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# THE CANADA LANCET,

A MONTHLY JOURNAL OF

MEDICAL AND SURGICAL SCIENCE.

VOL. XI. TORONTO, APRIL 1ST, 1879. No. 8.

## Original Communications.

### ADDRESS DELIVERED BEFORE THE BATHURST AND RIDEAU MEDICAL ASSOCIATION.

BY J. A. GRANT, M.D., M.R.C.P., LOND. & C. OTTAWA,  
PRESIDENT.

GENTLEMEN;—The important duty now devolves upon me, at the present annual meeting of our Association, to offer a few observations on some points of interest which have come to the surface during the past year, and chiefly through the untiring exertions of the recognized workers in our noble profession. However, before doing so, I must thank in an especial manner the members of this division for my election to so important an office as the one I now have the honor to occupy. During the five years which have passed, many valuable papers have been contributed by the members of the Association, giving evidence of earnest thought in working out many of the interesting problems developed by disease in the human system. Some of these contributions have already appeared in our medical journals, and others yet unpublished will, I trust, in time follow. Practical data, the outcome of patient and painstaking observation are always of service, and thus are the members of our profession enabled to sum up the result of their efforts in staying the progress of disease, and at the same time giving tangible form and expression to those various manifestations which constantly crop up during the discharge of the onerous duties of a professional life. From our midst within the past few months, an honorable and painstaking member of our profession has passed away. In the performance of his duties at Pembroke, the lamented Dr. Desloges made many warm friends, and the record achieved was alike creditable to the French nationality and to the medical profession. In

thus paying a tribute of respect to one of our worthy fellow-laborers, I feel satisfied it is but the expression of an opinion fully endorsed by this entire Association. The first duty which devolves upon me on the present occasion, is to congratulate the Society on the increase of its members and its visible additional vitality. Many have come here to-day at considerable inconvenience, but our profession is one of well-known self-sacrifice, and it is by your recognized energy and determination in the pursuit of science, that you have thus far been enabled to make our Rideau and Bathurst Society quite an institution in the land. There are, it is true, strange opinions existing as to the medical profession in Canada, with many in the mother country, who should certainly know more as to the existing progress of medical matters in this country. Do we not receive our information from the same fountains of scientific medical truth? Have we not the same literature? Are not many of our professors and general practitioners educated in the best schools of London, Edinburgh, Dublin and Paris? and up to the present our apparent provincialism has enabled our young Canadian medical students to carry off some of the highest honors of the "Parent State." A few weeks ago, Dr. Clarke, of London, delivered here an admirable address on the subject of Phthisis, and in conclusion expressed himself surprised at the status of our profession in Canada. There is an elevated and educated tone in our ranks, and our earnest desire is, while forming but a Provincial link in the world-wide professional chain, to so conduct ourselves as to uphold the honor and dignity of a profession which guards *the lives of the land*, and in the discharge of that responsibility, occupies a worthy and honorable position of recognized primary importance. During the progress of scientific investigation within the past year, many new points of interest have appeared, which have doubtless, already, received your attention. At present I shall briefly advert to a few of the most note worthy, in order to elicit the result of your own experience, for it is thus that intellectual friction develops new lines of thought and brings out new ideas, which when carried to the bedside are found to be of practical utility. Thus each meeting adds to our store of knowledge, and sends us to our respective spheres of opera-

tion better able to grapple with the many difficulties which arise in the practice of our profession. Of the various diseases observed in our section of country, few have attracted a greater degree of interest than diphtheria, and chiefly through the unfortunate circumstance, the death of the Princess Alice, which was a source of deep regret to the whole medical profession. It may with truth be said, that all classes alike in this country sorrow for the loss the Queen has sustained. Diphtheria as a disease has long been known, and its etiology shows it to be not of a continuous character, but rather of apparently unconnected outbreaks and epidemics. It has been traced back as far as the days of Aretæus, and during the 16th and 17th centuries it was observed in Spain, Italy, Sicily and various other parts of Europe, the records leaving no shadow of doubt that the disease which then prevailed was "*genuine diphtheria*." In the next century it was epidemic in several of the more northern parts of Europe, including Great Britain and France, and also in several parts of the Continent. In 1818 diphtheria made its appearance in Tours, and from that date it has been recorded by various writers as epidemic in France, Great Britain, Canada and the United States. In 1859, a series of questions were framed by Mr. Simon, then medical officer of health for the Privy Council of Great Britain, as points for enquiry in tracing the history of the disease, which resulted in much practical observation. These questions related to the general features of the districts effected; to the duration, extent and novelty of the epidemic in each district; to the local and personal conditions predisposing to the disease; to the degree of communicability of the affection; and, lastly, to the symptoms and forms of treatment adopted. Such heads certainly are of great importance, if carried into operation in the various infected districts in this section of country. The disease was frequently found to be communicable to persons under the same roof. It was also observed to cling to houses once the seat of the disease. It was also considered that if the poison did not arise *de novo*, the material cause was capable of existing and moving from place to place independently of its subjects, and in some instances the transference of the disease was found to be very remarkable. Such also were the characteristics of this disease, as observed in the Ottawa Valley dur-

ing the severe epidemic of 1860 and '61. In the early part of the present year, several outbreaks occurred—at the Desert, Gatineau, Hull, Papineauville, and the City of Ottawa, manifesting varied degrees of intensity. As is usual during such epidemics, a considerable amount of ordinary sore throat has prevailed, but not in any manner lessening the immunity from subsequent attacks of undoubted diphtheria. The country districts adverted to, in which this disease has recently been epidemic, have been known as healthy sections heretofore; high and elevated; well watered, and thoroughly drained. The few cases which came under my observation this winter, were in the best situations of our city, and in families where every possible degree of care and attention was bestowed upon the children attacked. So much has such been the case, that I have not been able to arrive at any definite conclusion concerning the etiology of diphtheria. I certainly incline to the opinion of Dr. Morell McKenzie, that the exciting cause of this disease is "a specific contagion." My own observation does not lead me to favor the opinion so vigorously advocated by Oertel, that a "minute fungus is the essential contagium" of the disease. The recent researches of Dr. Beale demonstrate beyond a doubt, that the presence of fungi in diphtheritic deposits, is not of importance, inasmuch as vegetable germs are present in almost every part of the body, in the normal state. These data are also confirmed by M. Duchamp and other able observers. At a meeting recently held in St. John's Wood, London, and presided over by Professor Huxley, the conclusion arrived at was, that diphtheria was due to defective drainage. The milk supply of the neighbourhood was also set down as the cause of the outbreak of the epidemic. The escape of sewer gas has also been considered as a prolific source of the disease. With all these defects non-existing I have seen the disease in full force, and therefore hesitate to express an opinion as to its precise origin, involved as it is in considerable doubt, not explicable even by the process of evolution, so ably advocated by Dr. Thorne, at the Epidemio-logical Society, London, in May last. Dr. Morell McKenzie, in his recent able paper on diphtheria, remarks: "There are few cases in which systematic feeding does not constitute the most important part of medical treatment, and that the administration of

alcohol is almost always advisable." In observing the course of this disease, and its peculiar outcome—a leathery, parchment-like membrane in the throat, I concluded it was a blood poison, determined by selective affinity to the mucous membrane of the throat usually embracing the tonsils and uvula, and occasionally extending to the trachea and posterior nares. Unmolested, the entire vigor of the morbid blood poison gains full force, and complete active elimination towards the formation of the throat membrane. The activity of the circulation once directed towards the skin, diverts, in a great measure, the ordinary current of elimination towards the throat, and thus renders incomplete the parchment-like membrane. Under these circumstances, the mustard baths direct the activity of the circulating medium towards the skin, and divert gradually the natural course of parchment elimination. Thus vigorous action, once established throughout the cutaneous surface, brings to our relief nature's most powerful safety-valve in various forms of disease. These baths are usually carried out once daily, for three or four days in succession, as circumstances demanded. The throat brushed, usually twice daily, with tinct. iodine, and applied externally as well, over the swollen glands, and followed by the frequent application of sponges, saturated in hot water, much preferable to the ordinary flax-seed poultices; milk diet and beef tea vigorously plied throughout the entire treatment. Under this method the results have been most satisfactory.

In over 30 cases of sore throat, noted during December, 1878, and January and February, 1879, only five were genuine diphtheria, all of which recovered. These were ushered in by well-defined constitutional symptoms, such as high temperature, headache, sickness at the stomach, and vomiting, well marked prostration, and usually a desire to sleep. With few exceptions, the disease was confined to children. As to the treatment, I certainly attach much value to nourishing diet, but the point of primary importance is the diversion of the diphtheritic poison from the throat, which is rapidly brought about by the vigorous use of mustard baths. Once thorough action of the skin is thus established, the formation of the membrane in the throat subsides, and even that already formed, loses its morbid power, and relaxes its hold on the mucous membrane. Prior to the introduc-

tion of this treatment, the mortality in my own practice, under the old system, was very considerable, whereas at present the results are of the most satisfactory character. Beef tea and milk diet were freely administered; alcohol seldom; quinine; iron in various forms; liquor ammon. acet., salicylic acid, sulpho-carbolates, sulphur and chlorate of potash, have been found useful as circumstances dictated. Antiseptics, such as chloride of lime and carbolic acid, are certainly valuable. In Canada, croup and diphtheria are considered as entirely distinct diseases, in which opinion by far the greater number of American authorities are also agreed. The committee of the Royal Medical and Chirurgical Society, appointed in 1875, reported in October last, and the result may be summed up as follows: "That the term croup "be henceforth used wholly as a clinical definition "implying laryngeal obstruction, occurring with "febrile symptoms in children. Croup may be "membranous or not; due to diphtheria or not "so. The term diphtheria is the anatomical definition of a zymotic disease, which may or may "not be attended with croup. The committee "suggested that the term *membranous laryngitis*" should be employed to avoid confusion, whenever the knowledge of the case is such as to allow of its application.

To our rural members we look for valuable information as to the history of sudden and isolated attacks in their districts, as such data would be of great service in arriving at a correct conclusion as to the proper history of this disease, which has made itself felt both at home and abroad. The restriction of diphtheria, by proper sanitary precautions, is a matter of great moment. Until within a recent date, small-pox was the only disease in which sanitary regulations were strictly enforced. The same precautions are certainly necessary in diphtheria. In our public schools careful enquiry should be made, and a certificate of safety procured from the attending physician prior to the re-admission into the school of those children coming from families where diphtheria has been known to exist. By the strict enforcement of these sanitary precautions, by the local Boards of Health, where such exist, much good may be accomplished, and in carrying out the necessary regulations, the public will receive the hearty co-operation of the medical profession. At present

no subject is so widely and so generally discussed as *public health*. The public are seeking information on the sanitary duties by which diseases are prevented and health protected in the widest acceptance of the term. The recent pestilence of yellow fever in the South, and the present plague in Russia, have combined to arouse more than ordinary degree of interest in such matters. Should the health of a city, town or village, not occupy a place even superior to the protection of real estate? Fortunately there is at present a more than ordinary degree of right-thinking in this direction. The loss of human life by preventable disease implies exceedingly important considerations, and it is time that such action should be taken as would place all sanitary matters on a sound and substantial working basis. In this country, a knowledge of private hygiene and domestic sanitation is required from every student of medicine, such being imperative as the basis of a sound medical education. In the Province of Ontario alone over 80 died daily from various causes. Of these 27 are children under five years of age; 10 are between the ages of five and twenty; and 30 between 20 and 60. Of these, it is estimated that fully one-third of the deaths are of diseases which might be prevented by proper sanitary precautions. What authority should be called into requisition in order to guard the people's interests? Was there ever a better opportunity for public men to give evidence of their determination to be progressive in the highest sense? The problem of health is simple, and necessarily so, when the requisite means to preserve it are so easy of access. Dr. Richardson, at a recent meeting of the Sanitary Institute, London, England, remarked "that there was nothing opposed to the establishment of a Minister of health, for whose creation there was overwhelming argument. Such an officer, placed in a central position, must be an authority, not a disciplinarian; a judge and a director, not a commanding officer; a collector and a teacher of all learning relating to health, not a dogmatic professor. The work of estimating life and death which now goes on, is the true basis of all our efforts." In a young country like Canada, it is true there is difficulty in introducing a "State Department of Health"; however, some action on the part of the proper authorities is necessary; for as science and social culture advance, the public

service of hygiene becomes more imperative. Provision by statute should be the order of the day, to secure the amplest possible means of sanitary improvement and public health care. Such are purely the material and ordinary requirements of personal safety, public safety, and political economy.

#### ON DISEASES OF THE EYE IN CONNECTION WITH AND DEPENDENT ON GENERAL DISEASES OF OTHER ORGANS AND THEIR DIAGNOSTIC VALUE.

BY ADOLPH ALT, M.D., TORONTO, LECTURER ON DISEASES OF THE EYE AND EAR, TRINITY MEDICAL SCHOOL, SURGEON TO THE EYE AND EAR DEPARTMENT, TORONTO GENERAL HOSPITAL.

(Read before the Canada Medical Association.)

It is a prevalent idea among general practitioners, and it seems to me, especially so in Canada, that modern ophthalmology has become so far separated from general medicine, as to constitute a precedent from which will result in the future a general breaking up of medical science into its branches; and, moreover, that even some knowledge of ophthalmology is either unnecessary or more or less useless to the general practitioner. That this is not so, every one at all familiar with the subject will readily acknowledge. Ophthalmology, it is true, has become such a large branch of medical science that no one can master it without devoting all his time and energy to it. However, no one can practice, and no one should dare to practice ophthalmology who is not perfectly acquainted with the principles of medicine. This is the stand-point of every true specialist, and to show you how our specialty, ophthalmology, brings us in our daily practice into contact with general medicine, and how impossible it would be for an oculist to sever the ties by which this specialty is united to general medicine, I thought it worth while to bring the following paper before this learned audience. It is, however, not my purpose to go into details, but will confine myself to those diseases which I suppose to be less known, and of more special interest. I further propose to show in the following paper, of what great value the diagnosis of the eye diseases may be to the diagnosis of general diseases; and how desirable it is, therefore, that every general practitioner—as is the

case in Germany and France—should have some knowledge of ophthalmology—far more than our Canadian schools enable their students to gather; and far more than the average Canadian student cares to acquire, (I speak from my own experience as a lecturer), since the high Court of medical knowledge of Ontario (the Medical Council) has not yet advanced so far as to put some knowledge of ophthalmology (to say nothing of otiology) on the list of requirements exacted from every one desiring a license for medical practice.

RELATION BETWEEN ACUTE AND CHRONIC INFECTIOUS DISEASES AND DISEASES OF THE EYE.

