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THE  
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**Original Communications.**

**CASES IN PRACTICE.**

BY JAS. F. W. ROSS, M.D.,

Surgeon to the Woman's Hospital, and lecturer in Gynecology,  
Woman's Medical College, Toronto.

**RECTOCELE—COMBINED PARING AND FLAP SPLIT-  
TING OPERATION—SECONDARY HÆMORR-  
HAGE ON THE ELEVENTH DAY.**

Mrs. G., æt 47; married, several children. Last labor bore twins. Perineum torn—laceration not complete. Labor was very rapid. Ceased menstruating 12 months ago. Suffers from protrusion of posterior vaginal and anterior rectal wall. No prolapse of uterus, also has large hemorrhoids. Is kept in a very uncomfortable condition by this protrusion. Advised operation. I determined to combine Hegars paring operation for the posterior vaginal wall and Tait's flap splitting for the perineum. Patient anæsthetized and drawn to the edge of the bed, in the dorsal position, with knees elevated with a Clover's crutch. A continuous douche was used to keep the parts free from blood. I then began my incision well up to the cervix and ended at the side of the perineum. The same was repeated on the other side. The flap with a broad base below at the perineum and the apex above was dissected off, beginning above and working downwards. To prevent hemorrhage, the edges of the cuts were stitched up from time to time, with a continuous catgut suture, and after stitching them then more

flap was dissected off until at last the perineum was reached. The flap was severed straight across at its base with one cut of the scissors. The perineum was then split, the splitting running well up into the labia. These sutures were passed with a perineum needle, beginning inside the skin, and going outside the mucous membrane on each side. They were of silk worm gut. The parts were thus drawn nicely together. In dissecting up the posterior vaginal flap, the recto-vaginal septum was found to be unusually thin, and it was only by great care that the rectum was not opened. Hemorrhage was rather troublesome, but was checked by hot water. The piles were then ligated and removed. The patient subsequently suffered some pain from the hemorrhoids, but an opiate and the local use of 4% oleate of cocaine checked this. Everything went well until the eleventh day, when during a fit of uncontrollable laughter, she felt something give way. Hemorrhage began at once, and was very profuse. As soon as I arrived, a small speculum was passed beneath the pubic arch, so that the parts should be but slightly disturbed, and the vagina was tamponed. This did not altogether suffice, and some oozing continued, until at last the bleeding spot, as seen by reflected light from a laryngoscopic mirror, was touched with tincture of iron. This had the desired effect. Tampons were changed every 24 hours, and on one or two days were changed twice a day. Some oozing continued to wet them, but as it was not enough to endanger the patient's life, I

determined to watch and wait. The tampons produced irritation of the rectum, and necessitated the secondary use of the catheter to draw off the urine. The bladder resented this interference, and the use of the catheter had to be discontinued. A slight diarrhœa set in, and this produced some fresh hemorrhage, so that I almost determined to tear down the parts and tie the bleeding point. But at last the bleeding ceased, the tampons were discontinued, and the patient made a good recovery. It is now nearly 3 months since the operation, and I find the parts well healed, the vaginal outlet well narrowed without any sign of protrusion of the rectal wall. The flap splitting operation saves much time to operator and patient, and I believe is successful in nearly every case in which it is used. The patient can get up and go round with the stitches still in situ, and can return to the operator for their removal in from 3 to 4 weeks after they have been inserted. This is a decidedly rapid method of performing a colpo-perineorrhaphy.

BROAD LIGAMENT HÆMATOCELE—SUPPURATION  
—PUNCTURE FROM VAGINA—CURE.

Mrs. M., æt. 22; first seen August 1st, 1889. Married two or three years, one child 10 months old. Catamenia, now absent, commenced after the birth of baby in the fifth month, and she has been regular up to July 1st. Never missed a month. She went away to a picnic on July 14th, two weeks after her last menstruation. Fell off a swing to the ground. Only fell a short distance, but came down on her seat without being able in any way to break the fall. Immediately felt severe pain in the front and lower part of the abdomen; could not straighten up. Felt very faint. A desire to have an evacuation of the bowels came on, and she had her friends assist her into the neighboring grove, and endeavored to empty her bowels, but failed. She could pass nothing. She was brought home to Toronto by steamboat, and felt very ill all the way. The pain subsided, but in the middle of the night a severe griping pain came on. She became feverish. My father, Dr. James Ross, sr., was called in to see her. She was kept in bed; tongue became furred, bowels were very obstinate, until at last no fœcal matter passed through. Temperature rose to 103 and

104, pulse from 90-120. Dr. Ross, sr., asked me to see her with him. At first sight she looked like a patient in about the third week of typhoid fever. She could retain nothing on her stomach. Temperature 102. Pulse 100. Great thirst. Passing mucus every few minutes from the rectum. Pain when emptying the bladder. On examination perineum normal, but somewhat congested. Bloody mucus seen discharging from anus. Uterus fixed behind the pubes, not very tender, enlarged to about one-third more than its normal size. Density about normal. The parametrium filled to the left and behind by a large tense mass with distinct fluctuation. A resistance over the lower abdomen could be made out, but no defined tumor could be felt externally. There was slight dulness on percussion. It reminded me particularly of a broad ligament cyst I had seen while with Mr. Lawson Tait. Mr. Tait made his diagnosis and confirmed it by abdominal section a few days later. But a "puffing" seemed to extend down to the utero-sacral ligaments, producing a tense band across the rectum. This accounted for the obstruction of the bowels present. The patient had had castor oil and other aperients, as well as several enemata, but they failed to move the bowels. As the mass was pressing down well into the vagina, I advised puncture. I concluded that the case was one of suppuration in the broad ligament. Next day, with the patient under chloroform, I thrust in a good sized wooden handled trocar, and at once the diagnosis became clear. A tarry fluid, mingled with pus, pronounced the case to be one of suppurating hæmatocele of the broad ligament. Along the trocar, the flat blade of a pacquelins cautery was passed, and thus the opening was enlarged. The vagina was washed out, and packed with iodoform-gauze. Next day the temperature fell to normal, a natural evacuation of the bowels took place, and the patient was free from pain. Twice subsequently, I passed a sound into the opening to keep it from closing too soon. Each day the vagina was washed with water night and morning, and then packed with iodoform gauze. The puncture was made on August 2nd. My notes say on September 1st, "Patient up and around. Uterus quite movable."

There are two or three points that bear out the clinical history of such cases as recorded by others.

1. The sudden onset of the symptoms, after some violent injury or exertion.
2. The sudden obstruction of the rectum through tension of the utero-sacral folds.
3. The peculiar mucus discharge, like pink stained white of an egg, as diagnostic of rectal irritation. I have seen this symptom in other cases, and especially in a case of an abscess in a male, between bladder and rectum.
4. The good effect of operation, both immediate and remote. In cases with the fluid high up away from the vagina, I should always open them through the abdominal wall.

### THE NECESSITY OF ENCOURAGING SCIENTIFIC WORK.\*

BY VICTOR C. VAUGHAN, M.D.,

Professor of Bacteriology in the University of Michigan.

Science is knowledge; art is the application of knowledge. Science consists of facts; art utilizes these facts. Science investigates; art adapts. Science is the foundation; art is the superstructure. Science is the mariner who sails out over the seas of ignorance, and discovers fair islands and broad continents of truth; art is the immigrant who comes later, and tills the soil, and builds the cities.

We are fond of saying that this is a practical age. By this we mean that our knowledge is utilized for some purpose. We are prone to speak lightly of those who may give their time and attention to the pursuit of knowledge for its own sake. But we should remember that we must possess knowledge before we can apply it. Science must always precede art. Convert all of your investigators, who are the discoverers of knowledge, into adapters of knowledge, and you will arrest the world's progress. Without a Franklin and a Faraday, there could have been neither a Morse nor an Edison. What would have been the condition of applied chemistry to-day, had not the Priestlys and Scheeles of 100 years ago worked and plodded? At that time the study of chemistry was pursued as a pure science, and its devotees were re-

garded as but little better than fanatics. To-day a hundred arts make practical applications of the discoveries of chemistry. The industries founded upon the researches of the humble chemist now feed and clothe millions, and enrich thousands. It has been stated that the commercial value of the discovery of the aniline dyes alone has repaid Germany a thousand-fold for all the money which that Government, as liberal as it has been in this direction, has invested in its numerous and well-equipped chemical laboratories. There is scarcely an honorable trade or profession which is not indebted to a greater or less degree for its position and efficiency to the labors of the scientific chemists of the past. Without a knowledge of the chemistry of metals none of our vehicles of transportation, from the dainty baby cart to the great ironclad of war, from the cheap dray of the poor man to the elegant private car of the rich man, could have been constructed. Without these labors, which are said to have been begun by Tubal Cain, the world to-day, instead of being occupied for the most part by great nations, would have remained a wilderness, with its solitude broken only by the cry of wild beast and savage man. No great cities, indeed, not even a hamlet, could have been built. There would be no commerce, no learning, no religion.

You must not understand from what I have said that chemistry is the only science which has benefited mankind. I have simply taken it as an illustration, and I do not know that it has any claim to first rank. Rob us of the knowledge which constitutes any of our great sciences and we are affected seriously, physically, intellectually, and morally. A wise nation will foster the sciences, for upon these depends its prosperity. Germany has been pre-eminently wise on this point. It has built and equipped universities as no other nation has done. It has filled Strasburg with soldiers and has walled and entrenched the quaint old city with the magazines of war, but the most impregnable fortress raised by the confederation in Alsace is the great university, to which many of the wisest and most learned men of the empire have been called, and the intelligent citizen who is still French in his patriotism, will tell you that his city has more cause of self-congratulation

\* An address delivered at the Opening of the New Building of the Biological Department, University of Toronto.

tion than it had before '72, and he will point with pride to the stately university buildings which are but the outward manifestation of the genius and intellect which labor within.

Now, good neighbors of Ontario, I am happy to be with you, and do rejoice with you in this dedication of these handsome and well-equipped rooms to the holy cause of science. I can assure you that the ability and learning of the director of this department, Prof Wright, are well-known and highly appreciated by his co-laborers in the United States, and many of us have long regretted that you have not earlier supplied him with improved facilities for his work.

Let us briefly inquire into some of the scientific problems, the solution of which will demand the time, attention, and energy of this department. A simple enumeration of all these questions would require more time than I have at my disposal; therefore, I will dwell only upon those in which I am most interested.

