

Technical and Bibliographic Notes / Notes techniques et bibliographiques

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

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

- | | | | |
|-------------------------------------|---|-------------------------------------|---|
| <input type="checkbox"/> | Coloured covers /
Couverture de couleur | <input type="checkbox"/> | Coloured pages / Pages de couleur |
| <input type="checkbox"/> | Covers damaged /
Couverture endommagée | <input type="checkbox"/> | Pages damaged / Pages endommagées |
| <input type="checkbox"/> | Covers restored and/or laminated /
Couverture restaurée et/ou pelliculée | <input type="checkbox"/> | Pages restored and/or laminated /
Pages restaurées et/ou pelliculées |
| <input type="checkbox"/> | Cover title missing /
Le titre de couverture manque | <input checked="" type="checkbox"/> | Pages discoloured, stained or foxed/
Pages décolorées, tachetées ou piquées |
| <input type="checkbox"/> | Coloured maps /
Cartes géographiques en couleur | <input type="checkbox"/> | Pages detached / Pages détachées |
| <input type="checkbox"/> | Coloured ink (i.e. other than blue or black) /
Encre de couleur (i.e. autre que bleue ou noire) | <input checked="" type="checkbox"/> | Showthrough / Transparence |
| <input type="checkbox"/> | Coloured plates and/or illustrations /
Planches et/ou illustrations en couleur | <input checked="" type="checkbox"/> | Quality of print varies /
Qualité inégale de l'impression |
| <input type="checkbox"/> | Bound with other material /
Relié avec d'autres documents | <input type="checkbox"/> | Includes supplementary materials /
Comprend du matériel supplémentaire |
| <input type="checkbox"/> | Only edition available /
Seule édition disponible | <input type="checkbox"/> | Blank leaves added during restorations may
appear within the text. Whenever possible, these
have been omitted from scanning / Il se peut que
certaines pages blanches ajoutées lors d'une
restauration apparaissent dans le texte, mais,
lorsque cela était possible, ces pages n'ont pas
été numérisées. |
| <input type="checkbox"/> | Tight binding may cause shadows or distortion
along interior margin / La reliure serrée peut
causer de l'ombre ou de la distorsion le long de la
marge intérieure. | | |
| <input checked="" type="checkbox"/> | Additional comments /
Commentaires supplémentaires: | | Continuous pagination. |

THE
CANADIAN PRACTITIONER

FORMERLY "THE CANADIAN JOURNAL OF MEDICAL SCIENCE."

EDITOR:

A. H. WRIGHT, B.A., M.D. Tor., M.R.C.S. England.

Business Management, - - THE J. E. BRYANT COMPANY (Limited), 58 Bay Street.

TORONTO, DECEMBER 1, 1891.

Original Communications.

A PLEA FOR PROGRESSIVE SURGERY.

Being the President's Annual Address to the Southern Surgical and Gynecological Association, Nov. 11, 1891.

BY L. S. M'MURTRY, A.M., M.D.,
OF LOUISVILLE, KENTUCKY.

My first duty upon this occasion is to express my grateful appreciation of the honor conferred by the Fellows of this Association in calling me to this responsible place. Following in the footsteps of my distinguished predecessors, I feel keenly my own unworthiness for this eminent position. My earnest desire to promote the interests of this Association and to forward the two great branches of our art fostered by this organization constitutes whatever claim I might lay to your generous consideration.

The fourth annual meeting of our Association confirms the wisdom of its founders as to the necessity for such an organization. At our second annual meeting our distinguished Fellow, Dr. Hunter McGuire, then our president, depicted in eloquent words the peculiar conditions and influences of our Southern civilization. Our gifted colleague described the pursuits and characteristics of our people; the conditions surrounding the labors of our professional brethren, and the peculiar necessities for local and special medical societies. After pointing out the influence of state and county societies in advancing the standard of the profession, he declared that there was a special need for foster-

ing this organization. The three volumes of Transactions given to the professional public, and this assembly of eminent and active practitioners of surgery and gynecology, attest the truth of those utterances.

Within fifteen years the entire practice of surgery has been revolutionized. New methods have been introduced and new regions invaded; comparatively recent teachings have become obsolete in practice, and modern treatises recast. The science and art of gynecology, which a few years since was limited to a small and narrow field, has grown into a great branch of medical science and practice. Formerly divided between midwifery and surgery, as a minor branch of one or both, gynecology has become an independent and essential department of the healing art. To promote the study of these two great and growing branches of medical science, to quicken research, and diffuse knowledge among the profession in the Southern States, is the special mission of this Association. Assembled in this historic capital of the Old Dominion, so intimately associated with the grand old colonial times, and with the later severe ordeals of our internecine troubles, we have reason for congratulation upon the success which has crowned our efforts to establish the first and only special society in the South.

It is not my purpose upon this occasion to attempt to recount the advances and triumphs of general surgery or gynecic surgery in recent years. These advances and their beneficent results are too familiar to this assembly to need

recital or accentuation. It has fallen to our lot to witness the realization of the hopes of our predecessors who have toiled in these fields in years ago, and to see in many instances the perfection of methods hitherto incomplete and inefficient. The highest attained science is established truth; the greatest perfection in art is efficient simplicity. Both are reached only through a long process of evolution, wherein the essential truth is often overlooked and the pioneer work frequently overdone. Neither is it my purpose to recite the influence of the optimist and the pessimist, so often found in the ranks of our profession; those who have, as it were, discovered a panacea in some new method or remedy, and those who decry all advancement and find inefficiency and imperfection in everything. I desire to direct your attention to an abuse of terms, as it appears to me, by which great improvements in our work are obstructed, and injustice done both to surgery and surgeons. I wish to make a plea for progressive surgery.

Webster defines the word *conservative* as follows: "Having power to preserve in a safe or entire state, or from loss, waste, or injury." All will concede at once that in time of peril to health or life this word embodies the purpose uppermost in the surgeon's endeavors, and the object of all his labors. This term is a conspicuous one in surgery, and has been used to indicate and classify certain surgical procedures known as "*conservative* surgery." But of late this term has been made to have a very wide and altogether arbitrary significance, and is often used in antithesis to *progressive* surgery. Indeed it has come to be used by certain surgical writers and speakers as synonymous with the word *expectant*, to mark methods wherein nature is left unaided in her efforts to resist disease and injury. The word is very winning to the popular professional mind, as well as to the laity, and in its perverted sense is misleading and deceptive. We should enter a protest against the perversion of the word *conservatism* when that word is used to oppose and retard *progress* in surgery the supreme purpose and object of which is "to preserve in a safe or entire state, or from loss, waste, or injury."

Not many years have elapsed since it was the established usage of surgeons to defer operation

in cases of ovarian cystoma until the patient's general health was impaired and she was reduced by emaciation. This was pronounced *conservative*. When under the leadership of Bantock it was urged that the time for ovariectomy was as soon as the tumor was discovered, before complications arose and before the health was impaired, it was regarded as an expression of "the modern craze for operative interference." With the mortality of the two courses before us, which, I would ask, is *conservative*?

There are certain abnormal conditions of various organs and structures in which the individual can only be rescued from impending death by prompt surgical aid; such, for example, is a ruptured tubal pregnancy. Here delay and opium and palliatives have been advocated under the misleading plea of conservatism. Is it not the part of conservative surgery to tie the bleeding vessels and remove the disintegrated embryonic structures? In other conditions, wherein safety lies only in surgical interference, it is claimed that surgical aid should be invoked only after a prolonged treatment by palliative measures, when the medical attendant has been convinced that he is leading a forlorn hope, and that relief will come, provided it comes at all, from operative treatment. This course, whereby operations are performed upon dying patients, is commonly called conservatism.

One of the great advances of modern times is in the knowledge we have acquired of the inflammatory diseases of the uterine appendages. Almost thirty years ago two able French surgeons discovered and described these lesions and their deadly effects, but the profession did not heed them. When modern surgery opened the peritoneum to frequent exploration, the truth and importance of the researches of Bernutz and Goupil were realized and accepted.

A large proportion of the Fellows of this Association devote themselves exclusively to gynecology and pelvic surgery. These gentlemen are constantly removing suppurating masses (pyosalpinx and ovarian abscess) from the pelvis. All of us have seen women dragging out a miserable existence with chronic inflammatory disease of the uterine appendages and associated recurrent attacks of peritonitis. We have also seen these women restored to health and activity, after years of invalidism, by removal of

the diseased and disintegrated structures. Moreover, we all know that throughout this broad land every year women perish of this condition of disease for want of operative treatment, and that no other treatment known will cure this class of patients. Yet, under a plea of *conservatism*, this great advance in pelvic surgery, this brilliant improvement in our resources for saving life and restoring health, has been denounced from the rostrum and ridiculed in the medical press. That some rash enthusiasts, or some injudicious operators should misapply an operation of great worth is not new. The same has obtained with other great improvements in both general and surgical therapeutics. Surely it does not justify inveighing against the operative treatment of such a grave form of disease without discrimination. To allude flippantly to the "castration of women," to "removal of the ovaries," "spaying," etc., is to convey an idea of a great advance in pelvic surgery, by which hundreds and thousands of lives are saved, as erroneous as it is unjust. I wish to record here that no gynecologist, so far as I am aware, advocates or approves the removal of ovaries and tubes except for lesions which destroy the health and usefulness of the individual, impair and destroy the functions, and which are incurable by non-operative treatment. To counsel delay and palliative methods in the treatment of a sac of pus within the peritoneum, enclosed in friable walls growing thinner each day, is as far from a conservative method of treatment, in the correct acceptation of that term, as one can conceive. To open, evacuate, remove disintegrated structures, and drain, is the application of sound surgical principles, "having power to preserve in a safe or entire state, or from loss, waste, or injury," according to Webster's definition of conservatism.

