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VALEDICTORY ADDRESS

DELIVERED TO THE GRADUATES IN MEDICINE AT THE ANNUAL
MEETING OF CONVOCATION OF MCGILL UNIVERSITY,
APRIL 1ST, 1890.

By J. CHALMERS CAMERON, M.D.,

Professor of Obstetrics, McGill University; Physician-Accoucheur to the Montreal
Maternity, &c.

Gentlemen, Graduates in Medicine :

It is the time-honored custom in the University for the Faculty to select one of their number to address a few words, in their behalf, to the graduating class—words of congratulation, encouragement, advice and cheer.

First, then, we congratulate you most heartily upon the successful completion of your Collegiate Course. Four long years of patient, steady work culminate to-day in your Doctor's degree. The parchment you have just received testifies that you have attained to the standard laid down by the University, have fulfilled all her requirements, and are fit and proper persons to practise Medicine; while you on your part have solemnly sworn to practise your profession *carefully, honestly and uprightly*. The diploma you now hold is one of which you may well be proud, for in whatsoever part of the civilised world your lot may be cast, you will find that the reputation of your Alma Mater has preceded you, and will bespeak for you the confidence of the public and the respect of your confrères. You will never have cause to be ashamed of your Alma Mater; look well to it that you never, by word or deed, give her cause to be ashamed of you.

To-day is with you a red-letter day, marking a great epoch in your lives. Four long years you have been toiling up the hill, with eyes fixed upon graduation day as the great final goal of your efforts. Other realities of life have been obscured or overshadowed by the intense reality of *this*. Your degree has been your *summum bonum*, and every nerve has been strained to win it. To day the degree is yours; you have climbed the hill, reached the goal, but as you look around, lo! the realities, responsibilities and possibilities of life open out before you. Your perspective is wholly changed, your life-climb has but begun. You were students before, if you would succeed you must be students still. You worked hard before, you must work harder still. Toil, the birthright of mankind, must still be yours, if you are not to be laggards in the race. Under the careful guidance and supervision of your teachers, you have learned first to creep, then to stand, and at last to walk. The way has been marked out for you, its roughness smoothed, your faltering steps steadied. Now you are cut loose from leading strings, you must choose your own road and make your own pace; how far you will manage to push along will depend very much upon the energy, perseverance and singleness of purpose you henceforth display.

In welcoming you to our ranks, we would remind you that our profession is one of intrinsic nobility and dignity. In it science and charity, knowledge and sympathy, skill and pity go hand in hand, ministering to the sorrows and sufferings of human kind. Its annals teem with deeds of heroism, self-sacrifice and devotion. When pestilence stalks the earth, when panic and fear seize upon the people, the physician will be found at the post of danger "firm, fearless and faithful." When human pity may wipe away a tear, human skill ease a pain, or human sympathy comfort and console, there, too, will he be found. Of all the brave and gallant deeds by land or sea, none are more truly great and noble than those of men who amidst the horrors of pestilence, in the privacy of daily life, without the stimulus of excitement, publicity or hope of reward, have toiled without repose to assuage the misery of the sick and dying, and at last without a murmur have laid down their lives for their fellow-men.

Such is our profession. Would you prove yourselves worthy

of it? Would you emulate the brave deeds and noble spirit of your predecessors? Then you must begin well, and as you begin so must you continue to the very end.

Duties to yourselves.—You owe certain duties to yourselves. First and foremost, your character must ever be above reproach. Honor, uprightness and integrity must be the very *Warp* of your lives. Then to the best of your ability you must keep well abreast of the times, and strive always to be accomplished, educated physicians. Though now, no doubt, you “*know everything about medicine that is worth knowing,*” you can not maintain that happy state of affairs without constant diligent study. He who is content with what he knows soon drops out of the ranks and is left behind; in the medical profession, there is no such thing as standing still; you must either push on or fall back. An eminent professor was once asked by a young graduate what he should do to secure success in his profession. “Three things,” replied the Professor, “1st, observe; 2nd, observe; 3rd, observe.” Careful observation is the surest road to success; it is the magic key which unlocks the mysteries of Nature and reveals her secrets to the studious enquirer. Train eye, ear and touch; investigate every case thoroughly and systematically; observe everything, considering nothing too trivial or minute. Study the laws of cause and effect and apply them in your daily practice; consider each case as a problem you are called upon to solve. Study out carefully and estimate at its proper value the *personal* factor; aim to treat your patient, not his disease, and you will find the practice of medicine an absorbing, fascinating study—a never-failing source of pleasure and gratification, the best antidote to jealousy, irritation and querulous discontent. I pray you, do not allow yourselves to degenerate into the routine practitioner—a sort of peripatetic prescribing machine. Such a man cares very little for principles or deductions therefrom. The prescription is his great stand-by; and with a pocketful of them he is armed for any emergency. He poses as a *practical* man; no theory or nonsense about him. At Medical Societies and Conventions he comes out in full force. Notebook in hand, he goes about buttonholing prominent men for their favorite prescriptions; if he succeeds in capturing any, he goes home happy and

proceeds to use them upon all and sundry for the balance of his professional life, or until he can replace them by some newly-captured favorites.

While you study the cases which come under your care and train your faculties of observation and reflection, do not fail to acquaint yourselves with the results and opinions of others. Attend Medical Societies and Conventions, for there you come in contact with fellow-workers of riper experience, and mutual benefit is derived from criticising and being criticised. *Read diligently.* Read the current journals; they give you the latest news from the front; the pioneers of thought, the original workers and investigators are there, like pickets and skirmishers, spying out the land, sometimes advancing, sometimes retreating, sometimes gaining new positions, sometimes abandoning old ones no longer tenable. At all events it is news from the front, of absorbing interest, though subject to much alteration and correction, and not always trustworthy. In the text-books you find the solid ground that has been won. And so you perceive the professional army marching along; pickets, pioneers and skirmishers away at the front, busily exploring, prospecting, making roads and bridges; the rank and file with baggage and equipments moving more slowly, trying and proving the ground, testing the strength of roads and bridges. On they march with face ever to the front, fighting disease and death. Alas for the stragglers who face to the rear, who sleep by the way.

Duties to patients.—In the practice of your profession you have certain well-defined duties to your patients. There is in fact an implied contract between you. They on their part place confidence in you and trust you. In your hands are placed sometimes health and happiness, honor and reputation, the issues of life and death. You on your part, in accepting such grave responsibilities, are bound to possess and maintain a competent knowledge of your profession, to devote due care and attention to your patients, and exercise your best skill. In your professional relations, you will be admitted into the privacy of the family circle; in sickness the society mask is off and you will see poor humanity in all its weakness. You will know the shadows that darken many a home, the hidden sorrows that embitter many a life; weighty secrets, important

confidences may be committed to your care; and thus not only the lives, but often the prospects and fortunes of individuals, the peace, honor and happiness of families, and even the welfare of the community may rest in your hands. Upon your prudence and caution great interests may hang, beware how you betray them.

Remember, too, that the personal factor enters very largely into the problem of success. By your patients you are valued, not only for your medical skill, but also for the refreshing or soothing influence of your own personality. To the pain-wracked sufferer your daily visit may be the one bright oasis in the dreary monotony of life; a gentle manner, a gentle voice and sympathy are potent factors in the cure. While you strive to be skilful in your profession, do not forget that when human skill is of no more avail, sympathy and kindness may temper a blow you can not ward off, or lighten a sorrow you can not avert. Be honorable, honest, upright; a sympathetic listener, a wise counsellor — but a *gossip*, a *talebearer*—never. Strive to be a ray of sunshine in every home; let the sick brighten at your entrance; let the little ones long for your visits; then, when your life work is drawing to a close, when you are old and grey, men and women grown, whom you have watched and tended from infancy, will love and revere you and cherish your memory in the tenderest esteem.

Duties to Confreres.—When you begin the practice of your profession you will be at once thrown into contact and competition with other medical men. Remember you are fellow-workers; let no unseemly rivalry or jealousy mar your friendly relations. Pay no attention to those who laugh at the strictness of our professional etiquette. Follow strictly our *Code of Ethics*, for it is nothing more or less than a practical application to medical matters of the Golden Rule in its negative form, “*Do not unto others that which you would not have them do unto you.*” Be modest in your demeanor, especially to older men. Perhaps they may not be as well up as yourselves in the latest teachings of the Schools, but from long personal observation and experience they have gathered rich stores of knowledge which no mere book lore can give, and which you must work many years to acquire. Do not forget

that there is often room for honest difference of opinion. We sometimes hear it said that doctors differ. Of course they differ. And so do all men who are not mere machines, men who reflect, weigh evidence, balance probabilities, and use their own judgment and common sense. The clergy differ—witness the multiplicity of sects and parties, the wide divergence of opinion and belief in the religious world. Lawyers and judges differ—witness the elaborate machinery of our courts, with appeal, review and final appeal, one court modifying or reversing the finding of another. Philosophers, men of science, politicians, political economists, thoughtful men everywhere differ—and so do doctors. In the practice of your profession, not only is there room for honest difference of *opinion*; there is room also for honest difference in *treatment*. You wish to go from McGill College to the Post Office; you have your choice of many different ways, each of which will eventually bring you to your destination—some longer, some shorter, some pleasanter than others; if time is no object you may go around by Cote St. Antoine, and yet finally reach the Post Office. Your choice of road is really very much a matter of taste and urgency. So you will find in practice, the same end may be accomplished in many different ways; the ultimate choice of method being largely a question of taste and tact on the part of the practitioner. How very foolish and unjust, therefore, to criticise the methods of a confrère and act as if your own way was the right way, the *only* right way. The wise man is always glad to learn from his neighbours, observing wherein their methods are better than his, and modifying his own accordingly.

Duties to Science.—Besides our more immediate duties to our patients, there are other indirect obligations none the less binding. We cannot directly repay our parents for their love and care to us during our infancy and childhood. We repay them indirectly by bestowing like care upon our children. So in medicine, from the past we inherit the accumulated knowledge and experience of the ages; it is incumbent upon us not only to transmit this goodly inheritance unimpaired but also to contribute all we can to increase the store. Science entrusts us with various talents; in return she demands from us a profitable service. The best men in the profession everywhere

consider it one of the first duties to record for the benefit of the profession their cases, methods and results. In this way only can science be advanced. Deeds of darkness love darkness, but science and truth love the light. Secrecy begets carelessness and ignorance, and is the favorite refuge of the charlatan. But some of you may say, that is all very well for the city men with their great hospital and other advantages, it is easy enough for them to do original work and advance the cause of Science; but what can be expected from a poor country practitioner, isolated from converse with his confrères, with limited experience, few books, scanty means and opportunities all too few. No man's lot is so humble that he cannot cherish the scientific spirit. Your books may be few, but the great book of Nature lies ever open. Read thoroughly the few lines or chapters spread before you, and by mere concentration of attention you may discover therein a hidden meaning undetected by those who perforce must skim from page to page. The country practitioner has one great advantage over his city confrère; *he has time to think*. The rush and whirl of city life are fatal to steady, fruitful thought. and we find that many of the brightest discoveries of scientific medicine are the contribution of quiet, thoughtful men with limited opportunities, but imbued with the scientific spirit. You are beginning your career in a time of unusual scientific activity. Chemistry, experimental physiology, pathology, and pharmacology are rapidly changing the aspect of practical medicine. Sanitary science and preventive medicine offer specially rich fields for original research. The problems are legion and demand for their solution carefulness of observation, accuracy of thought and soundness of judgment. Every one of you can do something; will you try? You will not be losers thereby, for if the true scientific fire burns in your hearts and illumines your daily work, you will find work no longer wearisome, poverty no longer despicable, disease and death no longer loathsome or terrible. Above all, have faith in yourselves; have faith in your art. Let a firm abiding faith be the mainspring of your practice. No human theory is perfect. Science and art are progressing, improving. Be ready to abandon the *old* when proved *false*, to accept the *new* when proved *true*. But do not throw away the faith you have until you are sure of another

to take its place. An imperfect, defective faith is far better than no faith at all. It is after all very easy to pose as a sceptic or iconoclast, to sneer and rail at prevailing belief and practice, to profess disbelief in the efficacy of drugs, and the possibilities of nature, science and art. But such a mental attitude betokens weakness, not strength,—conceit, not knowledge. I beseech you, do not join the ranks of the medical nihilists; the man without faith in *science*, in his *art*, in *himself*, is like a ship without ballast or rudder, tossed about hither and thither with every wind of doctrine.

Duties to the University.—Now, finally, you have some duties to the university. Hitherto you have been students of medicine, and your chief allegiance has been to your own professors. To-day your Alma Mater enrolls you among her sons and sends you forth into the world bearing her name. In all her departments she has claims upon your life-long interest and sympathy. While her reputation is in a manner your reputation and her success your success, do not forget that in like manner your reputation is her reputation and your success her success. Strive to be worthy of her. Guard well the charge this day entrusted to your care. According to ancient Jewish legend, the patriarch Abraham ever wore upon his breast a jewel whose light raised those who were bowed down, and healed those who were sick. And when he died the jewel was set in the heavens, where it still shines among the stars. May the badge conferred on you to-day be as mighty for good as the patriarch's jewel of old; and if you guard it untarnished to the very end, your names will shine forever among those starry hosts to whom the eyes of humanity ever turn with admiration, gratitude and love. Go forth, graduating class of '90, bearing aloft as your banner the motto "*Excelsior*," ever onward and upward, and may success attend your efforts. In the name of your professors, in the name of the University, Godspeed and fare you well.

VAGINAL HYSTERECTOMY FOR UTERINE CANCER.

By T. K. HOLMES, M.D., CHATHAM, ONT.

The unsatisfactory results that have followed the various plans of treating uterine cancer have led surgeons to resort to operations more and more radical until complete removal of the organ has been resorted to. The number of times this has been done successfully warrants the hope that with the improved methods of operating the mortality may be reduced, many lives saved and others prolonged, or, if death result from recurrence of the disease, it may at least be less painful and loathsome.

It is certain that a careful selection of cases must be made for the operation of hysterectomy if this surgical procedure is not to fall into disrepute. Conditions applicable to the surgical treatment of cancer elsewhere in the body should guide us in the treatment of cancer uteri. The rule should be to resort to that operation by which the whole of the disease can be removed with the least risk to the patient's life. If the disease be in the body of the uterus, or if beginning at the os uteri, it invades the cervical canal far up to the body or even to the internal os, extirpation of the entire organ is the most reliable means of cure. If other tissues than the uterus be involved, hysterectomy could only be palliative, and is too serious an operation to be undertaken with no prospect of a radical cure. If the disease be so confined to the cervix that the whole cancerous part can be removed by supra-vaginal amputation, this should be the operation selected.

The following case was one in which cancerous growth began around the external os and extended beyond the internal os, so that extirpation of the uterus offered the only means of cure. Microscopic sections prepared by Dr. Caven and exhibited before the Pathological Society of Toronto showed the extent of disease to be as stated above :

Mrs. C., aged 55, has had several children, and has always enjoyed good health until nine months ago, when she began to have menorrhagia, which gradually grew worse until she came under the care of Dr. Jenner of Kingsville, who applied nitric

acid to the diseased part of the cervix. This controlled the hemorrhage, so that for six weeks it has been much less profuse. Dr. Jenner, through whose advise I saw her, had recognized the nature of the disease, and I was told by the patient that Dr. McGrath of Detroit had pronounced it malignant. The macroscopic and microscopic appearance left no doubt as to its malignancy. The operation was performed at Kingsville, on October 7th, 1889, with the assistance of Drs. Jenner and Campard of that place, Dr. Dewar of Essex Centre, and Mr. Pearson, medical student, of Chatham. A saline aperient was given the morning before, and the bladder and rectum were evacuated before anæsthesia. The patient was placed in the lithotomy position, the external genitals were shaved and washed with soap and water and bathed with a bichloride solution 1 to 1000, and the vagina thoroughly douched with the same. A large Sims' speculum was introduced under the pubic arch and the vulva held apart by retractors. Owing to the shortness of the vaginal portion of the cervix and the fragile character of the diseased part it was impossible to draw the uterus down either by a silk cord passed transversely through the cervix or by volcellum forceps, and it became necessary to operate *in situ*. A curved incision was made with scissors through the vagina at its line of junction with the posterior surface of the cervix, and extended each way to the base of the broad ligaments; the connective tissue was separated by the finger until the peritoneum was reached, and this was then opened and the incision extended laterally to the broad ligaments. A similar procedure in front of the cervix was followed, and the uterus was held now only by its ligaments and by a small portion of vaginal tissue at each lateral fornix. The latter was snipped through on each side, care being taken not to divide the tissues high enough to wound the uterine arteries. The second and first fingers of the left hand were next passed up so as to include the broad ligament between them, and the clamp was guided so as to compress as much of it as the jaws would reach, and the part so clamped was then divided between the clamp and the uterus. It was necessary to use a second clamp for the upper part of the ligament

and the tube, which were then divided as before. The opposite side was managed in the same way, and the uterus then came away through the wound. As soon as Douglas's sac was opened a portion of omentum prolapsed, but it received no further attention than the avoidance of its being wounded. The vagina was gently cleansed with the bichloride solution, no material of any kind was placed in the vagina, and the only dressing consisted of bichloride gauze placed over the external genitals and renewed as often as it became soiled. The catheter was used for three days, the clamps were removed in thirty-six hours, and the case did well under the care of Dr. Jenner, to whose skill and watchfulness the successful termination of the case is largely due.

In the performance of this operation care is necessary to avoid injury of the rectum, bladder and ureters. Keeping close to the uterus is the safest way. The ureters pass about one-third of an inch from the antero-lateral surface of the cervix, and must be carefully avoided. Where the vaginal portion of the cervix is very short and fragile, as in this case, the operation is more difficult. The use of the clamp simplifies the operation very much. The operation occupied forty-five minutes, but would have been completed in half-an-hour had not some time been lost in efforts to draw down the uterus with a cord passed through the cervix. The patient gained her former weight, and at the present time looks and feels well.