Among the infectious diseases, the one which most frequently attacks the eye is syphilis. It causes secondary pathological conditions in nearly all the membranes of the eye; in one certain case (Mauz) even the primary ulcer was found upon the eyelids. The part of the eye which is most liable to syphilitic disease, is the uveal tract, especially the iris. Statistics have shown that among all the cases of *iritis*, from 50 to 60 per cent. are syphilitic. There is no symptom which at once would show that we have to deal with syphilitic iritis, unless there exist at the same time other evidences of the constitutional disease. However, there are some symptoms which, although found in non-syphilitic iritis, are most common in the syphilitic form. Syphilitic iritis mostly attacks both eyes; photophobia, lachrymation and pain are, as a rule, not very pronounced in the beginning, and the disease is more of a quiet chronic than of a vehement acute character. It often does not involve the entire iris, but is more or less localized. This localization is most pronounced in cases of *iritis gummosa*. Gummy tumors in the iris are, of course, an unmistakable evidence of general syphilis; they are, however, comparatively rare, and are seen only in about 3 per cent. of the cases. Gummy tumors have been found also in other parts of the eye. However, only those lying upon, or near the external surface of the globe may be recognized with certainty during life. The existence of isolated gummy tumors in the ciliary body and choroid has been proven only by post mortem examinations. Next to iritis in frequency is syphilitic *choroiditis*. Like iritis without gummy tumors, this affection has no special pathognomonic symptom. It is more frequently a

diffuse exudative choroiditis than a disseminate one, and involves generally the retina to such an extent that the pigment epithelium cells can easily grow into the latter, and we find then in later stages, a kind of pigmentary retinitis which very closely resembles the genuine pigmentary retinitis. Syphilitic choroiditis is one of the later symptoms of syphilis, while iritis is one of the earlier ones; moreover, it is mostly found in individuals of mature age. Since this kind of choroiditis nearly always involves the retina, it is often called choroido-retinitis. There is, however, also a genuine syphilitic *retinitis*. Its diagnosis as a symptom of syphilis is nevertheless just as uncertain as that of the former diseases. The same applies to the *optic neuritis* developed on a syphilitic basis. Syphilitic neuritis has that peculiarity, however, that it more readily yields to treatment than any other form of optic neuritis, and the patient may often regain normal sight, whereas in non-syphilitic optic neuritis this result could never be obtained. In these cases of optic neuritis we find sometimes also symptoms of brain syphilis. The latter, however, are more frequent in cases of simple *amblyopia*, without any abnormal ophthalmoscopic appearance. Paralysis of the external ocular muscles, and consequent diplopia, is more frequently observed than amblyopia, without visible alterations of the background. These symptoms are often the very latest in the course of acquired syphilis, and the paralysis of the muscles very often appears only when the disease has been perfectly latent for a good many years. There is one syphilitic eye-disease which is most frequently the result of hereditary syphilis, *v. z.*, diffuse parenchymatous, or as it is often wrongly called, interstitial keratitis. Hutchinson, who was the first to call the attention of the profession to this fact, maintains that all the cases of diffuse parenchymatous keratitis in children bear symptoms of hereditary syphilis, especially the unformed teeth; this, however, is not the general experience. With regard to the treatment I will only mention that it must, of course, be chiefly constitutional, supported by such local remedies as the case may require. No other infectious disease causes as frequent disease of the eye as syphilis: however, some of them do so, often enough to be mentioned here.

*Diphtheria* very seldom attacks the eye when it is manifest upon the mucous membrane of the res-



piratory organs. If it does we find diphtheritic conjunctivitis characterized by a hard, whitish infiltration of the lids, causing extreme pain, and rendering, in an advanced state, the lids so stiff that it is impossible to turn them. The intense pain is caused by the pressure of the infiltration upon the nerves. Cold and cleanliness are the only treatment required until the diphtheritic membrane begins to dissolve. In the state of purulent conjunctivitis which follows, the usual remedies may be applied. Only in a few cases does diphtheritic conjunctivitis pass by without a lasting injury to the globe. Abscesses and ulcers of the cornea, which lead either to leucoma or leucoma adherens, or phthisis, are the most frequent results. As another result of diphtheria of the respiratory organs, we find more frequently paresis of accommodation. This pathological condition is sometimes combined with paresis of the sphincter pupillæ, and consequent dilatation of the pupil; in most cases, however, we find no visible sign of the disease. The patient is perfectly unable to accommodate, and consequently unable to read or write. It is not unfrequent to hear of children, (where it is mostly observed) suffering from this pathological condition; and they are sometimes punished by teachers and parents for pretending not to be able to read, because these observers could not detect anything wrong with the eye. This paresis of accommodation disappears, as a rule, in from 4 to 8 weeks, without treatment. Extract of calabar-bean and electricity may help to accelerate the process of recovery. If necessary, the patient may be furnished with a glass enabling him to read at a distance of twelve inches, which at the same time removes the inability of doing near-by-work, and has some influence upon the healing by inducing some exercise of the muscles of accommodation.

During the course of *variola*, and afterwards during convalescence from this disease, a number of external diseases of the eye have been observed, as conjunctivitis, parenchymatous keratitis, ulcer and abscess of the cornea, and *variola* of the eyelids. While some authors maintain that these diseases of the conjunctiva and cornea are the result of *variola* pustules, Landsberg tried to prove that in their beginning, they in no way differ from the same diseases happening when there is no *variola* present. Iritis and cyclitis have been seen

to follow an attack of *variola*, and are then called iritis and cyclitis *post-variola*.

*Scarlet-fever* is sometimes accompanied by amblyopia or even amaurosis. These eye affections are undoubtedly in direct connection with the affection of the kidneys. They occur, as a rule, in the stage of desquamation, are combined with albuminuria, disappear in a few days, and are to be considered as a symptom of uræmia. The ophthalmoscope does not reveal any pathological changes in the background of the eye during these affections.

In *puerperal fever*, as well as in all kinds of pyæmia a destructive purulent choroiditis is not unfrequently met with. This kind of purulent choroiditis has been called metastatic, and is most frequent in pyæmic diseases of the female sexual apparatus. It is generally admitted now that this metastatic choroiditis is caused by embolism of some of the ciliary vessels. My own investigations have not enabled me to ascertain this point. Amblyopia and amaurosis are sometimes also found after *typhus fever*. They are caused by the low state of nutrition of the patient, and the weak action of the heart. I had once occasion to see such a case in consultation. The patient was a child, convalescent from a severe pneumo-typhus. There was convergent squint and perfect amblyopia. I told the parents that under tonic treatment it would all disappear as soon as the patient would become stronger, and, as I had predicted, after several weeks amblyopia and strabismus were totally gone. Purulent choroiditis, probably of metastatic character, is also but rarely met with in cases of typhus fever.

Chronic poisoning with *lead*, *tobacco* and *alcohol* also produce diseases of the eyes. The eye diseases brought about by tobacco and alcohol poisoning, lead the patient generally at once to the oculist, because he cannot recognize any other pathological condition as easily as he becomes aware of his failing sight. Whilst lead-poisoning generally produces inflammation of the optic nerve, with subsequent atrophy of this organ, tobacco and alcohol poisoning produce atrophy without signs of inflammation. These patients are generally color-blind to some degree, and frequently we find defects of the visual field. It seems doubtful if the abuse of either tobacco or alcohol alone can produce all these symptoms; however, such patients are very

seldom found who do not indulge in both these habits at the same time. If they have enough energy left to discontinue alcohol and tobacco altogether, they are mostly cured, certainly always improved.

#### RELATION BETWEEN DISEASES OF SINGLE ORGANS AND DISEASES OF THE EYE.

We may pass rapidly over those combined with diseases of the respiratory organs, circulatory apparatus, and intestinal tract. The only eye-disease of importance, connected with disease of the respiratory apparatus, is found in chronic pneumonia or tuberculosis of the lungs, viz., tuberculosis of the eye. Whilst tuberculosis of the eye was formerly thought to exist only in the choroid, tubercles have recently been found in nearly all the tissues of the eye-ball. When first detected, this tuberculosis of the choroid was hailed as a valuable means of diagnosis in tuberculosis of the lungs. This is, however, not so in all cases, since ocular tuberculosis is not always present, and the occurrence of primary tuberculosis of the choroid has of late been several times observed.

The most important affection of the eye in diseases of *the heart*, is embolism of the central retinal artery or its branches, followed by sudden total or partial blindness of the affected eye. Patients subject to this affection are seldom found to survive long.

Among the diseases of the alimentary apparatus, *icterus* and *leukæmia* are the only ones to cause more important eye-affections. A common affection during jaundice is that the patient sees everything in a yellow tint. I had once occasion to examine such eyes, *post mortem*, and found the outer layers of the retina containing a large amount of little brown molecules, deposits of bile-pigments. Hemorrhages in the retina are also found in this disease.

In leukæmia some authors have observed a special kind of retinitis, *i. e.*, leukæmic retinitis, characterized by the yellow tint of the retina. In other cases it was totally wanting.

#### RELATION BETWEEN DISEASES OF THE SEXUAL APPARATUS AND EYE DISEASES.

Syphilis being not essentially a disease of the sexual apparatus, was spoken of when we treated of the connection between infectious diseases and eye-diseases. Although *gonorrhœa* might be count-

ed under the same head, I think its place is better here. *Gonorrhœa* has often in its wake the so-called gonorrhœic iritis. Although this is doubted by some authors, the large majority acknowledge it. This iritis is found especially in cases of chronic *gonorrhœa*, and there are cases on record where, with each new affection of the sexual organ, the iritis recurred. It seems, moreover, that gonorrhœic iritis is mostly found in cases where the *gonorrhœa* was combined with either simple pain in the joints, especially the knee-joints, or actual arthritis gonorrhœica. I have seen several cases where, some weeks after the infection, inflammation of the knee-joints occurred, and was followed by iritis in one or both eyes. I may merely mention here that gonorrhœic conjunctivitis is found after direct inoculation of the virus, a fact too well known to be here dwelt upon. A very important, though happily rare disease, which seems to be in direct connection with some disease of the sexual apparatus, especially in women, is "Basedow's" or "Graves'" disease. The symptoms of this disease consist in palpitation of the heart, struma and exophthalmus. With the protrusion of the eyeballs is combined another symptom, which is to be regarded as pathognomonic of this affection, *i. e.*, a lack of motion in the upper eyelids. When these patients look downward the upper lid does not follow the eyeball as in the normal condition, but lags behind so as to leave a strip of sclerotic tissue exposed between the ciliary margin of the upper lid and the upper margin of the cornea. The protrusion of the eyeballs may finally become such as to prevent the lids from closing over the eyes. Ulcerations and abscess of the cornea, with complete destruction of the eyes, have been seen to follow this pathological condition. The disease is found especially in women, only about 8 per cent. of the patients suffering from it being of the male sex. While in women the connection between this disease and a disease of the sexual organs seems no longer doubtful, there is only one case on record where in the male such a connection has been found.

There is another disease of the eyes which depends on sexual disorders, and especially on chronic parametritis in women, which has been called *kopiopia hysterica*. This pathological condition of the eyes has to be looked upon as a reflex hyperæsthesia of the optic nerve, and the fifth pair, and

is somewhat similar to the symptoms of asthenopia. The chief symptoms are pain and photophobia. The pain may be constant or come on in spells. It may come on only when the eyes are used, or without any apparent cause. Light and refraction are generally normal. The disease is more frequent in women than in men, and is found among the better classes only, and is always combined with general symptoms. It mostly disappears without special treatment, but sometimes only after many years. *Castoreum canadense* and *valeriana* may have some alleviating effect.

#### RELATION BETWEEN DISEASES OF THE URINARY ORGANS AND DISEASES OF THE EYES.

A disease which is often first seen and diagnosed by the oculist is interstitial nephritis, or Bright's disease. This is due to the characteristic albuminuric retinitis and neuro-retinitis, which occur often where the patient is in no way aware of the serious affection of the kidneys he is labouring under. Generally the disease of the kidneys is far progressed when the eye symptoms are noticed. There are, however, a few rare cases, where the eye-affection is present before any other symptom will support the diagnosis of Bright's disease. Patients showing albuminuric neuro-retinitis are almost invariably doomed to an early death. The treatment in these cases is merely referable to the kidney disease, as the eye-disease is only a symptom, and will get better only when the former does so. The albuminuric neuro-retinitis may render the patient's sight very dim; in some cases, however, it is only a little affected, until general uræmic symptoms occur. One of these is uræmic amaurosis. The patients may, in consequence of the uræmia become perfectly blind for several hours and days. I remember having once seen a case in which the patient was blind for three days. Light invariably comes back after these attacks, and they are repeated generally before death occurs. The uræmic amaurosis has been observed also during scarlet fever (as mentioned above), and in acute croupous nephritis. The ophthalmoscope does not reveal any alterations in the back-ground of the eye during these attacks.

#### RELATION BETWEEN DISEASES OF THE NERVOUS APPARATUS AND DISEASES OF THE EYE.

The eye is in the closest relation to the brain. Not only do the optic nerve and retina form a di-

rect continuation of the brain, but five pairs of nerves starting from the latter, enter the eye and its surrounding, viz: the oculomotor is, trochlearis, abducens, trigeminus and facialis. Moreover, the blood-vessels and lymphatic vessels of the eye are in direct communication with those in the cranial cavity. It is therefore *a priori* to be assured that any brain disease may directly influence the functions of the eye. And this is true to such a degree that some enthusiastic minds even tried to found a kind of systematic *cerebroscopy* on the conditions of the latter organ. This has, however, proven more or less worthless.

*Hemorrhages* in the brain seldom cause any change in the eyes, since the patient generally dies before they can be developed. It has, however, been pointed out, that frequent small subconjunctival hemorrhages in persons of advanced age, may confirm the prognosis of apoplexy. *Meningitis* and *cerebro-spinal meningitis*, often cause neuritis optica and neuro-retinitis. Of more frequent occurrence in these diseases, however, seem to be affections of the uveal tract, especially purulent iritis and choroiditis, with destruction of vision. This seems to be more frequent in children than in adults. There is another amaurosis observed as the result of meningitis, which shows at first no ophthalmoscopic signs, and is produced by an exudation around the chiasm of the optic nerves, with subsequent constriction of this organ. Paralysis of the ocular muscles and purulent infiltration of the orbital tissues, with chemosis and exophthalmus are also, but less frequently, found in meningitis. They may occur without any injury to the eyeball. Any pathological condition in the cranial cavity, which produces an increase of pressure, may at any time cause œdema of the optic nerve, optic neuritis and neuro-retinitis. This neuritis has no special pathognomonic symptom. It is caused either by an obstacle in the way of the venous blood returning from the eye, or by an over-filling of the inter-vaginal space of the optic nerve, and subsequent compression of the latter (and its blood-vessels). When this condition is present the sight may be only slightly altered; in other cases it is very much reduced. The diseases of the brain which cause these changes in the eye, are: mostly tumors, large hemorrhages, abscesses, hydrops of the ventricles, tuberculous meningitis, and diffuse

encephalitis. It must be mentioned, however, that all of these diseases are met with frequently enough without causing any eye-trouble at all. With regard to the diagnosis the conditions of the eyes may be of great value, and they are sometimes such as to allow even of a more direct localization of the brain disease than any other symptom. I speak here especially of cases showing a defect in the visual field, and especially of hemiopia. There are two kinds of hemiopia (an affection in which one half of the visual field is wanting), *medial* hemiopia, where the two lateral halves of the visual field are dark, and the patient's right eye sees only what lies to the left from the point of fixation, and the left eye only what lies to the right from the same point—and *homonymous* hemiopia, where the two right or the two left halves of the visual field are wanting. These conditions can only be well explained if we assume a semi-decussation of the nerve fibres in the chiasm, which of late has been undoubtedly proven. The more frequent kind: *homonymous* hemiopia, is caused, as *post mortems* have taught us, by a pathological condition in one optic nerve tract between its origin and the chiasm.