I would not be understood for one moment to declare that operations for removal of the uterine appendages have not been done unnecessarily. On the contrary, this operation, like many others, has been abused in many quarters. Eager desire for the eclat of a successful laparotomy has led many, who have never seen or recognised by touch a pus tube, to remove the appendages. This abuse has oftentimes thrown discredit upon pelvic surgery. But we must protest against the wholesale condemnation of a great life-

saving procedure, and a large and respectable body of earnest practitioners, on account of the recklessness of others. Those who are most prominently identified with this work and who observe the utmost circumspection in the selection of cases are made the target of criticism.

The operations upon the uterine appendages are the most difficult in the entire field of pelvic surgery. Indeed, when the tissues have been subjected to long-standing inflammation, when the pelvic organs are matted together by organized exudate, and degenerative changes are advanced in ovary and tube, no operation in surgery more severely taxes the resources and endurance of the operator. Normal landmarks are destroyed, intestines are readily torn, and large blood-vessels are opened; all requiring prompt and decisive action on the part of the operator while the parts lie fixed deep in the pelvis.

It seems incomprehensible that one who has performed such an operation for such a serious condition of disease, or who has seen it performed, could characterize the procedure by the expression, "removal of the ovaries." Hence we must conclude that many who criticise in wholesale terms operations upon the uterine appendages are unfamiliar with the lesions which obtain in those structures, and in consequence of which the operations should be performed. It is to be regretted too that many who operate upon the pelvic organs have not given more attention to the pathological conditions to which the uterus and its appendages are exposed before resorting to operative treatment. It is a want of appreciation of the character and variety of lesions to which these organs are subject, and unfamiliarity with the indications for operative interference, which have led to abuse of the operations and sweeping criticism of most valuable improvements in pelvic surgery.

Fortunately for science and humanity, no amount of misrepresentation and unjust criticism can permanently obscure the truth or obstruct the progress of science. Every great improvement in surgery must pass through the fierce ordeal of criticism before emerging into the fixed position of established acceptance. It has been our lot to see during the past decade the greatest achievements of modern times in surgery firmly established, despite the fierce criti-

cism and misrepresentation of men and methods. The progress of surgery, like that of all sciences, is an earnest and persistent search for truth.

When Marion Sims announced through the columns of the *British Medical Journal* that he believed the proper course of treatment in every case of gunshot wound of the abdomen is to open the abdomen, search for the bleeding points and secure them, and suture intestinal perforations, he was pronounced by many prominent surgeons to be a dreamer. The suggestion of Sims was most timely, and shortly afterwards Bull successfully executed the operation. For years the treatment of opium in full doses had been pursued, with death in waiting. Now there is scarcely a State in the Union that one or more patients have not been rescued from certain death by prompt resort to operative treatment. I mention these circumstances to illustrate and emphasize the point which I wish especially to bring before your attention, viz.: that surgery is advanced more by the aggressiveness of the surgeon than by timidity. In the face of desperate conditions of disease and injury, where there can be no safety whatever in delay and palliation, the only treatment worthy of consideration is the aggressive course which promises success. Under such conditions the most heroic surgery is conservative, and any other course is not conservative.

One of the most convincing arguments as to the efficacy of surgery is that surgeons believe in it. That they do so believe is attested by the promptness with which it is invoked in behalf of their own lives and that of members of their own families. Those members of our profession who are not familiar with operative work, or who do surgery as a last resort, or under protest, are disposed to oppose surgical treatment. They look upon surgery as dangerous, only to be resorted to as a last desperate chance; and they are right to this extent only: it is dangerous when utilized as a last resort, not otherwise. When the whole profession realizes that surgery is at all times conservative, when major operations are performed by those who believe in surgery and have by apprenticeship acquired surgical skill, then will the progress of this great science and art be unobstructed by misunderstanding and misrepresentation.

INSOMNIA.

BY A. M'PHEDRAN, M.B.,

Associate-Professor of Clinical Medicine, University of Toronto.

Nearly every physiologist has advanced some theory of sleep, without, however, adding anything to our knowledge of its nature, although many of its phenomena have been much elucidated. But of sleep itself we know little more than that she is "nature's sweet restorer." Mental activity is effected at the expense of increased metabolism of nerve tissue, which soon leads to a feeling of exhaustion. This demands the repose of sleep for the removal of the waste and the restoration of the active condition of the nerve cells.

In dreamless sleep all the organs are in a state of quiescence, only those functions necessary to the vital processes being continued, and even these are modified to meet the lessened activity of the organism, as seen in the slower pulse and breathing. The onset of sleep is gradual. It has been said that "sleep general is made up of many particular sleeps." It does not invade the whole organism at once, but the motor and sensory parts of the brain, the spinal cord, the organs, the muscles, must all repose themselves in order that sleep may be sound and complete. That the brain is subdued before the cord is shown by the frequent occurrence of starts while falling asleep; this is due to the inhibitory control of the brain being lost while the cord still maintains its irritability. The persistence of excitability of any part of the body may, and usually does, maintain such a state of irritability in some of the cerebral cells as to prevent, or at least disturb, sleep.

The amount of sleep needed varies with the individual, and even in him at different times, according to his condition. As the object of sleep is to restore the vitality, it follows that it should continue in each case until its object is attained; that is, until the individual is recruited and awakes vigorous and active. Each person should therefore be a "law unto himself" in the matter of the duration of time spent in sleep. The time spent in sleep, however, is not all; the quality of it varies also. This is proved by the great degree of refreshment that often follows a short nap; also, in that one may awake from a long prolonged sleep unrefreshed. This

variation in the result of sleep depends rather on the accompanying conditions, especially the state of digestion, than on the sleep itself.

Insomnia of varying degrees is of extremely frequent occurrence, as would naturally be expected, not only from the great variety of causes, but also from the great variety of avenues by which these causes may act. There are few who do not suffer at times in some degree, but it is only in exceptional cases that no sleep is obtained during the night. Disturbed and uninterrupted sleep occurs much more frequently than complete want of it. Very many who complain of want of sleep, sleep much more than they care to admit; as with many other neurotics, they regard the ailment as rather a mark of distinction, and, like Tam O'Shanter's auld wife with her wrath, "nurse it to keep it warm."

Insomnia, not being a disease, but a symptom occurring in a great variety of diseases, anything like a classification of its causes is scarcely possible. The efficacy of the cause varies with the individual, in some the most trifling disturbance being enough to rob them of their night's sleep, while others are disturbed only by marked impressions. All the causes might be grouped into two classes, viz., those dependent directly on the conditions of the cerebral cells themselves, and, secondly, impressions conveyed to them from other parts.

The following causes will have occurred in the experience of all:

1. Impressions through the senses, as pain, cold, hunger, light, noise, position of discomfort, etc.

2. Abnormal conditions of the gastro-intestinal tract. Of all the causes, dyspepsia is the most frequent, and occurs in a more or less marked degree in connection with the majority of causes. We know that it may exist without any suspicion on the part of the patient; he is not conscious of any disturbance of the stomach or of his appetite, and even under such circumstances it may be the cause of much wakefulness and disturbed sleep. Constipation and intestinal parasites are included in this class. In children particularly does insomnia and disturbed sleep arise from digestive disturbances.

3. Disturbances of circulation nearly always disturb sleep. This may be due to too little or

too much blood being sent to the brain, or the disturbed circulation may interfere with proper elimination, and the excrementitious substances disturb the cerebral cells. One of the most distressing conditions present in advanced heart disease is the insomnia; and the insomnia may be the first symptom of heart disease, for which relief is sought. Disease of the arterial walls, syphilitic or other, may also be a fertile source of insomnia. Disturbance of the cerebral circulation may also arise from bad digestion, portal congestion, and constipation. In all these causes, there is combined with the disturbed circulation imperfect nutrition of the cerebral tissue also.

4. Over-fatigue, mental or physical. A state of irritability in the nerve cells is probably produced that causes a continued hyperæmia that is incompatible with quiet or sleep. The insomnia of physical fatigue may be due to the physical pain and discomfort, and as these abate sound sleep should follow. Those indulging in excessive mental work probably develop such an irritable state of the cerebral cells that a habit of sleeplessness is begotten; then the nutrition of the cells gradually becomes inadequate, the products of metabolism are imperfectly removed, and in time there is too often failure of health, mental and physical, that only prolonged rest, at best, can overcome. Excessive mental strain is, without doubt, the cause of much of the insomnia and disturbed sleep of children. This is not to be wondered at if we consider the excessive amount of evening work school children are called upon to do. Children from 10 to 15 years of age are often, if not regularly, I know, required to do from two to three hours of work in the evening preparing lessons for next day. That means that they have from seven to nine hours work per day to do. Robust laboring men complain at being asked to do more than eight hours work per day; and yet the school authorities think nothing of forcing children to devote themselves as many hours per day to work that in most cases probably makes a greater proportionate draft upon their vitality. Much of the restlessness that it has been the custom to attribute to worms and dyspepsia is no doubt due to excessive mental fatigue, either directly, or indirectly by the ill-digestion and health it engenders. So long as

a child at school or a student at college is able to take a sufficient amount of quiet dreamless sleep the work he is doing is well within his capacity, and will do him no harm; but if his sleep is disturbed his health is certain to suffer, and the disturbed sleep is but the prelude of a breakdown if not remedied.