Retrospect Department.

QUARTERLY RETROSPECT OF MEDICINE.

By R. L. MACDONNELL, M.D.,

Professor of Clinical Medicine in McGill University; Physician to Montreal General Hospital.

Lithæmic Manifestations in the Upper Air Passages.—In the *American Journal of the Medical Sciences* Dr. A. Whitehall Hinkel calls attention to this subject as one which has hitherto received but slight attention. The author uses the term *lithæmia*, as Murchison used it, to express a condition of suboxidation and overcharging of the blood and excretions with excretory matter in a state of faulty elaboration, due to inherent and hereditary abnormality of function or to prolonged exposure to depressing environment. Lithæmic manifestations in the upper air passages fail to present conditions that invariably announce their origin, and they are not uniform in type, but at the same time certain given appearances or symptoms are more or less connected with lithæmia and suggest treatment for that condition, whatever local measures may be indicated. A patchy congestion of the laryngeal face of the epiglottis, extending along the arytæno-epiglottic folds and over the posterior aspect of the ventricular bands, is occasionally seen in cases of irritable sore throat associated with lithæmia. There is a harsh, dry cough, with a sense of extreme irritation about the larynx. This patchy congestion of the mucous membrane has been observed by means of the cystoscope in the bladder of a lithæmic patient. A case cited, which was aggravated by aromatic inhalations, mild astringent sprays, etc., was promptly relieved by alkalies and antizymotics, together with inhalations of diluted lime-water and a carefully arranged diet. This patchy condition may exist in the pharynx, extending in streaks along the postero-lateral walls, with a sense of uneasiness or pain on swallowing. The pain of gouty sore throat appears severe, out of all proportion to the degree of inflammation. Lithic storms have been accompanied by marked naso-pharyngeal catarrh, not present in appreciable degree during the intervals, the symptoms appearing several days before the digestive and other disturbances.*

* The New York Medical Journal, Feb. 15th, 1890.

Cheyne-Stokes Breathing in Granular Kidney.—At the meeting of the Clinical Society of London, held on the 28th Feb., 1890, an interesting discussion on this subject took place. Dr. Samuel West read the notes of a case of granular kidney of three months duration, in which the phenomenon was present. The patient, a man of 53 years of age, with a history of gout occasionally, had been suffering from shortness of breath, especially after exertion, for eighteen months. Six months before admission he was suddenly seized with severe dyspnoea at night so that he thought he was going to die. After half an hour he rallied, but he had two similar attacks in the course of a month, and then remained well until three weeks ago, when the worst attack of all came on, since which time his breathing remained short. He had a pale, sallow, earthy complexion, with tortuous and thickened arteries, and a pulse of high tension. Pulse 104; respiration 48. Heart not manifestly hypertrophied; no murmur. Urine of low specific gravity (1010), and contained about one-sixteenth of albumen. The retina was natural. The case was diagnosed as one of weak heart resulting from granular kidney. A few days later Cheyne-Stokes breathing developed. There were several minor points of interest connected with the phenomenon itself, for which the reader is referred to *The Lancet* of March 8th, 1890.

Dr. Charlton Bastian said that old writers had remarked on the association of Cheyne-Stokes respiration with fatty degeneration of the heart, but he had seen no such cases; he had observed it in connection with cerebral lesion. It might be, he supposed, produced by the blood-poisoning associated with renal disease.

Dr. Stephen Mackenzie had observed in a patient of 80, with dilated heart, granular kidneys and a little albuminuria and Cheyne-Stokes breathing, that in the commencement of the series of ascending respiratory acts a distinct movement of the arms towards the head took place. He had seen two patients recently in whom, during the apnœic period, a distinct convulsive-seizure took place; one had between 150 and 200 such fits in twenty-four hours. He asked if any one had seen a case of Cheyne-Stokes breathing apart from injury of the head which had recovered.

Dr. West, in reply, said that the cases of Cheyne-Stokes respiration in association with fatty heart were easier to study than those associated with brain lesion. He thought it dangerous to lay much stress on convulsive movements in cases of unconsciousness. Oscillatory changes in the pupils were observed in other conditions, such as tubercular meningitis. One or two cases of recovery were on record, and in one a probably false diagnosis of tubercular meningitis was made.

In the following numbers of the *Lancet* the question as to recovery after the occurrence of Cheyne Stokes respiration is answered by several correspondents. Mr. John Adams reports two observations in children. The first case occurred six years ago in a boy five years of age, who was taken one afternoon with epileptiform convulsions. Temperature rose to 103°F.; pulse irregular. Cheyne-Stokes respiration lasted four hours, during which time there were two or three violent attacks of convulsions lasting from a quarter to half an hour, for which chloroform was administered. On recovery from each fit the characteristic breathing was resumed. The following morning the temperature fell to normal, and the breathing resumed its ordinary character. The second case occurred in Mr. Adams' own child, aged four months. The illness began with signs of meningeal mischief, but after a week Cheyne-Stokes breathing commenced and continued for four days. The pauses which occurred sometimes between the respirations (sometimes many more) were well marked. The temperature before the special breathing was noticed was raised, but afterwards was mostly subnormal; convulsive attacks occurred at intervals for several days, and squinting, which commenced a few days from the beginning of the illness, existed for several weeks. During the time the Cheyne-Stokes respiration lasted the fontanelles became much depressed, and remained so for two weeks. After the more acute cerebral symptoms ceased hydrocephalus developed, with consequent bulging of the fontanelles and opening of the sutures; these symptoms ceased to increase after six weeks, and although the head is more square than normal and slightly larger, it has long since ceased to grow out of proportion to the other parts of the body, and perfect health has been maintained.

Mr. Lawford Knaggs reports a case of recovery after Cheyne-Stokes breathing, but death occurred in three months and a half. Such cases are by no means uncommon. I can recall three instances occurring in the practice of the Montreal General Hospital, where the phenomenon was present for a similar period. It seems that Cheyne-Stokes breathing is more readily produced in children. Some readers may remember a discussion of this very subject at a meeting of the Canadian Medical Association in 1884, where Dr. Osler reported a case of Cheyne-Stokes in a child otherwise quite healthy.

So far as the discussion has gone, no real case of recovery after Cheyne-Stokes breathing has developed is on record, though an anonymous correspondent of the *Lancet* reports the case of his own father, in whom the symptom has been present for many years, having been observed as long ago as 1874. The old gentleman is 93 years of age, and otherwise enjoys good health.

Thirty-two Cases of Basilar Tubercular Meningitis.—Hermann Rieder relates the history of 32 cases of this disease which occurred in Ziemssen's service in the General Hospital of Munich* from the years 1880 to 1889. Of the 32 patients, 23 were men, 9 were women, and their ages ranged from 10 to 70 years. The age of the majority was between 21 and 30 years, and two cases occurred between the ages 61 and 70. The result of the autopsies showed: well marked chronic tuberculosis of the lungs in 10 cases, disseminated caseous foci of tubercle in various stages in 12 cases, caseous pneumonia in 1 case, caseous glands in 1 case, solitary cerebellar tumor in 1 case, and fibrous changes of the apex in 1 case without any caseous or tubercular centres. In the remainder of the cases the presence of tuberculosis could not be established, but in fourteen instances general miliary tuberculosis was found.

In the majority of cases the meningitis began without any specially predisposing cause, and in almost every instance with headache, dizziness, constipation, wakefulness, severe attacks of vomiting, and in but two cases with rigors. In one case there occurred, even in the beginning, paralytic manifestations in the

* *Munchn. med. Wehnehr.* xxxvi., 49-51, 1889.

right side with perverted sensations and epileptiform attacks ; in another patient a facial palsy was one of the first symptoms.

Among the important symptoms were : rigidity of the neck, 20 cases ; contraction of the muscles of the back, 20 cases ; unilateral contraction of the cervical muscles, 6 cases ; scaphoid retraction of the abdominal walls, 5 cases ; general convulsions, 5 cases ; spasm of the masseter muscles, 2 cases ; hiccough, 6 cases ; palsy of the facial muscles, 9 cases ; complete right hemiplegia, 1 case ; paraplegia of the lower extremities, 3 cases ; retention of urine, 3 cases ; incontinence of urine, 11 cases.

Eye symptoms : Ptosis in 8 ; variations in the size of the pupil in 16 ; general hyperæsthesia in 19. The pulse was, at the outset, unaffected or slowed, but later accelerated ; the temperature varied in most cases between 100.4°F. and 102.2°F. ; the respirations were in most cases accelerated ; in eight patients Cheyne-Stokes breathing was observed. Vomiting was common at the outset, but seldom occurred in the course of the disease. There was persistent constipation and rapid emaciation.

Fatal Cases of Ear Disease.—In the Gulstonian lectures* delivered at the Royal College of Physicians, Dr. G. Newton Pitt dealt with this very important subject, confining his observations to the unpublished records of Guy's Hospital, dealing only with those cases which proved fatal. First, with regard to the cases of ear disease which have proved fatal from the secondary complications they have set up in the cranial cavity—two of the commonest complications to which they may give rise are cerebral abscesses and thrombosis of the sinuses. In twenty years there were 57 post-mortem inspections of cases where ear disease had set up disease in the cranial cavity which ultimately proved fatal. During this period there were nearly 9,000 inspections. No case of simple otitis media with or without disease of the mastoid cells was fatal during the whole of this period, and only twice was the fatal complication outside the cranial cavity, it being in one a retropharyngeal abscess, and in the other hemorrhage from ulceration into the internal carotid artery. The difficulties of diagnosis in ear disease are much increased by the

* The Lancet, vol. i., 1889, p. 739.

fact that not only may a patient die without any otorrhœa being noticed, but in two instances the membrana tympani was found intact at the inspection.

Of the 57 cases 34 were males and 23 females ; the left ear was rather more frequently affected than the right. Seventeen of the patients were under 10, seventeen were between 10 and 20, fourteen between 20 and 30, and only nine over 30. The acute symptoms in ear disease appear to come on spontaneously ; at others, they have followed exposure to cold, a blow on the ear, mastoid suppuration, the introduction of foreign bodies into the external meatus, or the removal of a polypus. If the pus is pent up under tension, earache and headache will develop ; but only those cases, in this series, proved fatal in which the inflammation had spread outside the petrous bone. The majority of the cases, if freely drained by opening up the mastoid cells, recover, and many of them ultimately discharge their pus externally without surgical aid. Toynbee thought that affections of the external meatus and mastoid cells produced disease in the mastoid cells, lateral sinus and cerebellum, that affections in the tympanic cavity produced disease in the cerebrum, and that affections of the vestibule and cochlea produced disease in the medulla oblongata. As the lecturer shows later on, thrombosis of the lateral sinus often has originated from caries of the posterior wall of the tympanic cavity, and mastoid disease sometimes spreads to the middle fossa of the skull : still, the usual sequence is that indicated by Toynbee. Disease of the internal ear appears usually to set up meningitis in the posterior fossa of the skull. Post-mortem evidence shows that the condition of the mastoid cells and of the roof of the tympanum and the situation of the lateral sinus play the most important part in determining the direction in which the disease shall spread, and that therefore too great stress should not be laid on the presence or absence of disease of the mastoid, although it may be somewhat of a guide to the seat of the mischief. The condition of the wall of the middle ear teaches nothing which can be of assistance in diagnosis. The most convenient arrangement of the complica-

tions to be discussed will be according to their site: (1) dura mater, (2) cerebral tissue, (3) sinuses, (4) pia-arachnoid.

Owing to the thinness of the tympanic roof, the dura mater over the anterior surface of the petrous bone is rather more often inflamed than that over the posterior wall of the middle ear, but less often if we include the part bounding the mastoid cells as well. The otorrhœa in these cases is of old standing; generally the bone beneath is inflamed, discolored, carious or necrosed, and in some of the cases the bone presented carious apertures, through which the infection had spread directly. Inflammation or sloughing of the dura mater occurred in ten out of twelve cases of temporo-sphenoidal abscess, and probably seven of these could not have recovered unless the dura mater as well as the abscess could have been allowed to drain. In extra dural abscess which may produce optic neuritis, the inflammation has probably spread along the lymphatics around the veins. In three cases of mastoid disease which recovered after trephining and one without trephining, there was optic neuritis.

Of 18 cases of cerebral abscess, 9 occurred on each side of the brain. All the patients were men, and 13 of the cases occurred between the ages of 10 and 29, the only case over 40 being one of pontic abscess. They agree with the general experience that otorrhœa does not set up cerebral abscess until it has lasted months or years, for in only two was its duration under a year. Three of the abscesses were in the cerebellum, one in the pons, two in the cerebrum ovale, and the remaining twelve in the temporo-sphenoidal lobes near the tympanic roof. The dura mater in this latter group was healthy in only two, in eight it was sloughing, in two inflamed, and in one there was a localized extra dural abscess.

When there is healthy brain tissue between the temporo-sphenoidal abscess and the bone it is probable that the infection has been spread by the veins which empty into the superior petrosal sinus from the temporo-sphenoidal lobe on the one hand, and the tympanum on the other, by means of a septic phlebitis, or more probably by means of the peri-vascular lymphatics; for if it had been due to a phlebitis, thrombosis of the superior

petrosal sinus would have been occasionally noticed. Only five of the abscesses were less than an inch in diameter, while ten exceeded two inches.

Thrombosis of the lateral sinus occurred twenty-two times. In some there was well-marked phlebitis; in considerably more than half the thrombus was suppurating, and in others where not breaking down it had set up a pulmonary pyæmia, thus demonstrating its septic nature. The disease more often spreads from the posterior wall of the middle ear than from the mastoid cells; this is important, for any treatment to be successful must deal with the condition of the bone and dura mater as well as with the sinus. Whenever the mastoid vein, which perforates an inch and a quarter behind the meatus and on a level with it, is found thrombosed, the sinus should be explored. The clot may be a small one, or it may occupy the whole of the sinus and spread into the internal jugular or general venous system of the skull. Thrombosis is a fatal lesion, but there is some evidence that patients with the typical symptoms appear to recover, at any rate for a time. The otorrhœa is generally, but not always, of long standing; in only five it lasted less than seven weeks. The onset is usually sudden, the chief symptoms being pyrexia, rigors, pain in the occipital region and in the neck, associated with a septicæmic condition. Earache, as distinct from headache, is more common than with meningitis and abscess; vomiting and coma were also met with. In no other complication are erratic pyrexia and rigors so constantly present, and it will be always justifiable to assume that they probably indicate thrombosis in any patient in whom freely opening the deeper mastoid cells and draining the ear have not been followed by their subsidence. Well marked optic neuritis may be present, and is more suggestive of sinus thrombosis than of other lesions. The appearance of acute local pulmonary mischief or of distant suppuration is almost conclusive of thrombosis; and, as death in three-quarters of the cases ensues from pulmonary pyæmia after a course of but three weeks, treatment, to be of any value, must be directed to the prevention of the pyæmia.

QUARTERLY RETROSPECT OF GYNÆCOLOGY.

BY T. JOHNSON-ALLOWAY, M.D.,

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The Surgical Treatment of Puerperal Peritonitis.—Mathew D. Mann says that there is no reason why pus within the abdomen should not be let out as well as pus within the pleural sac, or within any other serous cavity. Under such circumstances the cavity is simply converted into a large abscess, and as such should be drained. Nor does it make any difference what the origin of this pus may be. It is all the same whether it comes from the bursting of an abscess of one ovary or from the gonorrhoeal salpingitis, or from a suppurative process originating within the uterus after confinement and extending through the tubes to the peritoneal cavity. The pus, if present, must be evacuated before recovery can take place. Several things stand in the way of the general adoption of the operation. One is the traditional fear of the peritoneum—a fear which still lingers in the minds of the general profession, but which has long since vanished from the thoughts of the laparotomist. If there is already inflammation with pus formation, what worse can happen? What harm can the opening of the cavity do? Such incision, if made with due care, is in itself absolutely without danger, as has been proven over again. So, if no good is done, or might happen in the case of mistaken diagnosis, no harm will result.—(*Trans. New York Medical Society.*)

Non-Retention of Urine in Young Girls and Women—No disease is more annoying or more depressing to a patient than a disease of the bladder which calls for an almost constant evacuation of that organ. Frequent micturition is usually due to cystitis, or urethritis, or to the presence of a tumor or foreign body in the bladder, but at times it is due to indifferent causes. After a time in certain cases the walls of the bladder contract, owing to hypertrophy of the muscular layer, and the capacity of the bladder is reduced to one or two ounces. Such patients are obliged to urinate every few minutes during the day, and at night when asleep the urine dribbles almost continually. Dr. H. Marion

Sims advocates the systematic use of injections of warm water to dilate the bladder and increase its capacity, for the alleviation and cure of this distressing condition; and reports a number of cures effected by the method. The apparatus used by Dr. Sims is a silver catheter attached by means of a rubber tube to a Davidson's syringe. He injects water, comfortably warm, into the bladder by means of this apparatus until the bladder is distended. This is indicated by the sensations of the patient. The process is quite painful, and, sometimes, to the patient, "unbearable," and requires patience on the part of the physician and bravery on the part of the patient to bring about good results. The injections are practised daily for one, three or more months, until the bladder will hold a pint of water, and then not so frequently. Improvement in the patient's condition and ability to retain urine usually keeps pace with the dilatation. The water injected should not be allowed to remain, but should be drawn off at the conclusion of each treatment. This method of treatment appears logical, and the results in the hands of Dr. Sims have been quite brilliant, as many of the cases had been the rounds of physicians and had been subjected to many methods of treatment. Apparently the only danger inherent in the method is the risk of rupturing the bladder, which could only occur under exceptional conditions of the walls of that organ, or when undue violence was used in giving the injection. Dr. Sims is to be congratulated for having perfected a successful method of treating a distressing class of cases.—(*Med. and Surg. Reporter.*)

Corporeal Endometritis.—It is considered that the increasing attention that is being given to affections of the interior of the uterus is being productive of great benefit to women suffering from uterine affections. Treatment implied as a necessary step dilatation of the cervix and os internum, and this dilatation is believed to be of itself a great, even in some cases the chief, factor in giving relief. Further, the fact that such dilatation could be done at one sitting, under anæsthetics, and without any previous use of dangerous tents, rendered it possible to examine and relieve many cases which formerly would have continued to suffer for years, imperfectly relieved by other methods. Dr.