All living things consist of individual parts, which the histologist calls cells. Some of the lowest forms of life are simple, free cells, and we say that they are unicellular. This simple cell must perform all the vital functions. It must digest, absorb, and excrete. Its range of function is necessarily limited. As we ascend the scale of organized life, we find a multiplication and differentiation of cells. In man certain cells have for their sole function the elaboration of the digestive juices, others are employed in the separation of effete and poisonous matters from the blood and their elimination from the system; some are devoted exclusively to the reception of impressions from the external world, some convey these impressions to the central nervous system, and others are more directly concerned in the intellectual processes. Health is maintained by the proper and correlated activity of these various groups of cells.

Within the past 15 years it has been clearly demonstrated that the introduction of some of the lower forms of vegetable life, called bacteria, into the body of man and other animals produces disease. The study of these micro-organisms has brought into existence and developed the science of bacteriology. A large amount of information has already been accumulated in this field of scientific work, and in the art of the

preservation of health, hygiene, and the art of restoration to health, medicine has made valuable practical applications of these scientific facts. One of the objects of these laboratories and lecture-rooms is to make the young student acquainted with what is already known in the science of bacteriology. But there are many problems in bacteriology which remain unsolved, and to this your most earnest attention will be given.

The study of bacteriology, so far, has been nearly altogether morphological. I say this in no spirit of criticism. Indeed, I recognize the fact that it could not have been otherwise. The study of form naturally and necessarily precedes the study of functions. The ornithologist, on finding a new species of bird, first studies its size, its general formation, the colour of its plumage, the shape of its beak, the spread of its wing, etc. It is only later, and after more extensive observation, that he can tell you about its habits, how it builds its nest, what it feeds on, what birds are its enemies, etc. And it would probably require still more extensive observation before he can tell you what effect altered environments would have on the bird, whether or not it would thrive in a different climate, with only unaccustomed food to feed upon, and with new foes to encounter. Therefore, I repeat that I am not offering a criticism when I state that the study of bacteriology has been largely morphological. But I am sure that all will agree with me that these enemies to man's health and happiness, for such we can pronounce the pathogenic germs, should be studied from every possible standpoint. Suppose that we knew nothing about the yeast plant save its morphology, the size and method of development of the cells, we would know but little. The fact that yeast produces carbonic acid gas and alcohol is certainly equally important with a knowledge of its morphology.

The chemical study of bacteria offers a fruitful field for the investigator. What chemical alterations do they cause in the various media in which they grow? What fermentations do they induce? Why is it that altered environment so materially affects the virulence of some of them? Why is it that the bacillus of anthrax is so invariably fatal with certain animals, while others are wholly immune against the

same germ? The theory of the action of phagocytes would at best be only a partial explanation of some of these questions. Granting that an army of these, the natural defenders of the domain of the body, turn out to do battle with the invader, with what weapons do they fight? If they digest the bacillus, what digestive ferment do they form? How do they destroy those germs which are found lying dead in the intercellular spaces in a case of anthrax in a man?

There are two factors which enter into the causation of infectious disease. First, there must be susceptibility in certain cells of the body; secondly, the inciting cause is the specific micro-organism. Indeed, we might say that the primary cause lies in the tissue itself. Then there is the ever interesting subject of immunity against disease secured by the use of sterilized culture of the various specific micro-organisms. Is such immunity, which has already been obtained in a number of diseases, due to a true vaccination, or is it simply due to the establishment of a tolerance for a poison? How long will the immunity thus secured continue?

But I must not dwell too long on a single word. Should this laboratory be the means of solving a single one of the problems which I have mentioned, the money, time, and energy given to it will have been profitably applied, but there are other questions which will take up a large share of the time spent by professors and students within these walls.

The study of food and drink by the bacteriologist has only been begun. In many of the infectious diseases the specific poison finds its way into the body through the mouth. We are told by those who have investigated the subject that the chief source of infection with cholera in India is by means of the drinking water. The water is collected during the rainy season in tanks. These tanks not only serve the inhabitants for water-supply, but are also used as laundry and bath tubs. We are shocked at these statements, but how many cities in America discharge their sewerage into bodies of water from which they or neighboring cities take their drinking water supply? More than 500 people die annually in Ontario from typhoid fever, more than 5,000 are sick during the same time, and it is certain that the majority of these

receive the poison which causes the disease with the water which they drink?

The probability of seriously affecting the health by eating food which has partially undergone putrefactive changes multiplies every year with the increased consumption of canned and otherwise preserved food.

But I must conclude, and in doing so, let me say that no one need fear that too much time will be given to theoretical or abstract science.

Every important scientific discovery in the past has sooner or later found its practical application, and always to the benefit of man. What could have been more unpromising of practical results than the discovery of micro-organisms in the blood of an animal sick with anthrax by Pollemler in 1849. When this observer reported that he had seen minute forms of life in the blood, some said that the objects which he had seen were bits of fibrine, others that they were not real at all but due to defects in the glass, while still others hinted very strongly that the defects were to be found in the observer's brain; but truth prevailed, and from that observation or discovery as a starting point, the science of bacteriology has been developed to its present importance, and by virtue of the facts forming this science the spread of infectious diseases has been limited as it could not have been done in the past. It was owing to knowledge founded upon that discovery that Asiatic cholera was arrested in New York harbor in 1838, and prevented from spreading through the United States and Canada.

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## Selections.

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### THE SURGERY OF THE KIDNEY.

The Harveian lectures by Mr. J. Knowsley Thornton, M.C., on the Surgery of the Kidneys, have recently been published. The method of treating most of the surgical diseases of the kidney by abdominal section, rather than by the lumbar methods, is advocated.

Floating kidney is essentially a congenital condition, the kidney having a true mesentery, so that it becomes practically an intra-peritoneal organ. Mr. Thornton states that its chief surgical importance lies in the fact that it may be altogether impossible to reach it by lumbar incision.

Of movable kidney there are several varieties, and a deficiency in the adipose tissue is the chief predisposing cause. The kidney in both these conditions is usually abnormally sensitive, and hydronephrosis may be produced, or torsion of the ureters or vessels may cause uraemia. In treating these cases great comfort is often derived from using a specially constructed truss; others derive more benefit from a simple spinal elastic bandage, or from a half moon-shaped pad worn inside an ordinary abdominal belt. In extreme cases nephrorrhaphy may be performed from the loin, and the kidney may be fixed as recommended by A. Pearce Gould, by kangaroo tendon sutures, which may be left in permanently. Nephrectomy for simple mobile or floating kidney is quite unjustifiable.

Hydronephrosis is a distension of the kidney with its own secretion from some obstruction to the escape of urine. The obstruction may occur at any point between the ureter and the meatus urinarius; it is not common in the ureter. Many cases are congenital, the ureter being abnormal in structure or in anatomical relation to the kidney; in other cases it is an acquired condition. It may affect the whole kidney or only some part of it, and the fluid in an advanced stage frequently contains neither urea or uric acid, but is watery with a little salt and a trace of albumin, later it may contain blood or become pyoid, producing one variety of pyonephrosis. The most certain symptom is the presence of tumor, which occasionally disappears, the disappearance being accompanied with increased flow of urine. Careful aseptic puncture far back in the loin is in many cases the only certain means of diagnosis. Puncture has been tried for treatment, but there is no good evidence that cures are often effected by it. If relief follow puncture then it may be repeated from time to time; but if the fluid rapidly reaccumulates some more radical operation must be undertaken. Mr. Thornton has completely failed in two cases with incision and drainage, and he believes that nephrectomy is the proper treatment in all cases which do not improve after one or two tappings.

Pyonephrosis is a condition in which we have distension of the kidney with purulent urine or pus alone; it commonly results from suppuration in an old pyonephrosis; it may follow calculus

and careless catheterism. It must not be forgotten, however, that the kidneys are the great excretors of septic organisms; hence suppuration may occur in them without direct external agency. The inflammation and suppuration may extend not only through the secreting structure but into the surrounding adipose tissue, and thus add greatly to the difficulties to be encountered in giving surgical relief. The symptoms are those common to all suppurations, together with the appearance of pus in the urine, and to these may be added at any moment the symptoms of septicæmia or of uraemia. The treatment will vary according to the cause and extent of the pyonephrosis. Simple pyonephrosis resulting from injury, from the transformation of hydronephrosis, from the earlier stages of tubercle and scrofula, and from the presence of calculus, may all be successfully treated by incision and drainage, combined in the latter variety with the removal of the stone.

Pyelonephritis is an inflammatory suppuration involving the whole kidney and is the result of some disease of the pelvic urinary organs, and is commonly known as "surgical kidney." It nearly always involves both kidneys and is not susceptible of surgical relief. Renal abscess is a collection of matter in the tissue of the kidney arising from injury, calculus, spread of inflammation from neighboring parts, or from the administration of some drug specially obnoxious to the kidney. It is usually unilateral, the symptoms being those of renal pain and possibly tumor. If physical signs be obscure, puncture may be employed, to be followed by lumbar incision and drainage when the exact situation of the abscess is made out. Perinephritic abscess is a collection of matter in the tissues immediately surrounding the kidney; it is very often diffuse, spreading in the subperitoneal fatty tissue and the sheaths of the abdominal and retro-peritoneal muscles. The treatment is free incision and drainage.

Gravel and calculus are the most common causes of all the diseases we have been considering, but although they are usually the cause, they may be in some instances the effect, being induced by the retention of urine too long in the kidney, as in movable kidney and hydronephrosis, which results from some abnormality in the ureter. Renal calculus is most common in

the young and after fifty years of age, urate of ammonium and uric acid being, according to Taylor, the most common nuclei in the respective periods. The oxalate or mulberry calculus, though not so common, is undoubtedly the one which causes the most severe symptoms and sufferings. All the varieties of renal calculus are susceptible of surgical cure by incision and removal.

The most common and important symptoms are pain in the loins and back, often shooting down the ureter into the testicle in the male, and into the ovary in the female, and into the hips, thigh and knee, aggravated by motion, especially if it be of a rough or jolting kind; hæmorrhage, which is especially liable to follow such rough movements, the urine when passed being either smoky, bright red, or coffee-colored; and the presence in the urine of crystals, or of small fragments of the calculus. In more advanced cases the presence of pus in the urine with irritability of the bladder, especially at its neck just after the act of micturition, are common. To these local symptoms must be added a number of reflex phenomena, especially disturbances of the digestive organs, indigestion, nausea, retching, vomiting, and flatulence. The latter being often markedly troublesome in the colon on the affected side, sometimes amounting to actual intestinal colic, is in the experience of Mr. Thornton, one of the most common and early symptoms in the majority of cases, and is one which is very apt to be overlooked and misunderstood. This intestinal colic frequently precedes and is apt to mask the true renal colic caused by the passage or attempted passage of a calculus down the ureter. It must be borne in mind, however, that most of these symptoms may be present in a case in which no stone can be found, and they may be markedly and constantly referred to one side whilst the stone is in the kidney on the opposite side—a sympathetic transference of pain from a diseased organ to its fellow, which Mr. Thornton had frequently observed in the ovary before he had any experience in renal surgery. It is not uncommon for the stone to become fixed in the ureter just at its entrance into the bladder: in one such case in which the kidney had become pyonephrotic and disorganized, Mr. Thornton removed it and left the stone, with a perfectly successful result.