5. The sleeplessness due to toxæmia of acute febrile diseases requires no more than mention. In chronic diseases, as phthisis, anæmia, joint disease, etc., insomnia may be partly due to a toxic state of the blood and partly to the exhaustion incidental to the disease. The same remark would apply to cases of dyspepsia and constipation. Toxic substances from without, as well as the autogenetic ones, are frequent and potent causes, such as the prolonged and, maybe, excessive use of tobacco, coffee, tea, opium, chloral, and bromides.

6. In the condition known as neurasthenia one of the prominent and troublesome symptoms is insomnia. The excitable and unstable condition of the nervous system renders its equilibrium more easily disturbed by any untoward condition that may exist. The condition has usually been long existent, having developed gradually. Males so affected are more difficult to manage than females; they tend to magnify their ailments more greatly, and it is more difficult to secure their confidence and imbue them with hope; at least, such has been my experience. It was notably so in a gentleman of advanced years living in a neighboring town. I saw him with his physician and gave a positively favorable prognosis. Much against my wishes, he came here a week afterwards to place himself under my care and have massage. I knew he would miss the comforts of his home and become discontented, so that the results were no worse than I had expected under the circumstance. I fully believe, however, that the experience made him more satisfied with home care, and this contributed to his recovery, which soon followed.

7. Affections of the brain or its membranes may be attended by insomnia or coma. The insomnia may be due to active hyperæmiæ, as in meningitis. One of the prodroma of tubercular meningitis is sleeplessness, a symptom, if persistent in a child, that should awaken our suspicion. Or the sleeplessness may be due to

anæmia, as sometimes occurs in convalescence from acute disease. Sleeplessness is of very frequent occurrence in the aged, and may be partly due to passive hyperæmia or to anæmia, or to both, anæmia in some parts, hyperæmia in others. The degenerated condition of the arterial coats renders the neighboring brain tissue anæmic and ill-nourished, so that the cells become easily disturbed. At the same time, the heart is weak, and propels the blood badly. On account of the degenerated condition of the vessels they fail to respond to vaso-motor influence, and this leaves them liable to passive distension when the recumbent position is assumed; or they may at first contract and prevent too great a flow of blood to the brain, and sleep is sound. But towards morning the vaso-motor contraction fails from want of power to maintain it, and the increased flow of blood resulting causes the patient to awaken. Such a condition is best remedied by a generous diet and stimulants, cardiac and general. Such conditions as intracranial tumors, organic diseases of the cord, etc., need but to be named as causes of insomnia.

8. Much of the insomnia we meet with is due to habits in regard to sleep practised perhaps for years. Instead of composing themselves for sleep as soon as they go to bed, some people choose this time to review the events of the day, usually the unpleasant ones, and worry over all the trials they have had; or they may spend the time evolving their plans for the future, or in some other equally pernicious way. As a consequence, they become bad sleepers from habit and complain loudly at not finding prompt relief on seeking it. It is difficult to make bad sleepers believe that much can be done by *trying* to go to sleep, and that the faculty of going to sleep at will, when sleep is needed, may be formed. It is said that Wellington, Napoleon, and Grant could go to sleep at once anywhere, as they had opportunity.

Insomnia is often due to other classes of diseases, especially those of the genito-urinary and the respiratory system.

Treatment: Insomnia being a symptom of almost an endless variety of diseases, it follows that its treatment will largely consist in that of the various conditions on which it depends: to correct evil habits; to remove causes of pain

and discomfort ; to relieve cardiac and general vascular disturbances ; to cease from overwork or strain, mental or physical ; to secure easy and perfect digestion, and perfect elimination of waste products ; to avoid the ingestion of unsuitable or toxic foods ; to build up results of exhaustion or waste. Beyond this we can do little but endeavor to relieve symptoms and improve the general condition. With attention to the sufferer's personal condition, due consideration should also be given to his environments ; that there are proper conditions, as room, quiet, air, and warmth for sleeping. Change of air and scene are of great importance. Sea bathing or even seaside air, camping, high, dry atmosphere, are aids to most sufferers. Outdoor exercise to the point of a certain degree of fatigue, unless specially contra-indicated, may overcome the sleeplessness. The late Lord Palmerston was wont to say that the outside of a house was the best medicine for the inside of a man. Such management not only directly tends to induce sleep, but it does much to improve the functions of digestion and assimilation, and of excretion, all of which may be the cause, or at least aggravate, the sleeplessness.

Various kinds of baths are of great use. The insomnia of a lady, æt. 60, at present under treatment for great mental depression with hysteria, the result of several weeks' watching over a sick husband, was quite relieved after a few days by a hot bath at bedtime, followed by cold effusion to the spine. Sedatives and soporifics, including sulphonal, had given only partial and temporary relief. Her husband, who was addicted to opium, and could obtain sleep only on the administration of that drug, was greatly relieved by a hot air bath, improvised by placing a spirit lamp under a wooden or cane chair, on which he was seated without clothing, and then enveloping him and chair in a blanket, which was pinned closely about the neck. After he began to perspire freely, he was rubbed well before the blanket was removed, a woollen night shirt put on, and then he was at once transferred to a bed which had been previously warmed.

Cold to the head and heat to the feet or abdomen, ice bags to the spine, galvanism, Faradism, massage, and the wet pack, have all been

found useful. Any means, if it is only a sip of water, if it only has the confidence of the patient in its efficacy, will do good and may succeed perfectly. There is much to be gained by forming a proper habit of sleeping. There are very many that are troubled with insomnia who, if they went to bed prepared to sleep and without misgivings as to the result, would soon acquire again the sleeping habit, and would be aided by any means in which they had confidence. In such cases the personal influence of those whose care they are under surpasses all others. As Folsom* says : "For these reasons the grotto of Lourdes, faith-cure, mind-cure, Christian science, spiritualism, hypnotism, have their devotees, and charlatany may succeed where medical skill and experience fail."

There are many people whose digestive organs are such that, living on the diet necessary to enable them to do their full complement of work, they are certain to have attacks of indigestion of more or less severity from time to time ; and it is better for such people to be able to do their own work, though they suffer the consequences of the malassimilation. So it is with many people of highly nervous temperament. It is better for them to do their work, though at times they suffer for want of sleep in consequence, than to refrain from work and sink into a life devoted to guarding against their malady, thus becoming useless members of a community. To such we have to content ourselves with mitigating their suffering and aiding them in bearing with that courage that enables them to still be up and doing.

Hypnotics : It should be ever present to our minds that nearly all hypnotics defeat their own ends by continued use. The judicious use of hypnotic drugs calls for much discretion on the part of the physician. People generally are impatient, and bad sleepers are no exception, and the temptation is strong to have early and frequent recourse to hypnotics for relief. Most people think their own sufferings the worst, and that there must be a specific remedy for *their* relief, if only it could be discovered. It is not to be wondered at, then, that drugs of this class should have such widespread and general use. The importunity of the patient is apt to lead the physician away from the principles

* Boston Medical and Surgical Journal, vol. cxxiii., p. 5.

that should guide him and cause him to administer that which will relieve the present suffering, forgetting what will be most conducive to the ultimate good.

In acute diseases, as fevers, want of sleep increases greatly the dangers by continued exhaustion, without the periods of lessened waste and increased excretion that sleep affords. Under such conditions there can be no question as to the advantage, or even necessity, of hypnotics. In painful incurable diseases, and often in the aged, their use becomes necessary, and their abuse improbable, and of little moment. It is in the neurotic that their use is so liable to be followed by their abuse that they should be given only with greatest precaution. So great is the danger from their use that they should not be resorted to until after other means of relief have failed. It should be remembered that, with rare exceptions, their administration is followed by disappointment; not rarely they fail to produce sleep, and often, if they succeed, their use is followed by effects almost as annoying as the want of sleep.

In the aged, and in states of exhaustion, no hypnotic is more useful than alcohol. With it may be given the cardiac tonics, especially digitalis, caffeine, strychnine, etc. Cases occur not rarely in which there is great desire to sleep while going about during the day, or while sitting in a chair; but on lying down on a sofa or in bed the sleepy feeling is at once dissipated. This condition is due to vaso-motor paresis, by which the blood, on account of the weakness and dilatation of the vessels, is allowed to drain from the brain in the erect posture, rendering it anæmic, hence the sleepiness. As soon as the recumbent position is assumed, the dilated cerebral vessels fill with blood, and sleepiness disappears in consequence. Bromides and general hypnotics do little good in such cases; the best hypnotic for them is digitalis, given sufficiently freely to cause vaso-motor contraction and a reduction of the blood supply to the brain. The general health and nutrition should also receive attention. Champagne at times succeeds admirably in such conditions. Ale succeeds in some when other forms of alcoholic stimulants fail. The continued necessity for such stimulation shows that the sufferer has little nerve vitality to draw upon; then

there is the great danger of the alcoholic habit being formed.

Opium is, in many respects, without a peer as a hypnotic. It is indispensable in painful affections, and equally so in the insomnia of heart disease. In the latter the dose should be carefully regulated, as in too large doses opium depresses the heart, while in small ones it acts as a heart tonic. When alcoholics fail in the insomnia of the aged, opium may succeed.

Chloral hydrate is probably our most powerful hypnotic, possessing a narrow range of other therapeutic use. Its use need not be discussed, being too well known. The grave objections to its use are the danger of the chloral habit, its depressing effect on heart and respiration, and toxic effect on the kidneys. Its prolonged use leads also to mental enfeeblement, with intractable insomnia.