Another eye disease connected with diseases of the brain, is paralysis of one or more nerves which go to the eyes, *i. e.*, the oculomotor, trochlear, abducens, and facialis nerves. Their origin is located at the floor of the fourth ventricle, and where we find such paralysis as a result of some brain disease, we may locate the latter in the same region. Diseases which impair the functions of the fifth pair produce two special eye-diseases: herpes of the cornea and neuro-paralytic ulcerations of the same membrane.

The spinal medulla has also some influence upon the condition of the eyes. How this comes to pass is as yet unexplained. The fact, however, is now well established, that *tabes dorsalis* (and sometimes wounds of the spinal medulla), produce myosis (contraction of the pupils) and atrophy of the optic nerve.

Not to trespass too much on your valuable time. I was obliged to treat this subject very superficially. It was, however, not my intention to give you here an elaborate lecture on a subject which is large enough to fill books with. I only intended to give you a hurried glance over it, in order to accomplish what I promised in the beginning of

this paper, namely, to show you that the oculist (as well as any other specialist) if he means to master his specialty, requires a full knowledge of general medicine, and on the other hand to show you how desirable it is for the general practitioner not to have too limited a knowledge of a branch of medicine which will so frequently aid him in the diagnosis of doubtful cases, and if the proper authorities here, as is the case in other countries, would take the necessary steps to force the student to acquire this knowledge, they would do him a great favor and humanity a greater one.

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#### ADDRESS DELIVERED BEFORE THE WESTERN AND ST. CLAIR MEDICAL ASSOCIATION.\*

BY DR. TYE, THAMESVILLE, PRESIDENT.

Gentlemen,—At the meeting of the Association in Detroit the question was asked, "Who will prepare papers for the next meeting of the Association?" A gentleman suggested that the President should read an address. To this proposal I thoughtlessly agreed. I can assure you, more than once I have regretted my promise. I have attempted to fulfil my promise, to establish a precedent to bind my successor to enjoy a similar opportunity. Previous to the passage of the present medical Act and its amendments, the state of the profession in Ontario was not entirely satisfactory. Its members were, however, equal to the occasion, and the means adopted for improvement were both radical and vigorous. The thorough preliminary examination, the almost complete independence of the teaching from the examining bodies, are the fundamental principles upon which our present system rests; a common door is thus open to all, so that all who can meet the conditions and wish to do so, may enter upon equal terms with every other person. The result is, the profession in Canada takes high standing both at home and abroad. Our matriculation examinations are accepted at the various medical colleges of Great Britain, and graduates readily pass examinations for memberships in the Royal Colleges. Canadian practitioners are highly estimated by our neighbors, and they are not ashamed to express a desire for medical organization equal to our own. The legislative enactments

\* *London Advertiser.*

founding the present system of medical representation and legislation, has done much to consolidate and elevate the profession; yet we do not assume to be beyond improvement. The general profession and the Medical Council seem too far removed from each other, and there is not so much sympathy between them as there might be. The terms of office are too long. Three years are quite sufficient, so that the constituents may be more often enabled to express their views and call their representatives to account for their actions. A part of the examiners should be selected outside the Medical Council and teaching bodies. Some legislation respecting suits for malpractice is required; the time for bringing them should be limited, and proof produced that there is some reasonable ground for action. The majority of these suits are groundless, yet they oblige the defence to undergo a large amount of derogatory criticism and expense. Another point is quite necessary, that is the power to expel unworthy members. The actions of a few are so gross and degrading, that their full membership is a stigma to our name. The legal profession, I believe, have power to unbar members for certain offences; this action is not only necessary to punish offenders, but to prevent their recurrence. I must not forget that part of our laws which provides for the establishment of Territorial Medical Associations. One of the great needs of the profession was to be brought together, that we might know each other better, and thus learn to value each other more. It is such knowledge that makes us more tolerant and sympathetic. We institute codes of ethics, and it is well that we should do so, but they must be founded upon genuine regard and respect for those with whom we meet. This desirable result is produced in the most agreeable and profitable manner by these associations. I can testify that this Association has been of great benefit to many of its members socially, professionally, and financially, also. Harmony, mutual assistance, and appreciation have taken, in many instances, the place of their opposites. This good result would be, of course, greatly increased, should a larger number take part in this Association and steadily support it. However, there are many, whether residents in Chatham, Sarnia, Windsor or Strathroy, that are still faithful to its interests. I consider our legislative functions, such as tariff of fees, places of meeting, questions of ethics—are

quite subordinate to that more delightful and profitable part. The reading of papers and consequent discussions refreshes the mind of every participant, enables every one to measure himself and find out his own short-comings; he can feel his weak points, and see views that are erroneous; or it consolidates some views already entertained—adds new facts to the stock already acquired. We are too apt to get into grooves; these meetings help us to get out again. Professor Alonzo Clark says it is hard to keep the medical profession plumb, they have a strong tendency to swing from one extreme to another. Our mutual discussions will do much to keep us near the true centre. These meetings incite professional readings and studies, and render necessary closer observation of the varied and interesting phenomena every day presented to us. Professor Flint says much of his success is due to close observation and careful note taking. Facts of our own collection are the best premises from which to draw new conclusions. A paper containing any *new fact*, and properly applied, is worth many compilations from standard authors and periodicals. This Association can appoint committees whose duties shall be to gather statistics and other facts relating to important epidemics, such as cerebro-spinal meningitis, scarlatina, malaria, typhoid fever, etc. Facts of great interest may be gathered relative to climatic influence. Another field would be to note the various forms in which the laws of health are interfered with; for though we practise the healing art, we are yet the natural guardians of the public health. While speaking of the work of our Association, may I suggest that each member here to day make an especial effort not only to be present at our next meeting, but to induce another to come with him. We all can probably do more than we have hitherto, to make it the model Association of the Province. Our transactions are interesting and valuable papers, and will increase in value with our own efficiency. Medicine is now making a gratifying advance. Formerly it contained so much based upon routine ideas—so much of mystery and empiricism—that it was looked upon as an association of occult sciences. It has nobly won a much higher character. The assiduity with which the natural sciences have been cultivated has much to do with this elevation. The sciences of chemistry, physiology, and morbid anatomy have laid a foundation for

the clinical observer. Principles logically deduced from these sciences are well tested at the bedside. One is naturally the complement of the other. Weir Mitchell, in an article on "Nerve Section" in the October number of *Brain*, shows plainly that the work of the anatomist is completed by the clinician. The anatomist traces the distribution of the median nerve in the hand to the utmost limits of vision. The clinician shows by cases of median nerve section that the distribution exists in parts hitherto unsuspected. Medicine, by this correlation, is daily approaching nearer to an exact science. Instruments of precision have been the means of much positiveness and exactness in this art. None has afforded more extensive and useful aid than the clinical thermometer, so much so that those once using are not content without its assistance. What a lesson to us that the clinical thermometer should be so long known and so lately adopted by the profession. How many more, equally important and useful, may be close to us and yet we do not see them. In the more scientific branches, the microscope and the spectroscope and the various other ingenious instruments of physiological and pathological research reveal a world of new facts. Medical literature is receiving most unusual additions in Ziemssen's *Cyclopædia*. Another work, though not so extensive, yet of the highest merit, is Reynold's *System of Medicine*, now just completed in the fifth and last volume. We have few safer guides to practice than the writers of this *System*. Our relation to the State is receiving increased attention, and deservedly so. The State cannot dispense with the services of the profession. First, in respect to mental medicine, we have a large and increasing number of insane. The early detection of insanity and an appreciation of its causes is not only of importance to the scientist but to the general profession, for to these the case appears in its earliest days. Dr. Bucknill, in some admirable articles in the *London Lancet*, seeks to aid the general practitioner in coming to an intelligent conclusion. That many cases of mental aberration are due to physical causes, is becoming daily more apparent. In these cases the diagnosis of the condition is very essential, for in many instances relief may be procured by proper medical treatment. The cause and treatment of insanity must always continue chiefly in the hands of the specialist. This fact, however, does not relieve

the profession from greatly increased attention to the subject. I believe none will rejoice more than the specialist at an increased knowledge of this subject amongst outsiders. It is a matter of gratification that these unfortunate insane are so well treated, that humanity is exemplified, and cruelty frowned upon in the best of Institutions, and in no country in the world better than in our own. Preventive medicine is not pressed far enough yet, and we should make united and persistent efforts to stamp out diseases of a contagious nature. The undoubted power of vaccination is not properly valued by the public as it should be. Small-pox is steadily increasing in this country. It is time the State required general compliance with the prophylactic. Scarlatina is another disease that causes many deaths, and worse still, leaves a large number with serious impairment of health and vigor. When the severe epidemics of scarlatina occur, the afflicted families should be completely quarantined until the disease has passed, and complete disinfection obtained. Many lives and much suffering will thus be saved. Public hygiene has within a few past years received the most satisfactory attention, both from the State and profession in many countries. We all recognize the intelligence and zeal of our brethren in the Ontario Legislature in initiating this matter, and appreciate the liberality of that body in dealing with this matter. Although the committee had but a few days at their disposal, yet much was accomplished as a foundation for future work. Our Registrar-General's report is yearly becoming more reliable, and it is our bounden duty to do all we can to make it accurate. The public must be educated in this matter. The press is doing a good work. Good works are published that cannot fail to disseminate good ideas. Dr. Richardson's book, *Life and Health*, and *Diseases of Modern Life*, are suitable for non-professional readers. A series of health primers published in England and republished by the Harpers, are excellent things and cannot be found in too many households. We have abundance of work to do—and there are many problems to solve in the future. Our organization is a powerful means to concentrate and intensify our efforts. Our work is one of supreme interest, dealing with man as we do from the first faint flash of existence in the morning of life, onwards to the full sunburst of manhood, and again to watch its last glimmer in death. Let me con-

clude in the words of Dr. St. John Rosa, President of the State Society of New York, who says: "Let us who have with a united effort struggled for the prolongation of life, and the mitigation of disease, continue our advance in the same column with those who by cultivating the soil, by humane and wise legislation, and the administration of law, by the finding out of many inventions, by the inculcation of the principles of morality and religion, contended for the land and the time when the wilderness and the solitary place should be glad for them, and the desert should blossom as the rose, and the Eternal God should wipe away all tears from the face of man."

### CASES IN PRACTICE.\*

(REPORTED BY DR. GREENWOOD, HOUSE SURGEON  
G. & M. HOSPITAL, ST. CATHARINES.)

Dr. Mack exhibited a specimen of substance vomited by a gentleman at Clifton, at intervals during the last two or three months of his life. The specimen had been sent to him for examination, to determine as to its being animal or vegetable in nature. Dr. Mack here alluded to the ease by which this question could have been settled by ignition, when ammonia could at once have been detected, by fuming hydrochloric acid, or even by the odor proving it to be animal, or simple carbonization proving it to be vegetable. Dr. Mack had pronounced the mass to be enormously hypertrophied gastric mucous membrane from malignant disease.

After death, Dr. Mack assisted at the post-mortem. The pyloric extremity of the stomach was the seat of extensive carcinomatous ulceration, having still attached a few masses of the fungiform growths. What apparently confirmed the conclusion that the mass was not merely a morbid production, was that where once thrown off by ulceration at the base, no attempt at reproduction was to be found. The disease had not extended to the oedenum. It evidently commenced in the submucous tissues. Dr. Mack mentioned that before he received the specimen vomited, another portion had been subjected to the untutored analysis of a practical man, whose process consisted in eating a piece of it, upon doing

\*Read before the Medical Society for Mutual Improvement, St. Catharines.

which he pronounced it to be vegetable matter, and inasmuch as he swore to the correctness of his discrimination his audience implicitly believed therein. Dr. Mack was extremely sorry that strict regard for scientific truth compelled him to reverse this decision, yet the expert remained happy in his first conviction.

Dr. Greenwood then presented a specimen of scirrhous of the pylorus, of which he gave the following history:

#### SCIRRHUS OF PYLORUS AND FUNDUS.

M. H., æt, 52; laborer; born in Ireland; admitted July 30th, 1878; complaining of slight diarrhoea, and frequent chills and fever. The family history was not obtainable. In regard to previous history, has always been a healthy man until one year ago, when he began to suffer very much from malaria, and a slight but continued pain in the epigastrium, frequently extending to the lumbar regions. Has indulged in the use of liquor rather to an excess. One year ago had one or two attacks of vomiting of blood, which occurred in the morning; he believed them to be due to his drinking so hard.

*Present condition.*—He is a man of average height, rather thin, sallow complexion; face wears a peculiar pinched expression, hair dark, eyes dark and bright, cheeks flushed, skin hot and dry, tongue dry, brown and fissured. Complains of pain in epigastrium, not increased by pressure, and also of pain in the lumbar regions. Viscera of the thorax normal; spleen slightly enlarged; other organs natural; urine high colored, no albumen, but contains an excess of urates.

July 31st.—Pulse small and frequent, 110; temperature  $102\frac{1}{2}^{\circ}$ ; skin hot and dry; pain in epigastrium; tongue dry and brown.

Aug. 3rd.—Tongue gradually becoming clean; complains of pain in left loin.

Aug. 11th.—Free from pain, complains of sleeplessness.

Aug. 16th.—Pain in left loin and shoulder; is very feverish; bowels constipated.

Aug. 24th.—Temperature normal, pulse full, soft and regular; but complains of continual and obstinate constipation.

Sept. 5th.—œdema of feet and ankles; slight diarrhoea.

Sept. 22nd.—Diarrhoea increasing; stools yellow, offensive and liquid.

Sept. 25th.—Diarrhœa still continues ; complains of slight pain in the epigastrium.

Sept. 28th.—There is a marked increase in the number and loose character of the stools ; pulse very weak ; temperature. 97°.

Oct. 1st.—Number of stools lessened ; complains of slight pain in the epigastrium, and sleeplessness ; takes very little nourishment.

Oct. 4th.—Diarrhœa again very severe ; nothing whatever seems to relieve it.

Oct. 5th.—Diarrhœa continues ; vomiting occurred, the ejected materials being chiefly nourishment he had taken ; patient died at 9 a.m.

An autopsy was performed by Dr. Greenwood eight hours after death. The body was much wasted ; muscles soft and flabby ; skin loose ; viscera of thorax, normal. The liver was nutmeg in character, of average size. The stomach presented a hard, irregular feel. On section it was found to be the seat of a scirrhus cancer, occupying the greater portion of the fundus, and pyloric extremity, forming an adhesion to the under surface of the left lobe of the liver, and to nearly the whole length of the transverse colon. The kidneys were of ordinary size ; the right presented three small cysts, the left presented one. The spleen was slightly enlarged. Two or three mesenteric glands were hard and indurated ; intestines normal.

It will be observed that the treatment is not mentioned, as it was merely supporting and palliative. The peculiar features of the case were the absence of the usual diagnostic symptoms of cancer.

#### CANCER OF THE LIVER.

J. McK., æt 55 ; laborer ; born in Ireland ; admitted Dec. 5th, 1878 ; complaining of pain and tenderness in the epigastric and left hypochondriac regions, slight fever and loss of appetite.

Family history good. In regard to previous history he has always been a healthy man, has indulged freely in the use of alcoholic liquors. About twenty years ago he suffered from the same symptoms for which he was admitted, but not as severe. He obtained relief, and never felt any inconvenience until two weeks before admission, when his appetite began to fail, bowels became constipated, shooting pains from side to side, pain and tenderness over the epigastrium and left hypochondrium, and sleeplessness.