Calculus suppression of urine can arise from the blocking of one ureter, the opposite kidney and ureter being quite healthy. If one ureter be blocked and the kidney on that side enlarged, temporary relief may be obtained by puncture in the loin, but if there be any doubt as to which is affected, the only proper course is immediate abdominal section by Langenbüch's incision, through which both kidneys can be explored, and the further surgical procedure found necessary can be aided. The stone, if found in this way, should not be extracted through the peritoneum, but through a counter opening made in the loin; or if it be close above the bladder, suprapubic lithotomy should be done, and the stone extracted in that way. For the certain detection and removal of a renal calculus, Mr. Thornton prefers to open the abdomen by Langenbüch's incision over the suspected kidney, having examined carefully both kidneys and ureters, and having found a stone, he employs one hand in the peritoneum to fix the kidney and stone and to guard the colon, while with the other he cuts down upon the stone directly in the loin, merely making an opening through the loin tissues large enough to introduce the finger and the necessary forceps for the extraction of the stone.

The loin incision does not interfere with the peritoneum and no wound is made on the peritoneal surface of the kidney; it is much smaller than the ordinary lumbar incision, requires no sutures, does not leave a weak place in the loin with the chance of hernia, and it admits the necessary drainage tube through a small channel without risk of extravasation of urine into the tissues around the kidney, or the troubles of secondary suppuration. Another advantage in the combined operation is that we make sure the patient has the usual allowance of kidneys; there is the advantage of being able to ascertain the condition of both kidneys and of both ureters. Mr. Thornton holds that the increased risk, due to opening of the peritoneum is practically *nil*, provided the surgeon will take pains to perform a thoroughly aseptic operation. When the operator is convinced that no stone remains, the kidney should be well flushed out with warm 1-2000 corrosive sublimate lotion. One or more drains are then introduced up to the kidney but not into its interior, and a few inter-

rupted points of suture and a large absorbent antiseptic dressing complete the operation.

Mr. Thornton then briefly describes the pathology and treatment of simple and hydatid cysts of the kidney, and discusses the clinical history and results of treatment in so-called scrofulous and tubercular kidneys; he asks, "Is it not possible that there are cases in which the lining membrane of the pelvis of the kidney, a part specially exposed to irritations likely to produce pathological change, may be primarily and for a time solely attacked?" Bearing in mind the results of incision and drainage in some cases of peritoneal tubercle, a similar treatment may be able in this instance also to arrest the disease whilst still local. In cases in which it is advisable to employ puncture, never under any circumstances use for the purpose that "surgical abomination," a grooved needle, for it will allow infiltration or infection of all the tissues through which it brings the fluid. Always use a thoroughly aseptic trocar and cannula with Listerian precautions, not forgetting the now too often discarded spray.

Mr. Thornton is one of the few who remain faithful to the spray after even Lister himself has abandoned its use. The spray keeps a moist antiseptic atmosphere over everything, and thus renders the use of sponges more efficient in thorough and rapid cleansing of the wound and its surroundings than is possible if the same parts are dry, and the germs of infection are delivered over to the tissues weakened by being soaked in a strong antiseptic, which though perhaps not killing them, renders them a much easier prey to the active leucocytes. Mr. Thornton summarizes in his paper the indications for and the method of carrying out various surgical procedures for the relief or cure of renal disease; he emphasises the necessity for the employment of every protection that antiseptics can give.

Mr. Thornton would restrict the use of puncture as follows:

1. To decide in doubtful cases between solid and fluid tumors of the kidney.
2. To relieve painful distension when nephrotomy for some special reason is not at once advisable or possible.
3. To remove urine, or serum, or pus from a very large tumor, to reduce its bulk during the performance of nephrectomy.
4. As a tentative attempt at cure in some cases of simple cysts

or of hydronephrosis, though the chance of cure is very slight.

5. To localize the position of renal or circum-renal abscess when the physical signs are not clear enough for free incision. In such cases to be immediately followed by free incision when the pus is found.
6. To gain time and relieve the harmful tension in some cases of calculous suppression.

He would restrict the use of nephrotomy:

1. To cases of calculous suppression in which incision seems preferable to mere puncture with the chance of being also able to remove the stone, *i.e.*, if further experience shows that this is a safer and better operation than my combined method.
2. For the cure, by subsequent drainage, of simple cysts, abscesses and hydatids; the question of possible cure in some cases of hydronephrosis to be further tested.
3. For the cure, by subsequent drainage, of traumatic pyonephrosis or pyelitis and in the early stages of tubercular suppuration.
4. For the possible cure of more advanced calculous or tubercular suppurations when the patient will not submit to nephrectomy.
5. For the performance of nephrolithotomy in some cases, if extended experience shows that this procedure possesses any advantages over the combined method or when those who have no experience in abdominal surgery are compelled to operate.

#### FOODS FOR INVALIDS.

In a discussion on Foods for Invalids at the last meeting of the British Medical Association, Dr. Burney Yeo spoke as follows:

We feed fevers, and we are undoubtedly right in so doing. Bauer and Künstle appear to have established, by careful observations on the diet of typhoid patients, the fact that a due "supply of albuminous food to a fever patient" effects a saving of albumen in the body, "for though the excretion of nitrogen is increased, the loss of the same element from the system is reduced." But do we not sometimes overfeed fevers, and use less discrimination than is desirable in the kinds of food we administer?

It has appeared to me that we may formulate two chief rules which should guide us in the feeding of cases of acute disease:

1. Endeavor to utilize food to the greatest extent that is safe and possible for the purpose of checking the

waste of tissue which is associated with the febrile process. 2. Be careful to administer no food that cannot be readily absorbed and assimilated. Do not overlook the fact that the functions of the digestive organs are gravely impaired during fever, and, therefore, if we give food which the patient is unable to assimilate, this undigested food will decompose in the stomach and intestines, and cause much local irritation and augment the pyrexial movement.

I have been accustomed to teach, and I submit that teaching to your criticism, that in acute and short typical febrile attacks, such, for instance, as one of acute croupous pneumonia of average severity and running an average course, we should not manifest any anxiety as to the taking of much food, unless in the aged and feeble, for in forcing the consumption of a considerable quantity of food in such cases, in the absence of all appetite, and with obvious febrile derangement of the digestive organs, we do more harm than good.

There is a general consent amongst all authorities that, owing to the interruption of normal gastric digestion in fever, all food should be given in the fluid form, that is, in a form that can be readily and immediately absorbed, that it should be given in small quantities and at short intervals. The two kinds of fluid food most commonly used in cases of acute disease are, first, milk, and secondly, beef-tea, and under the latter denomination I would ask to be allowed to include all fluid meat extracts, broths, soups, meat juices, etc. The consideration of both these forms of food will probably yield some suitable topics for discussion.

The very great convenience of milk as a food has, I think, acted, in a certain sense, as a snare, for there is a tendency, especially with nurses, to think no evil of that which is so handy, requires no preparation, and gives so little trouble. But the great drawback to the use of milk in acute disease is in the fact that, although a fluid food out of the body, it becomes a solid food in the stomach or intestine. No doubt it is an excellent food in all cases in which it is well tolerated and quickly digested and absorbed, but there are many cases in which this is not so, and when these happen to be cases of typhoid fever very serious injury may be done the patient if this peculiarity is not observed. I have seen

several cases of typhoid in which the administration of milk has not appeared to cause any gastric disturbances, but yet has produced great intestinal irritation, and the motions have been largely composed of firm milk curd. One of the reasons why milk so frequently disagrees with patients is that it is given in too concentrated a form and in too great quantity.

Sir Henry Thompson has called attention to the absurd custom, now so prevalent, of using milk as if it were a simple beverage, and to drink it like water, with quantities of solid meat and other food. Why should we hesitate to dilute the milk we give to fever patients? They require water, pure water, in much larger quantity than they usually get, and yet we hesitate to mix water with the milk we give them. Their digestive powers are excessively feeble, and yet we will give them concentrated foods! When we wish to rely on milk as a food in acute disease we should give it in small quantities at a time at short intervals, mixed with water, or, better, with an alkaline water, such as Vichy or Apollinaris. I am accustomed in hospital practice to prescribe powders, each containing twenty grains of bicarbonate of soda and twenty grains of common salt, and to direct that one such powder should be added to every pint of milk, and this is to be diluted when administered, with an equal quantity of water. Two ounces of milk and two ounces of an alkaline water every hour (and a fever patient requires a drink every hour) will give the patient two pints and a half of milk a day. I am, of course, thinking of cases in which the digestion of milk is difficult.

Greater use ought also to be made of whey in those cases in which milk is not digested readily. I have often used it in private practice and in hospital with great advantage. It can be prepared in a pleasant form by boiling a pint of milk with two or three teaspoonfuls of lemon-juice and a few fragments of lemon-peel for the sake of flavour; if the curd be well-broken up, then strained through muslin, and all the fluid pressed well out of the curd, much of the cream and some of the finely-coagulated casein will pass into the whey, which will thus become a fairly nutritive fluid. If necessary, it can be made more nutritious by the addition of meat juice. Or if an egg be whipped up with twice as much boiling water, added slowly, and then

strained, a fluid will be obtained holding in suspension a considerable quantity of albumen coagulated in fine particles, and this may be added to whey (or to beef-tea), thus supplying the defective albuminate.

I must not dwell longer, however, on milk. I merely make these suggestions with the view of eliciting further observations. I will ask you at the same time to consider the use of "butter-milk" as an invalid food, not so largely used in this country as in Germany, but calculated, I believe, to be of service in many cases of gastric difficulty. It is highly acid from the presence of lactic acid, and it contains the casein of milk in a very finely divided form. I have known dyspeptic patients live upon it in comfort for considerable periods at a time, taking only a little thin water biscuit besides.