The bromides, by their sedative action and effect in rendering brain anæmic, are useful aids in inducing sleep, though they can scarcely be called hypnotics. They need to be given freely, and well diluted, during the day or evening. If long continued, they will defeat their own ends by their interference with cerebral nutrition.

In paraldehyde, I have had probably the most satisfactory hypnotic. In doses of one drachm or less it leaves no unpleasant effects, and usually is effective in producing sleep. It is useful in excitement, and its effect may be increased by the addition of a small amount of morphia. Its disagreeable taste and smell is its chief objection, and yet even that is of great use in some neurotic subjects.

Sulphonal, an excellent hypnotic in many, fails wholly in others. Its effect is not rarely prolonged into the next day, even then shown most markedly. It may even in moderate doses cause depression of the heart. It is dissolved with difficulty, and therefore slow in action. It is usually given, therefore, early after dinner, or dissolved in a good quantity of water, may be taken in divided doses later. So given, its effect has been found more certain.

Hyoscyamine I have not found of any benefit, even in doses of $\frac{1}{2}$ gr. repeated; but my experience with it has been very limited.

Phenacetine is a very useful remedy in many cases of restlessness, especially if there is some fever. It may cause profuse diaphoresis, and

thus be objectionable. It relieves muscular and other pains of slight degree.

My slight experience with urethan has not been satisfactory. It usually has failed, though it was satisfactory in some cases.

Turpentine is recommended in the insomnia of worry; it probably acts as a vascular stimulant.

SOUTHERN SURGICAL AND GYNECOLOGICAL ASSOCIATION.

When the chill breath from the icy north steals southward and tints with red the leaves of our emblematic and lovely maple, we feel that, if we had the wings of the waterfowl and could all move together, their example would be quickly followed. When such an attraction as the meeting of the flourishing Southern Surgical and Gynecological Association is added to that of a few days sojourn in a summer air, amidst a hospitable people, but few would refuse an invitation to go to Richmond, Virginia, in November. The temptation was too great for me. The journey can be completed in 26½ hours. The city of Richmond is one of unusual interest. I drove out one afternoon with the ex-president of the Medical Society of the State of New York, an army veteran who served as surgeon-major with the army of the North about Richmond. The recounting of his prison life when in Libby prison and of many other incidents was of great interest to me. Now, in 1891, in the elegant drawing-rooms of members of the profession of Richmond; now gathered around the dinner tables of near relatives of Southern generals; now seated at the banquetting table, there is but one united body of surgeons—surgeons of the United States of America. The past has not been buried, but the misunderstandings of the past are such no longer, and in our profession one sees nothing but the greatest of harmony. At this meeting many met for the first time since the time of battle.

The work of organization fell to younger men. A genial type of a Southern gentleman, a worker of a high order in the field of modern surgery, Dr. Lewis T. McMurtry, the president of the Association, working side by side with another able worker from the rich mineral region of Alabama, Dr. W. E. B. Davis, completed the

programme that was so successfully carried out. Dr. Hunter McGuire, with his committee of arrangements, completed a splendid programme of social events. The social features were enjoyed by the members and guests fully as much as the intellectual feasts served up at the meetings. The newspaper editors were evidently just recovering from severe illness, and in their gratitude noticed the meetings with a liberality truly Southern.

Among those present were: Drs. L. T. McMurtry, Louisville, Ky.; J. McT. Gaston, Atlanta, Ga.; W. E. B. Davis, Birmingham, Ala.; Vander Veer, Albany; W. W. Potter, Buffalo; C. A. L. Reed, Cincinnati; Seymour, Troy; Morris, Emmett, L. C. Gray, Wells, New York; Joseph Price, Philadelphia; Stone, Washington; Kelly, Rohé, Opie, Baltimore; Marcy, Boston; G. Ross, T. Nelson Page, Hunter McGuire, Geo. B. Johnston, Winn, Wellford, Richmond; and many others.

The list of papers has already been published elsewhere, and the transactions will be printed and bound in a handsome volume without delay. The annual fee for membership is but ten dollars, and yet the society publishes its transactions and has a surplus on hand. It is to be hoped that our Canadian societies will soon wake up and follow the good example of the Southern Surgical and Gynecological Association. It is not as large an association as our Ontario one. Our material is either used in building up other journals or transactions, or is lost. There is no encouragement to good work when papers are simply read at race-horse speed, in full or by extract, at a small meeting, and are lost, together with the discussion, that is often more valuable than the paper. With a membership of 200, our Ontario Association could readily publish papers and stenographic reports of discussions for a membership fee of five dollars a year, and perhaps a little extra for each volume. The Southern Association charges nothing for the volume to members, and pays for all plates inserted. There are two methods of publication, an expensive and an inexpensive method.

We have brains in Canada; we have as fine a body of general practitioners in Ontario as can be found in any country; and as it was in the Southern States until 1887, so it is here to-day; some splendid surgical work is being done by

our country practitioners and is lost to science. As one's acquaintance with men who are eminent from a literary standpoint—as writers of text-books—increases; as one sees them in the intellectual combats of their own societies, one's hero-worship ceases and his respect for his professional brethren at home increases. This hero-worship is too rife in Canada. At this meeting of the Southern Surgical Association, the greatest were on a common level with the smallest. If deserving applause, applause was given, and each speaker was very soon "sized up." No one was asked especially to take part in the discussion and introduced as "our celebrated and distinguished visitor from New York or Philadelphia," or made a lion of. They thought less of a man's past record. The hero-worship of foggism has no place in the Southern Surgical and Gynecological Association. They are anxious to help along young and earnest workers who are willing to help themselves. The fight between the surgeon of the past, who drew himself into his conservative shell, content that he knew "it" all, and the aggressive young searcher after truth, who soon learnt that there were yet rich regions unexplored, has now no place in the proceedings of this society. The conservative men may in their hearts be conservative still, but they stay at home. The work of Price alone is sufficient to demonstrate the reasons why the conservative gynecology has failed, and will fail. As he aptly put it, "You may as well leave a sequestrum of bone and expect to heal an abscess of a limb as to expect to heal a pelvic abscess by aspirating and draining a pus tube." His assertions may even have appeared offensive in the meeting of which we are speaking, but they are true. He has fought the old conservative gynecologist all along the line; he has removed pus tubes, torn bowels, stitched up fistulæ, and done a general cleaning up after many of the most eminent men of the conservative school, and has cured his patients. He has taught many of us to do the same, and we thank him for it. One comes back reassured and emboldened.

Social features are only of interest to those who are lucky enough to partake of them. They were not singularly Southern, but were Southern or Canadian.

We are pleased to welcome Dr. Gaston, a

name well known among Canadian surgeons, as the president-elect for 1891-2. He has done good surgical work, and is still a worker, though Father Time has whitened his locks and wrinkled his brow.

J. F. W. R.

TRAUMATIC HYSTERIA.

In the September number of *The Practitioner* (Eng.) there appears an article by Dr. Wherry on "Clinical Notes of Nerve Disorders in Surgical Practice." In this article he refers fully to the subject of hysteria among young men, especially undergraduates, caused by some slight accident received on the football field, or received when gathered together for some other purpose. "It would not be difficult," writes the doctor, "for any one practising much among young men to be led to conclude that hysteria is more common among males than among females." He also draws attention *en passant* to the peculiar fact observed in hospital, "that though many students *go down* at their first operation, it never happens in the case of nurses that they are definitely overcome by the first sight of bloodshed, or turn sick, as men do, at the sights and sounds of suffering." The first statement above quoted, so entirely different from what is generally taught in our schools, may nevertheless be well founded. It reminded me of a remarkable case, due to a fall, that I saw this summer while relieving a fellow-practitioner on the shores of one of our inland lakes. The case seems almost too ludicrous to report in such a serious periodical as a medical journal.

A few miles from my place of residence was a summer settlement of fishermen, many men, but very few women. Willie Mc——, age about 20, with two others, were out hauling in their nets, when he fell, receiving a severe blow in the upper lumbar region of the spine. He became unconscious, and so remained for about two hours, while the others finished hauling in the nets and sailed for shore. I saw him about four hours after the fall; he was then quite conscious and surrounded by a great many sympathizing friends. After careful examination, I told them it was a case of spinal concussion and that no bones were broken. I got him to bed, ordered local applications, an aperient, and sed-

atives. No woman graced the shanty to which Willie belonged, but in the next was a young girl, Nellie, the belle of the settlement, who could easily count her ten to fifteen ardent admirers. She was very sorry for him in his troubles. Two days later I was again summoned to the settlement, for "Willie was having convulsions." On entering the shanty I found him in a so-called unconscious state, Nellie kneeling by the bedside and asking in a most imploring tone, "Don't you know Nellie?" In a few minutes he recovered consciousness sufficiently to throw one arm around Nellie's waist and with his free hand to press her cheek down to his. In a moment he began to throw about his arms in a most violent manner, striking the wall and striking his fists madly together, but not touching Nellie, who has meanwhile changed her position and is now sitting near the head of the bed. He keeps telling her not to be afraid, as he would not hurt her. Suddenly he sits up, throws his arms about her, embraces her warmly, and sinks back on his pillow, consciousness being now fully recovered. It was not until now that he recognized me. Many others besides myself had gathered in during the convulsion. His father told me that Willie had been going on like this for twenty-four hours; that each attack was more prolonged than the preceding one, and that Nellie was the only one who seemed to have any quieting influence over him. He was very anxious to know if the boy's life were in serious danger. The boy was eating and sleeping well, and on examination I found no symptoms except hyperæsthesia. I assured the father that there was no serious damage, continued the sedatives, and ordered that the shanty be kept absolutely quiet, and that Nellie must not be present during a convulsion. I saw patient again two days later. I found that my orders to keep the shanty quiet had not been carried out, and I was therefore not surprised to find that the patient's symptoms were as before, but much exaggerated. He was apparently unconscious, his arms were flying about violently, his feet were beating a continuous and noisy tattoo in the bed, his anxious friends were standing about him, and Nellie was at her old seat on the bed. Every now and again he would sit up and embrace her, sometimes several times in quick succession. What with throwing himself

from the lying to the sitting position, and back again to the lying position; what with his arms flying about and his feet beating a wild tattoo, he was really alarming to look at. After consciousness was fully restored, I asked Nellie and the others to leave the shanty. This annoyed him and almost immediately he rolled out of bed. I noticed that with all his tossing and throwing his bed-clothes had, up to this time, not been in the least disturbed. I scolded him sharply, sat with him for half an hour, and in that time, by the virtue of scolding, aborted three or four incipient convulsions, assured his father and brothers that they were unnecessarily alarmed, and repeated my previous orders as to keeping the shanty quiet. The next day he was very much improved and left for home, since which time I have seen or heard nothing of him.