Robert Bell considered that endometritis was not a rare disease. With regard to the diagnosis, he considered there was not much difficulty ; in fact, it might almost be diagnosed by the subjective symptoms alone. For example, if a patient complained of a bearing-down sensation, accompanied by pain and a burning sensation in the pelvis, acute suffering over the sacrum, dysmenorrhœa, a copious purulent or muco-purulent discharge, and an irritable condition of the bladder and bowel, and also suffered from lowness of spirits, irritability of temper, disturbed sleep, on a vaginal examination the uterus would be ascertained to be hyperplastic and flabby, while from the os a copious purulent or muco-purulent discharge would be seen to exude. In addition, there might be exaggeration of pain in the pelvis at the menstrual period ; in consequence of this aggravated congestion, there was coagulation of the blood occurring at the moment of its exudation which necessitated the clots being expelled by uterine contractions. The inflammatory conditions might be so acute that coagulation actually took place within the lining membrane itself, and thus there would be, if not absolute absence, yet paucity of discharge, and from the same cause there might be an absence of catarrhal discharge also. He held that salpingitis never occurred without a prior endometritis having existed, and that the inflamed condition of the tubes was due to the inflammation having spread by continuity of tissue. In treatment, the first object must be to dilate the os internum, then to swab out the uterine canal, and apply freely some form of stimulating antiseptic (iodized phenol).—(*Pridgin Teale, M.D.*)

The Surgical Treatment of Local and General Peritonitis.—The author (*Gill Wylie*) reports five successful case of laparotomy for intestinal trouble, in two of which perforation of the intestine and general septic peritonitis were present. He presents the following conclusions, which are based upon his large experience in abdominal surgery :—

When there are symptoms of local peritonitis, intense pain and tenderness, followed by tympanites and vomiting, with chilly sensations and rise of temperature, search should be made for the cause. As a rule, the pain will soon become localized over

the region of the Fallopian tubes, the cæcum, or gall-bladder, or some old ventral or inguinal hernia. If signs of a tumor or exudation can be definitely made out, and the general symptoms indicate the formation of pus, then the patient should be etherized and the pus reached by incision, the pus evacuated, and the cavity washed out and drained. If it is in, or involves, the tubes and ovaries, the abdomen should be opened, and if the tube or tubes are occluded and pus found, they, with the ovary or ovaries, should be removed. If the abscess is around the appendix vermiformis or cœcum, an incision should be made near the crest of the ilium and the peritoneum dissected up till a place is reached where the peritoneum is adherent to the tumor, which should then be carefully opened, the pus evacuated, the sac washed out, and a drainage-tube introduced without opening into the free cavity of the peritoneum. If it is about the gall-bladder, if the signs of pus can be made out, an incision over the sac should be made and the pus evacuated.

If the general symptoms are severe and no localized centre of pus made out, then an incision should be made in the median line and the peritoneal cavity explored with the index finger. If then a pus sac is found, if it be so situated that it can be reached by another lateral incision and the pus evacuated without allowing the pus to escape into the free peritoneal cavity, it should be made, and the median incision closed. If it cannot be reached by a lateral incision where the wall of the sac is adherent to the abdominal wall, then the pus should be drawn off from the sac by an aspirator or trocar, and the cavity washed out clean with an antiseptic solution before it is freely opened, and a drainage-tube inserted.

If signs of general peritonitis show themselves—that is, by vomiting, obstinate constipation, tympanites, etc.—then a free incision should be at once made in the median line and the starting-point of the peritonitis found if possible. If it is over the cæcum an incision should be made over it, and the pus washed out by means of hot water of a temperature of 110° to 115°F., run from a large fountain syringe with a large-sized glass drainage-tube attached to the rubber. After the free pus about the

cæcum is well washed out, several fingers or the whole hand should be put in the abdominal cavity and the intestinal adhesions broken up, and all puddles of pus completely washed out. Then a glass drainage-tube should be introduced into each opening and the wounds closed around them, etc.

In pelvic peritonitis, as a rule, the operation is not necessary to save life ; but it may be, and it is, better to operate during the first attack, if there are symptoms plainly indicating the formation of pus, for the adhesions are much more easily broken up, and more complete removal of the diseased organ can be done than after contraction and dense adhesions have formed, as they do after repeated attacks of inflammation. Besides, dangerous pelvic abscesses are avoided and the bad influences of chronic invalidism are prevented. Of course, I refer to severe cases of local peritonitis, where there are symptoms either subjective or objective, indicating beyond reasonable doubt the presence of pus.

In typhlitis the operation should be done before the fourth day, the earlier the better, so as to prevent the chance of rupture and septic general peritonitis, which is, as a rule, attended by so much shock that no operation can do any good. As a rule, general peritonitis from a rupture of a septic abscess is likely to be attended with more shock and rapid failure and death than peritonitis from direct perforation.

In all cases of general peritonitis an exploratory incision should be made as early as possible, after trying to lessen the tympanites. If an exploratory operation does no good, it is not likely to add much to the danger.

There may be cases of idiopathic peritonitis, but I have never seen one proved by anything to be relied upon. Certainly in septic peritonitis, where shock is not too great, free opening, washing out, and drainage will cure some cases. It helps, if it does not cure, tubercular peritonitis, and exploratory incision has proved to be, in the hands of experts, almost entirely free from danger, and it must become the practice in all cases of general and severe cases of local peritonitis where there are marked symptoms of the formation of pus, an extension into a

septic peritonitis, or intestinal obstruction. Many cases of local peritonitis due to salpingitis may never necessitate a laparotomy, for they often become encysted, and give comparatively little trouble. Not infrequently the symptoms are due to a severe metritis, where the peritoneum covering the enlarged and inflamed uterus becomes so sensitive as to give in a marked degree almost all the symptoms of a peritonitis due to salpingitis, and repeated attacks of this kind are often mistaken by good physicians for genuine cases of salpingitis. But I am referring here to cases where a distinct tumor can be felt in the broad ligaments, accompanied by other symptoms indicating the formation of pus, which, when not operated on, rarely fails to cause a general peritonitis, and kills or makes the patient a confirmed invalid.

In typhlitis the diagnosis is, as a rule, comparatively easily made, and I believe it will soon become the general practice to operate early in all well-marked cases. What I wish to especially advocate is early operation in cases of general peritonitis, both those starting from a local peritonitis and those due to the escape of septic matter into the peritoneum, and to make it plain that to succeed in such cases it will not do to merely open the belly, allow pus to escape, put in a drainage-tube or gauge, and leave intestinal adhesions causing obstruction to remain to kill even more certainly than septic poison, or fail to empty and wash out puddles of septic fluid encysted among the coils of intestines; but we must make free incisions large enough to introduce the hand, to break up all adherent intestines, and freely wash the whole cavity of the peritoneum and put in two more drainage-tubes. Without question, in many cases where the patients are debilitated weeks before the starting of the peritonitis, and in those cases where the septic poison is too virulent to be successfully washed out, our patient will die in spite of an early operation. But are the chances of this class of cases getting well lessened by the operation? I think not. Death may be hastened, but that is all. But the majority—the large majority—of cases of general peritonitis taken early are not in this desperate condition, and yet, if not operated on, at least four out of five die.—(*W. Gill Wylie, M.D.*)—*Medical Record.*

Injuries of the Bladder during Laparotomy.—The author (Reeves Jackson) has collected 67 cases of injury of the bladder during the performance of laparotomy among 41 operators, and thinks that this list is sufficiently large to show that the accident is by no means infrequent. Considering the conditions under which bladder injuries may happen during laparotomy, it is not discreditable to any surgeon to meet with them, for they may not be due to any carelessness or lack of skill on his part. In many of the foregoing cases no possible degree of diligence could have averted the accident. Adhesions of the peritoneal surface of the elongated bladder to that of the anterior abdominal wall frequently cannot be known in advance, and their existence is only demonstrable after the viscus has been opened. The use of the catheter as a diagnostic means is not always available, because the compression of the bladder against the pubis may prevent the introduction of the instrument beyond that point. Certainly, however, this should always be attempted in any case of suspected difficulty, and would seem to be even a proper and unobjectionable routine method. Another useful precaution is to avoid prolonging the abdominal incision far down toward the pubic bone until the opening into the peritoneum has permitted the relations of the bladder to be ascertained. The mortality of the cases in which the bladder has been wounded is large, namely, about 30 per cent. ; but this is due to the complicated and serious character of the cases in which the accident has occurred, the consequently increased length of the operation and the greater danger from shock, rather than to the mere vesical injury. Inasmuch as the bladder is recognizable with more difficulty when empty than when full, it would be better, in cases presenting doubtful features, to commence the operation with the viscus wholly or partly distended. When its position has become known, after the completion of the abdominal incision, it may be emptied by an assistant.

Treatment.—When it is known at the time of operation that the bladder has been cut or torn, the opening should be at once closed with a continuous suture of catgut or fine silk, applied so as to invert the edges of the wound and bring together the peri-

toncal surfaces. A permanent catheter ought to be used during the first two days. After the expiration of that time its constant use is usually unnecessary; and if the wound has been small—less than one inch in length—the instrument may be subsequently dispensed with. If, however, the wound has been large—exceeding two or three inches—the bladder ought to be artificially emptied as often as every three hours during three or four days additional. The catheter should be used so long as the urine contains blood.

In the cases in which urine appears through the abdominal wound subsequently to the operation, at a time and under circumstances which might make it dangerous or inexpedient to reach the seat of the vesical injury, the catheter ought to be used either continuously or at short intervals, for the purpose of lessening the amount of urine which escapes through the fistula, and thus aid in the closure of the latter. If, however, the fistulous opening should show no disposition to close after two or three months, the edges ought to be freshened to the depth of half an inch or more and stitched together.

In exceptional instances it may be expedient to affix the edges of the wounded bladder within those of the abdominal incision, in the manner detailed by Thomas and others; but as this method must interfere to some extent with the subsequent contractility of the bladder, it is not to be commended as a usual practice. The suturing and “dropping” of the vesical wound is the better method.—(A. Reeves Jackson, M.D.)—*Journal American Medical Association*, Feb. 22, 1890.

The Surgical Treatment of Cancer of the Uterus.—The author for convenience divided the uterus into three parts as they are affected by the disease, viz., the vaginal, cervical, and body, and then proceeded to explain his views as to the palliative and radical methods of treatment. In very bad cases, or any such that were beyond operation, he advised the patient to be kept at perfect rest, and that the vagina should be washed out twice daily with sanitas or some other antiseptic lotion, and then through a speculum carefully wiping out the cavity with plugs of wool, and finally applying tampons of wool soaked in equal parts of pinus Cana-

densis and glycerine in ten parts of sanitas oil, ten grains of chloride of zinc, and one ounce of vaseline. By adopting these methods, it is claimed that the patients are freed from pain and all bad odors, and that they improve in general health, strength, and gain weight in cancer of the vaginal and cervical portions. Mr. Jessett discussed the treatment by caustics, the cautery and *écraseur*, and finally said he objected to all of these, and contended that the disease could be more easily and certainly removed by dragging the uterus as far down as possible, and then with scissors bent on the flat he snips cautiously the mucous membrane, and by pushing the vaginal portion with the adjacent tissues upwards and dragging the uterus freely downwards, and cautiously snipping, he claimed to be able to remove as much of the uterine tissues as he required, even to the fundus of the uterus, as explained by Dr. John Williams. Mr. Jessett quoted six cases in more or less advanced states, in which he had operated with success in all; nine months after the operation there was no recurrence. Mr. Jessett finally discussed extirpation of the uterus for cancer of the body of the uterus, but expressed his opinion that owing to the severity of the operation and the uncertainty as to whether the disease had extended to the Fallopian tubes and ovaries, he did not think the operation was to be recommended except when the disease was recognized in a very early state.—(*Mr. Fred. B. Jessett.*)

Adherent Omentum.—Several authorities have observed that in the course of operations for the removal of the uterine appendages the omental adhesions are often found to be very extensive and troublesome. The omentum may adhere to the parietes, the bladder, the intestines, the uterus, or the appendages. In rare cases it draws the tube and ovary upwards high out of the pelvic cavity. As a rule, however, the omentum is drawn downwards by its adhesions, pulling after it the transverse colon, the stomach, and the coils of small intestine to which it adheres. This condition cannot fail to cause much local trouble. Certain operators have found that, after very careful removal of inflamed ovaries and cystic tubes, the surrounding parts being disturbed as little as possible, the patients often suffer as much pain and

discomfort after convalescence as before the operation. On the other hand, in similar cases, where the ovaries and tubes are found too adherent to neighboring structures to allow of removal without great risk, the patient is often permanently cured of the pain and gastric and intestinal trouble for which she sought relief. The "exploratory operation" has proved a cure, not by the faith of the patient who feels sure that an operation will cure her, but by the breaking down of troublesome omental adhesions. In the *Hospitals-Tidende*, 1889, Dr. Howitz describes a case of strongly adherent omentum, with displacement of the stomach and intestines, as described above. The patient had been treated for gastric ulcer, also for "the womb"; pessaries had been applied, and douching and massage of the hypogastrium practiced in vain. Dr. Howitz carefully liberated the omental adhesions, so that the displaced viscera returned to their normal positions. All the pain and discomfort from which the patient had so long suffered rapidly disappeared.—*Brit. Med. Journal*.

Malignant Disease of the Corporeal Endometrium—In the *New York Medical Record*, April 5th, 1890, Dr. Henry C. Coe writes a very valuable essay on the above subject. Under malignant disease of the corpus he includes, in the order of frequency, carcinoma, sarcoma and adenoma. He cannot speak positively regarding the relative frequency of occurrence of these different varieties, due, he says, to the unfortunate negligence of those who are in a position to form statistics. In regard to frequency of sarcoma of the corpus, statistics are often based upon the microscopic examination of scrapings, or the naked eye examination alone; this method, of course, should not be in evidence at all. Dr. Coe draws attention to the difficulty of deducing facts of value from hospital statistics because of the biased views and inaccurate statements of the men who make them. Dr. Coe states that in spite of statements of clinical observers to the contrary, sarcoma of the endometrium, especially the diffuse form, is very rare. In speaking of diffuse recurrent adenoma, he states that our statistics are still more imperfect. Cases, however, have been recorded by Winckel, Gusserow, Schröder, Thomas, Goodell and himself. The author shows that in between

20 and 30 per cent. of reported cases of malignant disease of the corpus uteri the patients were sterile, showing that pregnancy and parturition are not active etiological factors. Sarcoma is more common before, and carcinoma and adenoma after, the menopause. Pathologists of late are regarding malignant adenoma of the endometrium of more frequent occurrence than had been heretofore considered, and that it is wise to regard as histologically malignant an adenoma which infiltrates the submucous tissues and yields on examination epithelial nests with a well-marked alveolar arrangement. In speaking of the gross appearances of primary epithelioma and sarcoma of the endometrium, Dr. Coe states that it is difficult to distinguish macroscopically these two malignant varieties of disease in any given case, and that the microscopical examination will present the characteristic appearances of both in the same specimen, entitling the disease, according to Klebs, to be described as carcino-sarcoma. Dr. Coe discusses the classical symptoms of carcinoma and sarcoma of the corpus uteri—*pain, hemorrhage, and foetid discharge*,—symptoms which are rigidly indicated in recent American treatises on the subject. He shows how, and adduces Winckel in support, these symptoms are only indicative of advanced disease, when it is too late to refer the case to the surgeon with any hope of benefiting the patient. 'The same pain is due to exposure of nerve-endings in the deeper layers through ulceration or to peritonitis. The offensive discharge marks the necrotic processes of advanced disease. The cachexia so much spoken about is due to septic absorption attendant upon the necrotic process. Hemorrhage is more often a slight "show" on exertion, and should lead to an examination, especially if it occurs after the menopause. Dr. Coe gives some good advice to general practitioners in regard to the importance of these symptoms, and not to wait until the disease has advanced so far that operative treatment can be of no avail. Dr. Coe states that in his experience the two conditions most frequently mistaken for malignant disease are hyperplastic endometritis (*endometritis fungosa*) and intra-uterine fibroid, especially if sloughing. With regard to the treatment of malignant disease of the corpus uteri, Dr. Coe is decidedly in favor

of total vaginal extirpation. He believes that the curette is a dangerous instrument in these cases; he has made several autopsies in fatal cases and found perforation of the uterus by the curette. He concludes his most instructive paper by a detailed report of four cases.