Another form of fluid food very extensively used in cases of acute disease is "beef-tea;" this term is usually applied to very strong extracts of beef, and this fluid is generally estimated in exact proportion to its concentration. Why, I have never been quite able to understand. As I have already said, a patient with pyrexia requires and should be given much water; why not give him some of that water with his beef extract? The intense dislike of beef-tea which many patients manifest is especially directed to this very concentrated form. It is mere slavery to routine—mere want of resource—that has perpetuated the invalid's sad restriction to milk and beef-tea. Conceive the dread monotony of a six or seven weeks' limitation to these two articles of diet. Now, there are many forms of meat infusion or meat extracts that can be rendered very palatable by suitable care in preparation, infinitely better adapted to serve as foods in pyrexial cases than strong beef-tea. Well-made mutton, veal, and chicken broths, to which some well-strained oatmeal or barley gruel can be occasionally added, make excellent invalid foods. They contain in a dilute form the same constituents, and, with the additions I have named, even more nutritive alimentary principles than beef-tea. But clear soups—*consommés*—are exceedingly agreeable, readily absorbable, and stimulating foods, and they usually contain some vegetable juices and salts which greatly add to their food value.

Sir William Jenner some time ago directed

the attention of the profession to the remarkable oversight so frequently practised in the feeding of cases of fever, of the omission of vegetable juices from their dietary. It is quite easy to obtain the juice of fresh boiled vegetables and savoury herbs, and to add to these clear animal soups. "Fruit soups" are used in Germany, and are made by boiling fresh or dried fruits with water, expressing the juice and straining.

I am not one of those who think ill of beef-tea as an invalid food, but I object to making either beef-tea or milk the universal invalid food and I see no reason why we should desire to use such very concentrated beef-teas, when we know that fever patients need so much water. I regard beef-tea as an excellent stimulant and restorative as it contains very little, if any, albuminates in solution. But it contains gelatin which is very readily digested, and appears to serve as an "albumen-sparing" food in the body, as well as saline and stimulating extracts.

I was greatly surprised a short time ago on being told by a hospital sister, that in the hospital she nursed in they were forbidden to put any salt into the food of the typhoid patients. Surely this was a very unwise regulation. If chloride of sodium is so important in health, may it not be quite as important in disease?—*Brit. Med. Journal.*

## CURES; SCHEMATA OF TREATMENT; AND THERAPEUTICS IN GENERAL.

### No. 1.—*The local treatment of Psoriasis.*

My favorite prescription for psoriasis is the following—

R—Acid., Chrysophanic,	gr. x.
Liq., Carbonis Deterg.	(Wright's) m x.
Hydr., Amm.-Chlorid,	gr. x.
Adip., Benzoat.,	ʒj.
Misce fiat unguent.	

The patient is instructed to remove all scales as much as possible, either by washing or a warm bath, and then to spend half-an-hour (before a fire if the room be cold) in rubbing this ointment into all patches. It is better to leave the ointment on all night, but if this is, for any reason, too disagreeable, it may be wiped off (not washed). In the morning a bath with soap is taken. In most cases I prescribe arsenic, along with the local treatment, as helping the cure, and

tending to make it more permanent, but I rely chiefly on the ointment, and sometimes use it alone. I have published a portrait, in which it was used on one side of the body only, while arsenic was given internally, the result being the disappearance of the eruption on the parts treated locally, whilst it still persisted on the others. This experiment was conclusive. It will be observed that the quantity of chrysophanic acid is but small, and I may say that I often prescribe a yet weaker ointment. Strong ointments both irritate and stain much more, and not unfrequently the patients naturally refuse to continue them. With this ointment there is but little risk of inconvenience, and patients rarely complain much of the staining, especially if they are allowed after a prolonged inunction to rub it off at once. This formula has been for many years in constant use at the Blackfriars' Hospital for Skin Diseases, and gives great satisfaction. I believe that the tar solution often has a material effect in preventing staining. As years go on I find that I prescribe arsenic with increasing caution, and rely more and more upon local treatment of the kind indicated.

As an illustration I will quote the experience of one of the last psoriasis patients whom I have seen. Mrs. A— consulted me in June, 1888, for common psoriasis, from which she had suffered for twelve years, and for which she had had much specialists' treatment. I ordered arsenic and the ointment above mentioned. I did not see Mrs. A— again for ten months. She then came to report that the ointment was so effectual that she had long ago left off the mixture. Her experience was that two weeks of the ointment always removed the patches, and that after a six weeks' interval they would usually begin to threaten again. At the time of her visit her skin was absolutely free. The ointment she said always left her skin brown, and it took a week or more for the discoloration to wear off. Then followed a month of a perfectly clean skin, and then a few spots would again show themselves. Thus she could always keep the eruption in check, though it was never permanently cured. This, I fear, is almost as much as we can expect in most cases of psoriasis. With perseverance, however, the relapses become more and more slight, and the intervals

longer, so that in the end the disease is virtually cured. The reverse is the fact if psoriasis is neglected.

No 2.—*Simulation of Hodgkin's Disease in Syphilis (?) Immense glandular tumours removed under Iodides. Does a cure by specifics prove specific nature?*

I find in Dr. Mc'Call Anderson's interesting brochure, just published, on "Syphilitic Affections of the Nervous System," a very noteworthy example of the cure of an immense glandular tumour by iodide of potassium. Not only is the case important as an instance of recovery from a very formidable complaint, but because it raises the question as to how far we are justified in regarding recovery under the iodide as proof of the syphilitic nature of any malady so cured. The case was one which was at first considered to be Hodgkin's disease, the patient, a man of thirty-five, apparently in "perfect health," having enlarged glands in both sides of his neck. The tumour on the right side is described as "enormous," and as having first commenced two years ago behind the ear. Not only were the cervical glands enlarged, but those also in the axillæ and inguinal regions. On the right side the tumour extended from the middle of the neck to several inches below the nipple, and measured fourteen inches in length, and ten in width. It was crossed by enlarged veins, and at parts the skin was reddened. The patient had been accustomed to laborious work, and had drunk freely; he was, notwithstanding, "well nourished."

In the belief that the disease might be syphilitic, iodide of potassium in large and increasing doses was ordered, and the man was advised to abstain from all labour. The salt was commenced in doses of ten grains, and increased to thirty three times a day. It was begun on the 29th of January, and the improvement was almost immediate. On the 12th of July, Dr. Hugh Cunningham, of Dumfries, who was in charge of the patient, wrote, "You will be glad to hear that the tumours have almost entirely disappeared, scarcely a vestige of any of them now exists."

We have, then, in this case, a clear and definite instance of recovery from a general tendency to enlargement of the lymphatic glands, under the use of the iodide of

potassium. Does the cure by this remedy prove that the disease was syphilitic? I cannot think that it does. I have never seen enlargement of lymphatic glands advancing to the condition described in this case in connection with syphilis; and further, the evidence of the man having had syphilis at all is very slight. The case is, in all its features, a typical one of lymphadenoma; in other words, of general infective enlargement of lymphatic glands without tubercle. We must remember that iodide of potassium and iodine gained repute in the first instance as remedies for enlargements of glands. It was only after their credit had been well established for this disease, and for bronchocele, that they came to be employed for syphilis. In making these remarks, I by no means wish to be considered as expressing an opinion that the disease in question was not syphilitic. I merely raise the doubt, and demure to the doctrine that the mode of cure proves the nature of the disease. Whatever the latter may have been, the fact of the cure is of great interest, for we are not accustomed to see any form of lymphadenoma yield so quickly and definitely to treatment. More usually this malady resists all our remedies.

No. 3.—*Arsenic as a cause of Herpes Zoster and of Dull Eyes.*

I prescribed arsenic, in very full doses, for Mrs. H——, in order to cure psoriasis of the nails. It was effectual; and she took it regularly for several months. In March, 1888, she reported to me that about the previous Christmas she had suffered a most severe attack of shingle on the right side of her chest. Her surgeon, in Yorkshire, where she was, had told her that he had never seen a case with so much inflammation. Fortunately for me he had not suggested to her any suspicion as to its having been caused by the medicine. The latter was, however, discontinued, as Mrs. H—— was suffering from a

In this case, my patient was strongly of opinion that the arsenic did not improve her personal appearance. She was greatly distressed by the state of her nails, and willing to do anything for their cure, but she thought that the arsenic made the whites of her eyes look thick and a little yellow. The blue of the sclerotic, which in her showed through, did not do so as

much as usual. A friend who lived with her had assured her that the medicine made her eyes look dull, and that the blue iris became more grey. I could myself somewhat confirm this impression, for Mrs. H—— certainly looked older, and had a less brilliant complexion than formerly. She was naturally fair and florid. The nails, which had got well when the drug was pushed, had somewhat relapsed during the two months during which it had been left off. The arsenic had not disagreed in any other way.

By several observers cases have been published in proof that in some obscure manner the skin may be made muddy and dull by the medicinal use of arsenic. I have myself given an extreme illustration of this in the *Pathological Transactions for 1888*. In this instance the skin became earthy and brown, and in some places took on the conditions of psoriasis. Pricking of the eyes and redness of the conjunctiva are also well-known results. The patient whose case I have given above is, however, the first who has complained of objective dulness of the eyes. She was an acute observer, and so was her companion, and I have no doubt they were right. It is quite certain that arsenic does affect the nutrition of all the tissues and produce changes, it may be very minute at first, concerning the precise nature of which it is difficult to give any explanation. In arsenical herpes zoster we have a definite form of peripheral neuritis, but it is far from being the only disturbance of nutrition which we witness in connection with the use of this powerful drug.—*Archives of Surgery.*

## TWO CASES OF RUPTURE OF THE OESOPHAGUS.

Formad:—

*Case I.*—J. B., white, male, aged 59, labourer. He, with others, had partaken of a hearty meal at 12 o'clock. Shortly afterwards all were taken ill, and all vomited except him. He was treated for intestinal colic. At 7 the suffering had become greatly intensified. The pain was griping, burning, and tearing in character, and situated in the epigastric region. Pulse rapid and weak. Temperature 98°, dyspnœa extreme, great thirst, countenance

cyanotic and pinched, nausea most intense, efforts at relief being frequently made by thrusting the fingers down the throat. This *singular condition* existed, viz., external emphysema under the right eye, over whole of left cheek, and down the neck to three inches below the clavicle. This rapidly spread, till both sides became equally involved. It was being apparently produced by the attempts to vomit. These efforts continuing, mustard was given by the mouth and apomorphine hypodermically. Fifteen minutes before death, the patient being unconscious, a stomach tube was introduced with the greatest care and delicacy. It met with no obstruction, and three-fourths of a pint of half digested food was removed. At 9-20 death took place.