Was this a case of subacute meningo-myelitis? or a case of traumatic hysteria? or a case of "a young man's fancy lightly turned to thoughts of love"?

C. F. McG.

Selections.

RECOVERY FROM HIP DISEASE BY NATURE'S METHODS.—Dr. V. P. Gibney presented a case of hip disease showing a remarkable recovery by nature's methods, at the October meeting of the orthopædic section of the New York Academy of Medicine. A boy of eight years was admitted to the hospital in 1882 with disease of right hip in second stage. Family history, tuberculous. Disease dated back to the previous April. On admission he was fairly nourished, hip flexed to 100° and held in this position. *Practical* shortening of 3¾ inches. On July 7th, 1883, flexion had increased to 135°, and an abscess filled the whole gluteal region. On October 12th the abscess opened. November 16th he had become greatly emaciated, pale, and waxy, the thigh acutely flexed on the abdomen and abducted, the head being apparently dislocated on the dorsum, while the whole thigh, from the junction of the lower and middle thirds to the trochanter major, was undermined, and large quantities of pus were discharging from two sinuses. Could only sleep with the aid of two drachms of the U. S.

solution of morphia, and his condition was so bad that it was thought there was no chance of his recovery and he was advised to be taken home. On the 27th of November he was visited by a member of the house staff, who found him suffering from diarrhoea and night sweats, with poor appetite, a pulse of 130, and a temperature of 101°. On the 7th of December his condition was about the same, except that a bed sore as large as a half dollar, had formed over the trochanter on the sound side. Not seen again until October 14th of the present year, when he returned, looking hale and hearty. He said that after leaving the hospital, he had been confined to bed for one year and a half, and had then begun to go about on crutches. For the past four years he had been wearing a five inch high shoe. The site of the old abscesses and of the bed sores, are marked by very large cicatrices. The angle of greatest extension is 100°, and that of greatest flexion, 90°. The adductors are very tense.

BILLROTH'S STATISTICS ON RESECTION OF THE STOMACH AND INTESTINES.—Professor Billroth has published statistics of 124 resections which have been made in his clinic from 1880 to 1890; 83 were by himself, 3 by Wolfier, 8 by Hacker, and 15 by Saltzer and Eiselberg. The cases were all chronic processes with pyloric stenosis, malignant forms of swelling. There were 41 cases of pyloric resection (7 males and 34 females, with ages from twenty-six to fifty-eight years). The operations lasted from 1¼ to 3½ hours, with removal of 4 to 21 ctm. of the intestine. The cause of operation was: In 28 cases, carcinoma; in 1 case, sarcoma; in 12 cases, callous cicatrices. Results: 19 cases recovered, 22 died. Of 27 typical pyloric resections, 12 were favorable and 15 fatal. Of the 13 cases of carcinoma that had endured the ordeal of the operation, 5 died after ten months, and 1 after 5¼ years, from recurrence. There were yet living three women, of whom two had been operated upon 2½ and 4½ months. There were 6 operations on account of scar stenosis, of whom 3 recovered. One patient died after three months from peritonitis, caused by an abscess in the cicatrix. There were 28 gastro-enterotomies on account of carcinoma, with 14 recoveries. These all died in from one to

eighteen months. Of 11 resections of the small intestine (7 males and 4 females), all were favorable. (Eight times on account of preternatural anus, once traumatic opening of intestine, and once carcinoma). Of 24 resections of the cæcum, there were 11 on account of carcinoma (with 5 recoveries); 13 on account of fistula after perityphlitis (7 recoveries, 5 deaths, and 1 persistent fistula). Of total cases of cæcum resections, 11 deaths, 13 recoveries. Of 8 colon resections, 4 deaths and 4 recoveries. Of 7 resections of rectum all recovered, 5 times with formation of fistula.—*Wiener Medizinische Wochenschrift*.—*Medical Record*.

THE ELIMINATION OF ANTIPYRIN IN CHILDREN.—It is a well-known fact that children bear proportionately large doses of antipyrin, and that unpleasant symptoms are more rarely observed in them than in adults. MM. Perret and Givre have made experiments to discover whether antipyrin was not eliminated in the urine more rapidly in children than in adults, and if it was not possible to explain in this way the increased tolerance. Their conclusions are:—

1. The urinary elimination of antipyrin begins at the same time after its ingestion, whether in the old man, the adult, or the child (¾ to 1 hr.).
2. The child eliminates the antipyrin more rapidly than the adult, and the latter more rapidly than the old man.
3. Large doses have no effect on the time of appearance of the antipyrin in the urine, but the duration of the period of elimination is notably prolonged.

It seems, therefore, that, to a certain extent at least, the more rapid elimination of antipyrin in children explains the greater tolerance of the latter for this medicament.—*Le Bulletin Médical*, August 16, 1891.

MEDICINE AT THE WORLD'S FAIR.—We are informed that the Medical Director of the World's Fair is Dr. John E. Owen, and that he has promised that women shall receive official recognition upon the medical staff. The number to be appointed has not yet been announced, but assurance has been given that women physicians will rank with men and share the duties of the exhibition hospital. The profession will look forward with interest to Dr. Owen's exhibi-

tion hospital, with its exhibition staff of male and female doctors. According to the reports of the last exposition at Paris they may expect about 732 cases of hysterics, 197 syncopes, 11 deaths, and 3 births. This will be enough to make the hospital interesting as an exhibition.—*New York Medical Record.*

COMPOSITION OF KOCH'S TUBERCULIN (Conclusion of paper by Wm. Hunter, M.D., M.R.C.P., F.R.S.E.).—In their order of importance, as well as of amount, the chief substances present in tuberculin are, according to these observations: (1) Albumoses; chiefly protalbumose and deuteroalbumose, along with heteroalbumose, and occasionally a trace of dysalbumose. (2) Alkaloidal substances; two of which can be obtained in the form of the platinum compounds of their hydrochlorate salts. (3) Extractives; small in quantity, and of unrecognized nature. (4) Mucin. (5) Inorganic salts. (6) Glycerine and coloring matter. So far as my observations go, the following substances are absent from tuberculin, namely, serum albumin, globulin, peptones.—*Pacific Record of Medicine and Surgery.*

TREATMENT OF SMALL CYSTS WITH INJECTIONS OF CHLORIDE OF ZINC.—According to the size of the tumor 0.2–1.5 ccm. of a 0.1 proc. chloride of zinc solution should be injected. These injections are painless. The cyst becomes then harder, later soft, and shrinks after four or five weeks. After this small operation, a pale œdema is seen, sometimes a slight hyperæmia of the surrounding skin; Priessnitz's compresses may be used with great advantage for this œdema. Landerer reports cured: Three simple ganglions on the back of the hand, two diffused tumors of the sinews on the back of the hand, one hygroma præpatellare, one hydrocele of the size of an egg in a man fifty-six years old. The treatment is *tuto jucunde*, but moderate *cito*.—Landerer, *Munchner Med. Wochenschrift.*

LATENT TUBERCULOSIS.—A prize of three thousand francs (\$600) has been offered for the best essay on the subject of "Latent Tuberculosis," to be presented to the next Congress of Tuberculosis, which will probably meet in 1893.

THE Canadian Practitioner

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

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

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

TORONTO, DECEMBER 1, 1891.

UNIVERSITY OF TORONTO: REPORT ON FINANCE.

The recent report of the standing committee on finance, as presented to the Senate of the University of Toronto, contains certain clauses which are of interest to the friends of the Medical Faculty. The new addition to the Biological Laboratory contains the large rooms which are necessary for the museum, together with certain store rooms, etc.; some rooms which are used by the Medical Faculty and the department of Mineralogy and Geology, respectively; and a lecture-room used at present by both. The University authorities have estimated that the portion of the building which is occupied by the Medical Faculty is worth thirty thousand dollars, and have decided to demand for rent the sum of twelve hundred dollars a year, or four per cent. on the value.