Dr. Coc also writes a paper upon *Laparotomy for Intestinal Obstruction following Vaginal Hysterectomy* (*Amer. Journal Obstet.*, vol. xxiii. No. 2, 1889). He reports one case rather fully, in which symptoms of obstruction set in on the fourth day after the operation. He delayed re-opening the cavity until about the sixth day. He found a coil of intestine firmly adherent to the wound in Douglas's pouch and obstructed. The patient died next morning from shock following the second operation. He regretted very much he did not operate earlier, but was otherwise influenced by council. He mentions six other cases reported by other surgeons which had been operated upon a second time. All of these cases died as a result of the second operation. This experience is consistent with what is generally known of secondary operation for the relief of obstruction, if not done immediately after onset of symptoms. Dr. Coc says:—
“In reviewing these seven cases (including my own), one is struck with the fact that the pathological conditions and the clinical symptoms were almost identical. In each one there was an adhesion of one or more coils of small intestine to the edge of the vaginal wound, with distention and bending of the gut above the point of adhesion, thus obstructing the lumen. Although there was intense congestion of the serous covering of the intestines, in no instance was general peritonitis found at the operation. In all but one case death seemed to be due primarily to exhaustion or, where laparotomy was performed, to the shock of the operation. The symptoms continued to be indefinite until after the fourth day, and the classical symptoms of intestinal obstruction (especially fæcal vomiting) appeared when it was too late to profit by them. Certain points are to be noted in this connection, as emphasized by Reichel, bearing on the differential diagnosis. Ileus is most likely to be mistaken for general peritonitis, especially if there should be general tender-

ness. But, as I noted in commenting on my case, pain is conspicuous by its absence. There is little, if any, elevation of temperature, the pulse may not be accelerated for several days, and tympanites is not excessive. As in the case reported, it may be unsymmetrical, being more marked on one side; this I regard as an important sign, in fact almost confirmatory when taken in connection with the visible movements of the distended gut. The absence of flatus and fæcal movements after the repeated administration of cathartics and high enemata should at once awaken suspicion, especially if four or five days have passed without an evacuation, even though the patient may be entirely free from nausea. It is important to note that the passage of scybalous masses which were contained in the large intestine may mislead the surgeon as well as the nurse, and lull the former into a sense of security. Nothing but the thorough clearing out of the small intestine and the free escape of gas, with lessening of the tympanites, can justify him in feeling certain that his suspicions of obstruction were unfounded. Fæcal vomiting is, of course, conclusive evidence, but the histories of these cases, as of those in which the obstruction has followed laparotomy, show that it usually occurs at a stage in the case when the time for successful operative interference has passed."

Total Extirpation of the Uterus.—Dr. Münchmeyer described in a recent number of the *Archiv für Gynäkologie* an account of 110 cases of total vaginal extirpation of the uterus in the Dresden Women's Hospital. Eighty-eight were cancerous; the mortality in these malignant cases was five per cent., and 64.5 per cent. of the patients who recovered remained over two years free from recurrence. The appendages were latterly removed entire whenever that step was practicable, as in two cases where they were left behind they became involved in the cicatrix at the top of the vagina and caused so much pain that an operation was needed for their removal. Parametritic induration was frequent, but it gave less trouble than narrowness of the vagina. Dr. Münchmeyer did not particularly dread injury to the bladder, as if immediately sutured a wound in the vesical walls was not serious. Recurrence of cancer did not appear to be more frequent

when inflammatory infiltration in the parametrium and utero-sacral ligaments existed at the time of operation. Carcinoma of the cervical canal proved the most serious form; cancer of the body was less, and cancer of the vaginal part of the cervix least prone to rapid recurrence. Total extirpation was also performed for small fibroids, which crippled the patients, in 17 cases; the mortality was given as 11 per cent. Five of these operations were performed, all successfully, for total prolapse of the uterus; eight, also all successful, for disease of the appendages, on the plea that without tubes and ovaries the uterus was useless, and that the operation was less dangerous than an abdominal section. In this country it is doubtful whether many authorities approve of total extirpation of the uterus excepting for malignant disease. The above statistics will be interesting in reference to the recent discussion on Dr. Cullingworth's paper at the Obstetrical Society.

Technique of Vaginal Hysterectomy.—The late Dr. Jas. B. Hunter of New York published shortly before his death a paper upon the above subject in the *Transactions of the New York State Medical Society*. The author emphasized the necessary demonstration of two facts in regard to this operation. First, the immediate mortality from the operation must be small; second, the results, immediate and remote, must be such as to show that the benefit to the patient is sufficient to compensate for the risks incurred.

The principal dangers following this operation are shock, hemorrhage, peritonitis and septicæmia. The author points out in very emphatic language the great necessity for rapidity of action on the part of the surgeon in this as in all gynæcological operations. Shock has been the cause of death in a large number of patients in which the operation was prolonged to over one hour. Much valuable time in such cases was lost in securing vessels with ligature. He refers to the advantage of Péan's method with hæmostatic forceps, and gives him priority of claim in this matter over Richelôt. He shows how vastly superior the forceps are to any form of ligature in this operation. In eight cases recently he used no ligature of any kind. In several cases the time occupied for the operation was forty-five minutes,

and in one case it was thirty-five. The forceps favor drainage when it is most required. There is less danger of injuring the ureters than with the ligatures, as they can be applied more closely to the uterus. More traction on the tissues is required in applying a ligature than in applying the forceps. Dr. Hunter did not try to include all of the broad ligaments in one instrument. He used a Tait forceps having a bite of about one inch and a half. Richelôt's forceps are too long in the blade and needlessly heavy.

ABSTRACT OF TRANSACTIONS OF THE AMERICAN PEDIATRIC SOCIETY.

BY A. D. BLACKADER, B.A., M.D.,

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The first meeting of the American Pediatric Society was held in Washington last September. Its transactions are just published. The meeting was opened by an address by Dr. Jacobi of New York. Among the papers read was one on *Two Cases of Double Empyema, by Dr. Francis Huber*. The first, a lad of 13 years, fell into an excavation eighteen feet deep, from which he was taken out unconscious. To restore him to his senses he had been thoroughly drenched with water, and shortly afterwards taken home. In a few hours he was seized with a chill, intense pain in the chest, fever and cough with bloody sputum. There was no vomiting of blood. On the third day he came under observation. There were no evidences of injury to the head, nor were any of his ribs fractured. A diagnosis of double pleuropneumonia was made, the percussion note being absolutely flat on the right side. The heart's action was very weak. On the fifth day he was seen by Dr. Jacobi in consultation and the diagnosis confirmed. In view of the extensive pulmonary œdema present anteriorly, it was not thought probable he would live longer than twenty-four hours. Free stimulation was ordered, half an ounce of brandy every half hour, one minim of digitalis with three grains of camphor hourly, and carbonate of ammonium every two hours. Morphia was given hypodermically to relieve

pain and restlessness. He made a slow improvement. At the end of a fortnight an exploratory puncture revealed pus in the right pleural cavity, and a pint was drawn off by aspiration. Two days afterwards the left cavity was opened posteriorly and two large drainage tubes inserted. Large quantities of pus escaped. No broken down clots were discovered, nor any evidence of an old hemorrhage into the cavity. Four days later the right side was freely incised, allowing a large amount of pus to escape. Antiseptic gauze dressings were applied in both cases. The patient made a good recovery.

The second case had a somewhat similar history of a fall, followed by pyrexia, with somewhat indefinite symptoms pointing to the lungs. On the eighth day an exploratory puncture revealed the presence of pus in the right pleural cavity, which was opened, a drainage-tube inserted, and antiseptic dressings applied. On the left side there was dulness on percussion, and bronchial breathing with friction sounds at the posterior and lower parts. A week later, evidences of pus being obtained, the left side was treated similarly. The boy made an excellent recovery.

Remarking on the cases, the doctor says the most careful examination gave no evidence of any direct injury to chest wall in either case. Both lived under poor hygienic conditions. In both cases the excessive dyspnoea contra-indicated the use of any anaesthetic. In reviewing the literature of the subject, less than a dozen cases of double empyema were met with.

In the discussion which followed, Dr. Osler said that he considered empyema a surgical affection. Free, full and satisfactory incisions should be made in the case of adults, but in children aspiration should first be tried. Many cases at an early age are cured by one aspiration. The aspiration should not be repeated, but if the pus re-accumulates, incision should be practised.

Dr. O'Dwyer, of New York, read a paper *On the apparent physical paradox involved in the Re-expansion of a Collapsed Lung, while a free opening remains in the Pleural Sac.* He said none of the theories so far advanced offer any satisfactory explanation of the mechanism by which this process is accomplished. If the inspiratory movement be nothing more than the

production of a partial vacuum within the chest, with consequent inrush of air, until the pressure is equalized there can be no force developed by this movement to overcome the contractility of the lung, because the atmospheric pressure being the same in both situations the power to create a vacuum is destroyed, and the lung will simply remain contracted as long as the external wound remained patulous. But every one who is familiar with the treatment adopted for the cure of empyema knows that the clinical teaching is directly opposed to the teaching of physiology in this instance. He knows not how it is accomplished, but he knows that a lung that has been completely collapsed and compressed becomes so fully reinflated that in after years it is impossible to distinguish any difference between the two sides, and that the principal part of this inflation takes place while free communication exists between the pleural sac and the atmosphere. The theories usually advanced are: 1. The small size of the opening or its valvular form produced by the dressing or otherwise, tends in some measure to exclude the air. 2. The presence of old adhesions, which prevent complete collapse of the lung, or the presence of new ones acting in a similar way. 3. The force brought to bear on the contracted lung by the recoil of air from the sound side on the act of coughing or other forcible expiratory effort. Dr. O'Dwyer thought that, judging from his own experience, the size of the opening or its valvular arrangement has no influence whatever in aiding the expansion of the lung. Old adhesions seldom exist in cases of empyema in young children. Before new adhesions can form, the opposing surfaces of the pleura must not only be brought in contact, but held in that position for some time. The last theory to be considered is the effect of forcible expiration on the collapsed lung while the glottis is either partially or completely closed. Here we have to deal, not with the presence of the atmosphere as in inspiration, but with compressed air, the amount of compression being in proportion to the muscular effort brought to bear, and the obstruction offered to its escape by the degree of closure of the glottis. Cough is probably the most powerful of these efforts, and were this act repeated with sufficient frequency, it might be sufficient to re-

expand a contracted lung, and even keep it in contact with the costal pleura sufficiently to allow some adhesions to take place ; but it is not frequent, in fact some children with empyema cough very little, and it can have no influence when both pleural cavities are open at the same time, as in the cases reported by Dr. Huber. Every inspiratory expansion of the chest operates in the opposite direction, drawing away the ribs from the lung and so tending to prevent adhesions.

In a previous paper the author has suggested the possibility of a physico-chemical force generated by the interchange of gases in the pulmonary vesicles, possibly as the result of an attraction between the oxygen and the hæmoglobin. The mechanical theory of the circulation which assumes that the action of the heart is sufficient to propel the blood through the whole circuit from the left back to the right does not explain the important fact that venous blood will not circulate in the systemic capillaries.

Dr. W. P. Northrup, in opening the discussion, referred to the Bradshawe lecture on Pneumothorax by Samuel West, F.R.C.P., Lond., in which the lecturer says : " The fact, therefore, that the pleural cavity may be laid open, and that yet collapse of the lung with consequent pneumothorax may not occur must be accepted, and an explanation sought." Again, " when the lung does not contract after the pleura is opened, it must be kept on the stretch by some force greater than the force of the normal elasticity of the lungs, and . . . this force is probably to be found in the cohesion between the two serous surfaces." Then follow elaborate experiments with disks of wood, upon which were stretched stomachs and other membranes, the cohesion of which upon one another, according to the lecturer, demonstrated that a lung would not let go its hold upon the parietal pleura except under force directly applied. Dr. Northrup then related experiments conducted on dogs in the Loomis laboratory by himself, with the assistance of Prof. W. Gilman Thompson, to determine whether there was sufficient cohesion between the two pleural surfaces to maintain them in apposition after the costal pleura had been opened without violence. A dog was placed under

ether—the tissues carefully dissected away till the parietal pleura was reached ; through it the fully expanded lung could be seen gliding back and forth in respiration. A small pinhole opening was then carefully made through it, when there was an instantaneous recession of the lung. On the next expiration a fine thread of air was expelled, and by the second respiration the lung was not to be seen at all and a probe passed two and a half inches straight down before it reached the lung. The experiment was repeated under varying conditions on different dogs, but always with the same result. In one, a glass disk was buttoned quickly through the slit so as to act both as a valve and as a window. Respiration at once improved. With each respiratory movement a few bubbles of air escaped at the margin of the glass, but none entered. Finally the lung appeared fully expanded, and glided rhythmically back and forth upon the glass as upon the pleura-covered wall. The dog, which had by this time recovered somewhat from the ether, got upon the floor, evinced great activity, walked about, and wagged his tail. All the dogs, while recovering from the ether, made repeated attempts at vomiting. In the repeated retchings one dog failed to express the contents of his stomach, but did compress the sound lung and force air from it into the contracted lung till, from being small and cyanotic, the latter became aerated, rose-colored and expanded, but there being nothing to maintain its expansion, it contracted as soon as the effort was over. This muscular action is similar to, and almost identical with, that of coughing, and the incident serves to fortify the position taken by Dr. O'Dwyer that cough exerts the strongest expiratory force.

As the result of his experiments, Dr. Northrup concluded that Mr. West was wrong in his conclusions ; that it seemed to him that there was not a complete collapse on the opening of the pleura, but the lung fluctuates in the anterior and upper portions in a state of equilibrium between the elasticity of the lung on the one side and on the other by the pressure of the air within, assisted by a certain amount of force from the blood, the blood-vessels acting to a certain extent as erectile tissue. The experiments suggested to him the desirability of a valvular canula

with which to drain empyemic chests, but he thought that all dressings which catch the tenacious discharge from an empyemic cavity can act more or less as a valve, allowing the exit of pus and air, but on inspiration more or less effectually applying itself to the aperture, sufficiently at least to disturb the equilibrium in favor of diminished external pressure.

Dr. W. H. Welch, of Baltimore, said—I have never noticed any expansion of the lung exposed freely to the atmosphere by an opening in the chest wall. I have made experiments upon animals bearing on this point, and am prepared to assert quite positively that under these conditions no expansion takes place, nor can I conceive it possible that the physical conditions admit of any expansion. I apprehend that the basis for the discussion of the point, as to the possibility of expansion of a lung while there is still an opening in the chest-wall, must be observation of cases where adhesions have formed between the pleural surfaces. Such adhesions must alter the physical conditions, and and it is quite possible to understand how these adhesions could be arranged as to permit of considerable pulmonary expansion even when there is an opening in the thoracic wall.

Dr. Jacobi said—I understand that Dr. Welch says that no expansion of the lung can take place while there is an opening in the chest. We know, however, as the result of clinical observation, that the lung does expand nevertheless. No reasoning can gainsay the fact. Dr. O'Dwyer, in conclusion, said there can be no inspiratory force that will have any effect on the contracted lung under such circumstances. I claim that there is no other way of explaining the inflation of a collapsed lung except by the mechanical effect of forced expiration.

Dr. C. W. Earle, of Chicago, described a case of *General Subcutaneous Emphysema occurring in a Child of 3½ years*. The child had been ailing for nearly three weeks. Its illness had commenced as an ordinary cold, but had developed into a catarrhal pneumonia. Its progress had been apparently satisfactory till the sudden onset of the emphysema. When seen the subcutaneous tissues of the forehead, cheeks, neck and of the entire trunk anteriorly to Poupart's ligaments and posteriorly to

the iliac crests were filled with air. The respirations were hurried, the pulse moderately rapid, and the face, in addition to its peculiar appearance, had a worried and anxious look. The swelling had appeared in the neck at first, and rapidly extended to every other part of the body except the scalp and legs. The child was bandaged from its feet to its chin, and a stimulating and supporting treatment administered. At times it seemed to improve, but at last began to show signs of exhaustion, and died on the tenth day after the appearance of the complication.

So severe and such almost complete subcutaneous emphysema occurs comparatively seldom in children, and in most cases has a fatal termination. The possibility of the occurrence of subcutaneous emphysema is sometimes alluded to in text-books, but very few cases are recorded. It is generally due to some interference with or obstruction to respiration, and is occasionally met with as a complication of catarrhal pneumonia, pertussis, croup, and diphtheria. It may arise from perforating laryngeal ulcerations, from rupture of the tracheal rings either by force or the results of disease, and from rupture of the œsophagus. The prognosis is good unless the preceding disease has induced great asthenia. In weak children suffering from a grave malady, a fatal result may be expected. The means at our command are limited. The skin may be punctured where the emphysema is most prominent, the body may be bandaged, and the most sustaining treatment should be employed.

The report of a case of *Membranous Croup in a Girl of 12 years*, when tracheotomy was performed, with eventual recovery, was read by Dr. A. Caille. Speaking on this case, Dr. Jacobi said the disease was rare at this age. He agreed with what Dr. Caille had done. He had been converted to a belief in the value of intubation, but where the membrane was below, and where the croup was ascending, tracheotomy should be employed. He recalled twenty or thirty cases of fibrinous bronchitis terminating in diphtheritic tracheitis and laryngitis. In these cases, when this ascending form of croup reaches the larynx, cyanosis sets in very rapidly, and as a rule tracheotomy yields but little relief, if any. Still it ought to be performed, furnishing the only way in which access to the pseudo-membranes can be had.

The *Artificial Feeding of Infants* is discussed in two papers—one by Dr. A. V. Meigs, the other by Dr. J. Lewis Smith. Dr. Meigs again emphasizes the fact that in all his analyses of human milk it never contained more than one per cent. of casein, whereas cow's milk contains three or four. He thinks that much of the difficulties in the artificial feeding of infants are due to this fact, which is so often disregarded. He has somewhat altered the formula which he published some years ago, on account of the difficulty in obtaining good fresh cream. He recommends now fresh milk should be allowed to stand in a tall pitcher or other vessel for three hours in a cool place. From this the upper third or half is then slowly poured off, so as to obtain the upper layer, which contains much of the cream. When the child is to be fed there should be taken of this weak cream three tablespoonfuls, of lime-water two tablespoonfuls, and of sugar-water three tablespoonfuls. The sugar-water is to be made in the proportion of eighteen drachms of milk sugar to the pint of boiled water. Dr. Rotch recommends the sugar in powder to be used, and has constructed a little measure that will just hold the quantity for each half pint of food. He also recommends a smaller proportion of lime-water. Dr. Meigs leaves these suggestions to be acted on or not by the physician as he finds his experience guide him, but finds that his own formula has given him excellent results in one of the large founding hospitals in Philadelphia. Dr. J. Lewis Smith strongly recommends sterilization of the milk and the use of a cereal in which a considerable portion of the starch had been converted into dextrine. He now uses largely barley or wheat flour which has been subjected to the heat of boiling water for seven days in a double boiler. If there is indigestion or gastro-intestinal catarrh, he peptonizes the milk or makes use of one of the preparations of pepsin at each time of feeding.