*Present condition.*—He is a man of average dimensions, of a waxy complexion, and irritable disposition. Skin warm and dry ; tongue brown and moist. Appetite much impaired. Complains of pain and tenderness over the stomach and left lobe of liver, and of occasional lancinating pains from right to left hypochondrium, and through the chest to the left shoulder. Lungs, normal ; heart, apex beat visible  $2\frac{1}{2}$  inches below and to the inner side of the left nipple, impulse strong ; dulness increased on percussion ; a systolic murmur is heard at the apex, transmitted around the side and heard at the lower angle of the scapula. The abdomen is enlarged, there is distinct fluctuation ; the abdominal veins are enlarged ; there is marked fulness above the free border of the ribs on the right and left sides, more especially on the right ; it seemed as if the extreme and rapid growth of the liver was pressing the ribs out ; there are distinct prominences to be felt over the left side of the liver ; dulness extends upwards as far as the 3rd rib, but does not extend below the free border of the ribs on the right side ; on the left side the dulness extends upwards to the 4th rib, and laterally as far as the border of the axillary region. The spleen, normal. Urine, high colored, sp. gr. 1030, slightly albuminous, no casts.

Dec. 6.—Temperature 100° ; pulse, 80 ; complains of restlessness, and pain in the epigastrium ; complete loss of appetite.

Dec. 8th.—Temperature 98° ; pulse, 78 ; bowels constipated ; slept well last night.

Dec. 10th.—Temperature and pulse normal ; patient cannot be induced to take nourishment, only a small amount of whiskey, so it was ordered to be administered per rectum.

Dec. 14th.—Pulse, weak, small and frequent ; œdema of lower extremities, and ascites are increasing.

Dec. 20th.—Slept well last night ; patient is sinking fast ; complains of lancinating pains passing from side to side.

Dec. 22nd.—Slight diarrhœa, supposed to be caused by the nourishing enemata ; temperature, 97° ; pulse, very small and frequent, 140.

Dec. 24th.—Is very low to-day ; temperature normal ; pulse can hardly be felt at the wrist.

Dec. 25th.—Patient expired at 9 a.m.

An autopsy was performed by Dr. Greenwood 24 hours after death. The skin had a peculiar



cachectic look, face thin; upper extremities thin and wasted; lower part of the chest and upper part of the abdomen particularly large; there is bulging between the ilium and the free ribs on both sides; lower extremities œdematous. The lungs were compressed to one half their usual size. The heart was twice as large as natural; the left ventricle was very much hypertrophied; the points of three fingers could be passed into the mitral orifice; weighed 18 oz. The peritoneal cavity contained about 4 gallons of thin reddish fluid.

The liver is very large, irregular on its external surface, of a bluish red color, the irregularities being as large as a walnut, and when cut into, a soft but grayish white substance escaped. The right lobe was adherent to the under surface of the diaphragm; the left was fully as large as an ordinary right lobe; weight, 12½ pounds.

The stomach was natural; kidneys, normal; a few of the mesenteric glands were thickened and indurated. No trace of disease could be found elsewhere.

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### Correspondence.

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#### THE "PROVINCIAL" UNIVERSITY.

To the Editor of the CANADA LANCET.

SIR:—I notice in the Form which students in medicine who propose to offer themselves for examination in the Toronto University are required to fill up and sign, the following question: "Are you an under-graduate or graduate in medicine of any other University?" It is also stated in the announcement of the Faculty of Medicine of Toronto University, that "that the scholarships and medals are not open to those who are at the same time under-graduates or graduates in medicine of another University." It is easy, therefore, to see the object of the question, and it is very much to be regretted that the senate should have adopted such a useless and unwise regulation. It can be of no possible use, because the honor students so debarred, can subsequently obtain their degrees in any University in which they may desire to graduate. It is unwise because it makes it appear to the public that the "national" University is hereafter to be carried on in open hostility to all other Universities, instead of becoming, as it should be, their exemplar. It is really no wonder

that an outcry has been raised against the management of the Toronto University, when such a regulation as the one here referred to, can find a place among the proceedings of the senate. The true policy would certainly be to encourage students to come up from all the Colleges and Universities in the land to the national University, rather than to throw restrictive barriers in the way. Of course students so admitted should be allowed to compete for honors only with students of similar standing, but no other question need be asked. No matter even if they be graduates of another institution, provided they have only recently obtained their degrees, they should be allowed to compete for honors along with other students of the same standing, as regards their collegiate year, as themselves. I venture to assert that in no other country in the world can there be found a similar regulation in regard to a national University. If enforced, it will either have the effect of shutting out many deserving students, or of forcing them to pass the examination of Toronto University before proceeding to any other University. A strong remonstrance should be made in regard to this matter to the Minister of Education, with a request to have the obnoxious regulation rescinded. The senate of Toronto University should not be permitted, by any restrictions of the kind here alluded to, to exclude any student, no matter where he has received his education, or of what University he is an under-graduate, from competing for honors and scholarships which are of a Provincial character. The honors of the University should be open alike to all the sons of our fair Province, without any other restrictions than those necessary to secure fair and honest competition.

Yours truly,

M. B. TORONTO UNIVERSITY.

March 12th, 1879.

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#### INSANITY.

To the Editor of the CANADA LANCET.

SIR:—In reading the February number of your journal, I found a communication from Dr. Clark, in reply to my letter in a former issue. His reference to the Wright case in his essay on "Insanity," surprised me, but his letter is a greater surprise. The Dr. has adopted the course which all weak

defenders take, namely, that of using disparaging language towards an opponent. Such action may be fitting in the eyes of Dr. Clark, but all intelligent readers of the *Lancet* will think otherwise. He still claims the credit of having discovered the root of Wright's mental ailment, but I am perfectly satisfied that the Dr. would have given evidence for the Crown, and returned home satisfied that he had discharged his duty as a witness, had it not been for the suggestion I made to him in reference to Wright. The Dr. may ridicule this statement, but others also are of my opinion. The Dr. says my evidence was so vague that the Court would not accept it as proof of the prisoner's insanity. Is the Dr. shirking the question, or showing his artlessness? He evidently is not candid, or is very forgetful. Does he not remember, the whole medical test before the Court and jury was, did the prisoner know right from wrong at the time he committed the felony? I could not swear on the positive or negative side of the question, as I did not see Wright on the day of the alleged crime, nor did I know anything of his conduct on that day. But at the Court I did swear that the prisoner was insane on religion, women, and the alleged hostile feelings of his neighbours toward him. Dr. C. would have your readers believe that all the medical evidence was adverse to the prisoner, although in his letter he admits that I, in a small way, gave evidence for the defence. \* \* \* What would the Dr. say in answer to the Judge's query: Did the prisoner know right from wrong? To such a query, I venture to say, his answer would be vague enough to assist the Crown. Dr. Clark says that he is "not responsible for my inferences, which are founded on a baseless fabric of imagination." I do not understand what he means; if he insinuates that I "fabricate," I hurl back the insinuation with scorn, and am quite willing to leave all questions of veracity to those who know me. As to the Dr.'s conduct in claiming it his duty not to interfere unless called upon by a process from the Court, I can only say that the medical profession is second to none in standing boldly forth in the true interest of humanity, and is ever imbued with a desire to aid to the utmost those who require it, so long as truth and right are on their side. Such was the object of the medical men in the defence of this case, more especially as the prisoner was a lunatic, and without a relative to assist him. It

was on these grounds that Dr. Clark, as a medical expert, brought for the purpose of deciding the *mental status* of the prisoner, should have boldly stood forth and given his evidence on the case as he found it to be, and not to have allowed a poor unfortunate man to be punished for a crime for which he was unaccountable.

Thanking you for inserting the former letter as well as this,

I am yours truly,

G. W. LING.

Wallacetown, Feb. 20, '79.

### Selected Articles.

#### DISLOCATION OF THE HIP;

REDUCTION BY BIGELOW'S METHOD.

Following the suggestion in Mr. Rivington's article on this subject in *The Lancet* of Sept. 7th and 21st, 1878, Dr. Ormond gives the following note of a case recently under his observation.

J. H—, aged fifty, a miner, was at work on the night of October 4th, 1878, and whilst in the act of pushing a heavily laden tub up an incline a large quantity of stone fell from the roof of the mine, a height of four or five feet, upon his back, half burying him in the débris. As the weight settled upon his back, it forced him to the floor of the mine, to use his own term, "all of a heap." He was released as soon as possible and conveyed home. I saw him two hours later, and found him lying on his right side, with the left thigh flexed and adducted so that the left knee rested over the middle of the right thigh; the left leg was flexed and the foot inverted. The attempt to restore the limb to its normal position caused great pain. The left limb was two inches shorter than the right. On the dorsum of the ilium was a hard tumour, and anterior and superior to this a depression could be felt. My diagnosis was dislocation of the hip behind and somewhat below the acetabulum. Being five miles from home, in the middle of the night, and without the slightest warning of the nature of the case, I was not well prepared for such an accident. However, I tried manipulation—flexing, circumducting, and extending the limb; but this did not succeed, and caused such excruciating pain that, at the patient's request, I was obliged to desist. So, placing the man in as comfortable a position as I could, after ordering hot fomentations to be constantly applied, I went home, intending to return with chloroform and try again. But I did not return as I intended, being kept by an urgent case in another direction. My partner, Mr. Douglass saw him for me, and finding the man pretty comfortable, arranged that we should see

him together the following morning. This we did, and found matters much as I had left them. Chloroform having been administered by Mr. Douglas, I proceeded to attempt reduction nearly in the manner described by Dr. Bigelow in his papers (*vide The Lancet*, June 15th and 29th, 1878). Having turned the man on his back, I placed my foot on the anterior superior spine of the ilium, expecting to have to use considerable force, and, bending the thigh to a right angle with the trunk, I grasped the ankle and knee and lifted the limb straight up. Instantly the head of the femur returned to the acetabulum. As near as I can tell, the force exerted would raise about thirty pounds from the ground. A long splint was applied for about ten days, and then removed, and the man went about on crutches.

This case illustrates the extreme ease and simplicity of Bigelow's method, as recently enunciated, compared with the elaborate direction formerly given. Seeing such cases so seldom, one is apt to forget the more complex formula of "flexion, a little inward rotation, then abduction of the thigh, circumduction and rotation outwards." Even the concise directions, "Lift up, bend out, roll out," do not always come to the memory of the operator when wanted. The mechanism of the accident is of interest, and it agrees with the case of Pierre Guillemot, quoted by Mr. Rivington from Dupuytren. My patient was pushing a heavy-laden tub up an incline; his right leg was extended and his left advanced; consequently the left thigh was flexed; it was adducted also. This can be demonstrated by placing the body in the position indicated, and attempting to push a heavy weight. The foot is turned on its outer edge to obtain a better grip of the ground, and the one thigh is carried somewhat across the other.

#### LISTON AND WATER DRESSING.

Dr. Erichsen, of London, gives the following account of Liston's water-dressing in the *London Lancet* for Jan. 11th, 1879:—Liston, undoubtedly thought and taught that water-dressing was the perfection of the treatment of wounds. And so it certainly was when compared with the other methods of treating incised wounds that were generally adopted by his contemporaries. It was the perfection of lightness compared with a poultice; the perfection of cleanliness contrasted with ointments, often irate, sometimes rancid. That Liston rode his hobby of water-dressing in the treatment of wounds rather hard is undeniable. But I doubt much whether, in this respect even, he has been beaten by more recent innovators in the same field.

Liston died in 1847, and it would be eminently unfair to contrast the views which he entertained

up to the time of his death with those subsequently promulgated, and yet more so with those which are the outcome of the great advance in physical science since his day. Liston's mind was eminent'y plastic. He was always ready to receive and act upon suggestions from others, and had he lived it is probable that his views with regard to the value of water-dressing might have been modified. His death occurred at the most critical period in the history of modern surgery—at that period, indeed, which, if I mistake not, the future historian of our art will date as the commencement of a new era in the treatment of wounds; for his death was almost contemporaneous with the introduction of anæsthetics into practice, and anæsthesia revolutionized the treatment of operation-wounds.

I believe that an erroneous impression prevails as to Liston's method of using "water dressing" in the treatment of large incised wounds, such as are occasioned by the amputation of a limb or the removal of a breast; and as, with one conspicuous exception, that of Mr. Cadge of Norwich, there is probably no one now living who has seen so much of his practice as I have, I may be excused for describing his manner of using this dressing.

It was as follows:—After the operation was finished the cut surfaces were deluged with cold water, so as to wash away all coagula, &c. A large piece of wet lint, doubled, was then placed between the flaps, which, being laid down on it, were covered with another large piece of doubled lint soaked in cold water. The stump was then put upon a pillow, exposed to the air, and left quiet, though wetted from time to time, for from four to six hours. By this time all oozing had ceased, and the cut surfaces were "glazed." The lint was then removed from between and upon the flaps; and if any vessel started bleeding it was immediately secured, and the "glazed" and nearly dry surfaces were carefully brought together by a few points of suture, and supported with strips of isinglass plaster. A slip of wet lint was then placed along the edge of the wound; the stump laid at rest on pillows, but otherwise exposed, without any covering except that afforded by the sheet thrown over a cradle. In this simple way the most favorable results were often obtained—quite as good, I do not hesitate to say, as can be shown by any of the more complicated modern methods of treatment. And it is not a little amusing to see many of those who have obtained their surgical experience during the last decade look upon the primary union of wounds as a modern invention unknown to surgeons who practised and taught thirty years ago. Such error is but an additional proof of that lamentable ignorance of the history of the surgery of the past which is so prevalent in our profession.

On the "glazing" of the wound—the coagulation of the fibrin of the liquor sanguinis over the cut surfaces—Liston laid great stress, and at the

time that I was house-surgeon at University College Hospital no one thought of bringing together a wound until this had taken place. He used the "water-dressing" partly as a means to this end, and partly as the cleanest and lightest covering at that time available for the protection of the cut edges.

But the introduction of anæsthetics led to a change in this method of treating operation wounds. From a natural and humane desire to spare suffering to their patients, surgeons, instead of waiting for the "glazing" of the wound, put it up permanently on the operation-table whilst the patient was still insensible to pain. The result of this practice was often most disastrous; for in those days methodical drainage of wounds was unknown, and surgeons had to trust to the apertures between the sutures and to the strings of the ligatures acting as conduits for the escape of blood-oozing or of that sanguineous ichor which is always freely yielded by a recently cut surface, and the retention of which in wounds we now know to be productive of the worst results.

It was not until some years later, when Chassignac invented and pressed most forcibly upon the attention of surgeons that most invaluable instrument, the "drainage-tube,"—that instrument which is the basis of most modern methods of treating wounds,—that a real advance in this department of surgery was established, and that it became possible to put up immediately a large operation wound without the more imminent peril from retained blood or ichor.

By Liston's method the drainage-tube was not necessary (even had it been invented in his day), for the wound was not brought together till its surface was "glazed" and free from blood and ichor. In this lay the great merit of his treatment by water-dressing; to this its success was due, and I venture to think that in this it might often be imitated with advantage at the present day.

Wounds cannot be "cured," but they will heal readily enough if not tormented by injudicious surgery. Drainage alone is all that is needed to place most wounds in the most favorable condition for healing. And methods of the most opposite character appear to owe their success to the fact of drainage being the one essential element that is common to all. The "antiseptic" method, in which every "germ" is rigorously excluded by clouds of spray and multiplied layers of gauze, and the "open-air" method, in which a wound is left open to all that the atmosphere may chance to deposit upon its surface, differing as they most absolutely do in the theory on which each is founded, appear, in many operations at least, to be about equally successful in practice. This success would seem to be due rather to the one condition which is common to both—perfect drainage—than to those in which they are so dissimilar. For whe-

ther drainage be effected by a tube, or by the free escape of fluids without the use of an instrument, matters nothing, provided always that it be complete.

