successfully treated by himself. Concerning the first two of these he observes that they exhibit almost precisely the same assemblage of symptoms, yet that one of them certainly did not originate in the teeth, although presenting all the features characteristic of dental neuralgia, according to the French author. The third case, the symptoms of which would place it in Magitot's first class (tic douloureux)—and which also strongly resembled an intermittent disease—shows that a neuralgia may arise from the teeth, although entirely uninfluenced by agencies affecting the interior of the mouth. Symptoms in these complaints may facilitate the discovery of their causes, and so guide us to a successful plan of treatment, but only the most accurate objective examination in every case will protect effectually against error. It is better to search in vain for a tooth-root, upon the slightest suspicion,

than uselessly to divide a nerve. A remark is appended relating to the mode of performing this operation. When it is designed to follow up to any considerable extent the ramifications of the infraorbital nerve upon the cheek, it is better to make the entering (semicircular) incision at a point somewhat below the orbital wall; otherwise a pouch will be formed too small for separate drainage, but large enough to act as a reservoir for the secretions, with the result of setting up a suppuration which will much prolong the process of healing. The latter, under favorable circumstances, should not occupy over five days.

M. Pasteur on the Etiology of Cholera.

—The Paris correspondent of the *Lancet* says: M. Pasteur having been solicited to lay before the public the instructions he had given the members of the scientific mission to Egypt to investigate the nature of cholera, now raging in that country, and which was noticed in your annotation of last week, has generously complied with the expressed desire of his friends. M. Pasteur prefaced his instructions (of which I send you an abstract copy) by remarking that the precautions hereinafter enumerated relate to those cases where the causes of contagion will be found to prevail in their maximum intensity. These precautions, he added, are instituted under the hypothesis, which he considers very probable, if not certain, that cholera does not enter the human organisms by the air passages, but that it does enter by the digestive canal, unless under very unusual circumstances.

1. Not to make use of the drinking-water of the locality in which the mission will be located without having previously boiled the water, and shaken it well, after it has become cold, for two or three minutes, in a bottle half filled; or the water may be put into vessels previously heated, “vases flambé”—that is to say, vessels that had been subjected to air heated to about 150° C., or even more; the higher the temperature the better. The natural mineral waters may be employed with advantage, instead.

2. Make use of wine that has been heated in bottles to from 55° to 60° C., and which should be drunk in glasses also previously heated.

3. To make use of alimentary substances only after being well cooked, and fruits in their natural state, but previously washed with water that has been boiled, and preserved in the same vessel in which it was boiled, or had been transferred into those previously heated.

4. To make use of bread cut up into thin slices and submitted to a temperature of about 150° C., during twenty minutes or more.

5. All the vessels employed for alimentary purposes should also be previously subjected to a temperature of 150° C. or more.

6. The bed linen and towels should be plunged into boiling water and then dried.

7. The water for washing or bathing should be previously boiled, and, after being cooled, mixed with solutions of thymic or of carbolic acid, the former in the proportion of 1 to 500 parts, and the latter 1 to 50 parts.

8. The hands and face should be washed frequently during the day with boiled water, and to which should be added solutions of thymic and carbolic acid.

9. It is only in cases where the bodies of patients who have died from cholera or their soiled linen has to be handled that it would be necessary to cover the mouth and nostrils with a small mask formed of two pieces of thin plates of metal, enclosing between them a little cotton wool of not more than 1 centimetre thick, the mask having been submitted to 150° C. only, and renewing the temperature of 150° on each fresh exposure to contagion.—*Med. and Surg. Reporter.*

Pomade for Comedones.—The *St. Louis Medical Journal* says that Una, in *Virchow's Archives*, recommended the following for comedones; Kaolin, four parts; glycerine, three parts; acetic acid, two parts, with or without the addition of a small quantity of some ethereal oil. With this pomade he covers the parts affected, in the evening, and if need be during the day. The comedones can be easily expressed after several days, most of them coming out by washing the parts with pumice-stone soap.—*Chicago Med. Review.*

CANADA

Medical and Surgical Journal.

MONTREAL, JANUARY, 1884.

THE UNIVERSITY QUESTION.