Dr. Huber, of New York, read the notes of a case of *Acute Peritonitis following Vulvo-vaginal Catarrh in a Girl of 7 years*, simulating a perforation of the appendix; laparotomy—death. The patient had been troubled with a vaginal discharge for a short time. She was very anæmic, and though frail, did not

complain much. The vulva was inflamed; there were a few drops of pus about the urethral orifice. The hymen was intact. Close questioning failed to discover any cause for the catarrh. Unfortunately an examination for the characteristic coccus was not made. The patient was treated at the office for a few days. Complaint of soreness was now made about the lower pelvic regions, and she took to bed. On the following day, June 1st, she vomited a little blood, being mixed with contents of stomach. Slight soreness was complained of on palpation over pubes. The pulse was good; no distinct pain; a little diarrhoea; temperature normal. The little one at this point was laughing and in excellent spirits. At the evening visit a state of collapse had set in. The temperature was subnormal, pain in right iliac fossa was marked, and there was distinct muscular rigidity of abdominal walls. She had vomited a number of times. A perforation of the appendix was now suspected. The parents only consented to an operation on the evening of the 3rd. The operation was performed at 1 A.M. June 4th. Chloroform was cautiously given. The abdomen was opened by lateral incision. Considerable seropurulent fluid was found in abdominal cavity; the intestines were distended with gas, congested, and here and there coated with lymph. The appendix was found and presented a normal appearance. The right fallopian tube, however, with its fibrillated extremity, was inflamed and thickened, and evidently had formed the channel by which the infecting process had gained access to the peritoneal cavity. The abdomen was washed out, a rectal injection of hot water and brandy administered. Twenty hours later death occurred from heart failure.

Dr. A. F. Currier, in an article on *Vulvo-Vaginitis in Children* (*Med. News*, July 6th, '89), says: In adults this disease not unfrequently extends to the uterus, the fallopian tubes, the ovaries and the peritoneum, and may end fatally. I can find but one recorded case in which such an extension occurred in children; but it seems to me extremely probable that many of the deformed and undeveloped uteri, with which are associated so much dysmenorrhœa, sterility and domestic unhappiness, are the legitimate consequence of vulvo-vaginitis in early life.

Dr. A. Caille, of New York, read a paper entitled *A Plea for a general adoption of Personal Prophylaxis in Diphtheria*. The author regards the usual measures for the prevention of diphtheria—isolation, disinfection, etc., of each particular case—insufficient. Although of certain value, it is not all that we as physicians should insist upon. Diphtheria is without doubt primarily a local disease, due to the invasion of a micro-organism which provokes tissue necrosis, and to the formation of ptomaine, which enters the circulation and produces constitutional effects. It is agreed by all that a hyperæmic mucous membrane offers favorable conditions for its development, and that different forms of micro-organisms, identical in appearance with those supposed to be pathogenic, are found in the naso-pharynx in individuals in good health, and thrive in naso-pharyngeal mucus. Hence the value of keeping in a healthy condition the mucous membranes usually affected, and in avoiding the accumulation of catarrhal secretions. This may be done by the use of gargles, the nasal insufflation of harmless antiseptic solutions several times a day, the removal or reduction otherwise of enlarged tonsils, and the proper treatment of carious teeth by a competent dentist. Any one who will make it a rule to enquire will find that in most cases of nasal or pharyngeal catarrh, filthy gums and carious teeth had existed for some time previous to the diphtheritic onset. Similar preventive measures should be used in all cases of scarlet fever, measles and pertussis to avoid the development of diphtheritic exudations.

The Necessity of Prolonged Rest after some attacks of Diphtheria was emphasized in a short paper by Dr. C. W. Earle of Chicago.

Aneurism in Early Life was the subject of a paper by Dr. Jacobi, with the history of a case of aneurism of the abdominal aorta occurring in a girl of five, the subject of tuberculosis, with destructive disease in the hip joint. Unfortunately the specimen was lost before an exact examination had been made, but it must with such a history have been tubercular. The literature of aneurism occurring in the young is scanty. This makes the twenty-ninth case of which any report in modern literature can

be found. The causes have been various. In the case reported by Mr. Hutchison the cause was *an abscess* which had ulcerated into the aorta. The lining membrane was smooth and perfectly healthy up to the edges of the orifice of communication (one-fourth by one-eighth of an inch) with the sac. This was the size of two chesnuts placed side by side, and hung from the arch of the aorta into the pericardium. The heart was normal, but in the lungs were tubercles. The child died of acute pericarditis. *Embolism* depending on valvular disease has been the cause in several. *Endarteritis* was the cause in a boy of two years, who had an atheromatous arch and a hypertrophied heart. *Congenital incompetency of the walls of bloodvessels* has been found in a few cases. A fifth cause is to be found in morbid *histological alterations of the bloodvessel walls*, especially in the pulmonary artery, owing to the formation of "hyaline" substance principally in the middle coat. Some of the cases reported were small aneurisms in the pulmonary artery occurring in connection with excavation of the lung.

Both Dr. Booker of Baltimore and Dr. Jeffries of Boston have long and excellent papers on their recent investigations *on the bacteria found in the fæces of Infants affected with Summer Diarrhœa*. Dr. Jeffries says "Bacteria I believe to be at the bottom of the disease—that is, rule bacteria out of all foods and the alimentary canal, and summer diarrhœa would cease to be." Passing to the mode of introduction of the bacteria, it is probable, judging from cases, that certain forms are able to slip in, multiply, and produce disease in the healthy infant. Other forms need assistance; they are not able to thrive in the normal healthy infant intestine; it is here that the predisposing causes of heat, food, catching cold, and the like come in. They throw the digestion sufficiently out of order to give the plants a start. Improper feeding offers fine opportunities, affording good food for bacteria, scarcely acted upon by the disturbed digestion of the infant. That these bacteria do not cause more trouble in adult life is probably due to the greater power of resistance of adults, the more stable nervous system, and the more active chemistry of digestion. In regard to prophylaxis, it is clear that

bottle-fed infants should have sterile food. The stomach can then start fair and work unhampered on the, at best, unsatisfactory substitutes for the breast milk. Once given an attack of summer diarrhoea, the desire to kill the bacteria in the digestive tract at once suggests itself. Unfortunately, we have yet to find a germicide which is not an infanticide also. Escherich, who has gone deeply into the subject, suggests starving the bacteria by giving albuminous foods in cases of fermentation, and vegetable in cases of putrefaction. The difficulty is to tell which is going on in the child, or perhaps both may be acting at the same time. Where sterile food is not well borne, therefore it seems desirable to cut off food for a time as much as possible. The writer recommends a sort of series from breast milk to sterilized milk, wine whey, and, lastly, spirits and water; and places himself among those having more or less faith in the alkaline treatment. In closing, he says: Over and above the bacteria, it must not be forgotten that we have a child with lesions of the digestive tract to consider.

Dr. A. Seibert, of New York, gave a report on *Two years of experience in the Treatment of Gastro-intestinal Disturbances in Infants*, by washing out the stomach and the large bowel with sterilized water, or water rendered slightly antiseptic. Since September 1887 he has records of 1404 cases of infants under three years of age treated in this way. Stomach washing was used in 521 cases. Every infant stood the washing well, and was evidently relieved. In not one case did depression, convulsions or death occur shortly after the procedure, although in several cases it was in a state of severe collapse before the washing. The same thing can be said of the bowel washing. The nausea and vomiting ceased in every instance. In the majority, pain subsided and the temperature was lowered. The youngest patient on which he used the stomach washing was only thirty-six hours old. The results were certainly good, but the author gives no exact percentage, as most of the cases were treated at the Dispensary, and many could not be followed up. Only fifteen deaths out of the whole number are definitely recorded. For stomach washing, a soft rubber velvet, eye catheter, in size cor-

responding to No. 10 steel bougie ; attached to this, by rubber tube, is either a regular irrigator or small glass funnel, a small piece of glass tubing being inserted in the tubing to judge of the character of the escaping fluid. In bowel washing, a fountain syringe answers all purposes so long as the child's buttocks are sufficiently elevated to let the water run up into the transverse and ascending colon.

Reviews and Notices of Books.

The Refraction of the Eye. A Manual for Students.

By GUSTAVUS HARBRIDGE, F.R.C.S., Consulting Ophthalmic Surgeon to St. Bartholomew's Hospital, Chatham ; Surgeon to the Royal Westminster Ophthalmic Hospital ; formerly Assistant Surgeon to the Central London Ophthalmic Hospital, and Clinical Assistant to the Royal Ophthalmic Hospital, Moorfields. Fourth edition. Two hundred and forty-nine pages, with ninety-eight illustrations. Philadelphia : Blakiston, Son & Co. 1890.

This fourth edition is considerably enlarged by the addition of new matter, and some chapters have been partly rewritten, though the original plan of the work is maintained. The author has quite discarded the old or inch system in dealing with the subject of refraction, and it is to be hoped that all writers of ophthalmic text-books will in this respect follow the same plan, since the metric system has met with the general favor which its manifest advantages justly merit.

This work is, perhaps, somewhat too comprehensive for the ordinary student of medicine during a college course, but for the student of ophthalmology who can devote sufficient time to the clinical study of refraction, it is all that could be desired, and undoubtedly may be ranked as one of the best text-books of the kind now in print. The first chapter deals with the elementary principles of optics as far as necessary to elucidate the action of convex and concave lenses, and is neatly illustrated with numerous diagrams. Three chapters are devoted to the physiology of vision and the determination of visual acuteness, both in the

normal state and in the presence of errors of refraction: These comprise also a full discussion of visual tests and the use of glasses in measuring refractive errors. Then follows a description of the use of the ophthalmoscope in estimating refraction. This instrument plays so important a rôle in the study of refraction that a discussion of the optical principles involved in its use could not well be omitted from a work of this kind. The chapter on rhinoscopy is particularly well written, and is well worthy of a careful study, especially to those who have not given to this recent and important addition to the uses of the ophthalmoscope the attention it deserves. There is, of course, nothing new in the chapters on presbyopia, hyperopia, myopia, and astigmatism, but they are given in a readable and attractive form. If the author has failed to present any portion of his subject in a satisfactory manner, it is in his discussion of muscular defects and their treatment, and it may safely be predicted that should he ever bring out another edition this part of the work will not appear at all in its present shape. The practical value of this work is greatly increased by the detailed description of illustrative cases, so arranged as to afford to the student of refraction a guide in the clinical part of his work, which in reality is by far the most difficult part to master.

The work is one which should be in the library of every advanced student of ophthalmology, and is certain to continue in favor with the profession.

A Guide to the Diseases of Children. By J. F. GOODHART, M.D., F.R.C.P. Re-arranged, revised and edited by LOUIS STARR, M.D. Second American from the third English edition. Philadelphia: P. Blakiston, Son & Co. Montreal: C. Ashford.

The American editor, while claiming to have altered in the least possible degree the author's forcible descriptions of disease, has certainly by his re-arrangement given us a much more convenient and readable volume than appeared in the first edition. It is an eminently practical work, and very pleasantly written. Dr. Goodhart quotes largely, throughout the work, from the

records of his clinical cases in the *Evelina Hospital*, and the American editor, in addition to inserting typical temperature charts wherever practicable, has given us valuable additional material. On the matter of infant feeding the directions are particularly full. We regret he has not given Dr. Lewis Smith's directions for preparing the boiled wheaten and barley flour, which give, in our opinion, a much superior article to the plan here recommended. Following this is a series of excellent articles on diseases of the digestive system. In all severe or persistent cases of diarrhoea, a thorough irrigation of the bowel as far as the cæcal valve is recommended, with either pure water or some weak antiseptic solution. The acute infectious diseases with their various complications are fully described in Part II. In speaking of the diagnosis between pertussis and enlarged bronchial glands, the author recommends strongly Dr. Eustace Smith's method of examination, which is as follows: If the child be made to bend back the head so that his face becomes almost horizontal and the eyes look straight upward, a venous hum varying in intensity is heard with the stethoscope placed upon the upper bone of the sternum. As the chin is now slowly depressed the hum becomes less audible, and ceases shortly before the head reaches its ordinary position. Part IV., treating of Diseases of the Nervous System, is particularly interesting, from the number of illustrative clinical cases which are given by Dr. Goodhart. The whole work has been brought thoroughly abreast of the recent advances in pediatric science, and can be very cordially recommended as a text-book to the student and practitioner. The type is large and clear and the binding excellent.

The Diseases of Children, Medical and Surgical. By HENRY ASHBY, M.D., M.R.C.P., and G. A. WRIGHT, M.B., F.R.C.P. Longmans, Green & Co, London and New York. Montreal: E. Renouf.

The authors tell us in their preface that the book is written chiefly from a practical point of view, with but little pathological detail. Their experience has been an unusually large one. It has been gained during ten years' service at the General Hos-

Hospital for Sick Children, Manchester, an institution at which some 1200 in-patients and some 10,000 out-patients are annually treated. The original feature of the book is that it has been written conjointly by a physician and surgeon, and therefore, perhaps more than any other similar treatise, presents a complete account of disease in children. Both the authors are already well known by their previous contributions, and in the present work have presented us with a most excellent volume, which can be cordially recommended both to the advanced student and to the practitioner. Not only do they draw largely on their own extensive experience, but full justice has been done to all recent writers on the various subjects. The illustrations are all good, most of them original. Numerous temperature charts are introduced wherever they are likely to be of service. The type, though small, is particularly clear.

Transactions of the Second Session of the Inter-colonial Medical Congress of Australasia, held in Melbourne, Victoria, January 1889. Melbourne: Stillwell & Co., printers, 195A Collins street. Pp. 1029.

The handsome volume of reports before us reflects the highest credit upon the energy and talent of the medical profession of Australasia. The Intercolonial Medical Congress represents in the main our Canadian Medical Association. It is an assembly of the medical men of all the colonies, and its members number some five hundred. The papers read at this meeting were very numerous, and of a high order of merit, a large proportion representing really good scientific work. We cannot notice separately, in the brief space at our disposal, any of the papers; we can merely mention those of Dr. Bancroft on Filaria and the various papers by J. Davies Thomas and others on Hydatid Disease, which called forth a most instructive discussion. Typhoid Fever, more especially its etiology, was the subject of another special discussion. The surgical section was well represented. Gynæcology, too, held its own, but failed to take up all the time of the meeting as it does in some not distant countries. All the other special branches showed great activity and progress, and

the meeting appears to have been most thoroughly successful. To our Australian brethren we offer our hearty congratulations on the success of their publication.

A Treatise on Materia Medica, Pharmacology and Therapeutics. By JOHN V. SHOEMAKER, M.A., M.D., Professor of Materia Medica, Pharmacology and Therapeutics in the Medico-Chirurgical College of Philadelphia; and JOHN AULDE, M.D., Demonstrator of Clinical Medicine and of Physical Diagnosis in the Medico-Chirurgical College of Philadelphia. In two volumes. Vol. I. Philadelphia and London: F. A. Davis, publisher.

This important work adds another to the already long list of works on Materia Medica and Therapeutics. The first volume is devoted to Pharmacy, General Pharmacology and Therapeutics, and remedial agents not usually classified with drugs.

Following a preliminary chapter on General Pharmacy, we have a description of a classification modified somewhat from the usual physiological classification of drugs. It will be seen from the following quotation that the authors recommend drugs freely even in trifling states. Referring to the abortive treatment of colds, they say "medicinal treatment will include attention to the condition of the skin, the kidneys, and the bowels, with the use of aconite, gelsemium, veratrum or other suitable remedy to reduce the activity of the circulation and overcome any tendency to fever. As soon as that has been properly effected the patient should be placed under the influence of quinine and the sulphide of calcium, so that within twenty-four hours he will be fully charged with both remedies." We would be very slow to recommend any one to adopt such heroic treatment.

Under the list of vascular stimulants the authors place chloroform. The pronounced action of chloroform on the heart is quite the contrary.

Under the head of vascular sedatives, acting especially on the heart, we have placed digitalis. This is an unfortunate error, for if there is any well established therapeutical fact, it is that digitalis is the type of cardiac tonics.

The second part of the volume under consideration deals with Electro-therapeutics, Hydro-therapeutics, Massage and other less commonly employed agencies in the treatment of disease.

Society Proceedings.

MEDICO-CHIRURGICAL SOCIETY OF MONTREAL.

Stated Meeting, 7th March, 1890.

G. E. ARMSTRONG, M.D., PRESIDENT, IN THE CHAIR.

DR. MILLS exhibited two specimens illustrating so-called hermaphroditism in the pig. True hermaphroditism, while common in invertebrates (*i.e.*, the tapeworm, earthworm, etc), is unknown among vertebrates. In the true hermaphrodite, both male and female organs exist, and are functionally active. In the specimen shown, in one case the penis was well developed, in the other but indifferently. In other respects both specimens closely resembled each other. The testes were of good size and the urethra embraced by the prostate. What was most remarkable was the large development of the Müllerian ducts, which usually atrophy in the male into an organ greatly resembling the two-horned uterus, the walls of which were as thick as in the gravid condition of the organ. Apparently these served as the vas-a-deferentia, while the latter seem to be fused with them. The specimens were obtained at the abattoir by members of Dr. Mills' class in physiology, and the butcher who first noticed them says they are the only specimens of the kind seen there in fifteen years.