*Autopsy.*—Body medium in size and lean. No external marks except prominent emphysema and congestion of subcutaneous tissue of neck. Left *pleural* sac filled with fluid, containing the contents of the stomach; right, empty. *Pericardium*, normal. *Heart*, hypertrophied. No valvular disease; no atheroma. *Lungs*—left, much congested, collapsed; right, oedematous. *Œsophagus*—on dissection a rupture was seen in the lower part of its left side, immediately above the cardiac end of the stomach, and just above the border line where the squamous covering of the mucous membrane of the *œsophagus* fades into the stomach. The tear, before its removal, was about one half-inch in length and longitudinal, and as the dissection had been performed most carefully, there was no reason to doubt that it was a rupture. The mucous and other coats, normal. No evidence of stricture or ulceration. *Diaphragm* perfectly intact. *Stomach*—mucous membrane was mammilated and thickened; a few ecchymoses, caused by the strain in vomiting. Rest of organs normal.

*Case 2.*—J. P., German, male, aged 36, baker. Intemperate. Never sick and never had missed a day's work in his life. While at work he was suddenly seized with dyspnoea, colic in epigastrium, swelling of the neck, and hæmatemesis. Unable to move, and enormous emphysema of neck and upper part of chest. The dyspnoea and pain increased greatly, and death took place in a few hours.

*Autopsy.*—Body of medium size, muscular,

fat. Emphysema of neck and chest very marked. *Thorax*—left pleural cavity full of liquid which had induced complete atelectasis of left lung. Fluid contained contents of stomach. Right cavity contained little fluid, and the lung was highly distended, congested, and oedematous. *Pericardium and heart* normal. Diastolic arrest, showing all the chambers filled with red clots.

The *œsophagus* showed a tear anteriorly, just above the cardiac end of the stomach. It was about two inches long and in the long axis of the tube. Edges clean cut, but there was no doubt that it was a rupture, because the contents of the stomach were seen in the pleural cavity before anything else was disturbed. T. W. BUTCHER, in *Phil. Univ. Med. Mag.*

#### NOTES ON HERNIA IN INFANTS AND YOUNG CHILDREN.

Miller:—

In very young children there are two principal forms of abdominal hernia, the *umbilical* and the *inguinal*. The former is the most feared by mothers, and the excessive care taken to prevent it is sometimes a cause of the *inguinal* variety. In addition to the commonly recognised causes of umbilical hernia, mention is made of a practice some nurses have of rubbing the scar left by the newly fallen cord, in the idea that by so doing they are strengthening the part. The author holds that closing of the orifice is thus delayed, and that as it brings about violent fits of crying, a hernia may readily form there. Then as to inguinal hernia, he attempts to prove that it is often produced by anxious mothers binding the abdomen very tightly, to prevent the umbilical form. For as this will necessarily interfere with the respiratory function, and disturb the action of the bowels by the compression, the child will be constantly crying, and will suffer from constipation, and irritative diarrhoea, thus causing much straining. As regards treatment Dr. Miller recommends for the umbilical form a modification of the ordinary pad and bandage; its essential points being, that it is as firm as can be worn with comfort, sufficiently large to protect well the borders of the orifice, and at the same time not so much so as to penetrate within the rings, and thereby prevent their

closure. He takes an old-fashioned button mould, and covers it thickly with soft muslin. This is then sewed firmly to three strips of plaster, each 6in. to 8in. long and  $\frac{1}{2}$ in. wide, about equidistant from the ends. It can be worn for a few days, then changed slightly in position to prevent irritation, and then back again, thus allowing its continued use, even in very fleshy children, over a long period. The method advocated for inguinal hernia is the one brought forward by Mr. Pye—*i.e.*, by means of a skein of worsted, one end of which is placed over the ring, the rest being passed horizontally across the abdomen, over the line of the crest of the pelvis, to the opposite side, around the hips, behind the pelvis, and over the hip on the side of the hernia. The end is then passed through the loop of the skein, and will here form a knot, the bulging portion of which must be carefully adjusted so as to be against the hernial opening, and, being carried down to the upper part of the thigh, it is then brought around the external side near to the great trochanter, and there tied or fastened with a safety pin.—T. W. BUTCHER, *New Orleans Surg. and Med. Journal.*

EXTIRPATION OF THE PANCREAS AND DIABETES.—At a recent meeting of the Société des Sciences Médicales, of Lyons, M. Lépine presented four anatomical specimens from dogs from which he had removed the pancreas. In the first case when the operation failed, there was peritonitis from perforation caused by gangrene of the duodenum. The second dog presented no glycosuria during all the time it survived; but at the autopsy it was found that part of the pancreas, perhaps six grammes of the gland, remained. This fragment had no connection with the duodenum. This dog which had no glycosuria, had, according to the analysis of M. Barral, hyperglycæmia, about two grammes of sugar per kilogramme of blood. The third dog presented no glycosuria for the first three days; then after it had been given some soup, there appeared suddenly five grammes of sugar per litre of urine. Two hundred grammes of glucose having been administered, fifty grammes of sugar per litre of urine were found the next day, and this intense glycosuria persisted until the death of the animal. At the autopsy only two grammes

of pancreas were found in place. The fourth dog survived twelve days; and during this whole period it passed from forty to eighty grammes of sugar daily. Examination of the blood by M. Barral showed an enormous hyperglycosuria, eight grammes of sugar per litre of arterial blood. M. Lépine called attention to the influence of antipyrin on dogs that had been made diabetic; antipyrin, in fact, diminished the sugar, as shown by the reduction of Febling's solution, and especially the polarimetric deviation. The dogs experimented on always had polydipsia. They did not seem to be in a condition to survive the operation very long; the last one was killed on the twelfth day, but it was dying.—*Lyon Medical, December, 1889.* G. A.

A POINT IN THE ETIOLOGY OF SUDDEN DEATH.—A note under this heading, and signed by the initials H.C., appeared in the *Lyon Medical* of December 1st, 1889, and is interesting in connection with the communication made to the Pathological Society of Toronto at a recent meeting by Prof. Welch, of Johns Hopkins University, a report of which is to be found in the *CANADIAN PRACTITIONER* of January 1st, 1890. The following is a translation: "The pathological anatomy of sudden death is far from having had its last word, and the expert, in spite of a careful autopsy, may sometimes fail in the discovery of lesions sufficiently evident to carry conviction. Thus every method for more precise investigation of such a subject ought to be welcome. We believe therefore that it will be of service to our readers to call attention to an important work published some time ago, but in two journals which are certainly not familiar to them—the *Nordisk Medicinsk Arkiv*, of Stockholm, and the *Vierteljahrsschrift für gerichtliche Medizin*, of Berlin. The author is Dr. Krey-Aberg, professor of legal medicine in the School of Stockholm. Dr. Krey-Aberg in this work has studied exclusively *chronic endarteritis as a cause of sudden death*. He has been enabled, thanks to material accumulated at the Medico-Legal Laboratory of Vienna, which was put at his disposal by Professor Hofmann, to make extensive inquiry on this point. Reports of 852 autopsies in cases of sudden death in subjects over fourteen years of age, between the 1st of June, 1881, and the 1st of June, 1886, have

been the basis of his researches. He has observed that in the enormous proportion of 74.5 per cent. death was caused by chronic deforming endarteritis, acting either directly, or by consecutive lesions; the direct causes of lesions; the direct causes of death were—paralysis of the heart in 52.7 per cent.; rupture of that organ in 1.7 per cent.; rupture of aneurism of the aorta, or of its immediate branches in 6.4 per cent.; rupture of the aorta in 1.9 per cent.; intra-cranial hæmorrhage, to which must be added a single case of embolism of the central arteries, in 11.3 per cent. Contrary to most general statistics of sudden deaths the maximum of frequency of these cases connected with a lesion of the circulatory apparatus is found between forty and forty-four years of age; the predominance of the male sex is very marked, especially for cases of cardiac paralysis associated with endarteritis without any other lesion. Tables have been drawn up showing all these points, as well as the seasons in which these deaths took place. For more simple details you are referred to the text of Memoire, and we draw attention here only to the last part of the work of our distinguished confrère, certainly the most original. It bears upon the roll which chronic endarteritis of the coronary arteries with stenosis of their aortic orifice plays in the pathogenesis of sudden death by arrest of the heart. In thirty-three cases examined by him from this view he recognized this influence in twenty-two. Finally he has related specially in detail thirteen autopsies in which he sought particularly for the relation of coronary arterio-sclerosis to alterations in the myocardium. The latter lesions were absent only in four cases; in all the others he noted softening and fatty degeneration rarely very extensive, more often limited, sometimes having its seat only in the papillary muscles, and having relation to the zone of vascular irrigation of a particular arterial twig. These anatomopathological results are obtained after minute search, but we do not think that the author has exaggerated their pathogenic importance. He has been able to apply them in several medico-legal cases where the autopsy otherwise would have been negative, among others, in the case of the sudden death of his regretted predecessor in the School of Stockholm, Jaderholm." G.A.

## Therapeutic Notes.

Prof. Bartholow recommends for habitual constipation, a few minims of wine of tobacco, taken at bedtime. It acts by increasing the secretion, and causing peristaltic action.—*Coll. and Clin. Record.*

TREATMENT OF NIGHT SWEATS OF PHTHISIS.—Rosenbach recommends the application of a bladder filled with ice over the abdomen for several hours during the night. This treatment is well borne by patients, and is more successful than treatment by atrophine and other agents.—*Lyon Médical.*

PILLS FOR COUGH.—N. Gueneau de Mussy.

R.—Picis liquidæ	gr. xxx.
Pulv. Ipecac. Co.	gr. xlv.
Pulv. Benzoni	q.s.

H. massa secundem artem, et divide in pil. No. xl.

Sig.—Two to six pills daily in cases of emphysema or chronic bronchitis, when the cough is frequent and rebellious.—*L'Union Médicale*, Nov., 1889.

TREATMENT OF PIGMENTED SPOTS OF PREGNANCY.—M. V. Monier advises the following ointment in the various pigmentations and chloasma of pregnant women:

R.—Ol. Theobrom	
Ol Ricini aa	3ij ss
Luici Onidi pur.	gr. v.
Precip. alb.	gr. ij.
Ol. Rosæ	g.s.
M. Ft. unguentum	

Sig.—To be applied night and morning.

—*Bulletin Médical.*

TREATMENT OF TYPHOID FEVER IN CHILDREN BY NAPHTHOL.—In imitation of the method employed by M. Ch. Bouchard in adults, one may, as M. Legroux has done, prescribe naphthol for young typhoid patients. This treatment is carried out as follows:

1. As soon as the disease is evident, prescribe a calomel purgative, 5-10 grains, to be taken in two doses.

2. Two days afterwards give naphthol alone,

or associated with salicylate of bismuth, or salicylate of magnesium.