It should be the ambition of all concerned in educational matters in Canada to push forward our institutions to that stage at which they may become not merely the recipients and purveyors of current knowledge, which they are now, but centres from which may originate valuable contributions to the common stock—contributions which will make Canadian learning and research universally respected. We may reasonably claim that something towards this has already been done by Canadian workers, but two things, amongst others, sadly retard progress in this respect; first, imperfect training of teachers and professors, and second, a plurality of subjects professed and taught. It is one thing to know thoroughly and be able to teach well any given subject in a college, it is quite another thing to be able to take-up that subject and by original work and investigation add to our stock of knowledge concerning it, or throw light upon the dark problems which may surround it. Many a man pitchforked, so to speak, by local exigencies into a professional position has done the former well, but, unless a man of extraordinary force, he cannot break the invidious bar of defective training which effectually shuts him off from the latter and higher duties of his position. We have, however, many men in our colleges with good records as investigators, and we hear from them but seldom on account of the excessive drudgery of teaching which the restricted means of their college compel them to undertake. The instances are few indeed in our Universities in which a professor has but a single subject to deal with, and those which do exist are in subjects of great extent

and often subdivided in other colleges. In looking over the list of branches taught by a single professor in some of our colleges we may indeed say with Dr. O. W. Holmes that he does not occupy a *chair* but an entire *settee*. If Canadian scholarship is to be fostered, if progress in science is to be made, this condition of things must be remedied, and we may confidently hope will be, as years roll on. The above remarks have been suggested by the active discussion which is taking place in Ontario about additional endowment to the provincial University. That it is needed everybody admits, and that it should be granted by the State every one will concede, unless affected with denominational myopia. Private benefaction has done much, or rather everything, for university extension in this Province, and the bequests in favour of the sectarian colleges in Ontario have been large. But unless the liberality of individuals is manifested in the manner of the late Mr. Johns Hopkins, of Baltimore, we shall have to wait long for a *fully equipped* Canadian University. The Government of Ontario, however, has now the opportunity to put Toronto University on a proper basis, and do a great work for the intellectual life of this country. And it can consistently do so, as the Institution is a State foundation and is under State control, and the condition of the local Exchequer is plethoric.

What we have said concerning checks to progress in our universities applies equally to our Medical Schools. Compared with other countries, the medical profession here is in an enviable position. We have satisfactory laws regulating the study and practice of medicine, and a general body of practitioners very much above the average. What we want now is increased efficiency in our medical schools, not only as regards teaching facilities but for the higher work of research. Canada can never take an active part in the scientific work of the profession until her schools have proper laboratories with well-paid professors and assistants to work in them—men placed above the worries and vexations of practice, and whose time will be devoted solely to teaching and investigating the subjects they profess. To accomplish this the schools must have money—much money.

That the necessary endowments will come in time we have not the slightest doubt. People are only now beginning to understand that we have needs, and what has been done is an earnest for the future. And while waiting, the duty of the hour is clear—to work honestly and faithfully with the means at our disposal, having but a single aim, and that a high one, to place Canadian medicine in a position every way worthy of our country.

PERINEAL SUTURES.

—We believe it is agreed on all hands by the modern school of obstetricians that puerperal lacerations of the perineum ought to be brought together and so maintained by sutures, immediately, or as soon as possible within a few hours after, the labor. Experience shows that it is not necessary that the sutures shall be applied immediately after the expulsion of the placenta. In our personal experience in one instance complete success followed the introduction of the sutures six hours after the receipt of a most extensive, ragged, and profusely bleeding laceration, extending through the sphincter, and some distance up the recto-vaginal septum. A variety of material for suture may be used. Silver wire, though possessing advantages, is certainly not necessary to success, and it is open to objections, not the least of which is, that it is much more painful than a more pliable material. The twisted ends of the wire catch on bed clothes and body linen, and acute suffering is thereby caused. Chinese twisted silk is equally efficient and not open to these objections. It is easier of application than wire. We have heard of a case treated with linen thread, and resulting in perfect success. These facts should be borne in mind by the obstetrician who meets with this accident far from home and his armamentarium. A darning needle and a strand of strong thread may suffice. Hitherto the interrupted suture has been exclusively used. In a recent number, (the last but one,) of the *Centralblatt für Gynäkologie* (No. 49, 8th Dec., 1883) appears a short article by Brosé, Assistant Physician at the Royal University Clinic for Women, in Berlin, on the "Continuous Catgut Suture for closing Perineo-vaginal lacerations." The author claims decided advan-