Ruptured Tubal Gestation.—DR. WM. GARDNER exhibited the foetus, placenta and umbilical cord from a case of ruptured ectopic gestation on which he had done abdominal section. The patient, aged 31, had been married fourteen years. One pregnancy to full term twelve years ago, and one early miscarriage shortly after. Since then she had suffered more or less from pelvic symptoms. Emmet's operation for laceration of the cervix had been done eighteen years ago. Menses had been regular till the last period in October, 1889, whether beginning middle

or end of the month she could not tell. She had some of the signs of pregnancy and suspected it. Early in January, 1890, she was seized with pelvic pain and collapse, but rallied. Symptoms recurred, and at the request of her medical attendant, Dr. England of Point St. Charles, Dr. Gardner saw her with him. Pain was not severe, but the patient was blanched. The uterus was soft, bulky, fixed and discharging blood in moderate quantity. Behind it lay a small mass. Nothing could now be felt through the abdominal wall. Dr. Gardner again saw her on the 4th February. There had been little change till three days previous, when an increase of pain and faintness had occurred. A tumor-like mass had now appeared in the hypogastrium, and per vaginam the uterus was pressed forward by a firm mass which filled the pelvis. Four days later pain and collapse became alarming, and the abdominal tumor now reached above the umbilicus, distending uniformly the whole of the lower part of the belly. On the 9th February, at 4 A.M., the abdomen was opened. On reaching the peritoneum it bulged through the incision; the omentum being adherent, was cut through. An enormous quantity of clot and fluid blood was removed with foetus and placenta. The sac on the left side of the uterus was grasped, tied and trimmed off. A second bleeding point in the pelvis needed ligature. The pelvis and abdomen were then thoroughly washed out by Tait's large tube. The value of this instrument in carrying a large volume of water to the deep parts of the cavity and forcing out clots was beautifully shown. A large glass drainage-tube was carried to the bottom of Douglas's pouch and there left. When put to bed the patient was very weak, but steadily rallied. She, however, died on the sixth day apparently from septic peritonitis. The foetus, cord and placenta were perfectly fresh-looking, their being neither discoloration or any other evidence of death for more than a few hours before operation. The length of the foetus was seven inches, and the points of ossification and other evidences present indicated a foetal age of four or five months. The absence of very urgent symptoms till the day before operation, and the rapidly-growing abdominal tumor, were the grounds for waiting in the hope that

a viable child might develop in the abdomen. The result well shows the danger to the mother of inaction.

Report on foetus in Dr. Gardner's case of ruptured tubal gestation :

“ Received in good condition, with shreds of placental tissue and some fibrinous blood-clot. No trace of amnion. Umbilical cord inserted 1 cm. above pubes ; seems rather small ; vessels pervious. Foetus measures 12.5 cm. in length ; surface gelatinous-looking, no traces of vernix. Skin over back of neck œdematous. Penis and scrotum distinct ; anus pervious. Nails on hands and feet rudimentary, but distinctly visible. No hair. Eyelids not separated. Brain diffuent. Liver large and soft ; gall-bladder small and empty ; small intestines contain bile ; testes lie in iliac fossæ ; kidneys size of beans, lobulation distinct ; lungs pale and firm, undilated, microscopically no pneumonia ; heart pale. Extremities (leg, upper arm and fore arm) measure 2 cm. ; femur $2\frac{1}{2}$ cm. Centre of ossification distinct in calcaneus on both sides. Microscopically, in subcutaneous tissue nuclei abound ; mucin absent.”

Stated Meeting, 21st March, 1890.

G. E. ARMSTRONG, M.D., PRESIDENT, IN THE CHAIR.

DR. JAMES STEWART read an interesting paper on *Exalgine as an Analgesic*, which appeared in the April number of this JOURNAL.

Discussion.—DR. FINLEY—How do the members of the aromatic group compare with croton-chloral or gelsemium in their action ?

DR. BELL—Would it compete with opium in relieving pain due to traumatism, or only suited to pain of a nervous origin ?

DR. ARMSTRONG—I have used exalgine extensively within the last few months, and found it reliable in many cases of simple neuralgia which did not yield to antipyrin ; the dose requires to be increased. I have tried it in a case of cellulitis of the hand and in cases of inflammation about the cæcum, but without effect, and had to fall back upon morphia. It possesses advantages, in

small doses, of (1) easy administration, (2) heart not affected, and (3) stomach not deranged. What influence has it upon the temperature?

DR. GARDNER—What effect has it upon migraine, which is found so frequently to accompany gynaecological cases, and which, in my experience, yields only to morphia?

DR. STEWART, in reply, said chloral and gelsemium are simply peripheral nerve sedatives, attacking only special nerve areas. It will not, I think, take the place of opium. The drug has, like all members of the same group, an antipyretic action, but in doses larger than four grains.

Epithelioma of the Cervix Uteri.—This specimen was exhibited by Dr. Alloway at a previous meeting.

DR. WM. GARDNER remarked that he had met with two cases of typical sprouting epithelioma of the cervix uteri in which no symptoms at all were present, the existence of such a grave condition being accidentally discovered by the patients themselves. A great deal can be done in relieving these by high amputation of the cervix rather than complete extirpation, where the disease is localized in the cervix. Dr. Skeene's (Brooklyn) statistics of cases operated upon by the galvano-cautery knife look as if we might expect better results than by other methods now existing.

DR. TRENHOLME exhibited two specimens. (1) *Hydrosalpinx*, which he had successfully removed. (2) *Par-ovarian retro-peritoneal cyst*—This tumor proved difficult to remove on account of the peritoneum being pushed away from it. After tapping cyst it was readily shelled out.

DR. GARDNER said he had met with several cases of cyst of the broad ligament which easily shelled out, but had not met with one similar to that now under consideration. He would substantiate the remark that often the pain was severe with objective symptoms being almost *nil* and *vice versa*. Many cases did not seem to improve at once; but when nutrition improved then pain became lessened.

Stated Meeting, 4th April, 1890.

DR. HINGSTON IN THE CHAIR.

Peri-oesophageal Inflammation.—DR. JOHNSTON exhibited the specimen for Dr. Bell. The patient, a young girl aged 15 years, about a week ago, whilst swallowing a piece of tongue, was suddenly seized with a sensation of choking. Slight relief followed the passing of an oesophageal bougie. This difficulty of swallowing had existed since an attack of scarlet fever, which patient had had when five years old. There was a sensation of something like a lump in the throat. Upon examination, a sac-cule was seen between the pharynx and larynx. The next day after this obstruction occurred there was a marked cellulitis of the pharynx and neck; temperature 103°F. Forty-eight hours later there was emphysema about chest and neck, and breathing labored. The patient died suddenly 60 hours after first attacked with dysphagia. The mucous membrane of the oesophagus was found perfectly normal, and free from traces of laceration or any foreign body. Posterior to the pharynx was a large saccular space extending from one side to the other, about the size of an egg. This sac was partly filled with foetid putty-like substance. It communicated with the pharynx low down on the left side. The tissues about the larynx were normal. The cellular tissue between oesophagus and trachea was in a state of acute phlegmon, being infiltrated with foetid pus. The sheath of the vessels of neck was involved in this infiltration. The right pneumogastric nerve was swollen to the thickness of a slate pencil. There was slight emphysema of cellular tissue at root of neck, for which no cause could be detected. There was caseating tuberculosis of the bronchial and mesenteric glands and spleen, with acute tuberculous peritonitis; thoracic duct free.

DR. SHEPHERD asked why the swelling could not have been reached by an incision behind sterno mastoid muscle?

DR. BELL—On account of the uncertainty as to the nature of the case.

Papilloma of Ovary.—DR. GARDNER exhibited this specimen and related the history of the case. Patient, 27 years old, un-

married, suffered for the last two years from pelvic and abdominal pain, with enlargement. Examination by palpation and percussion revealed the presence of fluid in abdomen; but, strangely, percussion in the flanks, with patient lying on the back, gave a clear note. An exploratory abdominal incision was made, giving exit to a large quantity of pale straw-colored fluid. On the ovary was seen a cauliflower excrescence surrounded by a wall. The parietal and visceral layers of the peritoneum were studded with nodules of a similar nature. Examination microscopically of the tumor by Dr. Springle showed it to be made up of large round cells imbedded in a scanty stroma.

DR. GEO. ROSS asked Dr. Gardner how he would explain the presence of a clear note in the flanks, patient lying on the back, when there were evidences of fluid in the abdomen.

DR. HINGSTON said that from the appearance of the tumor, and from its having invaded the parietal and visceral peritoneum, he would adjudge it to be a round-celled sarcoma. He would like to know how Dr. Gardner came to operate in view of the fact that the symptoms were so indefinite.

DR. GARDNER, in reply, said that the clear note in the flank was explained by the fact that the omentum was adherent to the abdominal wall. He was in doubt himself as to the exact nature of the case, as the symptoms were so anomalous, and thought that the best way of ascertaining it was to make an exploratory incision.

Embolism of Abdominal Aorta.—Patient, female, aged 44, was admitted into the General Hospital suffering from gastritis and nervousness, the effect of a drinking bout. Shortly afterwards one leg became cold and insensitive, gangrene setting in; then, after a short period of time, the other leg was attacked in a similar manner, patient subsequently dying of heart failure.

DR. JOHNSTON, who exhibited the specimen for Dr. Bell, said there was gangrene of the right foot and lower half of left leg. An embolus had lodged at the bifurcation of the aorta. In the left auricle, loosely attached, was a rounded thrombus, softened in the centre, and moderate mitral stenosis.

HAMILTON MEDICAL AND SURGICAL SOCIETY.

Stated Meeting, April 1st, 1890.

J. W. ROSEBRUGH, M.D., PRESIDENT, IN THE CHAIR.

Malignant Disease of the Bladder.—DR. COCKBURN reported the case as follows:—

About the latter end of November, 1888, my father came to me complaining of a feeling of discomfort just over the pubes, not severe, which eased at times, but never quite disappeared. During the next four or five weeks it gradually and almost imperceptibly became more palpable, till one day, about Christmas 1888, a small clot of blood was washed out with the urine, which from its shape, must have been lodged in the urethra. I now began to feel some anxiety, for the sequence of symptoms tallied unpleasantly closely with the earliest symptoms of malignant disease of the bladder. On January 7th, 1889, Dr. Leslie saw my father, and took a favorable view as to any vesicle trouble, but (if I remember aright) thought he suffered from lithiasis, an opinion afterwards confirmed by Dr. Osler. After this my father went about as usual; he did not complain much, but when questioned, always said the pain was getting slowly worse, and small casts of blood were passed from time to time. Still feeling very dissatisfied with my father's condition, I mentioned my suspicions to Dr. Bertram of Dundas, the family physician, and suggested he should examine per rectum, which was done. Dr. Bertram discovered nothing abnormal, and at this time took a hopeful view. On March 26th my father had a sort of hysterical attack and took to his bed. Under Dr. Bertram's care he improved for a time, but he now began to pass small particles of tissue. These were carefully examined microscopically on several occasions by Drs. Malloch, Osborne and myself; their appearance was suspicious, but by no means pathognomonic. Some of these shreds of tissue were sent to Dr. Osler of Baltimore, who very kindly examined them and (to the best of my recollection) said such particles were often passed by patients suffering from chronic degenerative changes in the kidneys. The pain gradually increased, but no great change occurred till May 26th, when a

considerable discharge of blood occurred at the end of micturition. On May 30th, Drs. Malloch and Bertram met me in consultation over my father's case. A perineal section was suggested pending an examination of the urine. The urine showed a considerable quantity of albumin and the operation was abandoned. From this date my father commenced taking morphia hypodermically. His general condition became worse, the pain over the pubes became more severe, and the whole hypogastric region became intensely tender on pressure. The albuminuria continued to increase, but although the urine was examined for casts by Dr. Malloch and myself on several occasions none were found. On August 9th, 1889, Dr. Osler saw my father in consultation with Dr. Malloch, Dr. Bertram and myself. (Speaking from recollection) Dr. Osler was unable to detect anything by firm pressure over the pubes, and digital examination per rectum gave a negative result. Dr. Malloch examined my father per rectum on his first visit, and both he and Dr. Osler agreed in pronouncing the prostate normal and no pathological condition to be detected. On this occasion my father was sounded by Dr. Malloch with a negative result. To the best of my recollection, Dr. Osler believed it to be a case of gouty kidneys, remarking that the cause of the hæmaturia was obscure. Dr. Osler opposed any operation. This opinion, expressed by so eminent an authority, gave myself and my family great relief, and I began to hope I might be wrong in my view of the case. From this time my father went steadily down hill, the pain became more severe and constant in the region indicated, and blood and pus were constantly being passed. The morphia was gradually increased. As time went on he began to emaciate; blood was constantly passed at the end of micturition, and the suffering on these occasions became intense, especially towards the close of the act. The pain spread down the penis as in cases of a calculus. Uræmic symptoms appeared from time to time, and the urine became loaded with albumin, but in spite of repeated examinations no casts appeared. Morphia was given in increasing doses to mitigate the constant suffering. All the symptoms became

worse and worse. From time to time large quantities of blood were passed, sometimes mixed with pus. Albumin was always present in large quantities, and the pain in micturition became most intense. On January 28th, 1890, I was telephoned for, as there was some obstruction in the bowel. I found a hard mass blocking the rectum, which was with difficulty removed. Three days later a second mass presented, and was removed under chloroform. The chloroform was pushed to complete anæsthesia, and I then proceeded to explore per rectum. I easily mapped out the prostate and satisfied myself that it was normal. In the situation of the bladder I was able to make out a hard, irregular mass, movable, and, to a bimanual examination, apparently about the size of the gravid uterus at the fourth or fifth week. I now felt absolutely certain I had a case of malignant disease of the bladder to deal with. From the feel of it, I judged it to be most probably scirrhus cancer, involving principally the fundus. From this time my father began rapidly to sink. The suffering became so terrible that he was kept more or less constantly under chloroform, as the morphia seemed to lose all power, an injection of $4\frac{1}{2}$ grains producing no appreciable effect. He died Feb. 15th, 1890; the duration of the case from the earliest onset of symptoms being therefore about one year and three months. From May 30th, 1889, to February 15th, 1890, he took over 2,000 grains of morphia hypodermically, and that with only partial relief to the suffering.

Remarks.—The specimen showed a growth on the posterior wall, which it infiltrated, measuring about $1\frac{1}{2}$ inches in width, $1\frac{1}{2}$ inches in depth, and 1 inch in thickness. Over its free surface were numerous elongated papillæ, which formed a fringe-like covering to the growth. The tumor had not a very firm consistence, although it had been in methylated spirits for two weeks.

In the discussion which followed, Drs. Mullin, Malloch and Olmstead dissented from the view of it being scirrhus.

Oöphorectomy for Chronic Ovaritis.—DR. H. S. GRIFFIN reported the following case :

Mrs. H., aged 41, married, nullip. Family history poor,

several members having died of phthisis. Spare and nervous; menstruation regular. December 3rd, 1888, on making an emergent night visit, I found her suffering from intense pain referred to the lower part of the back and extending into the left inguinal region. She gave a history of previous tenderness and uneasiness in the same locality extending over several weeks, but not sufficiently severe to call for treatment. A vaginal examination discovered a small-sized mass posterior to the uterus, movable, but intensely tender; making steady pressure in Campbell's position I readily succeeded in placing it above the pelvic brim. This relieved the intense pain, but considerable distress and soreness still remained. She was instructed to lie on her face and side as much as possible.

Dec. 4th to 14th—A few hours after replacing the ovary it again prolapsed, with return of the severe pain. It was quite impossible for her to retain a pessary, but persisted attempts were made to support the ovary with cotton wool tampons, aided by rest and posture. It would, however, invariably descend within twenty-four hours and have to be replaced with the finger. Nausea and anorexia were prominent symptoms.

Dec. 14th—Menstruation occurred with amelioration of her condition. She was able to be up and attend to her household affairs to some slight extent.

Jan. 2nd to 12th—The severe pain returned. All local treatment seemed only to aggravate the trouble and irritate the parts. She had to be constantly visited and the ovary replaced. Until the beginning of March this condition persisted; then occurred an improvement, and for two weeks she did not require a single visit.

March 22nd—In response to a call, I found her suffering intensely. Examination showed the ovary firmly pressed down and so intensely painful that I had to abandon attempts at reduction. Under sedatives and hot water douches I was able to replace on the 28th. I still hoped that patient treatment would succeed in releasing her, but towards the end of April it was apparent that operative measures were necessary. She had become unable to take sufficient nourishment, and loss of rest with continuance of the pain had greatly reduced her.

April 30th—Operated at 11 A.M. Dr. Miller gave chloroform and Dr. Leslie assisted at the operation. A two-inch incision in the usual place enabled me to hook up the left ovary from Douglas' pouch; the pedicle was tied and dropped, the right ovary examined and found normal, and the wound closed. The operation occupied about twenty minutes. On returning to the patient a few hours after, I found her suffering from the most severe retching I ever saw. It was promptly relieved, however, by a half-grain hypodermic of morphia.

May 14th—The patient convalesced rather slowly owing to irritability of the stomach. The temperature, which was 100° on the day of the operation, has never reached that point since, and is now normal.

June 1st—Patient able to leave her room, and feeling quite well.

Since then (nearly a year ago) she has enjoyed perfect health, and has never had a pain since the day of the operation. The ovary removed was but slightly enlarged, and had three small cysts about the size of marrowfat peas.

Selections.

How to become Strong.—MR. WILLIAM BLAIKIE recently delivered a most invaluable lecture upon this subject. It was our pleasure to hear Mr. Blaikie lecture at Gormantown. It was not only an invaluable discourse, but a highly interesting one. We were much impressed with the forcible way in which the speaker dwelt upon the importance of physical development and the health, strength and long and happy life it brought. We here publish some extracts from the lecture :—

“ As I came along I saw that your town was dotted with three public libraries. Along Chelton avenue I noticed handsome churches. You have here valuable agencies ; one trains the mind and the other trains the moral nature. This is what constitutes our American system of education. What do we do for the body ? Oh, they say, the body will take care of itself. Well, so will the mind. How about the men and women who cannot read and write ; they are no worse off than the man whose body has not been trained. A man whose body is trained has an annuity fund laid in on which he can draw. I see you have a sort of make-believe gymnasium down stairs. There are so-called gymnasiums in this country. The man in charge takes your money, and generally takes plenty of it. You go in to get your money's worth ; you take hold of the big dumb bell, and try everything in the place ; next morning you've got your money's worth, and you go around asking, what ails me ? This is very much as if you should fill a school-room with desks and slates, and blackboards and books, but provide no teacher, and then say to the boys and girls, educate yourselves. There would be lots of education going forward, wouldn't there ? Brains are needed in a gymnasium.