This somewhat extraordinary position of affairs is said to be caused by the exigencies of the times. The needs in other departments are so urgent that the great Provincial University is unable to give one of her own faculties house-room. If there be another instance of the sort in the whole universe we have been unable to discover it. We may say, however, that the authorities, in deciding on such a course, are not actuated by any unfriendly feelings towards this department, but, on the other hand, are extremely gratified at the success which has attended its teaching. We are somewhat inclined to agree, however, with those who think they employ strange methods in showing their gratification. The members of the faculty have accepted the position with becoming meekness,

but without boundless enthusiasm over the generosity of the Senate.

In another clause we find that the examination and degree fees in medicine had been written to the credit of a Medical Faculty Surplus Account in the years 1888, 1889, and 1890; but we are told that "during last winter the Minister of Education, having heard of these credits, had an interview with the chancellor and vice-chancellor, on which occasion he objected to them, and pointed out that the amounts should be written back to the University on the grounds next mentioned." "It appears to us (Committee of Senate on Finance) that these amounts do properly belong to the general funds of the University which performs the examinations, pays the expenses, gives the certificates, and confers the degrees."

The amounts involved aggregated in the three years mentioned \$6,942. Certain members of the Medical Faculty, however, had discharged gratuitously a portion of the work of examination by which an amount had been saved to the University, aggregating in four years, \$2,360; and this amount was written to the credit of the faculty. In the early days of the faculty, before the eye of the Minister of Education was turned in the direction of "these credits," when certain people in their innocence supposed that all the earnings of the Medical Faculty would be expended for the purposes of the faculty, some enthusiastic members of the staff endeavored to swell the surplus by popularizing the M.D. degree. To accomplish this they and their friends, about thirty in all, made application for the degree, which was duly conferred upon them, and the sum of six hundred dollars was added to the University coffers. Some of these, who cared nothing for the degree itself, are somewhat disappointed now because they had not desired particularly to contribute to the general funds of the University. From an Arts point of view, it is considered rather a good joke on the medicals.

Many who are well acquainted with the methods of procedure in other universities in various parts of the world are somewhat surprised at some of the decisions that have been reached, and feel inclined to wonder why a university should discriminate against one of its own faculties. Such discrimination appears all

the more unnecessary when we consider the original bargain made at the time of the establishment of the faculty. It must be self-sustaining. Forty per cent. of the fees paid by students were to be retained by the University. The members of the staff were to discharge the work of examination for nothing. Recent decisions actually compel the transfer of the profits of medical examinations from the faculty surplus to the general funds. The students of the faculty are allowed the privilege of attending lectures already given in Arts, but it has been decided that in every case where extra instruction is given exclusively to medical students, the faculty must provide for the payment of the same.

The following figures will show to what extent the University has been endowed by its new faculty. Examination and degree fees placed in general fund \$4,751.94. The fees of 1891 will be added to these. In addition there is a Medical Faculty Surplus Account composed of the following items:

Gratuitous work at examinations	-	\$ 2,360.00
Interest	- - - - -	150.60
Saved from 40 % students' fees	-	5,323.96
Interest	- - - - -	351.80
Return of money paid for university work	- - - - -	400.00
Total	-	<u>\$ 8,586.36</u>

It is understood that none of this surplus fund is to be expended on the payment of the salaries of professors. This plain statement will show that neither the Government nor the Senate of the university has shown any marked spirit of generosity towards the Medical Faculty.

THE SLEEPING WOMAN.

From time to time there appears in the daily press accounts of women who are said to have slept for months or years. It has been known for some time that there was one of these curious cases of lethargy residing in the vicinity of Kingston. Dr. C. K. Clarke, medical superintendent of the Kingston Asylum for the Insane, by the exercise of considerable address, managed to obtain access to her, and at length had her put under his care. In the *American Journal of Insanity* for October, he has published a very

interesting account of the case. A woman of 69, of neurotic inheritance, she seems to have spent almost half of her life in this state of lethargy; to all appearance asleep, but partaking of food when it was placed in her mouth. After years of lethargy she would be aroused and remain so for some time, but to return gradually to the same condition. Upon her death the only noticeable discovery was that of some tubercular deposit in her lung.

Dr. Clarke, who has under observation another case, in which the patient is asleep all winter and awake all summer, draws attention to the analogy of the condition, in some cases at least, to hibernation in animals.

To sleep seven years at a stretch and then return to the active cares and duties of life, as this woman was wont to do, is indeed a Rip Van Winkle existence. By which of the theories of sleep will physiologists explain such cases? What are the subtle changes which ever elude us in this protean hysteria?

SOUTHERN SURGICAL AND GYNECOLOGICAL ASSOCIATION.

The growth of this flourishing young society has been almost phenomenal; and although it is now but little more than three years old, its influence is felt in all parts of North America. The "Sunny South," so dear to a large portion of the citizens of Canada, contains many of the brightest lights among American physicians and surgeons, and many of these may be found in this Association. Dr. McMurtry, of Louisville, Ky., the retiring president, although quite a young man, has made a reputation for himself which is not confined to this continent. We have much pleasure in publishing his presidential address in this issue. Dr. Ross' impressions of the meeting and its surroundings, which we also publish, will be read with much interest.

A NEW society to be known as the Western Association of Obstetricians and Gynecologists, will come into existence soon. Geographically, its territory will include the Missouri river, cities of Iowa and Missouri, and the states and territories of Kansas, Nebraska, Colorado, New Mexico, Indian Territory, and Oklahoma.

Meeting of Medical Societies.

TORONTO MEDICAL SOCIETY.

October 15th, 1891.

The president, Dr. A. A. Macdonald, in the chair.

TUMOR OF INGUINAL CANAL.

Dr. I. H. Cameron reported a case seen in the practice of Dr. G. H. Carveth. The patient was a shoemaker, *æt.* 40 years, and in good health. About 8th of September a painful lump appeared in the right groin, which disappeared suddenly and with a gurgle. A few nights ago it returned. The swelling was tender and irreducible. It was elastic, tense, and scarcely translucent. On percussion, the note was found dull throughout the whole tumor. The testicle was found below and behind. A hypodermic needle was introduced and straw-colored fluid withdrawn. The escape of this fluid did not reduce the tumor in the inguinal canal. The needle was then introduced into the tumor, but no fluid could be obtained. The tumor was then cut down upon, the sac opened, when the contents were found to be a hernia of the *cæcum*. The omentum and the appendices *epiploicæ* were adherent to each other. The hernia was no doubt congenital. There was even then found difficulty in returning the hernia on account of the thickening of the walls of the *cæcum*, and on account of the fat attached to it. More room was obtained by nicking the sack, and the hernia was returned. The interesting part of the case was the difficulty of diagnosis.

Dr. Atherton narrated a similar case in a middle-aged man, in whom there suddenly appeared an irreducible swelling. Under chloroform and taxis, it was reduced. As in this case, the bowel was strangulated at the neck of the ring, and there was an accumulation of fluid below, due to the plugging of the neck of the sac, and consequent obstruction.

VAGINAL HYSTERECTOMY.

Dr. I. H. Cameron related a case of vaginal hysterectomy in a woman of middle age. One year ago, subsequent to a fall into a lake, phlebitis had developed in the right leg. This summer she suffered from diarrhoea. Disease of the uterus was discovered by her physician, and she

was sent into St. John's Hospital for operation. The os was eroded, the cervix scooped out by disease, so much so that, until informed to the contrary, the other members of the staff thought that a curetting must have been done. In spite of such an advanced stage of the disease, the woman had never had any symptom to draw her attention to it.

A discussion then arose as to the best method of operation. Dr. Atherton preferred ligatures rather than clamps, because the latter cause more or less death of the tissues which they grasp, and thus make healing slower. The vessels are as easily controlled, and secondary hemorrhage is less likely to occur.

Dr. Allen Baines had done the operation but once. The fatal result in that case he ascribed to the forcipressure used. The ligature is certainly very tedious, yet it is to be preferred. In point of rapidity of operation, the advantage is all with forcipressure. He believed a mistake was made in the length of time the forceps were left on. They should not be left on longer than twenty-four hours; if left on longer, secondary hemorrhage is more likely to occur.

Dr. Cameron's greatest objection to forcipressure was that it necessitated an incomplete operation; that is, the vaginal cavity is not shut off from the abdominal. It is true that there is a danger of adhesions forming between the bowels and the raw surface. This rarely occurs however. With the ligature peritoneal edges can be drawn together and the vaginal later on. Acting on the advice of the late J. B. Hunter, of New York, he was in the habit of leaving on the forceps for at least forty-eight hours. Secondary hemorrhage might occur from removing the forceps too soon, as well as too late.

EXTRA-UTERINE PREGNANCY.

Dr. Strathy reported the case of a multipara, æt. 31, who during the summer had been twice to consult him for what were thought false pains. These were relieved by half-drachm doses of paregoric. Auscultation at that time discovered two foetal hearts. On 2nd September a child was born at full term. Examination showed the uterus to be empty, but another living child within the abdomen. The next day a laparotomy was done, the incision being made three inches to the left of the linea alba. The head of the child was found adherent to the mother's

colon. The child's third finger was strangulated by the omentum. The cord was tied, but very free hemorrhage set in, controlled as far as possible by packing the cavity with cyanide gauze, and by the application of forceps. The child died during the operation; the mother two hours afterwards. The placenta was attached to the anterior abdominal wall; its posterior attachment could not be made out. The child was free in the abdominal cavity, as shown by the adhesions to bowel and omentum. There was nothing to show a ruptured tube.

Dr. Atherton asked if the child in the abdomen was as well developed and of the same apparent age as the uterine one. Would it not have been better to have deferred the operation until the woman had recovered from confinement?