tages for the continuous or furrier's suture (kürschernaht) over the interrupted suture. It is more rapidly applied. He begins at the upper part of the rent in the vagina by making one knotted suture. He then continues in a spiral. If the rent be deep it is first brought together in its deeper parts by a spiral, which prevents the formation of pockets. The same process continuously applied closes the upper parts. If catgut be used no attention need be given to its removal. At the end of the sixth day it has disappeared, and the union is firm. The thicker sorts (about No. 2 of Lister's catgut) should be used. Before and during the suture the wound is irrigated with a solution of corrosive sublimate, 1 to 2000. Afterwards it is covered with a thick layer of iodoform. Eighteen cases treated after this method are reported—all being successful. One of the cases, with a slight perineal laceration, died of peritonitis on the sixth day, but the wound had united. The method deserves a trial.

DISPENSING POISONS.

On the 12th ult. a fatal case of poisoning by carbolic acid occurred in this city. The victim was a little child suffering from diphtheria. A bottle of medicine and a bottle of pure carbolic acid stood together on the table. In the night-time the mother unfortunately mistook the bottles, and administered the acid in place of the mixture. This lamentable occurrence affords another warning of the necessity of protecting with scrupulous care the vials which contain poisons. In this case the poison was simply placed in an ordinary bottle with a poison label and directions for use. It has been shown time and again that this is not sufficient—that the majority of such accidents occur in imperfectly-lighted rooms—and that the sense of touch must be appealed to in order to warn of the present danger. Some of our chemists use rough blue bottles for all washes, liniments, and poisonous drugs. We commend the practice, and we only wish that we could see it carried out far more generally. We regret to state that many of our dispensary-houses, whose care and attention in dispensing is well recognised, still fail to avail themselves of this simple method of insuring their customers against accident.

THE SPIROMETER CASE.—At the Civil Assizes in Toronto, before Mr. Justice Rose on the 9th inst., the interesting case of *Lennox v. McCammon* was tried. Lennox is one of Souvielle's spirometer men, and has the Toronto establishment. He is a legal practitioner, registered in Ontario. At the last meeting of the Ontario Medical Council, Dr. McCammon of Kingston is alleged to have referred to the prosecutor as a "medical prostitute and quack, and as a disgrace to his *Alma Mater*." Some interesting facts came out in evidence. Instead of twenty-eight physicians employed in Toronto and Montreal, as advertised, there were only five; and of the two in the Toronto office, the address of only one could be given, a "Dr." Aiken of Weston, who had been in the Institute for a year, but whose name Dr. Lennox could not spell. As to the \$250,000 alleged to be invested in the business, it could not be shown in what way. We are glad to see that the reference to Souvielle's fraudulent attempt to get the Erlangen degree was brought out publicly. Professor Rosenthal, of that University, wrote out about it, and his letter was in possession of the defence. The counsel agreed that his Lordship should enter a verdict for the defendant. If not appealed, this will dispose of the case against Dr. Bray, who was also accused of slander and libel at the same time as Dr. McCammon. We congratulate these gentlemen on the issue of the case. It will do good, as it brings out publicly the character of these spirometer men.

THE "INDEX MEDICUS."—This admirable publication appeals to the professional public for further support, otherwise it cannot continue to exist. They ask for further subscribers at either \$10 or \$12 per annum, according to the number who come forward. We hope that the *Index* may not be allowed to die. It would be a great assistance if the local societies everywhere would subscribe. The cost to each member would thus be small and the assistance rendered great.

THE "ARCHIVES OF PEDIATRICS."—We have received the first number of this journal, edited in New York by Dr. Wm. Perry Watson. It is a monthly and, as its name implies, is devoted to the diseases of infants and children. There is ample

scope for such a publication. The special features of infantile affections, the causes of infantile mortality, and the hygiene of young children are all subjects which do not, in our medical and surgical journals, receive that attention which their importance deserves. A number of able collaborators are associated with the editor; and amongst them we are pleased to see the name of Dr. A. D. Blackader, of this city, who gives instruction on the diseases of children in the University Dispensary of McGill College. We wish the "Archives" every success.