“ Oh, but we have lots of athletics. The papers are full of them. But what good does it do you ? The old Greek and Roman athletics could not compare with our records. They sent a famous courier to bring up the hardy Spartan troops, and he made 149 miles in 48 hours. A few years ago, in Madison Square Garden, New York, little Charlie Rowell made 150 miles

in 24 hours. Rowell would have warmed the old Spartan's jacket for him in a go-as-you-please race. Vanderbilt's Maud S, out at grass, would not be brought in and put in a race right off. She would be got in condition, and then let that other horse look out. But the portly citizen of Germantown runs along Chelton avenue for a train and topples over, all because of his ignorance of elementary knowledge.

"We develop our muscles in a one-sided, partial way. There's rowing: it exercises us in pushing and pulling. I was referee at the race between Hanlan and Courtney, where the latter's boat was so mysteriously cut. I asked Hanlan to try the simple experiment of resting his hands on two chairs and then letting himself down between them. How often did he do it? Well, he got down and could not get up. He hadn't trained the right muscles. There is a great man—John L. Sullivan, a man of striking ability, who always makes a marked impression. He trains the other muscles. But put him in a shell against Hanlan and the Canadian would pull clear away from him. Change the scene a little and the symmetry of Hanlan's head would be seriously impaired inside of two minutes. Had they started in a race with Rowell they would both soon have been hopelessly behind.

"Our mechanics train only the muscle each wants in getting bread and butter.

"Among American women walking is a lost art. I don't know how it is here in Germantown, but in New York I have seen them shopping on Fourteenth street; they go dawdling along at about a two-miles-an-hour gait. Some one has said that a woman in America runs fast enough for a man to catch her. Some of them can't do that. There is 70,000 of them in Massachusetts. Once I went up to Vassar College to see their gymnasium. They had lots of apparatus there that looked like as if it was the kind that Noah used when he was loafing around in the ark. Then the girls showed me how they ran. After a few trials they came in puffing and blowing, and their hearts beating about 140 to the minute. 'What do you think of the running?' they asked. 'What running?' said I. Then I showed how the sandal of the

runner was made, with no heel, and how he ran on his toes with his head up and his chest out, and they admitted that they couldn't run."

He told the girls how to develop weak arms, make them strong and so that they would be well rounded and shapely when they wore evening costumes. "One of the hardest problems is how to keep the girls who go into this training from doing too much hard work at the beginning. Ham is a good thing for breakfast, but no one wants to eat a whole ham for breakfast. They must start off easily. A man at Englewood came to me about his daughter. She was low-spirited and weak. 'Well,' I said, 'what does she do?' and he said, 'she went five miles to school every day and carried a great strap full of books.' 'Does she walk?' 'No, she rides in a horse-car.' Oh, the lovely horse-car! Oh, the beautiful horse-car! Sidewalks deserted to hang by a strap in a crowded horse-car. Give up walking to be hauled home in a lovely horse-car. Get her a pair of Waukenphast shoes, broad enough at least for two of her toes to touch the ground. Ugly, of course they're ugly; but they are comfortable. Let her go off the car one mile from home the first week. Rain? Well, let it rain; I hope it will. Rain doesn't look half so bad when you are in it as when you look at it through the window. Then let her try two miles the second week, and so on up to five. I met the father in two months. He said: 'The aches are all gone, and we are afraid she'll eat the table-cover. Her brother has taught her boxing, and we are all afraid of her around the house. She's actually getting good-looking.'"

He compared Bernhardt's attenuated proportions with Lily Langtry's fine physique. "The Lily had six brothers, all athletes. She joined in their sports, she became a practical yachtswoman, and her average daily walk now is ten miles. This accounts for it all. She says American girls don't take exercise enough. The finest figure in all Europe is the Empress of Austria. At fifty-five she is a great horseback rider. When Dr. McCosh's daughters came to Princeton, one of the young men took them out for a stroll. They walked him to Trenton and back, some twenty miles. That young man could have been called a sub dude when he got back.

“Did you ever hear of neuralgia, nervous prostration, insomnia? Ask any expert in neural disorders what to do. He will not advise drugs and chemicals as an antidote, but exercise. Get your muscles in grand running order and you need have no fear for the nerves. The dyspeptic needs exercise. Some one has said dyspepsia was a disease of the legs. When an old woman heard that John Bright was coming to the United States she wondered whether he was going to bring his disease with him. She needn't have asked; we have it, it is insidiously but surely undermining our bodies.

“John Morrisey was told by his physician that he must die in two weeks of Bright's disease of the kidneys. He considered what he should do. He went into the same course of training that he used when he was preparing for a prize fight. It made him a new pair of kidneys, and he was a vigorous man for twenty years afterward.

“I could name four young fellows at Harvard who wouldn't take exercise; said they didn't need it; in five years they were laid under the sod. You all know Tom Corwin. He's the man who stood up in the United States Senate and said: 'Mr. President, I deny the allegation, and I can thrash the alligator.' One time his son, who was in college, wrote home: 'Dear father, I am studying very hard, so hard that I fear I will die.' Corwin wrote back: 'My dear son, it would give me great pleasure to attend your funeral under the circumstances. Your affectionate father.' I don't know whether this applies in Germantown or not. You see them digging up a street for a sewer. The men in the offices complain of malaria and go home and get nourished and coddled. The Irishmen who do the digging don't complain of malaria. Men who are great accomplishers are men of great bodies as well as great brains.”

Then the speaker went on to illustrate by, “Alexander the Great, whose teacher, Aristotle, withdrew him from the Court and trained body as well as mind; Julius Cæsar, who was an athlete; John Wesley, who had a sturdy, well-knit frame; Gladstone, who cuts down an oak four feet in diameter between luncheon and dinner, when he is at his Welsh estate. Washington

was a man of grand physique. He was six feet two inches in height and weighed 213 pounds. If he had been in training, John L. Sullivan couldn't have stood five minutes before him. He was a straight-sided man, and was a great wrestler when a young man. Frazer has made the running-board jump record twenty-three feet; Washington did twenty-four feet. They talk about throwing a baseball four hundred feet; Washington threw a silver dollar six hundred feet. A United States senator showed Chief-Justice Coleridge the place where he did it, and when the Englishman asked how it was done, the Yankee replied, 'a dollar went farther in those days.'

"What kind of school-yards have you got? In New York they have them a little bigger than a postage stamp. Every school should have a large yard for the children to run and leap in and exercise."—*Anti-Adulteration Journal*; *Cincinnati Lancet-Clinic*.

Some Points in the Treatment of Gonorrhœa.—The early use of astringents in gonorrhœa is advocated by many practitioners. We do not agree with those who advise the use of astringent injections in the early stage of the disease. The effect of astringents is to thicken the mucous membrane upon its surface, and seal up the gonococci in the meshes of the arcolar tissue and the deeper portions of the mucous membrane. Aside from this effect, injections in the early stage of the disease are pernicious from their mechanical effect. We believe that they often cause stricture, not because they are used in too powerful solution, but simply because they act mechanically on the inflamed canal. One of the most potent causes of stricture, independent of cases treated by the use of injections, is the passage of urine over certain portions of the canal (normal points of contraction). The entire calibre of the canal is lessened. There is a good deal of friction during the passage of urine, and consequently the epithelium becomes abraded, and a habit of rapid proliferation and removal of epithelium supervenes. It is at these points of extreme friction that granular patches occur, which result in a perpetuation of

gleet and a liability to the formation of stricture. Injections very often act in the same way if used frequently.

We do not believe in the practice of passing into the urethra medicated applications in the acute stage of the disease. We have tried soluble bougies, hot water irrigations, and various other things that have been recommended, with but little benefit. We do not believe any antiseptic in combination with an ointment is capable of paralyzing the gonococci, as has been stated. When the surgeon passes an instrument into the canal it carries the discharge into the deeper portions of the urethra, and unless the ointment is sufficiently powerful, he will defeat the very object he aims to secure by his applications.

We have noted objections to the use of irrigation by the recurrent catheter in gonorrhœa. Dr. Palmer, of Louisville, recently wrote an able article on a particular method of treatment of urethritis by irrigation. After reading Dr. Palmer's article on the subject we tried the method, and immediately had a succession of cases of inflammation of the vesical neck and prostate. A number of cases of epididymitis arose, and seemingly were also due to the manipulations of the canal. The poison is carried by the catheter into the deeper portions of the canal, and the inflammation extends to the deep urethra by affecting contiguous structures. By any of these mechanical methods a greater number of cases will be affected by complications and become chronic than under ordinary conservative methods of treatment.

The probabilities are that if we treated cases of gonorrhœa as we treat other diseases of like severity and importance as regards serious complications and results, we would have very few cases of stricture, very few cases of abscess, and very few cases of epididymitis or bladder troubles secondary to gonorrhœa. If every man with a gonorrhœa went to bed and remained there for two or three weeks there would not be one-tenth part of the number of strictures which we have now to treat.

The regulation of the diet is a most important feature of treatment of genito-urinary troubles of an inflammatory character. The patient should be instructed to live on bread and milk. This

particular dietetic regimen continued for a few days affords more benefit than almost anything else we could give. Large quantities of milk produce alkalinization of the urine, and produce it more effectually than does the administration of drugs during the acute, or, what Van Buren and Keys have termed, the ascending stage of the disease.

When the disease has come to a stand-still—when the purulent discharge has begun to diminish, antiseptic injections should be given; the bichloride of mercury is the most reliable remedy we have. It may be used in a solution of half a grain to four ounces of rose-water. There is one very important point with reference to the bichloride of mercury which we will mention. If there is any remedy to which there is a varying susceptibility on the part of the mucous membrane, it is this drug. Some patients using the drug in the strength of one-eighth grain to the ounce may not complain of any immediate effects of the injection, but after its use for a few times will find that urination is painful. Retention from inflammation may occur in a few patients who are using solutions much milder than those which have been found to perfectly agree with others. In using bichloride of mercury, it should be given in a strength of, on an average, half a grain of the drug to four ounces of rose-water and glycerine. In a few days, or perhaps a week, it will be found that the bichloride has lost its beneficial effect. After a few days it will be necessary to substitute astringent injections, and if these are properly and carefully used, it makes no difference what form of astringent is selected. Matico, hydrastis, etc., are as useful as anything. In the way of minereal astringents the sulpho-carbolate of zinc, glycerine and rose-water form a good combination. If the case does not get along well, the explanation is not that the injection is improper, or that some other form of astringent would be better, but usually that the patient is carousing with women, drinking or over-exerting himself. Patients are very apt to tell us that an injection does not work well in spite of their good habits, but as a matter of fact they lie in a great many cases.

As regards balsams, we believe that they have decided virtues

in the treatment of gonorrhœa. We use at first sandalwood, subsequently, in the later stages of the disease, copaiba and cubebs in the order named. If they are used in this way they are decidedly efficacious and beneficial.

One point that is worthy of attention is that gonorrhœa is a self-limited disease. The normal duration of gonorrhœa is from three to six or eight weeks. There are exceptionally few cases that recover in three weeks or less. If a case comes to us early for what we suppose to be gonorrhœa, and we cure the disease in a few days, we conclude that the patient did not have a virulent urethritis. When we use the term *gonorrhœa*, we do not speak of it as an entity. By *virulent urethritis* we mean that the poison has arrived at its highest degree of culture and always produces definite results.—*Western Medical Reporter*.

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THE ABUSE OF COFFEE.

Mendel, of Essen, has recently pointed out that when coffee is taken too freely for long periods it induces a peculiar train of symptoms which are characteristic. It affects not only the nervous system, but also the circulatory and muscular systems. The nervous symptoms include a feeling of general weakness, apathy and mental depression. The motor symptoms noticed were loss of power and tremor in the extremities, while the circulatory disturbance was evidenced by a small, weak and irregular pulse, with palpitation. Nervous dyspepsia and constipation were usually present also.

THE GERMAN CONGRESS FOR INTERNAL
MEDICINE.

At the recent Congress held this year in Vienna, several very important discussions took place. The distinguished president, Prof. Nothnagel, opened the proceedings of the Congress by an able address on the past, present and probable future of medicine. Immermann, of Balse, introduced a discussion on the treatment of empyema. He prefers puncture of the thorax with aspiration of the pus contained in the pleural cavity, while Schede recommends the more radical operation of resection of the ribs with the subsequent antiseptic treatment of the wound. It was decided to form a collective investigation committee to report at a subsequent meeting of the Congress.

Prof. Mosler read a paper on the pathology of pemphigus. He looks upon it as being due to nervous influences, repeated

examination having failed to discover any micro-organisms. He has found changes in the spinal cord in fatal cases. Kaposi referred to the great mortality in cases of pemphigus, the death-rate in two hundred cases that came under his own observation being 90 per cent.

Probably the most important discussion held was that on the treatment of Albuminuria. The subject was introduced by Prof. Senator, who remarked that the prognosis is not at all as grave as it is commonly held to be. The great importance of dietetic treatment was insisted on. Albuminous food should be sparingly taken, while fats and carbo-hydrates are indicated. Fish and the meat of young animals might be taken, but eggs should be avoided. The milk and koumiss cure were frequently of great service. Several of the speakers looked upon bodily quiet as being of great importance.

INTERNATIONAL MEDICAL CONGRESS.

The preliminary programme for the discussions on subjects connected with internal medicine at the coming International Medical Congress at Berlin has been published. It includes—

- (1) The Treatment of Disease of the Heart, by Nothnagel of Vienna.
- (2) The Treatment of Diseases of the Kidneys, by Lepine of Lyons and Grainger Stewart of Edinburgh.
- (3) The Treatment of Anæmia, by Osler of Baltimore and Laache of Christiana.
- (4) The Treatment of Diphtheria in America, by Jacobi of New York.
- (5) The Treatment of Pulmonary Consumption, by H. Weber of London and Loomis of New York.
- (6) The Treatment of Diabetes, by Pavy of London, Dujardin-Beaumetz of Paris, and Seegen of Vienna.
- (7) The Treatment of Gallstones, by Ord of London.
- (8) The Nature and Treatment of Uræmia, by Landois of Greifswald.
- (9) The Nature and Treatment of Tabes, by Strümpell of Erlangen.

(10) Myxœdema, by Ord of London.

(11) Dengue Fever, by Fleras of Constantinople.

It will be seen the above include subjects of great and pressing importance. There is every reason to hope that much will be added to our knowledge as the result of these discussions.

CANADIAN MEDICAL ASSOCIATION.

The twenty-third annual meeting of the Canadian Medical Association will be held in Toronto on Tuesday, Wednesday and Thursday, the 9th, 10th and 11th of September next.

LEGACY TO THE POST-GRADUATE MEDICAL SCHOOL AND HOSPITAL.—Among the legacies of the late Honorable Daniel B. St. John, of Newburgh, N.Y., was one of ten thousand dollars to the above-named institution.

—The death-rate in the city of New York for the year 1889 was 25.1 per 1,000. The deaths exceeded the births by upwards of 2,000.

—It is sad commentary on the boasted civilization of our mother country to find that nearly two millions of the surplus revenue for the past year was made up from the increased consumption of alcoholic liquors.

Obituary.

—We regret to announce the death of Dr. Allison of Bowmanville, at the advanced age of 85 years. Dr. Allison has been for over half a century a leading and much-respected practitioner in the Bowmanville district. He was for a number of years a member of the Council of the College of Physicians and Surgeons of Ontario, and during 1880-81 he was president of this body.

McGILL UNIVERSITY.

FACULTY OF MEDICINE CONVOCAATION.

The annual public meeting of Convocation for the conferring of Degrees in Medicine, and in comparative Medicine and Veterinary Science, was held in the William Molson Hall, on Tuesday, April 1st, at 3 p.m.

Sir Donald A. Smith, the Chancellor, presided, and at his left was the Principal, Sir William Dawson. Around him were the Governors, Mr. John H. R. Molson, Mr. W. C. MacDonald, Mr. Samuel Finley, Alexander Johnson, L.L.D., Dean of the Faculty of Arts; Dr. Craik, Dean of the Medical Faculty; and Dr. Ross, the Vice-Dean; Prof. Bovey, Dean of the Faculty of Applied Science; N. W. Trenholme, Q. C., Dean of the Faculty of Law; Dr. McEachran, Dean of the Faculty of Comparative Medicine; Dr. Stewart, Dr. Shepherd, Dr. Wilkins, Dr. Cameron, Dr. Mills, Dr. Girdwood, Dr. Gardner, Dr. Rodger, Dr. Grant, Dr. Birkett, Dr. Johnston, Dr. Finley, Dr. Ruttan, Dr. Baker, Dr. McEachran, Rev. Principals MacVicar, Shaw and Barbour; Prof. Penhallow, F. W. Kelley, Ph. D., Prof. J. Clarke Murray, John Dougall, M. A., Prof. C. E. Moyse, Rev. Dr. Cornish, Rev. Prof. Scrimgeour, Mr. Justice Cross, Rev. Prof. Coussirat, Dr. Godsgen, J. W. Brackenridge, B.C.L.; W. Skaife, B. A. Sc.; P. Toewes, M.A.; E. H. Hamilton, B.A. Sc.; J. A. MacPhail, B.A.; M. W. Hopkins, B.A. Sc.