If there is *moderate* diarrhoea, give every hour one of the following powders:

R.—Naphthol B gr. xxx.  
H.S.A. et. div. in pulv. No. x.

If the diarrhoea is *profuse*, give at intervals one of the following:

R.—Naphthol B  
Bismuthi Salicylatis aa gr. xxx.  
M. et. div. in pulv. No. x.

S.—The 10 powders to be taken in 24 hours.

3. If there is constipation, replace the salicylate of bismuth by salicylate of magnesium, and administer in the same way:

R.—Naphthol B  
Magnesii Salicylatis aa gr. xxx.  
M. et. div. in pulv. No. x.

—*Gaz. hebdomadaire de médecine et de chirurgie, Lyon Médical.*

TREATMENT OF DYSPEPSIA.—There are ptomaines which are formed in the stomach as the result of the fermentations which the food often undergoes; hence it is a therapeutic indication to prevent these fermentations, and destroy these toxic substances. This may be done by using saturated chloroform water, which is possessed of antiseptic properties, preparations of naphthol and salicylate of bismuth, according to this formula of Bouchard's:—

R.—Naphthol B. ʒiiss.  
Bismuthi Salicylatis ʒiii.  
M. et. div. in capsulis No. xxx.

Sig.—One capsule with each meal.

Here are two other formulæ which have been frequently employed:—

R.—Naphthol B.  
Bismuthi Salicylatis.  
Magnesiæ aa gr. lxxv.  
M. et. div. in capsulis No. xx.

Sig.—One capsule immediately before each meal.

Or

R.—Bismuth Salicylatis.  
Magnesii Salicylatis.  
Sodii Benzoatis aa gr. lxxv.  
M. et. div. in capsulis No. xx.

Sig.—One capsule immediately before each meal.—*Bull. Méd., Oct., et Lyon Méd., Nov., 1889.*

## THE Canadian Practitioner

A SEMI-MONTHLY REVIEW OF THE PROGRESS  
OF THE MEDICAL SCIENCES.

*Contributions of various descriptions are invited. We shall be glad to receive from our friends everywhere current medical news of general interest.*

*When a change of address occurs please promptly notify the Publishers, THE J. E. BRYANT COMPANY (Limited), 58 Bay Street.*

TORONTO, FEBRUARY 1, 1890.

### LODGE PRACTICE.

We have received a letter from a subscriber containing questions which we can scarcely answer without making some remarks on the subject of lodge practice. We consider it exceedingly unfortunate that such practice has become so common in many of the cities of Ontario, including Toronto. We must, however, admit that custom and usage have sanctioned it to such an extent as to make it reputable and respectable, and as a consequence there is no stigma attached to the character of a physician who does contract work. So general has this practice become that many of our young graduates are practically driven into it in self-defence, and in distinct opposition to their scruples and objections to it.

One of the worst features connected with it is that the doctor who "takes a lodge" becomes the servant of that lodge, and thereby must, to some extent at least, lose his independence. The system is radically wrong, and interferes with the principle that the surgeon or physician should be the sole judge of the number of visits he is required to make, should receive a proper remuneration for the work that he performs—no more, nor no less. Unfortunately in the practical working of the system some worse features frequently appear—such as "touting" for lodges, electioneering for positions in them, and sometimes actually under-bidding opposing candidates. There is certainly nothing very dignified in an election of this kind between two or more practitioners.

Apart from what may be said for or against the system we have no doubt that the general

tendency is to degrade the profession. The lodge doctor gets into a groove which as a rule effectually prevents him from reaching any eminence in his profession. Many whom we know have very soon recognized this fact after a short trial at the business; have given up lodge work as soon as possible.

Under the present existing circumstances, no matter how much we may deplore them, we have no desire to throw any stones at lodge doctors. We fully realize the peculiar conditions surrounding them, and think they have a perfect right to adopt a system which professional opinion has legalized from an ethical standpoint. We hope, at the same time, that before long a change in this respect will take place, and that physicians will unite in a strenuous effort to do away with lodge practice entirely.

Our correspondent has given us particulars of a case which we will epitomize as follows: Dr. A. is surgeon of a certain lodge; Dr. B. becomes a member of the same lodge, and is proposed as a candidate in opposition to Dr. A., at the regular annual election of the lodge, and is elected. We are asked if Dr. A. has any grievance against Dr. B. because of the election of the latter. Our answer is simply no. The members of the lodge must be considered the proper judges in such a case, and their decision should be universally accepted.

#### HOSPITAL CONSTRUCTION AND HOSPITAL MANAGEMENT.

The proposed construction of a new Hospital in the Queen's Park, Toronto, has received the most kindly encouragement from the daily press of our city. The munificent donation of Senator Macdonald has been highly appreciated by all classes in the community. A very able and sensible editorial which appeared in the *Evening Telegram*, deserves more than a passing notice. This paper, in speaking of this gift says: "God bless the benefactor of universal humanity, for in his kindly act he not only exemplifies the Master's teaching, but presents an example to some of the many rich men of Toronto who hold their purse strings with a tight hand." It goes on to speak of the actual necessity for the erection of such a hospital, in consideration of the fact that our

present accommodation for the sick poor is not sufficient to meet the demands.

The *Telegram* is anxious that the new hospital should be in all respects equal to the most modern hospitals of America, and fears that it might be an error to utilize or modernize any old building for the purpose. We cordially endorse the desire that the new buildings should be erected with all the latest and best facilities that are known in modern hospitals, and we have reason to believe that the trustees, who have been appointed to carry out Senator Macdonald's views, are fully impressed with the great importance of these considerations. Some of those interested in the undertaking have, in company with a competent architect, visited, and carefully examined, the best hospitals in the United States, and we feel certain they are not likely to make any mistakes. Whether the building, at present known as Wycliffe College, can be retained as one of the group of buildings, which it is hoped will be erected in the near future, we know not. It is to all intents and purpose a new building, well and substantially constructed with some fine lofty rooms, well lighted, well ventilated, well plumbed, and well drained. It is thought by some that it can very easily be utilized, especially for the executive work of the hospital, and that a number of pavilions with wards of various sizes can be added in such a way as to make the institution complete for its purposes in all respects. This is one of the matters of detail which is now being very carefully considered.

The *Telegram* thinks that the management of the new hospital should be entirely separate from and independent of all other institutions, and that the rivalry and competition thus established would be productive of good. We are not prepared to express a decided opinion on this point, but we think the suggestion is in some respects a good one. Much, however, will depend on circumstances, and from an economical point of view, it might be advisable to make the new institution part of the general hospital system of the City. As far as the executive work is concerned it is about as easy to look after 600 beds as 300. Small hospitals are placed at a great disadvantage in many respects, and as a consequence do not com-

mand the confidence of the public as the large ones do. In the present case it is in any event important that there should be some sort of an understanding with the General Hospital, by which the two institutions will work together, because it is understood that no patients suffering from contagious or infectious diseases will be admitted into the new hospital.

We hope the all powerful press of Toronto will continue to extend a warm and generous support to the new charity, and we believe that a full and friendly discussion on the methods of construction and management is quite in order, and is likely to be beneficial.

#### THE OPERATION FOR ŒSOPHAGOTOMY.

This operation for the removal of a foreign body is one rarely performed. In our last issue was recorded an interesting case, under the care of Dr. MacFarlane, in the Toronto General Hospital. It was necessary to open the gullet in the neck, in order to extract a foreign body which had become firmly impacted there; the patient, a young man 23 years of age, had swallowed a vulcanite tooth-plate, whilst drinking a glass of water. The operation was eminently successful, and the man was discharged from the hospital quite well.

In the *Lancet* of December 28th, 1889, Mr. Southam, surgeon to the Manchester Royal Infirmary, records the history of two patients successfully operated on by him last June.

These two cases, taken along with that of Dr. MacFarlane, form an interesting series. In all three cases the foreign body was a tooth-plate, and in all, the plate could be reached by the mouth, but was so firmly impacted in the œsophageal wall, that extraction by forceps, coin-catcher, etc., was impossible.

In one of Mr. Southam's cases the facts recorded are almost identical with those in Dr. MacFarlane's patient. The plate was located by measurement 8 inches from the incisor teeth. (Dr. MacFarlane's case was  $8\frac{1}{4}$  inches.) The operation in each case was conducted on precisely the same lines throughout; there was no difficulty encountered, and the œsophageal wound in each instance was not sutured.

In Mr. Southam's second case there was

considerable difficulty experienced during the operation, in consequence of the fact that the tooth-plate was impacted at a much lower level. On passing a bougie the foreign body, which was beyond the reach of the longest œsophageal forceps, could be felt at a distance of about twelve inches from the teeth. The foreign body therefore did not serve as a guide to the gullet during the operation, it could not be felt with the finger at the bottom of the wound. A full sized bougie was passed, which could be easily felt with the finger, and by cutting upon this as low down as possible, the gullet was opened. On exploring the œsophagus with a sound introduced through the wound, the foreign body was detected three inches below the upper border of the sternum, it could just be touched with the tip of the forefinger. It was so firmly impacted, that at first it was quite impossible to withdraw it. Attempts were made to break it up *in situ*, by means of bone-nippers, bone-forceps, and a lithotrite introduced through the wound, but they proved unsuccessful owing to the toughness of the vulcanite composition, and the limited space in which the manipulations had to be carried on. It was finally extracted, though not without considerable laceration of the mucous lining of the gullet, by forcibly pulling upon it with a pair of strong forceps. A drainage tube was inserted, and the external wound closed by suture as in the other cases. The left vocal cord was found completely paralysed on the following day; during the operation the left recurrent laryngeal nerve, which had been observed, was drawn aside by a retractor, this probably explained the subsequent paralysis of the cord: it was gradually recovered from.

The after treatment in both of the cases recorded by Mr. Southam was, that, for the first fortnight the patient was fed entirely by nutritive enemata, they were allowed to suck a little ice and an ounce of a solution of boracic acid, (10 grs. to the ounce) was administered by the mouth every four hours: this relieved thirst and kept the wound sweet and clean. After the first fortnight the patient was fed by means of a soft tube passed into the stomach every 4 hours; the tube was discontinued on the 25th day in one case, and on the 21st day in the other: in the latter the passage of the tube had on several occasions, been

followed by hæmorrhage, and it was therefore discontinued earlier, and for a few days the patient was again fed on nutritive enemata, and was allowed milk by the mouth.