#### THE TREATMENT OF SPINAL CURVATURE BY CONTINUOUS EXTENSION—A MODIFICATION OF THE PLASTER-OF-PARIS JACKET.

[The following paper was read before the New York County Medical Society, Jan. 27th, 1879, by John A. Wyeth, M.D., and reported in the *Hospital Gazette*.]

*Extension, fixation and rest* are the cardinal principles in the treatment of lesions of the vertebral column. Add to these good hygiene and judicious medication and we have the sum of all the indications. Instrumentation can be successful, only as it meets these demands, and when we speak of the *wheel crutch*, the *Taylor brace*, and the *Plaster-of-Paris-Jacket*, we witness in each of these a decided advance of our own progressive science. Each of these has its merits and demerits. Each has its champions and advocates among some of our most earnest workers and practical surgeons. It would be *well* for us, it would be *better* for humanity, if in the liberal spirit of true progress, we could, regardless of individuality, lay aside our prejudices, meet in the broad field of scientific discussion, courteously compare our notes, and profit by that wisdom which is found in a multitude of counsel. The plaster jacket was a great stride in the right direction. Its simplicity attracted universal attention, and it spread like wild-fire before the blasts of its enthusiastic advocates. Some of us thought that we had found the *ne plus ultra* in the management of Pott's disease; that sufferers had now nothing more to do but be suspended by the arms and neck, enveloped in Plaster-of-Paris and be cured. But let us ask pointedly, has it fulfilled these expectations? Does it meet fully all the indications in Pott's disease? I believe it comes nearer it than any other method yet made known to the public, but it has failed at times; it has its faults and these I shall try to point out, and hope to suggest the remedy.

In order to obtain the first great requisite, *extension*, by this method, the patient is suspended by the neck and arms, lifted well up from the floor, the lower portion of the body is the counter-extending force, the diseased surfaces are separated, and while in this position, the trunk is locked in the plaster jacket. If this *grip* of the jacket could be uniformly maintained, it would meet more fully than it does the indications. But any one experienced in its use will recognize this objection; it loses its firm hold in from 7 to 10 days after its application, and hence loses its property of holding at rest and separated, the diseased surfaces.

This results from two causes, 1st, the atrophy and yielding of the abdominal and thoracic structures under this abnormal pressure; 2nd, the softening and relaxation of the plaster itself from the absorption of bodily moisture. It follows of necessity, that the support having yielded, the upper portion of the body telescopes down upon the lower, the diseased structures are grinding in contact, and *the benefit obtained by extension is lost by the collapse which follows.* Hence arises the necessity of removing the apparatus and reapplying it, in itself at times painful and annoying. So I have found it, notwithstanding, I have been able to finish the dressing in ten minutes of suspension. Again, pressure upon the protruding spine often excoriates or prevents the healing of a pre-existing sore, and although a *fenestra* is cut, it is objectionable, since the discharge from the ulcer gets beneath the dressing, causing an offensive odor and removal of the jacket. Or a fragment of plaster, or foreign body dropping between the dressing and its re-application.

The method to which I now ask your attention, obviates these various difficulties. Without suspending my patient, the arms being held out of the way by an assistant; outside of the tightly-fitting knit undershirt, I apply *two* jackets of the required thickness. The lower edge of the upper jacket is just above the diseased points and extends upward to the arms. The upper edge of the inferior jacket is just below the seat of disease, and extends down over the hips. As the plaster bandages are "setting," I place three zinc plates about 2 by 4 inches perforated by numerous holes from opposite surfaces so as to prevent them slipping, in each section of the jacket. To the center of the plate is securely riveted a flattened staple of iron. One of these is fastened over the spinal column above and below, one under each arm and one directly underneath these over the hips. These are held securely in position by several turns of the plaster bandages, passed over them alternately above and below the *staples* which are left exposed. As soon as the jackets are firmly "set" the *extension* bars can be applied. Each bar consists of a shoulder at each end, and a solid section cut with cogs and grooves which telescopes into a hollow section, with a key for lengthening or shortening, and a "spring-catch" to hold it fixed at any point. It is the same mechanism that is used in Prof. Sayre's knee-joint splint.

The shoulders are caught in the staples riveted to the imovable plates, and the requisite extension is secured by means of the key.

Mr. Harz, of Reynders & Co., has, with creditable ingenuity, devised for me a lighter *extension-bar*, consisting simply of a male scw, which works into a movable female screw, which secures the same extension. The principle, the application and the mechanism of this method is so simple

that I deem any detailed explanation unnecessary. The amount of extension is under the perfect control of the surgeon, and can be graduated to suit the comfort of the patient and the necessities of the disease. As the jackets yield, as they will under all circumstances to a greater or lesser extent, the extension is increased to meet the exigency and the same jackets will last throughout the treatment. At night, or at any time while the patient is reclining, when there is not a demand for much support, the middle bar is removed, allowing the patient to rest comfortably on the back. It will be seen that by my method the upper portion of the body rests upon the tripod of bars which are anchored, one over the sacrum and one over each hip, and that the diseased spinal column is relieved from all pressure from above or laterally. If there exists a lateral curvature one of the lateral bars can be extended more than the other and the curvature corrected. If the curvature is antero-posterior with the concavity backward (lordosis) the posterior bar will demand extra extension, and if the convexity of the curve is backward, the two lateral bars will require extension at the expense of the posterior. Around the portion of the body between the two jackets, a dry unplastered roller is carried moderately tight in order to retain any dressing on the sore (if this exist) and to equalize the pressure. Dr. Wyeth gave the history of a case which was in every respect a critical test of the value of this method, since it was successfully tried under the worst possible conditions and after all other methods had been faithfully tried under conditions which should have insured a better chance of success.

#### SYME'S AMPUTATION AT THE ANKLE JOINT FOR CLUB FOOT IN THE ADULT.

By Stephen Smith, M. D., Bellevue Hospital.

The following clinic on the above subject is from the *Hospital Gazette*. You will remember this patient, whose left foot was amputated at the ankle joint in the early days of the session. She has now perfectly recovered and is supplied with excellent artificial feet on which she walks with ease and grace. The occasion is opportune for calling your attention to the class of cases which she represents, and deducing from her case some useful practical conclusions.

Her disability was congenital talipes-equinovarus of both feet, she has never been able to walk about with any freedom. When she first came under observation about one year ago, the foot was dwarfed to the size of the foot of a child 10 years of age; the tarsal bones were firmly united at their articulation, and the whole foot was very painful after every considerable effort to walk. It was re-

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garded as not only useless, but an encumbrance, and accordingly I amputated it at the ankle-joint by Syme's method.

The left foot seemed in a more hopeful condition, being of fair size, without ankylosis, and capable of being brought around so as to give a partial pressure upon the plantar surface. To aid in overcoming the obstacles to rectifying the position of the foot, I excised the cuboid bone, which enabled me to bring the foot into good position with comparative ease. But the gain in position did not greatly improve her condition; she was never able to walk about without suffering severely afterwards from neuralgic pains through the foot. Every effort was made to improve the condition of the foot by apparatus and adapted shoes, but proved unavailing; the foot continued so painful that she at length begged to have it amputated like the other, which had now healed, and gave a firm and durable stump on which she could readily bear her weight. Accordingly the amputation was performed as you recollect, and she has made a good recovery, and now presents two firm well rounded stumps on which she will walk with nearly as great firmness as she would, had her feet been well formed. In this adult patient we have an illustration of a class of distortions of the foot which are amenable to no other treatment than amputation. The most persevering efforts may be made to bring the foot into position, but without avail. And even if these efforts are partially successful, it can not be doubted that the feet will remain very inefficient for purposes of progression. They present dwarfed, or atrophied extremities quite unfit for that function. The questions which you will have to consider and answer when such a case comes under your care are two-fold, 1, What are the advantages of amputation, and 2, will the advantages compensate for the risks? The first question you must answer fully and explicitly, for on a proper understanding of the explanation given will depend the answer to the second question. It may safely be asserted 1, that the limb will hereafter be free from troublesome neuralgic pains, and 2, that she can walk with an easy and natural step. I do not take into account the possibility of a neuralgic stump, nor of a painful and tender cicatrix; for the former never, in my experience occurs at this point, and the latter will not exist if proper care to secure perfect cicatrization is taken. This is effected by removing all incrustations from the small raw surfaces that so often are allowed to remain unhealed, and applying zinc ointment.

The ability of patients to walk easily and gracefully with a properly constructed artificial foot is undoubted. Indeed, the perfection of the functions of the foot is often marvellous; the patient may run, dance, leap, with as much freedom on the artificial, as on the natural foot. A nurse in one of the upper wards of this hospital wore one of

these for years and none of the staff of resident surgeons knew or even suspected the fact.

If the operation is determined upon, the questions for you to settle are, 1, at what point shall the operation be performed, and 2, what method shall be practised. There are two points at which amputation may be performed, viz. through the medio-tarsal articulation or Chopart's operation, and through the ankle-joint. Between these two points you must not hesitate to decide in favor of the ankle-joint. Medio-tarsal amputations are not less fatal than those performed at the ankle-joint, and they have far less serviceable stumps for the reason that there is an inevitable tendency in the stump to turn its face downward; by the elevation of the heel it soon becomes ulcerated and the patient is unable to walk upon it, nor does it admit of the adjustment of a serviceable appliance.

Having decided to amputate at the ankle-joint you must choose between two methods, viz., between that known as Syme's, and that known as Pirogoff's. The former consists in raising a heel flap and applying it to the extremity of the tibia, and the other in dividing the os calcis obliquely, and applying the cut surface to a cut surface of the tibia. Between these two methods I do not hesitate to advise, and even urge you to select Syme's method. My reasons for this preference are two-fold, viz. 1. It is the safer operation, and, 2, it gives the more serviceable stump. That it is the safer operation you must infer from the fact that the bone in the flap of Pirogoff is liable to caries and necrosis; when that occurs the process of repair is exceedingly tedious, and may even prove fatal. In the Syme stump, union is generally very prompt, sometimes being completed as early as the 15th day. Sloughing of the flap may occur, as after any amputation, but is only exceptional.

2. The Syme stump is the more serviceable. By this I mean that it is best adapted for a good artificial limb. It is claimed for the Pirogoff stump that being longer it is more readily adapted to an artificial foot, but the truth is that this additional length is injurious. And for this reason—the easy working of the applied foot depends largely upon the position of the ankle-joint; if it is low down there is little play of the foot, and the patient has the gait of one suffering from a broken arch of the foot, or splay foot. To give real effectiveness to the foot the ankle-joint must be elevated as high or higher than the natural foot. This position of the ankle Syme's stump provides, hence patients amputated by that method, have an elastic, easy gait, closely resembling the natural. I cannot better illustrate the value of the Syme stump than by quoting the conclusions of one who has had the largest experience of any surgeon in this country in adapting compensative apparatus to stumps formed in this region. Dr. Hudson says:—

"The apparatus as properly constituted and

adapted to the Syme stump is artistic, natural in its movements, and in every respect practical and pleasing to the wearer, and contrasts wisely with the artless, anomalous appliances of the "manufacturers of artificial limbs." Not infrequently intelligent subjects of leg amputations with very good stumps, when having an incidental opportunity to compare their occasions for an amputation and their condition with those of like occasion who had been favored by a Syme operation and its benefit, have expressed their *indignation at the surgery* they have suffered. In no instance which has come to my observation have inflammation and ulceration occurred to the base of the stump of a tibio-tarsal amputation after the tissues were united healthily and were subjected to the same service as those of the natural heel; nor are there any existing histological data for the anatomist, physiologist, or pathologist by which they can reasonably be led to argue such a consequence. The condition of the stump, its capacity for any degree of service, have proved equal to the condition and capacity of the heel of the other limb."

#### THE TREATMENT OF PSORIASIS.

The following is the treatment of this obstinate affection by Dr. Bradbury, of Cambridge, (*London Lancet*):—There are few physicians who have not met with cases of psoriasis which have been most rebellious to treatment. During the last few years several such cases have come under my notice, and I venture to place before the profession the methods of treatment I have found most useful in these obstinate forms of the disease. At one time I treated all cases of psoriasis with Fowler's solution, and an ointment containing in each ounce of lard six grains each of the bisulphuret and red oxide of mercury and two minims of creasote. The success attending this mode of treatment was most marked. Four or five cases have, however, of late been under my care in which this method of treatment has signally failed.

One of these cases was that of a young girl, fourteen years of age, who had never menstruated, and whose body was almost covered with the eruption, the patches being especially well developed over the elbows, knees, and abdomen. In this case all the ordinary remedies were tried, including red ointment, alkaline and bran baths, Plummer's pills, arsenic alone in ordinary doses and combined with iodide of potassium, liquor potassæ, tincture of iron, tar capsules, Donovan's solution, the biniodide of mercury, tar and carbolic acid ointments, &c. There was, however, little or no improvement, although the remedies were fairly tried for a sufficient length of time to test their efficacy. The girl was well nourished, otherwise I should have given her cod-liver oil. What benefitted the

patient most was a mixture containing eight minims of liquor arsenicalis and ten grains of potassium sulphate, in an ounce of water, given thrice daily; and subsequently a mixture containing sulphate of iron and sulphate of magnesia. The eruption did not completely disappear till the catamenia had been for a long time established.

Another case was that of a gardener, between thirty and forty years of age, whose arms, legs, abdomen, and forehead were covered with white scales. He had had one previous attack. He was rather thin, but in other respects in good health. In this case arsenic, in any shape and in any dose, was useless; so were all outward applications except the alkaline and bran baths. He was ultimately cured by taking drachm doses of citrate of potash twice daily, and five grains of Plummer's pill every other night, and leaving off all stimulants. There was no syphilitic history.

A third case was that of a publican, aged forty, a private patient. In this case the eruption speedily disappeared under the influence of arsenic and the red ointment and a non-stimulating diet. The patient could not be induced, however, to discontinue altogether alcoholic drinks, in consequence of his business. The result was a return of the eruption and the appearance of albumen in his urine. Arsenic alone now failed to remove the disease, and so did phosphorus, but a combination of arsenic, carbonate of ammonia, and acetate of potash, quickly removed every trace of the malady, although the patient took a considerable quantity of wine and spirits. The patient had never had gout.

A fourth case is still under observation—viz, that of a young girl, aged nine, whose head, face, legs, arms, and trunk have been affected. No internal or external treatment benefitted this girl, except the ointment of chrysophanic acid (thirty grains to an ounce of lard). In a few days this removed the eruption without any internal remedies. The disease has, however, a great tendency to return, but speedily disappears under the influence of the ointment.

#### USE OF CHLORAL IN LABOR.

Dr. Reany in the *Lancet and Clinic*, speaks as follows regarding the use of chloral in labor:—After an experience which has enabled me to thoroughly test its effects, I wish to add my testimony to that of many recent obstetric writers as to the value of chloral hydrate in certain cases of labor, especially during first stage. In cases where pains of cervical dilatation produce unbearable suffering, resulting in nervous irritability, often arresting the progress of labor, and rendering the situation one of anxiety both to patient and physician; the remedy administered in from 5 to 15 grain doses, from one

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to two hours apart, acts often as by magic. The excessive suffering subsides, the dilatation proceeds and the second stage is entered upon and completed without difficulty.