Dr. Peters asked if there was any hemorrhage at the point of attachment of the head. It was impossible to conceive of a case in which the oval membranes were entirely absent. They might have been so atrophied as to easily escape discovery.

Dr. Cameron said that there is a succession of formation and disappearance of these membranes, but they give way, and are scarcely to be found at the time of operation. As to the time of operation, the danger from septic infection perhaps counterbalances the danger from exhaustion due to labor. The placenta certainly should not be meddled with unless one can certainly control the hemorrhage. The site of the placenta will, of course, settle this. To both tan and disinfect by dusting in tannic acid and salicylic acid is the best way to treat the retained placenta. Spiegelberg reports twelve cases of abdominal pregnancy, so that such a pregnancy is possible. He asked whether the pains of the extra-uterine labor had ceased. From the history it was evident that these had occurred, and, no doubt, occurred when the amniotic membranes ruptured.

Dr. H. A. Machell asked whether there had not been some signs of rupture of the tube during the second, third, or fourth month; viz., colicky pains; hemorrhage for a few days.

Dr. Macdonald thought this a case of tubal gestation which had ruptured into the broad ligament and then into the abdominal cavity.

Dr. Strathy said that he had been unable to

obtain an autopsy. The children were of full term, and of equal development. There were no granulations on the head; hair was growing on the part of the head attached to the bowel. The finger was, with a sponge, easily separated from the omentum. The child's lower jaw was elongated, probably by pressure. About the twelfth week the woman did lose blood, and thought she had had a miscarriage.

TRANSACTIONS OF THE FOURTH ANNUAL MEETING OF THE AMERICAN ASSOCIATION OF OBSTETRICIANS AND GYNECOLOGISTS.

Held in New York City, September 17th, 18th, and 19th, 1891, at the Academy of Medicine.

(Abstract; continued from page 533.)

SECOND DAY—MORNING SESSION.

The President, Dr. A. H. Wright, of Toronto, in the chair.

Dr. M. B. Ward, of Topeka, Kan., spoke on

REMOVAL OF THE UTERINE APPENDAGES, WITH RESULTS.

He prefaced the report of his cases by saying that operation for removal of uterine appendages is truly missionary work in Kansas. He performed the second operation of this character done in the State, February, 1890.

He then made a brief report of fifteen cases, in which he gave a history of the patient before the operation, the character of the operation, and the results at the time of writing the paper.

Three deaths were recorded, his first, third, and eleventh cases terminating fatally. Only one of the three was caused by the operation, and in that case the previous condition was deplorable. The reports of the cases were interesting and the results gratifying. Some of the conditions were extremely grave before the operation, and yet recovery in most of the cases was satisfactory.

Dr. Joseph Price, of Philadelphia.—We all know how satisfactory the results have been of late with this class of cases in dispensary and in public practice. We also know how distressing the results have been among the more wealthy, where harm follows from the delay due to treatment by rest and every other known method before resorting to radical measures.

Our mortality among the rich varies between six and ten per cent. higher than among the poor, and there is no excuse for such a difference. A pus tube, an abscess in the pelvis, a pus accumulation in the axilla, under the deep tissue anywhere, should be removed. The treatment is precisely the same. Good surgeons throughout the world will trephine for an accumulation of pus not larger than a hazel nut. Surely, if it holds good in brain surgery, it should hold good in pelvic accumulations. Again, just this state of affairs is common

in all branches of abdominal surgery. It is so with gall stones, hepatic accumulations. It is so notwithstanding we have had many years of special pleading, many voices crying in the wilderness—such men as Bantock, Keith, Tait, Thornton, and others, pleading specially for early ovariectomy. We find large numbers of neglected cystomata, and the mortality remains higher than it should in that class of cases.

Dr. E. W. Cushing, of Boston, said he appreciated and believed every word that Dr. Price had uttered. The bad cases that he had seen were the ones that had been neglected; early operations had done well. Allowance must be made for the position of a man with his elders against him. It is dangerous for one to get too far ahead of the sentiment of the community. The weight of the teaching and the intent of every operator, as far as he can carry his people along with him, should be to operate early.

Dr. Mordecai Price, of Philadelphia, thought many of the delays were attributable to the cowardice of the surgeon. We all should know that when we approach a question where a life is involved we should boldly consider every side, even though, if we operate and the life is lost, the community say that it was the operation. If we refuse to operate and death comes, we feel and know that it was but a consequence of our own cowardice. It is our business to go to these cases, and when we discover that pus exists to remove it, and the sooner the better.

Dr. Joseph Price, of Philadelphia, said that gonorrhoea is unquestionably responsible for a majority of these cases. Gonorrhoea is no longer treated by intelligent physicians. Every drug store in the land is a clap shop, probably as well in Boston as Philadelphia. It is a neglected disease. The sequelae, in the male as well as in the female, are very much more marked than they were several years ago when the disease was treated by the educated physician.

Dr. C. A. L. Reed, of Cincinnati, extended his congratulations to Dr. Ward for his good paper, which is certainly to be recognized as pioneer work in the great State of which he is a citizen. He was impressed with the idea that gonorrhoea in woman is a very serious affair. It progressively invades the mucous tract, climbing the vaginal wall, climbing the endometrium, invading the sanctum sanctorum of the female anatomy, and producing its most serious ravages upon the uterine appendages.

Dr. Ward, closing the discussion, thanked the Fellows for their kind compliments. In the West it is extremely difficult to get consent to perform these operations except as a last resort.

Dr. Joseph Price, of Philadelphia, read a paper upon

A CONSIDERATION OF EMMET'S LAST OPERATION FOR SO-CALLED LACERATION OF THE PERINEUM, OR PROLAPSE OF THE POSTERIOR WALL OF THE VAGINA FROM LOSS OF FASCIAL SUPPORT, OR MUSCULAR RELAXATION, OR TEAR.

At the meeting of the American Gynecological Society in 1883, when Dr. T. A. Emmet presented his paper on the "Etiology of Perineal Laceration, with a new method of Operation for its Repair," it was evident, in the words of an eminent gynecologist

logist, that the members of the society were very much at a loss to comprehend the steps of the operation as described by its illustrious originator. It is still not understood generally in Philadelphia, while at the present time we rarely hear of any one's performing the true Emmet operation unless it has been improved by some supposed modification. These modifications are for the most part meretricious. The Emmet operation seems to fulfil every indication for the restoration of the damaged perineum, far better than any other operation before or since devised, not excepting the so-called flap-spitting or Tait's operation, over which so much furor has lately been raised. The value of the operation has not been recognized because the published reports of it have been so meagre and so little descriptive, excepting some explanations of modifications, that the very idea of the operation has not been grasped except by those who, like the writer, have been fortunate enough to have Emmet personally demonstrate the operation and its advantages. Unfortunately, his original pamphlet was rather confusing than instructive and explanatory to those not already comprehending the operation. A drawing was necessary for the exact understanding of the successive steps of the operation. In several cases in which Emmet's operation was performed the writer had the assistance of Dr. J. Madison Taylor, who has sketched the appearance of the various stages. The theory of the mechanism of laceration is original with Emmet. He believes that the damage that leads to the severe consequences of loss of support to the pelvic diaphragm is principally in the deep layers of the pelvic fasciæ, a separation of the fibres of those fasciæ from the outlet of the vagina. The soft parts of the vagina are crowded up in advance as the fetal head passes. When the head of the child is forced down upon the so-called perineal body, the perineal tissues are stretched transversely before the head appears at all at the vaginal outlet. The so-called perineal body is attached principally at the two rami of the ischia through the strong and almost inelastic ischio-perineal fascia. When the head, following the sacral curves, crowds down the vaginal tissues before it, it meets its almost entire resistance from a lack of extensibility in these ligaments. If the force is severe enough they will separate, not by a tear from the fourchette downward, but by a separation of those fibres within the mucous membrane from their insertion without and below the vaginal orifice. It is the pelvic fascia that supports the vagina, and this fascia is often separated from its attachment to the vagina, or latterly from one or both rami at the passage of the head during parturition. The tear at the orifice of the vagina is of infinitely less importance than is the rupture of the ischio-perineal fascia. These fasciæ preserve the proper resilience of the floor of the pelvis. This removed, the anterior and posterior walls of the vagina have lost their support, and they must prolapse through the now weakened vaginal ring. It is well known that rectocele occurs constantly in patients in whom the fourchette has not been torn. A vagino-perineal laceration may pass around the sphincter ani. It is easily shown that the perineum is a thin diaphragm, not a body of firm fascia, muscle, or connective tissue. The rupture, which may or may not have been submucous,

is not in the median line, but has been more severe on one side than on the other. In Emmet's expressive illustration, the bag has lost its puckering-string. The prolapse is evidently due to a want of resisting power of the pelvic floor. Other operations have been previously devised to meet the same indications, such as those of Simon, Hegar, Hildebrandt, Freund, Bantock, Baker Brown, and Emmet's trefoil operation. Some of these restored the perineum so that it was even longer than before, but failed in its real intention, since little by little the rectocele again prolapsed through the narrowed outlet to its original condition. A great advance was made when the denudation was extended so as to include a portion of the rectocele and so restore by cicatricial healing the perineal body. The results were frequently anything but happy. The old operations aimed to replace the perineal body by a new structure built from the adjacent parts; but when a perineum is lacerated it is not destroyed. If we can bring together the ends of the ruptured ischio-perineal ligaments, we will absolutely restore the supporting power of the perineum. Emmet's last operation aims at removing the superfluous vaginal mucous membrane at the vulvo-vaginal orifice, continuing at the same time the denudation along the line of the original rupture. As this line extends usually along the two sulci, the denudation assumes rudely the form of a crescent, whose convexity is the boundary of skin and mucous membrane of the vulva, while the concavity is marked by the summit of the projecting rectocele, and the cusps extend up the lateral deep sulci and posterior wall of the vagina. Finally he introduces sutures entirely within the vagina, beginning at the apex of a cusp, and closing by bringing the two denuded edges of the cusp or sulcus together. After the insertion of the crown stitch, one or more superficial stitches are sometimes necessary, according as there has been greater or less laceration. The essential landmarks of the operation—to wit, the crest of the rectocele or its most projecting part, and the lateral mucous membrane at the highest point to which it is intended to carry the denudation—are not to be lost sight of or changed as the operation proceeds. After the sulci have been closed, when the crown stitch is introduced, the inside stitches entirely disappear. The after treatment is simple—rest, catheterization if necessary. The bowels are to be kept easily open. The writer has yet to see the slightest inflammation—cellulitis or phlebitis—from the operation. The stitches are removed at the end of six or ten days, except those in the sulci. These latter are removed in the second week. This is best done by partially everting the vagina by a finger introduced into the rectum.