Mr. Southam discusses several points in connection with œsophagotomy, suggested by a study of his own cases; these find illustration also in the case reported by Dr. MacFarlane. With regard to the question of operative interference, Mr. Southam states that when the foreign body is of considerable size, and irregular in shape, as in the case of a tooth-plate, and when it is so firmly fixed in the gullet that it resists all attempts at extraction through the mouth, œsophagotomy should at once be performed. Church has shown in a paper published in the St. Bartholomew's Hospital reports, that very serious results may follow if it is left. It frequently ulcerates into the surrounding tissues, where suppuration takes place, and fatal hæmorrhage may ensue from ulceration into one of the large blood-vessels.

The sooner the operation is done the better; according to Fische, the mortality is only 15 per cent. when œsophagotomy is performed within the first two days after the introduction of the foreign body: while if delayed until the third or fourth day, it reaches 30 per cent.

The œsophagus may be sutured, after the foreign body is extracted, provided that the margins of the wound are clean cut and free from bruising; there is a possibility in such cases of primary union taking place. Experience has shown however, that it is useless to attempt this if the œsophageal walls are in any way bruised or injured. In Dr. MacFarlane's case the foreign body had been in the gullet firmly impacted for fifty-three hours before operation, and the idea of attempting to suture the œsophageal wound, under such circumstances, was not entertained.

With regard to the after treatment, Dr. MacFarlane allowed the patient to sip a little water occasionally; this was expelled through the wound, and was given with the deliberate intention of flushing the wound and thereby cleansing it, at the same time quenching to some extent the patient's thirst. Mr. Southam administered an ounce of boracic acid solution, (10 grs. to the ounce), every four hours, with the same end in view and with good result.

The administration of food by nutritive enemata was resorted to in all three cases. Occasionally enemata cannot be retained by the patient; in such cases Mr. Southam recommends the passage of a soft rubber tube by the mouth, in preference to the method suggested by Markee, of introducing it directly through the wound in the neck.

According to Cross, the number of cases of œsophagotomy recorded up to 1886, is 82: of these 63 were successful, and 19 terminated fatally. Since that date Mr. Southam has found 14 additional cases recorded, of which 10 were successful and 4 followed by death. If the two cases recorded by Mr. Southam, and Dr. MacFarlane's case be added, we will have a total of 99 cases, of which 76 were successful, and 23 unsuccessful. This places the mortality of the operation of œsophagotomy at a little less than 24 per cent.

#### NOTES.

SYSTEMATIC OR DIDACTIC LECTURES.—During the Spring session of the General Medical Council, of Great Britain, Dr. Kidd, on the part of the Education Committee moved a resolution intended to reduce the enormous number of systematic lectures, which students are now required to attend. A candidate for the degree of the University of Edinburgh had to attend, it was stated, 1,300 lectures. The Education Committee in its report, expressed itself "strongly of opinion that the number of systematic lectures in certain subjects of medical education should be reduced." We wonder what the General Medical Council would think of the 1800 lectures demanded by the Quebec Board, or of the 1700 we insist upon in this province.

THE TREATMENT OF CHLOROSIS.—It is frequently found that chlorosis is very obstinate in its resistance to the effects of ordinary treatment. When it was discovered that it was caused by, or at least accompanied with, a deficiency of iron in the blood, its cure appeared to be quite a simple matter. The administration of iron, however, in many cases, has no good effect—sometimes it is positively injurious. The *Medical News* states that M. Autiq was the originator

of a plan of treatment by the administration of enemata of defibrinated blood, but casts doubts on its efficacy. The *News* goes on to state that each case should be treated on its own merits—or demerits, and that hygienic reasons, such as exercise, sea-bathing, massage, etc., should be prescribed. Sir Andrew Clark has probably taught us one of the best lessons on this subject, in pointing out that it was frequently caused indirectly by constipation and reabsorption of noxious matters from the intestinal tract. In such cases an effective course of cathartic treatment should be instituted before administering iron tonics.

## Meeting of Medical Societies.

### THE PATHOLOGICAL SOCIETY OF TORONTO.

Saturday, Dec. 28th, 1889.

The President, Dr. Reeve, in the chair.

Dr. John Caven presented the following specimens:

1. Small globular growth in substance of supra-renal capsule. *Size*, about  $\frac{1}{4}$  inch diameter. *Color*, yellowish white. *Consistence* firm. The growth is embedded completely in capsule substance, and is possessed of a slight fibrous capsule of its own. Under microscope growth it is seen to be mainly made up of polyhedral epithelial cells, much resembling those in the fasciculi of the normal supra-renal. These peculiar cells are shut up in alveoli, formed of a very delicate fibro-cellular tissue. In some cases the alveoli are jammed full of the cell elements; in others they are arranged with some show of regularity around the alveolar wall. In many of the alveoli leucocytes are to be seen, scattered amongst the larger peculiar cells. The "peculiar" cells have a distinct nucleus, single, and much larger than that of a leucocyte. These cells measure on an average about  $\frac{1}{1000}$  of an inch.

2. A diverticulum on the small intestine about 3 feet from the ileo-cæcal valve—about  $2\frac{1}{2}$  inches long—opens into intestine—contains all the coats of the intestine in its structure—evidently a specimen of Meckel's diverticulum. Has no connection with the umbilicus.

3. A curious cyst found in an anencephalous

monster. This cyst, which occupies the position of the middle cervical ganglion, was about the size of an ordinary hickory nut. Contained a mucous fluid which the microscope showed to contain large quantities of cylindrical and flat cells, both separate and in masses. The cyst wall is made up of fibrous and muscular tissue (smooth) lined with flattened cells, apparently epithelial, and showing apparent gland structure with columnar cells.

4. A portion of the large intestine, studded with small grape-sized diverticula. These diverticula consisting of mucous coat protruding through the muscular walls of the intestine.

#### GROWTH IN THE ANENCEPHALOUS MONSTER.

Dr. Cameron thought that the supra-renal growth could not be cancerous, as it had a capsule. The cyst might be a relic of the branchial cleft, which contains muscular tissue.

Dr. A. B. MacCallum was not sure that the musculature could arrange itself in such a regular way as in this preparation, if the cyst were derived from the branchial cleft. Its position would favor the idea of such an origin. In these anencephalous monsters the organs frequently present these low types.

From the microscopic specimen it is hard to make out whether the muscle is striated or not. Not much importance was to be attached to the presence of the muscle. We can easily suppose that the muscular tissue would continue to grow, although slightly changed.

#### MECKEL'S DIVERTICULUM.

Dr. Primrose asked why these were more common in the child than in the adult. Was it because in the adult they close, shrivel, and become a mere fibrous cord?

Dr. Cameron had seen several specimens, but there had always been more than one diverticulum. He had always considered them to be of the same nature as the vermiform appendix.

Dr. McPhedran asked if these diverticula were subject to the same pathological changes as the vermiform appendix.

Dr. Caven replied that he thought that there might be the same pathological changes. We know that they may become cystic and even strangulated.

#### GRAPE-LIKE DIVERTICULA.

Dr. Cameron had seen a number of such grape-like diverticula but they were usually of

larger size. His experience had been that patients who have these usually die of dilated stomach. This might be attributed to the fluid diet which they have in their toothless old age. One would think that these slender walls of these diverticula might easily give way and cause the death of the patient. Probably this was prevented by closure of the mouths of the diverticula by the contraction of the intestinal muscles.

Dr. Nevitt, who had with Dr. Cameron made several post-mortem examinations on cases of this kind, said that in all the cases the mouths of the diverticula were patent and solid feces were found in them, while the rest of the bowel was empty. The feces might of course get in during intervals of quietude.

Dr. McPhedran thought that the real source of the patient's safety was his debility.

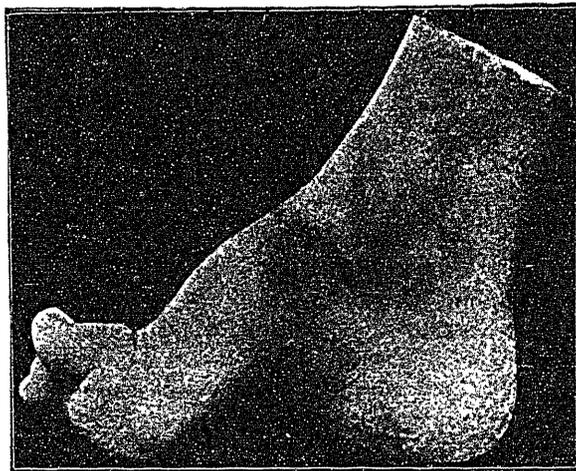
#### TALIPES CAVUS.

Dr. Primrose : The cast which I now show you, Mr. President, was taken from an exaggerated case of so-called "hollow-foot," occurring in a boy about fourteen years of age, a patient under Dr. Cameron, in Toronto General Hospital.

The deformity presented in the specimen is typical in character although excessive in degree, and one can with advantage examine such a foot for the purpose of determining the different factors which have been at work in producing the condition. The cast of the inner half of the foot is perfect ; note the marked exaggeration of the antero-posterior arch of the foot, the ball of the great toe is unusually prominent, the proximal phalanx is hyper-extended on the head of the metatarsal bone and the distal is flexed upon the proximal phalanx. The condition of the four outer toes is similar to that of the great toe, the proximal phalanges are abnormally extended, and the terminal phalanges flexed, producing

the deformity usually known as "hammer-toe."

It has been suggested that the cause of the deformity in hollow-foot is primarily paralysis of the interossei muscles. The anatomical plan common to all the interossei is that each muscle has its origin laterally from one or more metatarsal bones near their proximal extremities, and runs forward to be attached laterally to the bone of the proximal phalanx of the toe ; in addition to this there is an aponeurotic expansion continued from each muscle which blends with the tendon of the extensor muscle on the dorsal aspect of the proximal phalanx. The action of the interossei is two-fold, they act as adductors and abductors to and from the second toe ; they also by their contraction bring about flexion of the proximal phalanges and extension of the



FROM A PHOTOGRAPH OF CAST.

terminal phalanges ; this latter is the action with which we are concerned in the deformity under consideration. When the interossei are paralysed the physiological antagonists of these muscles will by their unopposed action bring about a condition of things the reverse of that which occurs when the interossei are in

action ; the reverse condition would be, extension of the proximal phalanges and flexion of the terminal phalanges ; in fact the exact condition of things which we find in this cast. There are no interossei inserted into the great toe but the oblique adductor and the short flexor of the great toe have insertions similar to that of the interossei, namely, into the bone of the proximal phalanx and also into the extensor aponeurosis on the dorsal aspect of the first phalanx, this I have verified by dissection. It is therefore these two muscles which take on the action of the interossei in the case of the first digit ; paralysis of these muscles would bring about the deformity which we find in the great toe of the cast. After the deformity has been

thus produced it is rendered permanent by a contraction of the plantar fascia.