In several instances I fancy that I have obtained the best results from the administration of 15 to 20 grains at once, which has rendered the second dose unnecessary. The middle ground which this agent occupies in its effect between an opiate and an anæsthetic under such circumstances renders it infinitely better than either. It is singular how an agent whose therapeutic power is not to relieve pain direct, nevertheless so completely relieves suffering.

During the past three years I have made special observations which convince me that no bad effects upon the child follow the administration of chloral, at least when its use is not continued for many hours consecutively. I cannot say as much either for opium or ether. A few cases which have come under my observation recently, two of them in consultation, lead me strongly to suspect, that when ether is administered to the mother in large quantities or for several hours prior to delivery, serious consequences may result to the child.

Observations of a similar character have been made by my friend Prof. Jenks, of Detroit, Michigan. The precise mode by which certain agents administered to the mother reach the child in utero, is still in doubt, but the fact will hardly be questioned, and must always be considered, when morphia or other preparations of opium are liberally administered to the parturient woman.

EXAMINATION QUESTIONS ROYAL COLLEGE OF SURGEONS, ENGLAND.—At the pass examination for the diploma of Membership there were 145 candidates, to whom were submitted, at the written examination on the 17th ult., the following questions on Surgical Anatomy and the Principles and Practice of Surgery, when they were required to answer at least four (including one of the first two) out of the six questions:—

1. Enumerate, in their relative position, the viscera and blood-vessels contained in the upper zone of the abdomen—i.e., between the diaphragm and a horizontal line drawn across the cartilages of the ninth ribs. Describe any surgical operations which may be performed in this region.

2. Mention, in their order, the structures divided in performing "Syme's amputation."

3. Contrast the symptoms and the condition of the limb which result from sudden plugging of its main artery with those which result from plugging of its main vein. State the treatment in each case.

4. Describe the consequences, immediate and remote, of a puncture of the brachial artery during resection, and the appropriate treatment.

5. What consequences are likely to ensue from the impaction of a fragment of iron, say from an anvil, in the cornea? How would you treat such a case?

6. What are the signs and symptoms of a loose cartilage in the knee-joint? Explain the origin of these bodies, and the treatment you would adopt.

The following were the questions on the Principles and Practice of Medicine submitted on the following day to those candidates who had not passed any recognised examination in Medicine:

1. How are the lesions of the various cardiac orifices detected and diagnosed? Where, in the different cases, are abnormal sounds heard? and what are the pathological conditions that induce them?

2. Enumerate the various modes by which lead may be introduced into the system, and what symptoms it gives rise to. What is the prophylactic and medicinal treatment?

3. Enumerate the various metallic and vegetable substances contained in the Pharmacopœia that are employed as evacuates of the alimentary canal. Describe their *modus operandi*, the particular indications for their employment, and write a prescription in full of a diuretic mixture for an adult.—*The Lancet*.

OUR CONFSSIONAL.—*The British Med. Journal* says: The long list of successes and of more or less meritorious and brilliant conduct of difficult cases to a satisfactory termination, which is weekly accumulated in our columns, might easily lead the superficial observer to the conclusion either that, as a rule and almost invariably, success is the reward of medical exertion, or that nothing is to be learnt by failures. Now and then, of course, we are enabled, by the wise courage and candour of contributors, to record failures in fact and blunders in act. The fact is, however, that reports of failure, the warning recital of blunders, and the candid confession of faults, would form an element of immense importance and invaluable instruction in medical chronicles. We have opened "a confessional," in which the main element which may attract to it confessors, if not penitents, is the inviolable anonymity which will be preserved in respect to it. In this way, we very earnestly invite the reports of mistakes, errors of omission and commission, and statements of special mortality, in medical, surgical, and obstetrical practice. We are assured that such records will be found of of singular value; and, as in this manner they can be put forward without undue sacrifice or the possibility of ungenerous abuse of confidence, we may hope that they will become more frequent than heretofore.

THE PLAGUE IN RUSSIA.—At a meeting of the Berlin Medical Society, (*British Med. Journal*), Professor Virchow, made some remarks on the



subject of the plague. After pointing out that the epidemic had not yet been investigated according to modern scientific methods, and that the results of the investigations which have been handed down to us from former times were most unsatisfactory and contradictory, he proceeded to show that the disease which raged in Astrachan was the oriental plague, and not the Indian plague which has been described by Professor Hirsch. The latter comprises two different classes of the infection; viz., the plague *pali*, which occurs epidemically in the western part of India; and the plague of the Himalaya, which breaks out also epidemically in some isolated spots on the mountains, but does not spread any further. The oriental plague comes originally from Syria, and spreads over Mesopotamia, Persia, and the borders of the Caspian Sea. During the last ten years, Russian doctors have frequently mistaken for the plague outbreaks of exanthematic typhoid fever. Anyhow, the plague is not more to be dreaded than cholera morbus. The best thing to do is to isolate the patients, placing them in a favourable medium. There is no doubt as to the plague being an infectious disease; but we do not know as yet the origin of the contagion. It is possible that, in studying the affection very carefully, the germs of the contagion might be found in the blood, as in cases of splenitis. As long as the causes of infection are unknown, it is puzzling to know what class of objects ought not to be imported, because they may carry the germs of infection. The best method of disinfection is doubtless dry heat, which proceeding has been largely put in practice in hospitals and barracks in Vienna.

TRACHEOTOMY BY GALVANO-CAUTERY.—M. M. Krishaber read a report before the Paris Academy, remarkable from different points of view. A patient drank contrary to his habit large quantities of cold water in a country where goitre was epidemic. A goitre developed rapidly and in two months affected respiration in a high degree. Sept. 22, M. Krishaber was called in all haste, one lobe of the tumor having suppurated and leaving a tracheal fistula by which pus fluctuated into the trachea and rendered suffocation imminent.

The surgeon performed tracheotomy with the thermo-cautery, without losing a drop of blood. In passing an œsophageal sound through the canula placed in the orifice he was able to dilate the part of the trachea on which compression was made and the patient entirely recovered.

M. Krishaber no longer makes linear incisions. He makes a series of punctures with the cautery *porté au rouge sombre*.

Last Wednesday, M. de St. Germain reported to the society of surgery five cases of tracheotomy by means of thermo-cautery in the hands of the same surgeon.

The success of M. Krishaber is an excellent argument for the employment of this instrument and it is probable that with the successive improvements it undergoes the opposition which it has encountered will disappear.—*France Medicale*, Oct. 12, 1878.

SPINA BIFIDA CURED BY IODINE INJECTION.—Dr. Geo. W. Thompson reports (*British Medical Journal*, November 30, 1878, *Medical Times*) the case of an infant having a spina bifida situated over the first and second lumbar vertebrae. It measured about twelve inches in circumference, with a pedicle about two inches by one inch. It was said to have increased greatly since birth, being then only the size of a common marble. The child was ten days old. The skin covering the tumor was as thin as membrane; some strands resembling nerve-cords could be seen by transmitted light. Pain was caused by pressure. The sphincter ani was paralyzed, allowing the feces constantly to trickle away; the feet were movable. On pressing the finger firmly into the root of the tumor on its upper surface, an opening in the spinal column, large enough to nearly admit the point of the finger, could be felt directly over the spot where the usual spinous processes should have been, one of which seemed wanting. Operation was performed by withdrawing two ounces of serum and injecting the following mixture, as recommended by Dr. Morton, of Glasgow: Iodine, gr. x; iodide of potassium, gr. xxx; dissolved in  $\mathfrak{ss}$  of glycerine. This was repeated twice, at intervals of about a week, and with the result of a complete cure.

DIRECT ABSTRACTION OF BLOOD FROM THE LUNGS IN CROUPOUS PNEUMONIA.—Dr. N. Finn, in a preliminary report on the subject, states that in croupous pneumonia, with commencing œdema of the lung, he has obtained the best results by the direct withdrawal of blood from the lungs by means of Dieulafoy's apparatus. This is proven he claims, to be a harmless procedure, and is, in his opinion, decidedly preferable to the usual modes of bleeding.—*St. Petersburger Medicinische Wochenschrift*. No. 50, 1878.

A NEW STIMULANT.—The *British Medical Journal* gives a long account of a new stimulant, which has lately been described by the papers of Australia. It is called pitcherine by the natives, and is used by them as we use tobacco, both for smoking and chewing. Its effect is that of a pleasant exhilaration; when long-continued, intense and continuous excitement follows. It is used, when on long foot-journeys, to invigorate and keep up the strength or excite them to courage in battle; large doses are said to infuriate all the passions. Some of the natives make a plaster of the plant and place it back of the ears, believing they are influenced by it.—*Am. Bi-Weekly*.

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# THE CANADA LANCET.

A Monthly Journal of Medical and Surgical Science

Issued Promptly on the First of each Month.

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

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TORONTO, APRIL 1, 1879.

## TREATMENT OF CHRONIC ABSCESS.

In a recent number of *Le Practicien*, of Paris, Dr. Bæckel, of Strasbourg, contributes an interesting article on the treatment of chronic abscess. All surgeons agree in recognising the dangers which result from the opening of chronic abscesses to a free exposure of air. An infectious fever is the ordinary consequence in the first forty-eight hours. The suppuration becomes foetid, the walls do not granulate, and if the patient does not possess considerable powers of resistance, he succumbs to marasmus unless well marked pyæmia happens to terminate the scene earlier. In leaving them to spontaneous opening, in order that they may empty themselves slowly and gradually by a very small orifice, we often avoid the accidents of the outset, because the air does not penetrate into the cavity, but infection rarely fails, sooner or later, to break out in the course of the illness. The source of this accident has always been attributed to the air, but without giving an exact *rationale* of the way in which the air became pernicious. Since the investigations of Pasteur and Lister, we have learned that the microscopic germs floating in the air are the agents of the decomposition of pus, and of consecutive septicæmia. In carefully applying the antiseptic dressings of Lister we can open these purulent collections without fever, and without infection, because the air has been deprived of the septic germs in traversing the numerous layers of carbolic dressing.

Nevertheless, however perfect this method may be in theory, it is difficult to realize it completely in practice, when we have to do with those profuse suppurations which soak rapidly the thickest dressings. If we could obliterate gradu-

ally these purulent cavities without making a permanent opening and running all the risks following it, we should have realised a great advance. This may be done in a great number of cases by combining aspiratory punctures with carbolic lotions. These means are simple and within reach of all. Three conditions are necessary to success; first that the abscess may be completely emptied, and does not enclose clots to block up the trocar; secondly that the carbolic lotion impregnates all the surface of the sac, and thirdly that the abscess is not the result of diseased bone. Even in the last case this method, if it do not radically cure, prepares the way for opening the cyst, and transforming it into a simple fistula. In suppuration of the joints, punctures followed by carbolic washings succeed well, provided that the osseous and cartilaginous surfaces are not seriously affected. The operation is very simple. An aspirator is used both for the purpose of removing the pus, and injecting the fluid for washing out the cavity. The needle is introduced and the pus removed, and without withdrawing it, the instrument is reversed, and the carbolic lotion introduced and again removed. This operation may be repeated six or eight times or as often as necessary, after which the needle is withdrawn and the puncture covered with a piece of adhesive plaster, or a layer of cotton soaked in carbolic lotion, or both may be used. After a few days the cavity is generally filled again with pus and serum, and is again treated in the same way. This is to be repeated until a cure is effected, during which time complete rest of the parts should be maintained.

## ONTARIO MEDICAL COUNCIL VS. BRITISH GRADUATES.

We notice in the daily press that certain members of the Executive Committee of the Ontario Medical Council have been at Ottawa, (at their own expense, we presume) to lay before the Government an alleged grievance of which they complain, viz., that British graduates in medicine have by Act of Imperial Parliament, the privilege of practising their profession in any of the colonies of Her Majesty's dominions, upon payment of the registration fees in force in such colonies: and, also, that Canadian graduates in medicine who

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subsequently qualify in Great Britain are accorded like privileges, and are thus enabled to return to Ontario and become registered without passing an examination before the Ontario Medical Board.

This self-constituted deputation, we understand, desires to obtain, through the influence of the Dominion Government, such alteration in the British Medical Act as would exclude the holders of British qualifications from practising in Ontario without first passing an examination before the Board of Examiners appointed by the Ontario Medical Council, and paying therefor such fees as they may think proper to impose. The same gentlemen introduced a Bill during the session of the Ontario Legislature just brought to a close, which, if passed, would give the Ontario Medical Council power to demand from the holders of British qualifications a registration fee of *four hundred dollars*, the ordinary fee being \$10 only. We cannot but express our regret at the course which these gentlemen have seen fit to pursue. What we desire most of all, and that which will be for the best and highest interests of the profession on both sides of the Atlantic, is *reciprocity in medical registration* between Great Britain and her Colonies. The general Medical Council of Great Britain has been moving in this direction, and we are of the opinion that if the views of these gentlemen are carried out it will have an injurious effect upon medical opinion in England, and tend to delay, if not jeopardize altogether, the question of reciprocity.

We care nothing about the legal aspect of the question which has been raised, concerning the right of the British Legislature to pass an Act which appears to conflict with our legislation. This question, no doubt, will make a safe cover of retreat for the busybodies who have been doing so much on their own responsibility in the name of the Ontario Medical Council. And we desire here to enter our protest against any two or three individuals assuming to act, speak and *legislate* for the profession of Ontario, without giving the latter an opportunity of even expressing their approval or disapproval of such action. It is a dangerous precedent, and as a public journalist, it is a duty incumbent on us, and which we owe to the profession, not to allow such action to pass unchallenged. No such arbitrary measures as these gentlemen would desire to enact appears to us to

be necessary at the present juncture, in any view of the case. There has been so far only one solitary instance of a candidate with British qualifications having sought registration (and he was a Canadian), nor do we believe there will be any considerable number asking registration under similar circumstances. The inducements, as we all know, are not of the most inviting character. This Province is well supplied with doctors, nay overstocked, and there is a much wider field for surplus medical practitioners in England to-day, than in Canada. Notwithstanding the very superior test of fitness claimed by the Ontario Medical Council, more medical men are licensed every year in Canada, in proportion to the population, than in England, and fewer rejections take place at the examinations.