Brigade-Surgeon Campbell Mellis Douglas, M.D. (Edin., '61), will deliver the course of lectures on "Domestic Surgery" at the Ladies' Educational Association, in place of Dr. Roddick, who is absent in Europe. Dr. Douglas, who is a native of Quebec, has had a distinguished career in the army, which he joined in 1862. He is one of the few non-combatants with the Victoria Cross, with which he was decorated, together with four privates of the 24th, "for the very gallant and daring manner in which, in May 7th, 1867, they risked their lives in manning a boat and proceeding through a dangerous surf to the rescue of some of their comrades, who formed part of an expedition which had been sent to the island of Little Andaman, and by which 17 officers and men were rescued from a fearful risk, if not sudden death."

Obituary.

CALVIN ELLIS.—Dr. Ellis, Professor of Clinical Medicine in Harvard University, and late Dean of the Medical Faculty, died on the 14th ult., after a prolonged illness, at the age of 47. He was appointed to the chair of Clinical Medicine in 1864, succeeding Dr. H. I. Bowditch, and soon became one of the foremost among the teachers of medicine in the United States. A more thorough or painstaking instructor there could not have been. We have had, on several occasions, the pleasure of listening to his lectures and clinical conferences. The latter, peculiar, we believe, to Harvard on this continent, were models, and displayed the earnest, conscientious teacher, sparing neither time nor labor, so long as the student was benefited. For many years he had abdominal trouble, which, some two or three years ago,

he diagnosed as duodenal ulcer. Death occurred from perforation and peritonitis. He has left \$50,000 to Harvard for scholarships.

DR. BEATTY, of Lambton, died suddenly on the 26th ult., of heart disease. As coroner for the district, he was holding an inquest on the body of an old woman, supposed to be murdered. He was a Licentiate of the Provincial Medical Board of 1852, and an M.D. of Victoria, 1856.

DR. A. A. RIDDEL, of Toronto, died on the 15th ult., aged 64. For many years he was coroner of the city. He was a Licentiate of the Upper Canada Medical Board of 1857. For some years he practiced in Mexico.

Personal.

Dr. Clarence J. Chipman, late of Prescott and Cardinal, has removed to Ottawa.

Dr. Griffin has been elected President of the Medico-Chirurgical Society of Hamilton.

John Smith, M.D. (McGill, '79), has left Emerson, Man., and is at present in Portland, Oregon.

Dr. Buchan, of Toronto, has succeeded Dr. Lett as Assistant Superintendent of the Toronto Asylum.

Dr. F. A. Dion, of St. Saveur, has been appointed Inspector of Anatomy for the district of Quebec.

B. F. W. Hurdman, M.D. (McGill, '82), has returned from England, and has begun practice in Inverness, P.Q.

Dr. Bell, of the General Hospital, was called to Winnipeg on the 3rd, by the sudden death of his brother in that city.

Dr. F. S. Greenwood, St. Catharines, has been appointed attending physician (with salary) to the City Hospital.

We are glad to hear that Dr. Lafontaine B. Powers, of Port Hope, has recovered from his recent illness, and is attending to his duties.

D. G. Inksetter, M.D. (McGill, '80), has given up his practice in Dundas, Ont. He purposes taking an extended course

in England before settling again. His partner, James Ross, B.A., M.D. (McGill, '81), continues the practice.

The many Canadian friends of Dr. Seguin, of New York, will be glad to learn that he has resumed practice at 47 W. 45th Street.

Dr. Winstanley, one of the oldest and most respected practitioners of Toronto, is about to remove to Southern California for his health.

Richard Price, V.S. (Montreal), has been appointed Lecturer on Materia Medica in the Northwestern Veterinary College, Minneapolis, of which Dr. Lyford is the Principal.

Kenneth Mackenzie, M.D. (McGill, '81), has been appointed Professor of Anatomy in Willamette University, Portland, Oregon, and Surgeon to St. Vincent's Hospital, in the same city.