Rev. Dr. Cornish opened the proceedings with the usual form of prayer, and then Dr. Craik, Dean of the Medical Faculty, presented the report for the past session. The number of students attending were:—From Ontario, 111; Quebec, 71; New Brunswick, 26; Nova Scotia, 20; Prince Edward Island, 11; United States, 7; Manitoba, 7; Newfoundland, 2; British Columbia, 2; West Indies, 2; England, 1. The number this year is greatly in excess of former years, as the following statement shows. Dividing the period into decades, the Dean showed that sixty years ago—in the session of 1829-30—there were but thirty students in attendance;—

	Students.
In 1839-40.....	20
In 1849-50.....	44

In 1859-60.....	108
In 1869-70.....	141
In 1879-80.....	166
In 1889-90.....	261

It will be remembered that in '39 an '40 the rebellion occurred, and for two or three years the classes were closed. Only eight or nine years ago the university had almost reached the limit of its accommodation; the class rooms and laboratories were overcrowded and students unable to obtain admission were forced to go elsewhere. Then it was that the Chancellor came to their aid (cheers), and enabled them to further extend their usefulness. The Campbell Memorial fund had also enabled them to extend their class rooms, laboratories and equipments. They had accordingly endeavored to increase the useful working of the institution. He felt that their efforts had been fully appreciated by the class from which their students are drawn. But while congratulating themselves they must face a feeling of anxiety. They had seen one period of stagnation owing to overcrowding; that must not occur again; they could not afford it. They must keep constantly advancing. Medical teaching is not a remunerative employment; advanced methods have to be employed with the forward move of the times. The Dean felt sure that their wants only require to be made known to friends in Montreal to gain the help necessary to carry on their work as it should be carried on.

Continuing, he said:—The following gentlemen, 56 in number, have fulfilled all the requirements to entitle them to the degree of M.D., C.M., from the University. In addition to the Primary subjects mentioned, they have passed a satisfactory examination, both written and oral, on the following subjects:—Principles and Practice of Surgery, Theory and Practice of Medicine, Obstetrics and Diseases of Infancy, Gynecology, Pharmacology and Therapeutics, Medical Jurisprudence, Pathology and Hygiene —and Clinical Examinations in Medicine, Surgery, Ophthalmology, Obstetrics and Gynecology conducted in the wards of the General Hospital and Maternity:—

G. A. B. Addy, St. John, N.B.; C. A. Ault, Oshkosh, Wis.; C. P. Bisset, River Bourgeois, N.S.; E. J. Bowes, Ottawa, Ont.; E. J.

Broderick, B.A., Fredericton, N.B.; C. H. Burritt, B.A., Mitchell, Ont.; J. M. Campbell, Longueuil, Que.; J. W. Clarke, Tatamagouche, N.S.; P. J. Clune, Warkworth, O.; A. H. Coleman, Belleville, Ont.; F. G. Corbin, Bedford, N.S.; I. B. Curtis, Hartland, N.B.; T. H. Ellis, Pembroke, Ont.; D. J. Evans, Montreal, Que.; A. S. Gorrell, Brockville, Ont.; T. J. Green, Appleton, Ont.; H. D. Hamilton, B.A., Montreal, Que.; N. M. Harris, Ormstown, Que.; John Hayes, B.A., Richmond, Que.; W. E. Inksetter, Copetown, Ont.; A. F. Irwin, Chatham, Ont.; W. E. Jenkins, Conqueroll, N.S.; C. P. Jento, Mellville, Ont.; D. N. Kee, Fordyce, Ont.; H. D. Kemp, Montreal, Que.; A. C. Leslie, Grand Forks, Dak.; A. A. Lewin, St. John, N.B.; G. L. Liddell, Cornwall, Ont.; O. Morris, Pembroke, Ont.; E. A. Mulligan, Aylmer, Que.; M. W. Murray, Beachwood, Ont.; M. S. Macdonald, Scotchtown, Q.; F. McEown, Winnipeg, Man.; H. H. McKay, Pictou, N. S.; R. E. McKechnie, Winnipeg, Man.; G. L. McKee, Coaticook, Que.; A. C. McLellan, Indian River, P.E.I.; H. D. McManus, B.A., Fredericton, N.B.; G. A. McMillan, St. St. Agnès de Dundoe, Que.; C. T. Noble, Sutton, Ont.; C. O'Connor, Worcester, Mass.; A. J. Oliver, Cowansville, Que.; H. M. Patton, B. A., Winnipeg, Man.; J. T. Reid, Winnipeg, Man.; W. Robertson, Chesterfield, Ont.; James Ross, Halifax, N.S.; H. R. Ross, Quebec, Que.; W. D. Smith, Plantagenet, Ont.; W. J. Telfer, Burgoyne, Ont.; F. E. Thompson, Quebec, Que.; D. De J. White, Montreal, Que.; W. A. Willson, Derby, N.B.; H. M. Williamson, Guelph, Ont.; E. H. Woodruff, B.A., St. Catherines, Ont.; F. S. Yorston, Truro, N.S.

The following gentlemen have passed their Primary Examination, which comprises the following subjects:—Anatomy, Practical Anatomy, Chemistry, Practical Chemistry, Physiology, Histology and Botany:—

G. A. Berwick, J. E. Binmore, G. A. Bowen, B. F. Boyce, F. W. A. Brown, D. A. Bruce, H. B. W. Carmichael, C. M. Carlaw, J. L. Chabot, R. J. Chipman, A. R. Day, G. H. Duncan, R. T. Glendinning, W. C. R. Graham, H. A. Grant, V. Halliday, P. J. Hayes, James Henderson, D. H. Hogg, A. F. Irwin, Thos. Jameson, Albert Johnson, F. W. Lang, A. F. Langley, A. A. Lewin, A. W. Mair, C. F. Martin, H. B. Massiah, C. J. Meade, W. F. Meikle, D. T. Mackay, J. E. McKenty, R. T. McKenzie, A. I. McKinnon, H. McNally, Lamont Paterson, E. D. Phelan, B. E. Robinson, W. Rogers, Geo. R. Shirriff, O. W. Sinclair, W. H. Smith, J. A. Stewart, T. T. Taylor, J. N. Taylor, M. M. Taplin, A. S. Wade, W. E. Walsh, W. G. Walker, H. J. Wasson, H. B. Yates.

THIRD YEAR.

The following have passed in Pharmacology and Therapeutics:—

W. W. Alexander, R. Bennie, R. A. Bowie, J. E. Brouse, W. A.

Brown, J. Busby, B. H. Calkin, C. M. Carlaw, J. Clarke, J. C. Clemesha, A. Dewar, W. A. Farwell, R. W. Fletcher, J. A. Fulton, R. J. Gibson, E. A. Grafton, W. F. Hamilton, J. D. Harrison, W. H. Hattie, J. Heweston, D. B. Holden, A. Internoscia, A. F. Irwin, C. I. Kelly, E. J. Keir, E. M. Lambert, A. Love, W. Lovering, A. I. Mader, C. G. Main, M. McL. Martin, J. M. Moore, W. S. Morrow, A. E. A. McCann, A. A. McCrimmon, G. F. McGauran, J. C. McGuire, J. H. McMillan, J. A. MacPhail, J. Neill, E. A. Robertson, T. F. Robertson, O. W. Sinclair, C. F. Smith, T. H. Smith, A. J. Sparling, J. R. Spier, C. A. Tunstall, W. Troy, N. M. Waston, R. E. Webster, W. P. Williamson.

The following have passed in Pathology :—

W. W. Alexander, R. Bennie, R. H. Berwick, R. A. Bowie, W. A. Brown, J. Busby, B. H. Calkin, C. M. Carlaw, J. Clarke, J. C. Clemesha, A. Dewar, W. A. Farwell, R. W. Fletcher, R. J. Gibson, E. A. Grafton, W. F. Hamilton, J. D. Harrison, W. H. Hattie, J. Heweston, D. B. Holden, A. Internoscia, A. F. Irwin, C. I. Kelly, E. J. Keir, E. M. Lambert, A. Love, W. Lovering, A. I. Mader, C. G. Main, M. McL. Martin, J. M. Moore, W. S. Morrow, A. E. A. McCann, A. A. McCrimmon, J. C. McGuire, J. H. McMillan, J. A. MacPhail, J. Neill, E. A. Robertson, G. Shirriff, O. W. Sinclair, C. F. Smith, T. H. Smith, A. J. Sparling, J. R. Spier, C. A. Tunstall, W. Troy, N. M. Watson, R. E. Webster, W. P. Williamson.

The following have passed in Medical Jurisprudence :—

W. W. Alexander, R. Bennie, R. A. Bowie, J. E. Brouse, W. A. Brown, J. Busby, B. H. Calkin, C. M. Carlaw, J. Clarke, J. C. Clemesha, A. Dewar, W. A. Farwell, R. W. Fletcher, J. A. Fulton, R. J. Gibson, E. A. Grafton, W. F. Hamilton, J. D. Harrison, W. H. Hattie, J. Heweston, D. B. Holden, A. Internoscia, A. F. Irwin, C. I. Kelly, E. J. Keir, E. M. Lambert, A. Love, W. Lovering, A. I. Mader, C. G. Main, M. McL. Martin, J. M. Moore, O. Morris, W. S. Morrow, H. H. Mackay, E. A. McCann, A. A. McCrimmon, G. F. McGauran, J. C. McGuire, J. H. McMillan, J. A. MacPhail, J. J. Neill, S. Richards, E. A. Robertson, T. F. Robertson, G. R. Sparling, J. R. Spier, C. A. Tunstall, W. Troy, N. M. Watson, R. E. Webster, W. P. Williamson.

FIRST YEAR.

The following have passed in Histology :—

E. D. Aylen, H. H. Barrett, H. W. Blunt, W. E. Bostwick, J. A. Brown, J. D. Cameron, Robt. Campbell, R. W. Carroll, M. A. Cooper, W. E. Deeks, G. F. Dewar, Ed. Duvernet, G. W. Fleming, J. A. Fulton, C. W. Girdlestone, H. N. Goff, F. B. Gunter, Mortimer Haight, S. W. Heweston, G. L. Hume, A. Internoscia, W. H. Jamieson, W. O. Lambly, J. W. Lawrence, J. T. Lewis, W. Lindsay, H. A. Livingstone, C. H. Masten, S. R. McKensie, A. D. McArthur, J. D.

McIntyre, R. B. MacKay, D. McLennan, K. McLennan, Wallace McMillan, R. F. McMorine, C. L. Ogden, W. Patterson, B. E. Robinson, R. F. Rorke, J. W. Scane, E. J. Semple, J. W. A. Seguin, G. F. Shaw, O. W. Sinclair, W. H. Smith, G. A. Trenholme, A. S. Wade, J. L. Walker, T. N. Walsh, Robt. Wilson, R. D. Wilson, C. A. Yearwood, W. E. Young.

The following have passed in Batony:—

N. Anderson, E. D. Ayles, H. H. Barrett, W. E. Bostwick, J. A. Brown, J. D. Cameron, Robt. Campbell, R. W. Carroll, M. A. Cooper, G. F. Dewar, A. T. Dewar, Ed. DuVernet, A. S. Esty, F. M. Ferron, G. W. Fleming, M. Haight, S. W. Hewetson, R. W. Jakes, W. H. Jamieson, A. Johnson, W. O. Lambly, J. W. Lawrence, J. T. Lewis, Wm. Lindeay, H. A. Livingstone, C. H. Masten, R. Mathieson, W. C. Mills, A. D. MacArthur, J. D. MacIntyre, R. B. MacKay, J. L. MacKenzie, K. McLennan, Wallace McMillan, R. F. McMorine, G. W. Parker, Wm. Patterson, E. McG. Quirk, F. W. Read, D. A. Rodger, R. F. Rorke, H. J. Robinson, J. H. Scammell, J. W. Scane, J. S. Seaton, E. J. Semple, J. W. A. Seguin, Thos. P. Shaw, G. F. Shaw, O. W. Sinclair, W. H. Scott, J. E. C. Tomkins, G. A. Trenholme, J. L. Walker, Robt. Wilson, R. D. Wilson, W. E. Young, C. A. Yearwood.

The Holmes Gold Medal, for the best Examination in all the Branches comprised in the Medical Curriculum, is awarded to Robert Edward McKechnie, of Winnipeg, Manitoba.

The Prize for the best examination in the Final Branches, is divided equally between Edward John Bowes, of Ottawa, Ont., and Michael William Murray, of Beachwood Ont.

The Clemesna Prize in Clinical Therapeutics, is awarded to Alfred Henry Coleman, Belleville, Ont.

The Prize for the best examination in the Primary Branches, is divided equally between James Henderson, of Warkworth, Ont., and Thomas Jameson, of Buffalo, N. Y.

The Sutherland Gold Medal is awarded to Thomas Jameson, Buffalo, N. Y.

The following arranged in order of merit, deserve honorable mention :

IN THE PRIMARY BRANCHES.—J. L. Chabot, A. R. Day, H. B. W. Massial, C. F. Martin, H. J. Wasson, P. J. Hayes, B. F. Boyce, R. J. Chipman, F. W. Lang.

IN THE FINAL BRANCHES.—W. D. Smith, W. E. Inksetter, F. S. Yorston, A. F. Irwin, A. H. Coleman, John Hayes, E. J. Broderick, C. T. Noble, W. A. Wilson, D. J. Evans.

Botany, Robt. Wilson, Montreal.
 Senior Anatomy, James Henderson, Warkworth,
 Junior " J. W. Scane.

Dr. Stewart, the Registrar, then administered the usual oath to the Candidates as they stood around the dais with uplifted hands.

Dr. E. J. Bowes was then called on to deliver the Valedictory on behalf of the Graduating Class of 1890. * * *

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Whatever the measure of prosperity it may be our future lot to enjoy, we shall ever remember that it is due in no small degree to the untiring efforts of our professors to instil into our minds some of that knowledge and love of science, which has brought so much honor to themselves and to their Alma Mater. And in bidding them farewell I can pay no higher tribute to their worth, or express better wishes for the welfare of my Alma Mater, than to hope that they may long be spared to preside over her Council Boards.

To our fellow students whom we leave behind, we also extend our hearty good will. We do not purpose to inflict upon you our gratuitous and unasked for advice. We only trust that you will ever work harmoniously together for the common welfare of yourselves and your university. By so doing you will, upon reaching your final year, be able to look back upon college career with the same satisfaction with which we do to-day.

Now as we go forth into the busy world, let us pause a moment and take a last fond look at our dear old Alma Mater, for we would indeed be unworthy of the name she gives us, if passing from her portals we cast no longing, lingering look on her whose loving care has brought us to this house and made us all we are. It is needless for me to sing her praises, her reputation and renown have already spread to every quarter of the globe where the English tongue is spoken. Then her graduates by their skill have been erecting a monument to her fame. The growth of her reputation has been constant and progressive, not instantaneous, and due to the electric flash of one bright genius, who illumined her horizon for a few short moments and then passed away to leave her in a deeper gloom. Her light shines with a constant and ever increasing brightness, kept aglow by the succeeding generations of her children. And whilst she has been giving her sons to other

universities to build up their strength, her's is the product of her own conception, and all her professorial chairs are filled by her own graduates. When in the natural course of events, one of her honored guides passes away to seek the rest and reward of a life of ceaseless energy and priceless worth, she can always find one of her graduates, even at considerable personal sacrifice, ever ready and willing to step into the breach, take up the work and bear her banner to the achievement of still greater renown.

Farewell, our dear old Alma Mater, you have been a kind and generous foster mother to us. You have taken us into your bosom and having nourished us with your own warm blood, you now, with your last benediction, send us forth into the world to fulfil one of the noblest duties of men.

Farewell—*ever* shall our hearts turn *to thee* with gratitude and fondest remembrance; ever shall thy precepts be engraven upon them and rule our lives, and wheresoever we shall drift on the flood of destiny, may our every deed and motive redound to *thy honor, our dear old Alma Mater.*

Dr. J. C. Cameron then delivered the reply for the Faculty. (See page 801.)

Medical Items.

—Drs. McKechnie, Coleman, Inksetter, Smith and Vidal have been appointed Resident Medical Officers to the Montreal General Hospital for the ensuing year.

—Drs. Evans and Hamilton have been appointed Resident Medical Officers to the Montreal Maternity for the ensuing year.

—We have received the first number of the *Montreal Pharmaceutical Journal*. It is edited by Joseph Bemrose, Esq., F.L.C., the well-known chemist. We wish the new periodical every success.

THE WILLIAM F. JENKS MEMORIAL PRIZE.—The second triennial prize of \$450, under the deed of trust of Mrs. William

F. Jenks, will be awarded to the author of the best essay on "The Symptomatology and Treatment of the Nervous Disorders following the Acute Infectious Diseases of Infancy and Childhood." The conditions annexed by the founder of this prize are that "the prize or award must always be for some subject connected with Obstetrics, or the Diseases of Women, or the Diseases of Children"; and that "the trustees, under this deed for the time being, can, in their discretion, publish the successful essay, or any paper written upon any subject for which they may offer a reward, provided the income in their hands may, in their judgment, be sufficient for that purpose, and the essay or paper be considered by them worthy of publication. If published, the distribution of said essay shall be entirely under the control of said trustees. In case they do not publish the said essay or paper, it shall be the property of the College of Physicians of Philadelphia." The prize is open for competition to the whole world, but the essay must be the production of a single person. The essay, which must be written in the English language, or, if in a foreign language, accompanied by an English translation, should be sent to the College of Physicians of Philadelphia, Pennsylvania, U.S.A., before January 1, 1892, addressed to Louis Starr, M.D., chairman of the William F. Jenks Prize Committee. Each essay must be distinguished by a motto, and accompanied by a sealed envelope bearing the same motto and containing the name and address of the writer. No envelope will be opened except that which accompanies the successful essay. The committee will return the unsuccessful essays if reclaimed by their respective writers, or their agents, within one year. The committee reserves the right not to make an award if no essay submitted is considered worthy of the prize.