We do not at all participate in the fears expressed by these gentlemen that the influence or the powers of the Ontario Medical Council as an examining and licensing board for Canadian graduates in medicine, will suffer in the slightest degree by a continuance of the arrangements which have been in operation for many years past; and we should be very sorry to think so, for the Ontario Medical Council, with all its foibles and shortcomings, which, after all are but few, and confined chiefly to a few ambitious and designing individuals, has done good service to the cause of medical education in Ontario. Nor do we apprehend that the usefulness of our Canadian medical schools will be injuriously affected by the few British practitioners, or Canadians with similar qualifications, who may seek registration in Ontario. We hold the opinion that medical practitioners of known ability and thorough training should be admitted to registration in Ontario without the expense of an examination, or the payment of an extraordinary license fee. The regulations which these gentlemen would desire to enforce would exclude even a man with as high a professional standing as Dr. Andrew Clark, who was amongst us lately, if his qualification had been obtained since 1870. We are of the opinion that Canadian graduates in medicine who have taken the degree of M.D., in any recognized Canadian University, and who have subsequently spent one or two years in a London Hospital, and have obtained such qualifications as will enable them to register in Great Britain, have given sufficient evidence of thorough qualification, and

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should be at once admitted to registration in Ontario without the expense of an examination on payment of the ordinary examination fees. Suppose two young men have gone through the same course of training in Canada, and are equally well qualified. At the end of their course of study, one of them goes before the Council Examining Board, and obtains his license, and settles down to practice in some town in Ontario; the other proceeds to London, spends one or two years in the large Hospitals there, passes the examination of one or more of the Royal Colleges at great expense, and then returns to Canada—we ask, which of these men is the better qualified, and whether or not some allowance should not, in all fairness, be made in favor of the man who thus so thoroughly qualifies himself for the practice of his profession? The grand object for which the Ontario Medical Council was brought into existence was to protect the public against incompetent practitioners, and to rid the community of quacks, and as neither the charge of incompetency nor quackery can be made with fairness against either British graduates, or Canadian graduates with additional British qualifications, they should be admitted to registration on payment of the usual fees. Even if a few British graduates should come and settle in Ontario, it would do no possible harm; there is nothing to be gained by exclusiveness in a scientific profession like ours. It may be urged that British graduates, who may be educated either as physicians or surgeons, should not have the privilege of practising both surgery and medicine, as they would have if registered under our Act. We admit that such would not be just, and an amendment to the Ontario Medical Act, which would limit them to the practice of those branches only in which they were qualified in England, would not be objectionable.

#### REPORT OF THE REGISTRAR-GENERAL OF ONTARIO.

We are in receipt of the report of the Registrar-General of Ontario for the year 1877, from which we take a few excerpts. The number of births, deaths and marriages registered in 1877 although not what it should be, yet shows a satisfactory increase over previous years, the increase over 1876

being 2935 or 4.2 per cent. The total number of births registered in Ontario for 1877 is 39,957, the total number of marriages 12,577, and the total number of deaths 20,053. The returns of births are as yet incomplete, and it is to be regretted that the public cannot be induced to pay more attention to this important duty. The ratio of registered births is only 24.6 per thousand, which is much below the average of English and European countries (35 per thousand). The report says: "The death rate of any county is a sure index of its health." If all the deaths were registered every year with a correct statement of the causes, it would be found of infinite value in determining the influence of epidemic diseases, change of seasons, sanitary conditions, etc. on the rate of mortality, so that when the rate of mortality is found to be higher in any locality than the normal rate of a healthy community, it will be the duty of those entrusted with the carrying out of sanitary regulations to supply the means for its remedy.

The returns from towns and cities generally, are much more complete than those from country places, though in a few instances the death rate of towns is evidently less than should be expected. Whether this is due in some cases to greater attention to sanitary measures or to the incompleteness of the returns, it is difficult to determine. In Toronto the death rate is in the ratio of 23 to 1000 of the population (67,386); Belleville 21 (population 11,192); Hamilton 20 (population 32,641.) In Ottawa on the other hand with a population of 24,431 the death rate is given as only 5.9 per thousand; in St. Catharines (population 13,143) the death rate is 15.6 per thousand, and in Brantford (10,631) the rate is 11.4. These figures show how very far from correct these returns must be.

The birth rate returns are equally far astray; for example in St. Catharines the births returned number 164, the deaths 206, or 42 more deaths than births, and we should expect to find a corresponding decrease in the population, but instead it has been increased by 273. The highest and lowest number of registrations of births in Ontario were in the months of January and December respectively, from which it would appear that a large number of the births which should have been returned in December were not registered until January. The total number of male births is 20,659 and the total number of females 19,298,

giving a slight preponderance to the males. The number of twin births has increased this year from 349 to 411. Of triplets there were five cases, one in each of the counties of Lanark, Prescott, Russell and York, and two in Lincoln. In two cases the parents received the Queen's bounty of £3 sterling. Notwithstanding the hard times there appears to have been a large increase in the number of illegitimate births, a circumstance greatly to be deplored. The number of children born out of wedlock registered during 1877 was 529, as against 392 in 1876.

In regard to marriages 25,154 were solemnized during the year; of these 34.89 per cent. were Methodists, 20.96 Presbyterians, 18.30 Episcopalians, 12.27 Roman Catholics, 5.59 Baptists, etc., and 345 were returned by the officiating clergyman without mentioning the denomination. Marriage by license instead of by banns still seems to be the favorite mode, 88.34 per cent. having been by license. The favorite months in the year for coupling still continue to be December and October. Among males the majority were married between the ages of 20 and 30; 134 were minors and 41 were over 70. Among females, 48 per cent. were married between the ages of 20 and 25; 22 per cent. were under 20, and 3½ per cent. over 40. A few instances of marriages at an advanced age are given. The age of the oldest man married was 88, and the oldest woman 68; the former married a blushing maid of 48 years, and the latter an old gentleman of 71 years. Two youths were joined in the holy bonds of wedlock at the early age of 17, and 32 girls were married at fifteen.

In considering that portion of the Report that relates to the deaths, we were struck with the want of definiteness which is painfully apparent in regard to the cause of death. For example, Lung Disease is given as a cause, without a word as to the true nature of the disease, whether tubercular or inflammatory, acute or chronic. Dropsy is also given, without one word as to whether it was due to disease of the heart or kidney. Convulsions are also given without any reference to the cause, real or supposed. From the last mentioned cause alone 573 deaths are given, and it can hardly be possible that in so many cases the physicians have been unable to make out the cause. We trust that in future reports, this matter of registering more correctly the

cause of death will be more carefully attended to by physicians.

The total number of deaths registered in 1877 is 20,053. The highest on the list are, phthisis 2,157, old age 1661, infantile debility 1164, pneumonia 1050, diphtheria 964, scarlatina 717, heart disease 697, diarrhoea 666, convulsions 573, enteritis 497, &c. The months of March and June show the highest and the lowest number of deaths respectively. The curve, or death wave commences to rise in December, ascends rapidly in January, more slowly in February, and reaches the highest point in March. It then recedes until June, the lowest point. In July it again rises and also in August, nearly to the level of March. It then sinks through September, October and November, when it is only a little above the level in June. The two highest points in the death wave are in March and August, and the two lowest are in June and November. These fluctuations are in all probability due to vicissitudes of temperature, and the existence of sanitary or insanitary conditions.

Among the causes of death, phthisis still heads the list, carrying off nearly twice as many as by any other specific disease, not including old age, and is likely to maintain its position on the list, unless some malignant epidemic should outstrip it in the race for victims. More females die of this disease than males. The report shows an increased mortality among children under one year of age, and also from one to five, the total number under five being 7,541. While the number of deaths under five years in Ontario compares favorably with other countries, yet the appalling fact remains that nearly one-fourth of all the children born die before they reach the age of one year, one-third die before the end of their fifth year, and nearly one-half before they arrive at the age of 20 years. The report says, "This reflects but little credit upon the manner in which the resources of medical science are applied in the nineteenth century, and the method in which the sanitary regulations are enforced." We cannot allow the former part of this statement to pass unchallenged. It is impossible to expect under present circumstances, that medical science can do more than it is doing, while there is so much "masterly inactivity" in regard to sanitation, and the improper nursing and feeding of children. Medical men are, as a rule, the only members of the community that seem to take a lively

interest in sanitary reform. The Government of the country has as yet done very little, and we fear this appalling death rate will still continue for years to come, until the public is taught by legislative enactment and otherwise to regard the non-violation of the laws of health as a sacred duty. The deaths from preventable diseases form a very large proportion of the whole number, and cannot fail to impress the most casual observer of the great necessity that exists for legislative action on a matter of such vital interest to the welfare of the nation.

The average age reached by members of different occupations may be of some interest. The average age of farmers was about 62, that of their wives 52, clergyman 61, physicians 53, lawyers 50, making an average by the three professions of 55; masons, shoemakers, tailors and carpenters averaged 55 years. The report concludes with an appendix on the weather and health of Toronto, Kingston and Stratford. The death rate per 1,000 in Toronto was 23.6, Kingston 17.2, and Stratford 9.2. The latter appears very low, and it is presumed that the registration there has not been as perfect as it should be.

REPORT ON THE MENTAL CONDITION OF PASSANANTE.—The Italian Commissioners in lunacy appointed to examine into the mental condition of Passanante, report that the plea of insanity is invalid, there being no evidence of any mental disease in the would-be regicide. The report shows that the commissioners have given him a most careful and thorough examination, having gone over every phase of his life, and tested every side of his physical and psychical organism, such as the measurement of the cranium; his psychical relations, as perception, ideation, memory, judgment; his sentiments, as vanity, affective sentiments, religious sentiments, moral sentiments; his will, speech, handwriting, physiognomy, demeanour; general and special sensibility (examined by Webers compass), response to electricity; dynamometry; functions of vegetative life, as the action of the heart, respirations, temperature, condition of liver, spleen, alimentary canal, amount of sleep etc., etc. We have no doubt that this in some measure accounts for the respect which is paid by the bench and bar of Italy, to the opinion of the medico-psychologist.

THE TORONTO UNIVERSITY.—In another column we publish a letter from a graduate of Toronto University in reference to certain restrictions lately adopted by the Senate of this University in regard to the admission of candidates for honors in medicine. We agree in the main with the views expressed by our correspondent, but we have every confidence that in a short time the restrictions complained of will be removed. It must be perfectly clear already to the framers of these restrictive regulations that they are not only useless for the purpose intended, but also exceedingly vexatious, and calculated to excite opposition and unfriendly criticism. Such restrictions are unworthy of a place on the statutes of a National University.

In the recent appointment of the Medical Examining Board, the Senate is to be congratulated on its liberality, and its anxious desire to appoint the best and most experienced men available, without reference to any particular school, or schools, and this action cannot fail to be fully appreciated by all who desire to uphold the national character of the University. We look upon this as a hopeful sign for the future of the Toronto University.

CÆSARIAN SECTION.—A case is recorded in *Le Progres Medical*, January 1879, in which the operation of Cæsarian section was performed ten minutes after the death of the mother, and a living child extracted. The mother was a manufacturer of hats, and lived constantly exposed to mercurial fumes. She had reached the seventh month of gestation when she was attacked with intra-peritoneal hemorrhage, from which she died. After death the child was found upon auscultation to be living, although the pulsations were feeble. The abdomen was immediately opened, when large quantities of blood and serum escaped. Artificial respiration had to be resorted to, and was continued an hour and a half before the child began to breathe.

REGISTRAR-GENERAL OF GREAT BRITAIN.—Dr. Wm. FARR, whose name has been so long connected with the work of this department, is a candidate for the appointment of Registrar-General, which becomes vacant at the end of the present year, by the resignation of Major Graham. The London *Lancet* comes out strongly in support of

his claims to the appointment, and very properly says that in the field of vital statistics he stands pre-eminently alone. The system of vital statistics of which England may justly be proud, and the reports of the Registrar-General which have been accepted as models in all parts of the world, owe their existence to Dr. Farr. One of Dr. Farr's most valuable contributions on statistical subjects is his English Life Table, which is calculated upon the deaths in England and Wales in seventeen years. His appointment would be a most fitting and graceful reward upon a meritorious public servant, and the appointment would be also an essentially popular one.

**MEDICAL EDUCATION IN THE UNITED STATES.**—A convention of the Medical Colleges of the United States is to take place on the 2nd of May, a day or two previous to the meeting of the American Medical Association at Atlanta, Ga. The object of the meeting is to adopt a uniform system and a more thorough course of instruction in all the medical colleges of the Union, and in keeping with the requirements of the age. Two reforms are very much needed at the present time, viz., a preliminary examination in the English branches, and some knowledge of classics, especially Latin; and a four years' course of study, including attendance upon three winter courses of lectures.

**ROYAL COLLEGE OF PHYSICIANS, LONDON.**—The following Canadian graduates in medicine successfully passed the examination of the Royal College of Physicians, London, and were admitted as Licentiates on the 18th February. W. H. Burton, N. Gillies, P. Z. Herbert, J. R. Jones, E. G. Kittson and R. B. Leslie.

A. D. Campbell recently obtained the double qualification of the Royal Colleges of Physicians and Surgeons, Edinburgh.

**USE OF CARBOLIC ACID BY MIDWIVES.**—The midwives in the Tyrol are only allowed to follow their vocation under certain restrictions. The following has been recently decreed respecting carbolic acid, viz.: "that all midwives, whether examining or treating the healthy or sick pregnant lying-in women, must thoroughly disinfect their hands, or any instruments they may use, such as catheters, enema-tubes, sponges, &c., with a solution of carbolic acid."

**ROYAL COLLEGE OF PHYSICIANS & SURGEONS, KINGSTON.**—The Lectures in connection with this School of Medicine closed on Friday, March 21st. Dr. Lavell, Professor of Obstetrics, delivered an able and eloquent valedictory to the students, which was well received. The past session has been characterized by a large attendance.

**ONTARIO MEDICAL COUNCIL EXAMINATIONS.**—The regular annual examinations of the Ontario Medical Council will be held in the Convocation Hall Toronto University, and also in the City Hall, Kingston commencing on the 8th inst. The matriculation examination will take place in Toronto only on the 15th and 16th inst.

**THE PLAGUE.**—The Fellows of the Royal College of Physicians, London, have passed a resolution requesting the British Government to appoint a Royal Commission of eminent statesmen, medical men, and specialists to investigate the plague now prevailing to such an alarming extent in Russia.

**INTRA-VEINUS INJECTION OF MILK.**—Dr Robert McDonnell of Dublin, lately performed this operation with success on a patient suffering from great exhaustion, consequent upon typhoid fever. The milk was drawn fresh from the cow, and ten ounces injected into the veins at the bend of the elbow. The patient was very much benefited.

**JOURNAL OF PHYSIOLOGY.**—The Classified List of Titles of Books and Papers on subjects of Physiological interest published during the year 1878, has been issued to subscribers. Any subscriber not having received his copy is requested to communicate with Messrs. Macmillan, New York. A few extra copies are on sale. Price \$1.25.

Dr. McDonald has been appointed Consulting Physician to the Hamilton City Hospital, and Drs. Mullin and O'Neil, Attending Physicians.

**TORONTO UNIVERSITY Examiner.**—Dr. Canniff has been appointed Examiner in Anatomy and Surgery, in lieu of Dr. Malloch, resigned.

**PERSONAL.**—Dr. C. H. Lavell, of Kingston, has removed to St. Paul, Minn., where he intends to practise his profession.

## Toronto Hospital Reports.

There are at present upwards of 220 patients in the Toronto General Hospital. The Andrew Mercer Eye and Ear Infirmary, which constitutes a wing of the Hospital, is now open for the reception of patients. Patients are admitted on payment of 40 cts. per day, or a guarantee from the Mayor or Reeve of the Municipality that the amount will be paid. A number of private wards are also at the disposal of those who desire them, at prices varying from \$5 to \$8 per week.