Dr. Beaumont Small is President this year of the Ottawa Field Naturalists' Club. The Doctor delivered the first lecture of a series to be given in connection with the Society, on "The Study of Natural History."

Medical Items.

—The tenders have been let for a new City Hospital at Charlottetown, P.E.I.

—Enemata of chloral hydrate as said to be useful in the vomiting of pregnancy.

—We regret to learn that Seguin's *Archives of Medicine* has been discontinued. The *Archives of Laryngology* has also succumbed.

—The committee appointed last year to revise the curriculum of the Ontario Medical Council met in Toronto on the 27th ult., and decided upon the amendments to be submitted to the Council.

—His Excellency Dom Smeulders, the Papal Commissioner, began on the 7th to take the evidence of the Professors of the Montreal Branch of the Laval School, in connection with the Laval-Victoria trouble.

—Depaul recommends the administration of iodide of potassium during pregnancy, in cases of contracted pelvis, with a view of lessening the size of the child.

—Taking advantage of the abundance of material, nearly 90 of the junior students of McGill College spent the Christmas vacation working at the extra subjects usually "brought up" at this time.

—Sponging the surface of the body with a solution of quinine in alcohol—one drachm to the pint—is now recommended for excessive sweating. It is a remedy that has long yielded us good results.

LAVAL UNIVERSITY, QUEBEC.—Dr. Jackson has been appointed Dean of the Medical Faculty; Dr. Verge, Professor of Medicine; Dr. Wells, Professor of Materia Medica; Dr. D. M. Brochu, Professor of Hygiene.

HEAVY BRAIN.—The brain of Turgenieff, the Russian novelist, weighed—so it is said—2012 grammes, one of the heaviest on record. In the *Edinburgh Medical Journal* for November a case of brain tumor is recorded; the brain weight was unusually high, 67 ozs.

MCGILL MEDICAL SOCIETY.—Nov. 17th—Mr. Renner read a paper on "Tumors of the Breast," giving the characters and diagnostic signs of the chief growths in this region. Mr. Wyatt Johnston exhibited a number of Pathological specimens, and Dr. R. J. B. Howard a series of microscopic slides of breast tumors. Dec. 1st—Mr. J. A. Hutchison read a paper on "Some sequelæ of Diphtheria," giving the details of a number of cases. Mr. Darey gave a reading from Thackeray. Dec. 15th—Mr. C. E. Gooding, of Barbadoes, read a paper on "Elephantiasis," dealing specially with the relation of the *Filaria* to the disease. A slide of blood showing the parasite was exhibited. Dr. Osler made some observations on the relation of *Filaria* to Chyluria. Mr. Rowell gave a report on a case.

HALIFAX DISPENSARY.—The following are the physicians to the Dispensary for the year 1884. The old staff were reappointed with the exception of Dr. D. A. Campbell, who retires voluntarily, viz:—Attending physicians, Drs. Rigby, Somers and McFatridge. Visiting—North District: No. 1, Dr. Marshall; No. 2, Dr. J. S. Lathern, vice Campbell. Central: Dr. Lindsay. South: Dr. Trenaman. Apothecary, Dr. Harrington. Dartmouth—Attending and Visiting: Dr. Cunningham, reappointed.

UNIVERSITY OF MANITOBA.—The committee of the Board of Studies, having met the representatives of the Manitoba Medical College, has recommended for adoption a statute on the degree of M.D. The requirements set forth are practically identical with those of other Canadian Universities. The matriculation examination differs in some respects from that recommended by the British Medical Council, but is sufficient to test the proficiency of the candidate, indeed, with ten papers, to each of which three hours are assigned, will be more extensive than usual. The committee also recommends the affiliation of the Medical College and the granting of representation on the Council of the University.

THE BUFALINI PRIZE.—Some of our philosophical readers may be interested in the following particulars, recently received, concerning this prize. The late Professor Buffalini, a learned physician, of Florence, being convinced that all principles of reasoning called *a priori* are entirely false, and that only the philosophy called experimental is true, appeals now, ten years after his death, to the learned, and will continue to appeal every twenty years for a solution of the following problem, for which a prize amounting to \$965 is offered:—“The necessity of the experimental method in arriving at the truth and the relation of all the sciences being assumed, it is required to demonstrate in a first part how far the said method is to be used in every scientific argument, and in a second part to what extent each of the sciences has availed itself thereof during the time that has elapsed since the last competition for a prize, and how they may be brought to a more faithful and complete observance of the method itself.”