The condition existing in this case may therefore be satisfactorily explained by having been brought about primarily by a paralysis of the interossei muscles along with that of the oblique adductor and short flexor of the great toe, a subsequent contraction of the plantar fascia, rendering it impossible to correct the deformity, by simple manipulation.

The material of which the cast is made is printers' "roll," very similar in composition to that suggested by Dr. Cathcart of Edinburgh. This has been called cathcartine and is made in the following manner: "Soak glue, or what is preferable, ordinary French gelatine, in water until it has been thoroughly softened. Allow it to lie exposed so that the water may evaporate to such an extent that the gelatine becomes pliable but not soft. Melt this in a water bath, and add to it as much glycerine by measure as there was dry gelatine by weight. It is also advantageous to add to the glycerine about one to forty carbolic acid. Mix them thoroughly, and stir in the finest ground oxide of zinc suspended in a little glycerine until the whole mass assumes an opaque white appearance."

Dr. Cameron: "I cannot give all the previous history of the patient, but there is no record of diphtheria, or of scarlatina. The treatment has been Electricity and Barwell's Elastic Muscle. To me, Dr. Primrose's explanation seems very reasonable. The term *Pes Cavus* is misleading. I do not think that there is any such condition. The case is really one of *talipes equino plantaris varus*. *Talipes arcuatus* is a better name. Simple division of the fascia and superficial muscles will cure. It is noteworthy that the other foot is now getting into the same condition."

Dr. Peters pointed out that the tonic contraction of the long flexors and extensors of the toes tended not only to maintain, but to aggravate the condition brought about by the paralysis or atrophy of the interossei. By such chronic contraction the proximal ends of the first phalanges become subluxated upon the heads of the metatarsal bones. These are in this way thrust down into the sole of the foot in such a manner as to increase its arch. The plantar fascia which is thus relaxed in process of time becomes short-

ened, and changes may also subsequently take place in the ligaments and articulations. In some cases of club foot, all the soft parts except the ligaments may be cut away without correcting the deformity of the foot. Hence in the treatment of this deformity it may be necessary to divide not only the plantar fascia and the contracted muscles, but also the long calaneo-cuboid and some other ligaments.

Dr. Primrose in answer to Dr. Peters said that the action of the flexor digitorum muscle has not so much to do with producing the deformity as his remarks might lead one to infer. It is the common extensor muscle and the extensor longus pollicis which have the chief action; if the interossei, the adductor hallucis, and the flexor brevis hallucis be paralysed then the extensor muscles are no longer retained against the dorsal aspect of the proximal phalanges and they would act from the proximal extremity of the distal phalanx as their fixed points below. The result of their action would be to draw the terminal phalanx upwards and backwards, producing thereby extension at the metacarpophalangeal joint and extension at the interphalangeal joints. The flexor tendon, on the other hand, is firmly bound down on the under aspect of the proximal phalanx, in a fibrous sheath and contraction of this muscle would tend rather to prevent hyper-extension at the metatarso-phalangeal joint. There is not necessarily any alteration in the shape of the bones of the foot although a partial dislocation may occur at the metacarpophalangeal joint.

## Book Notices.

*A Guide to the Diseases of Children.* By Jas. Frederic Goodhart, M.D., F.R.C.P., Physician to Guy's Hospital, and Lecturer in Pathology in its Medical School, etc. Re-arranged, revised and edited by Louis Starr, M.D., Clinical Professor of Diseases of Children in the Hospital of the University of Pennsylvania, etc. Second American from the third English edition; Philadelphia: P. Blakiston, Son & Co.

This is an admirable and delightful book. It is now pretty generally recognized that Dr. Goodhart's descriptions of diseases of children are remarkably clear and forcible, and, as has been remarked by others, closely resemble actual

bedside teaching. His advice as to treatment is also eminently clear and practical. Among all the diseases of infancy and childhood those of the organs of digestion are probably the most important. Our author's views and expressions on such diseases are, we believe, almost beyond criticism, and his directions on feeding are about as nearly perfect as possible. In connection with this subject we can recognize the hand of the editor in much that is written, and his reputation in this branch of pediatrics stands deservedly high on this continent. The work will undoubtedly be as popular with the profession as it will be useful to its members. Probably we would be more correct in saying that it has already attained this position. We may say that the excellence referred to is not confined to diseases of the digestive organs, but permeates the whole book.

### Books and Pamphlets Received.

*Spontaneous Rheumatic Nodules.* By William A. Edwards, M.D., San Diego, California, formerly Instructor in Clinical Medicine, University of Pennsylvania. Reprinted from the *University Medical Magazine*.

*Concealed Pregnancy: Its Relations to Abdominal Surgery.* By Albert Vander Veer, M.D., Professor of Didactic, Abdominal and Clinical Surgery in the Albany Medical College, etc. Reprinted from the *American Journal of Obstetrics*.

*A Digest of Twenty Years Experience in the Treatment of Uterine Cancer, including 367 Operations by Galvano-Cautery.* By John Bryne, M.D., M.R.C.S.E., Surgeon in Chief to St. Mary's Maternity, Chief of Gynecological Department, and President of the Faculty of St. Mary's Hospital, Brooklyn, etc. Reprinted from the Transactions of the American Gynecological Society.

### Personal.

DR. P. J. RICE (Tor. Sch. of Med., 85) is practising in Nanaimo, B.C.

DR. J. C. PATTON, after spending a couple of years in Great Britain and Germany, has returned to Canada and commenced practice in Toronto.

DR. C. R. CHARTERIS has removed from Chatham, and is now practising in Florence.

DR. W. C. BARBER (Tor. 88) has commenced his duties as an assistant in the London Asylum for Insane.

DR. FRANK BEEMER (Tor. Sch. of Med., 84) has entered the Asylum for Insane, Hamilton, as an Assistant Physician.

DR. F. W. CANE (Tor., 85) has resigned his position as an assistant in the Toronto Asylum for Insane, and will enter into private practice.

DR. A. MCDIARMID has been appointed Professor of Obstetrics in the Manitoba Medical College in the place of the late Dr. R. B. Fergusson.

DR. T. W. REYNOLDS (McGill, 81), who was for some years in the Hamilton Asylum is now in charge of the branch asylum for the insane at Mimico.

### Obituary.

DR. H. J. MULLEN (Trin., 89) died in Toronto last month, after a short illness from tubercular meningitis.

DR. R. B. FERGUSSON.—Dr. R. B. Fergusson died in Winnipeg, January 11th, after a brief illness, from pneumonia. He was Professor in Obstetrics in Manitoba Medical College, and was one of the incorporators of the College. He graduated in the University of Queen's College in 1863.

SIR WILLIAM GULL, BART, M.D.—Sir Wm. Gull was one of the eminent physicians of Great Britain. He commenced his medical career as a student in Guy's Hospital. His prospects were not then very bright and his friends were few. By his own unaided exertions he soon came to the fore. In 1871 he was one of the physicians in attendance on the Prince of Wales and received the principal credit for his recovery. In the following year he was created a baronet. He was for many years Physician and Lecturer on Medicine in Guy's Hospital. He was seized

with apoplexy January 28th, and died on the following day, in the 74th year of his age.

MRS. MALLOCH.—The deepest sympathies of the profession of Ontario will go out to Dr. A. E. Malloch, of Hamilton, and his six children, on account of their sad bereavement in the loss of a loving and beloved wife and mother. There has been considerable sickness in the family during the last two or three years, and it is probable that Mrs. Malloch's devotion to her family was partially the cause of her death, which occurred at her home in Hamilton, Jan. 28th.

MRS. GEIKIE.—We have to announce, with deep regret, the death of Mrs. Geikie, the wife of Dr. Walter B. Geikie, Dean of the Trinity Medical College, which took place on Thursday, January 30th. The students of both Medical Colleges in Toronto held mass meetings, and passed very kindly and considerate resolutions expressing the deepest sympathy with Dr. Geikie and his afflicted family. The funeral took place on Saturday, February 1st, when there was a large attendance of the Medical College Faculties and students.

### Miscellaneous.

Dr. Ricord left, by his will, ten thousand francs to the Paris Academy of Medicine for a biennial prize, five thousand francs to the Society of Surgeons for a biennial prize, ten thousand francs to the General French Medical Association, and his extensive library to the *Hôpital du Midi*.

The 8th yearly issue of the "*International Medical Annual*" (for 1890) is announced for early delivery. The Prospectus gives promise of excellencies surpassing all former editions. Its thirty-seven editors in the several departments are to give a summary of New Remedies alphabetically arranged, also a resume of New Treatment in Dictionary form, with references to the Medical literature of the world pertaining to the year's progress of Medicine.

In one volume of about 600 octavo pages; price, \$2.75, post free.

E. B. TREAT, Publisher, 5 Cooper Union, New York.

WARNER'S ANTISEPTIC PASTILLES.—Following a suggestion recently made by Dr. C. Seiler in the *Medical Record*, Messrs. William R. Warner & Co., of Philadelphia, are now placing on the market antiseptic pastilles for the treatment of certain nasal affections. These pastilles are not only powerfully antiseptic and comparatively innocuous, but also distinctly deodorant, as sodium bicarbonate, sodium biborate, sodium benzoate, sodium salicylate, menthol, and oil of wintergreen enter into their composition. One of the pastilles makes 2 oz. of a lotion or spray for the nostrils, and it is, according to Dr. Seiler, "sufficiently alkaline to dissolve the thickened secretion adhering to the nasal mucous membrane, and as it is of proper density, it is bland and unirritating, leaving a pleasant feeling in the nose."—*The Chemist and Druggist*.

J. E. Prichard, M.D., Baltimore, Md., says: The Aletris Cordial I think a most excellent remedy and have used it in ten cases of suppressed menstruation, in all of which with the best results. Among my patients was four unmarried women; one aged 20 years, had her menstruation arrested six months when she came under my care. She was swollen and suffered considerable pain at each monthly period, but she had no show of any catamenial discharge. I placed her on Aletris Cordial, teaspoonful doses, three times a day. She continued it for seven days, when she menstruated. I ordered her to commence again five days before her expected time to menstruate, which she has done. She is now regular and suffers no pain. Have also used it in cases of vaginal leucorrhœa with a happy result. In cases of hysteria which we sometimes find complicated with leucorrhœa I have combined it with Celerina.

**R.**—Aletris Cordial, 4 ounces.  
Celerina, 4 ounces.

**M. Sig.**—Teaspoonful every three hours for one day, then the next would give it four to five hours.

I am happy to say that it has not failed to give relief in all cases in which I have prescribed it.