### EPILEPSY.

J. V., æt. 20; of healthy parentage; strong and robust looking; had never received any injury, nor was the subject of any disease, hereditary or acquired; somewhat addicted to masturbation; was seized in August last with epileptic convulsions. At first they were not very frequent, but became more so in the course of a few weeks. The seizures were unilateral in character—left side, and were in some instances severe and prolonged; in others only of short duration. He was treated by several physicians, but without any benefit. The seizures became more frequent, and at the time of his admission to the Toronto General Hospital, they occurred every fifteen or twenty minutes. There was at this time partial paralysis of the left arm and leg. He dragged the leg more or less in walking, and required the use of a cane. He was ordered a warm bath, and was put upon bromide of potassium and liquor arsenicalis. After a few days the fits began to diminish in frequency and force, and in a few weeks, disappeared altogether. He remained in the Hospital about ten weeks, and was discharged apparently cured. He went home, and began to go about as usual, but from exposure to cold, the fits returned as frequently as before, and he was obliged to return to the Hospital. His condition on re-admission, was more unpromising than on his first admission. The convulsions were frequent and severe; the paralysis of the leg and arm was more marked, and the sensibilities more blunted; memory somewhat impaired. He had also lost flesh, and looked anæmic. He was again put upon the same treatment as before, and is rapidly improving. The fits have ceased, and he is able to move about with the slight assistance of a cane. It is the in-

attention to keep him under treatment and observation for a longer period, before he is allowed to leave the Hospital again.

### FOREIGN BODY IN THE AIR-PASSAGES.

The following is a brief report of a case in private practice, under the care of Dr. Fulton:—

M. E., of the Township of Enniskillen, æt. two years, robust, healthy child, was playing, on the 24th of February, with a small glass bead, which she accidentally "swallowed." She was immediately seized with a choking spasm, which lasted some time, and returned in paroxysms every few minutes, with great difficulty of breathing. About 5 or six hours after the accident, she was seen by a medical man, and the usual means were adopted to remove the offending body, but without avail. As the symptoms at this time were not very urgent, the medical man advised the parents to leave her alone, in the hope that she might cough it up. For 5 or 6 days there was no great amount of irritation, and only occasional paroxysms of coughing; but the child could not be induced to swallow anything except a little milk or water, especially the latter. The parents became uneasy, and consulted a medical man in Oshawa, who immediately recommended them to bring the child to Toronto without delay, and have the bead removed. The parents did so, and, accordingly, on the 7th of March—11 days after the accident—Dr. Fulton performed tracheotomy. On introducing the hook in the trachea, before making the opening, the bead could be felt impinging upon its point every time the child coughed. On opening the trachea, it was readily seized and removed. The bead was about  $\frac{1}{2}$  an inch long,  $\frac{1}{4}$  of an inch thick, oval in shape, with a hole running through its long diameter. There was very slight hemorrhage. The wound was at once closed by sutures, but on account of the dyspnoea which followed, the stitches had to be removed, and, to add to this difficulty, there was a good deal of congestion of the lungs. Stimulating cataplasms were applied to the chest, and an expectorant administered. The temperature of the room was ordered to be kept at about 70° F. 8th. Found the patient quite easy; a good deal of air escapes through the wound in the trachea, especially when the child coughs; also some frothy mucus. 9th. Wound suppurating; some difficulty in keeping



the opening in the trachea free from accumulations of mucus and pus. 10th. Child very feverish in the afternoon; ordered quinine and salicylic acid, and some Dover's Powder, to allay the cough, which was very irritable. 11th. Fever came on again in the evening, but the quinine and acid kept it down; the patient being weak, was ordered egg and milk. 12th. Much better; fever gone; taking more nourishment. 13th. Patient doing well; wound granulating nicely, and was brought together with adhesive straps, and dressed with carbolated olive oil. The patient continued to improve rapidly, and was allowed to go home on the 19th of March, looking healthy and well; wound granulating nicely, and the opening in the trachea nearly closed.

**BRANT MEDICAL ASSOCIATION.**—The regular quarterly meeting of the above Society took place at the Kerby House, Brantford, on Tuesday March 5th. Members present were: Drs. Burt (President), Marquis (Vice do.), Harris (Sec-Treas.), Drs. Dee, Griffin, Healey, etc. Owing to the inclement weather, and consequent bad state of the roads, the attendance was not as large as usual; however, this did not render the proceedings any the less interesting. A paper was read by Dr. Dee on "The Prevention of Diseases," which elicited a lengthy discussion. The Dr. also gave some notes of a case of dislocation of the head of the femur, of difficult reduction; and Dr. Burt those of a case of shoulder joint dislocation. A specimen of vegetable fungus (*penicilium glaucum*) was shown by Dr. Harris. Drs. Griffin and Clarke were elected to prepare papers for the next meeting, which will be held at Paris, on Tuesday, June 3rd.

### Books and Pamphlets.

**AN ATLAS OF HUMAN ANATOMY, ILLUSTRATING MOST OF THE ORDINARY DISSECTIONS, AND MANY NOT USUALLY PRACTISED BY THE STUDENT, WITH AN EXPLANATORY TEXT.** By R. J. Godlee, M.S., F.R.C.S., University College, London. Philadelphia: Lindsay & Blakiston: Toronto: Hart & Rawlinson.

The design of the author in issuing this series of plates is to supply a full illustration of the anatomy of the human body, and also dis-

sections not usually seen in the dissecting-room, in a form sufficiently portable to be easy of reference. The plates, which are beautifully executed, are accompanied by an explanatory text, which contains a full description of the dissections. Dr. Godlee is not only an able anatomist and successful teacher; but also a clever artist, as these plates abundantly prove. The work will consist of 12 or 13 parts, and will be issued bi-monthly, each part containing four large plates, two figures in each. When complete it will form a large folio volume of plates, and an octavo volume of from 300 to 400 pages of explanatory text. Price of each part \$2.50.

**TEXT-BOOK OF PHYSIOLOGY** by J. Fulton, M.D., M.R.C.S., Eng.; L.R.C.P., London; Prof. of Physiology and Sanitary Science, Trinity Medical School, Toronto; Surgeon to Toronto General Hospital, and Physician to the Home for Incurables. Second edition, revised and enlarged with numerous illustrations. Price \$4.25 net. Philadelphia: Lindsay and Blakiston. Toronto: Willing & Williamson.

The former edition of this work having been exhausted, within a comparatively short space of time, and as there was a large and increasing demand for the book, it was deemed advisable to prepare at once a second edition. In doing so the author has been at great pains to bring out prominently all the recent advances in physiology, which have been sanctioned by the highest authorities. This has necessitated a large addition to the size of the former work, bringing it up to 411 pages, but the original plan of arrangement has been rigidly adhered to. Many of the chapters have been entirely re-written, and numerous illustrations introduced wherever they appeared necessary to the elucidation of the text. The subject of histology has also received great care and attention, so that the work forms an excellent text-book for students on both the subject of physiology and histology. The former edition of this work is well known to the profession in Canada, and nothing further is necessary to be said in regard to it, than that the second edition is not lacking in those qualities which rendered the former so deservedly popular. An American edition will also be issued simultaneously by Messrs. Lindsay and Blakiston, Philadelphia.

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PHYSIOLOGICAL THERAPEUTICS; A NEW THEORY, by Thos. Poole, M.D., Lindsay, Ont., and dedicated to Dr. Workman, of Toronto.

The author in the work before us combats the generally received theory regarding vaso-motor nerve action, and presents a new theory based on the inter-relations between nerve force and muscular tissue throughout the body. His theory regarding the regulation of the vascular supply to different parts, is that the nerves distributed to the coats of the vessels are the agents concerned in producing dilatation, and the muscular tissue of the middle coats *per se* produces contraction by virtue of its own inherent power. He denies that there are two sets of nerves, one for the production of dilatation and the other for the production of contraction, as is alleged, according to the vaso-motor theory. In regard to the action of the heart he takes similar ground, and denies the existence of excito-motor and inhibitory nerve influence. In accordance with his theory the author proceeds to interpret the action of medicines and their influence in disease. He treats of the action of aconite, veratrum viride, opium, belladonna, digitalis, conium, hydrocyanic acid, bromide of potassium, calabar bean, mercury, alcohol, etc., etc., and shows how the individual action of each on the system can be readily explained on his theory. He takes aconite as a typical drug of the sedative class. It paralyzes nerve force, both sensitive and motor, but does not affect the brain. Arterial contraction is a prominent feature in aconite poisoning; the surface is pale, and cold, lips blue, pulse feeble, all bespeaking constriction of the calibre of the vessels. He alludes to the effect of opium in allaying after-pains and yet promoting the contraction of the uterus, in proof of his theory.

The author seems to have expected adverse criticism, and asks for his theory no favor beyond that to which on a fair and candid consideration it may be found to be justly entitled. While few will be found to agree with the writer in his premises, all must admire the firmness with which he upholds his views, and his courage in opposing accepted theories. The work is written in a very interesting style, and aside from the theory advanced, reflects no little credit upon the author.

The Diseases of Live Stock and their most efficient remedies by L. V. Teller, M.D. Philadelphia: D. G. Brinton. Toronto: Willing & Williamson.

The author of this work is not a veterinary surgeon proper, but a medical practitioner, who has

given great attention to veterinary medicine and surgery. The work is free from technicalities, and will therefore be equally acceptable to the physician, farmer, and stock-owner. The treatment of disease is most fully discussed, and the entire work is of the most practical character.

CLINICAL LECTURES ON Diseases peculiar to Women, by Lombe Atthill, M.D., Dublin. Fifth Edition, revised and enlarged, with illustrations. Philadelphia: Lindsay & Blakiston. Toronto: Hart & Rawlinson.

This is a most excellent resumé of the Diseases of Women. It is thoroughly practical, and contains in small compass a large amount of valuable information available to every practitioner. We have no hesitation in recommending it as a useful guide.

NATURE AND PATHOLOGICAL HISTOLOGY OF PSORIASIS, by A. R. Robinson, M.B., L.R.C.P. & S. Edin. New York: D. Appleton & Co.

MEDICAL MISSIONS AT HOME AND ABROAD, by J. G. Kerr, M.D., 23 years a medical missionary in Canton, China. Sanfrancisco: A. L. Bancroft & Co.

FIFTY YEARS AGO; An Address to the graduating class, Medical College of the Pacific for 1878, by H. Gibbons, Sr., M.D. Sanfrancisco: A. L. Bancroft & Co.

A CASE OF CLEFT PALATE WITH ACQUIRED DEAF-MUTISM, STAPHYLOPHRY, RECOVERY, by Adolf Alt, M.D., Toronto. New York: Wm. Wood & Co.

CONTRIBUTIONS TO THE PATHOLOGICAL ANATOMY OF THE EYE by the same author.

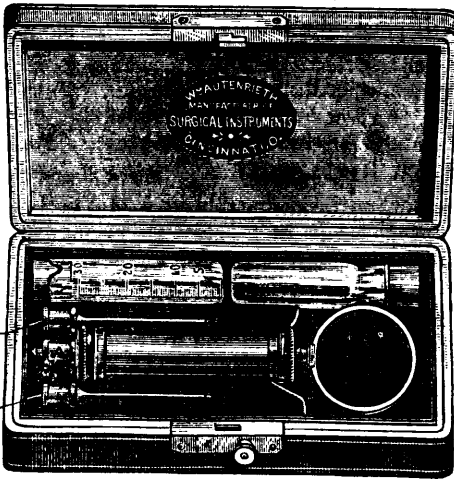
SUSPENDED PUBLICATION.—The *Ohio Medical and Surgical Journal* has suspended. It was published to supply "a want long felt," but that want having been succeeded by another and more imperative one—paying subscribers—the journal ceases to exist. The editor requests the friends of the journal not to aggravate his grief by letters of condolence, or expressions of sympathy, but kindly leave him to suffer in silence.

The death of Jacob Bigelow, M.D., LL.D., the father of H. J. Bigelow, M.D., surgeon, of Boston is announced in our American exchanges, at the advanced age of 91 years.

Dr. W. N. Keefer, formerly of Galt, Ont., is at present with his regiment, (20th) Punjaub Infantry, in the Afghanistan war.

## New Instruments.

### IMPROVED HYPODERMIC SYRINGE.



In most hypodermic syringes the piston, unless in daily use, becomes dry and shrinks, so as to lose its suction power, and requires several minutes manipulation before it can be made to work. In order to avoid this defect, and render the instrument ready for use at any moment, Dr. Whittaker, of Cincinnati, had a cap (A) made, which can be screwed on the end of the syringe as soon as the needle is removed, and which prevents evaporation of the few drops of fluid between the piston and the orifice of the syringe. This appliance is made by Mr. Autenrieth, of Cincinnati, and is affixed to all his syringes. The piston should not be forced down too close to the end of the barrel, otherwise all the fluid may be entirely pressed out. Readiness for immediate use, ease and accuracy of operation, are essential in the hypodermic syringe, and these are secured in this instrument, which is always ready for use.

**BROMINE IN LARYNGEAL CROUP.**—Dr. W. Redbacker writes in the *Ärztliches Intelligens-Blatt*, of January 7th, (*British Med. Journal*) that he has obtained strikingly good effects in two cases of laryngeal croup from the internal administration of bromine (in the form of bromide of potassium). For some time bromine inhalations have been used in the following manner: From 0.2 to 0.3 *gramme* of bromine, with a similar or greater quantity of bromide of potassium, has been dissolved in 120 *gramme*s of water, and, a sponge or handkerchief dipped in it being tied before the nose and mouth,

the bromine-vapour has been inhaled for five or ten minutes at intervals varying from half an hour to an hour. From this method, however, Dr. Redenbacher has not been able to obtain any good result. Two little girls, aged respectively 5 and 7, having come under his care with severe croup of the larynx and air-tubes, he ordered a tablespoonful of the following mixture to be taken every hour:  $\mathcal{R}$  Decocti althææ 120 *grm.*; potassii bromidi 4 *grm.*; bromi 0.3 *grm.*; syrapi simplicis 30 *grm.* On again visiting the patients, whom he did not expect to find alive, he was most agreeably surprised. The harsh respiratory murmur, the difficult breathing, the dry characteristic cough, the loss of tone in the voice, had all disappeared; the breathing was free, the cough loose, and the hoarseness diminished. Several portions of croupal membrane had been coughed up. The improvement continued on the next day, and perfect recovery followed in a few days. No toxic symptoms of any kind were produced. For children under one year the quantity of bromine in the mixture should be reduced to 0.1 *gramme*; and for those from one to four years old, to 0.2 *gramme*.

**IRON WHICH WILL NOT RUST.**—Prof. Barff has discovered that if iron be subjected to the action of steam having a temperature of 1500° F., it is covered by an incorrodible coating of the magnetic oxide, giving the finished article a dull-black appearance, susceptible of a slight polish. Salt or fresh water, vegetable acids, and all other ordinary oxidizing agents have no effect on the iron prepared by Barff's process. It should be called "Barff's iron," after the inventor.—*Med. Record*.

Codeia in one grain doses so completely stopped the vomiting and pain in a case of cancer of the pylorus, under Dr. Austin Flint's care, that the patient thought the tumor was decreasing in size.—*Mich. Med. News*.

The University of St. Andrews has recently conferred the honorary degree of LL. D. on Dr. J. Crichton Browne.

**CORONER.**—R. C. Young, M.D., of Ridgetown, to be an Associate Coroner for the County of Kent.

### Births, Marriages & Deaths.

On the 11th ult., Byron Field, Esq., M. D., to Emma, daughter of the late Jordon Post, Esq., all of Pickering.

On the 29th of January, 1879, at Tuscarora, Ontario, G. E. Bomberry, M.D., aged 30 years.

At Toledo, Ohio, on the 9th ult., Dr. Thomas Waddell, son of William Waddell, of Seneca, Ont., aged 35 years.