MUNICIPAL HONORS.—The following members of the profession in Ontario have been elected to municipal positions for the year:—

Mayor—Dr. McCammon, Kingston ; Dr. Rae, Oshawa ; Dr. Bogart, Whitby ; Dr. Standish, Palmersten.

Reeve—Dr. Willoughby, Colborne ; Dr. Bradley, Kincardine ; Dr. Mitchell, Wallaceburg ; Dr. McConnell, Brockton ; Dr. Allan, Arthur ; Dr. Means, Petrolia.

Councillors—Drs. Black and Bascom, Uxbridge ; Dr. Walker Dundas ; Dr. Harris, Brantford ; Dr. Cook, Chesley ; Dr. Gillespie, Cannington ; Dr. Webster, Esquesing ; Dr. Henry, Hamston ; Dr. Tennant, Lucknow ; Dr. Doherty, Markham ; Dr. M. S. Scott, Southampton ; Drs. Mathieson and Sinclair, St. Mary's ; Dr. Burns, St. Thomas ; Dr. Goodman, St. Catharines ; Dr. Aikman, Windsor.

—We regret to see that Dr. J. Collins Warren announces that he has, in conjunction with Dr. George Shattuck, examined the essays in competition for the prize of \$1000 offered on the subject of "Cancer, and the probability of the discovery of a cure of malignant disease," and cannot recommend any of them as worthy of the prize.

—At a meeting of the Board of Health last month, the following resolution was presented by Judge Dugas, and unanimously adopted:—"That in order to obtain a better knowledge of the sanitary state of the city, a circular be addressed to all the physicians of Montreal and surrounding municipalities, requesting them to make known to this Board the result of their experience concerning the extent of the ravages of Syphilis and of venereal diseases in general ; to state whether they consider it opportune to establish restrictive measures for the prevention of those diseases, and what, in their opinion, would be the best means to be adopted for that end." We learn from Dr. Larocque that about thirty replies have been sent in, the general tenor of which is that the disease is very prevalent, and that restrictive measures are necessary.

—Baronetcies have been conferred on Mr. Joseph Lister and Mr. William Bowman. There are now nine medical baronets,

all London practitioners. Four are physicians, viz., Burrows, Gull, Jenner and Clark. Five are surgeons, viz., Paget, Wells, Hewett, Lister and Bowman. Of Knights Batchelors, there are also nine, viz., Ridsen Bennett, Birdwood, Carroll, Cooper, Lentaigne, McCormac, Salmon, Thompson and Erasmus Wilson.

—It is always pleasing to notice a piece of solid scientific work done in the country. We see in the last number of the *Quarterly Journal of Microscopical Science*, of London, Eng., a valuable memoir on "The Osteology and Development of Syngnathus," by Professor Playfair McMurrich, of the Guelph Agricultural College. It is an able contribution to the morphology of the lophobranchiate fishes. Mr. McMurrich is one of a band of able workers at Biology, which has been trained by Professor Ramsay Wright, of University College, Toronto.

—It is asserted that carbolic acid, in the proportion of one part to one thousand, will keep solutions of atropia and eserine clear, and prevent the formation within them of a fungous growth, to the septic action of which the conjunctival inflammation, which is sometimes set up by the use of old atropia solutions, has been ascribed. Carbolic acid in this proportion produces no disagreeable sensation in the eye, and it is much more efficient than either salicylic or boric acid, which have been used for the same purpose.

—"Well," remarked a young M.D., "I suppose the next thing will be to hunt out a good situation, and then wait for something to do, like Patience on a monument." "Yes," said a bystander, "and it won't be long after you do begin before the monument will be on patients."—*Phil. M. & S. Reporter*.

—Dr. Carl Seiler, Lecturer on Diseases of the Throat, University of Pennsylvania, Philadelphia, Pa., says:—"I have used the preparation called BROMIDIA, as manufactured by Battle & Co., of St. Louis, both internally and locally by means of a spray, in cases of throat affections, and found it admirably suited to certain cases."