This operation most nearly approximates the natural perineum. The great degree of success attending the operation is alone sufficient to recommend it primarily in all lesions of the perineum.

Dr. L. S. McMurtry, of Louisville, thought the importance of the subject increased by the great number of cases there are of perineal rupture coming up daily in the practice of gynecologists, and the large amount of imperfect work that is done in this branch of surgery, and the incongruous advice that is given to patients upon this subject. The general surgeon does a good deal of this work,

and it is very often the case that the skin only is united, and in all probability the skin is attached away up the vulvo-vaginal fissure, higher than it was in the natural condition; and in many instances the physician, finding that the fourchette is not torn, assures the woman that her symptoms are due to nervous exhaustion and that there is no laceration of the perineum. It has been demonstrated this morning that you may sew together the skin without restoring the pelvic floor, and you may have the pelvic floor entirely destroyed without any rupture of the skin externally. Those are points which have been emphasized in the paper, which are not appreciated generally by the profession in regard to these injuries. The great difficulty in regard to the popularity of Emmet's improved operation for restoring the pelvic diaphragm is that it is difficult to clearly appreciate the operation without seeing it executed, and that it is very difficult to do the operation without giving it thorough consideration.

Dr. W. H. Wathen, of Louisville, thought Dr. Price had made an important subject unusually interesting because of the practical manner in which he had presented it, and because of the vast experience he had had in doing successful work in this department of surgery, which makes all he says practical. In the main, he fully agreed with him in his ideas and in his suggestions as to the proper means of operating. In operations where the tissues are torn down near the sphincter, with the anterior rectal wall presenting down in the vagina, he was practically in accord with the suggestions of Dr. Price, excepting that the procedure might be simplified by splitting the tissues between the rectum and the vagina latterly instead of denuding the mucous membrane. The splitting process can be accomplished by an experienced operator in less than half the time of the denuding process, and with not less than half the inconvenience from hemorrhage. The cardinal principle which should control us in this operation is to expose the ends of the torn muscles and the ends of the torn fascia, superficial, middle, and deep, and a failure to expose all these so that they may be brought together and held in that position necessarily results in a corresponding failure in the result of the operation.

We ought to impress upon the general practitioner and the general surgeon, as well as the specialist, the importance of attending to these cases wherever they are met, but, above all, we ought to impress upon the profession the necessity of attending to these cases when they occur. There is no operation of any magnitude in the whole range of gynecic surgery that has the element of simplicity so perfect and the universal results so attractive as the operation for complete or incomplete laceration of the perineum, if done immediately after the accident has occurred.

Dr. J. F. W. Ross, of Toronto, believed that the denudation of the tissues outside is superfluous, but is necessary in the vagina, and that we can combine the operation of denudation in the vagina with flap-splitting in the perineum, exactly as Dr. Wathen had said.

Dr. Mordecai Price, of Philadelphia, spoke strongly in favor of the Emmet operation. He believed with Dr. Wathen that we have no business to know anything about secondary perineal work. It ought to be the business of the physician to have

his materials with him, even if the case is a simple one, because accidents will occur in the best regulated households in that particular; and it ought to be his business to at once apply his sutures, because union is almost invariably by first intention in these primary operations, and there is no better way than to use the silk-worm-gut sutures, passing them as Dr. Emmet recommends. The tear in nine cases out of ten is in the right or left sulcus.

Dr. H. T. Hanks, of New York, said he had been associated more or less intimately with Dr. Emmet in the Woman's Hospital for the last thirteen years, and had watched the development of the operation. He had been pleased to have the subject brought up for that very reason, because he has not only done good work in teaching us how to operate on a lacerated cervix, but has also given us some points on the operation on the perineum that we had not considered before, and which, when carried out to the letter as he has taught us, and as those of you who have seen him operate have been taught, give entirely satisfactory results. He believed the operation to be a successful one when well done and done as Dr. Emmet had taught.

Dr. Joseph Price, of Philadelphia, closing the discussion, said: Some of us do the operation perhaps a little more than Dr. Emmet does—just a little more—but it all belongs to him. He taught us how to denude and everything that is good in plastic surgery. Some of us go a little further than Dr. Emmet. Dr. Hanks has made a perfect illustration of Dr. Emmet's operation. Many of us differ in this particular. Dr. Emmet does not go as high in the sulci as some of his pupils with the denuding. Dr. Emmet makes a triangle with a tenaculum; we make it with a denudation, and go into the apex of that sulcus. We give the woman as much pelvic floor as possible. There are very serious doubts as to whether a flap-splitting operation ever restores a sphincter. I have yet to see the first one, and know at least half a dozen women in Philadelphia who have had the flap-splitting operation. They have incontinence of gas and feces when they have a diarrhoea. I have seen men do it and absolutely miss, in their denudation and everything else, the dimples of the retracted sphincter, or half-moon. There are very few men in this country that can map out the sphincter in a perineal tear through the sphincter. Dr. Emmet, if you will follow him, will place his fingers on the sphincter and make you trace a hard, iron-like sphincter all the way round. He again has taught us all we know about sphincter tears that is worth knowing. Emmet's inside perineal operation with the sulci sutures closed is an operation which completes the woman's comfort. He need not put in those inside sutures, as far as the perfection of the operation and the comfort of the patient are concerned. The operation is complete when he completes his sulci work.

The President then delivered his annual address (See page 494).

Dr. W. W. Seymour, of Troy, read a paper on

A CASE OF CHOLECYSTOTOMY AND CHOLELITHOTRITY; DEATH FROM "LA GRIPPE" THE TWENTY-FIRST DAY.

The gall bladder was incised and fine stones removed from it, and one stone in the common duct crushed by forceps applied to the duct. The crush-

ing was done because the wound was so deep that the difficulties in the way of an exact suture of the duct in case of excision of the stone were enormous. At the autopsy, when death resulted from an intercurrent attack of grippe, the abdominal wound, save at the drainage opening, was firmly united, the adhesion of the gall bladder perfect, and there was not the slightest evidence of suppuration, inflammation, or ecchymoses, in or about any abdominal organ. The inferences drawn were: (1) That in large, fat, and flabby bellies crushing is safer than excision with its risk of imperfect suture. (2) That excision should only be a method of election where an exact suture is beyond question. (3) That if there is any suspicion of injury to the duct, drainage should be inserted to the suspected point, and, if needed, the abdominal cavity protected by gauze tampons. (4) That in case of stones projecting into or overlying the duodenum, the duodenum may be incised and the stone, if projecting, broken up, or the duodenal portion incised and the stone crushed or delivered intact, as Dr. Charles McBurney has recently successfully done with a stone as large as a pigeon's egg.

Dr. A. Vander Veer, of Albany, read a paper entitled

REPORT OF CASES OF CHOLECYSTOTOMY, WITH
SPECIAL REFERENCE TO THE TREAT-
MENT OF CALCULUS LOEING
IN THE COMMON DUCT.

He said: In presenting this paper as a contribution to the surgery of the gall ducts, I shall refer somewhat to the surgery of the gall bladder. Yet my chief desire is to get from you a discussion and your views regarding a line of treatment in cases where we find a contracted and perhaps almost obliterated gall bladder, or where the common, cystic, or hepatic ducts are entirely closed by lodgment of a calculus, or stenosis from other causes. He then presented a group of three cases illustrating these points, in which he had operated twice successfully, and exhibited specimens removed in each. From his experience in these and other cases he offered the following: This operation is not very difficult, and the results favorable beyond a doubt; but does not this method deter us in some cases from pushing ahead and relieving cases where practically no gall bladder is to be found? Are we not too conservative at times where we have stenosis, severe adhesions, and apparently no gall bladder present?

The intent of this paper is to deal only with those cases where there is an obstruction of the ductus communis choledochus, the cystic or hepatic ducts, from any cause whatever. Cholecystotomy, with suture of bladder walls to parietal wound, when the viscus is fairly well developed, is not a serious operation. Primary and secondary opening of the gall bladder I mention here to emphasize the fact that I believe the latter is always to be condemned, for the following reasons:

1. It is always necessary, before the closure of the abdominal wound, that the gall bladder be opened and emptied, as it is often impossible to recognize conditions until then which will require manipulations, not only within the gall bladder, but also within the abdomen.

2. Prolonged obstruction in the intestinal portion of the common duct may lead to its dilatation, together with that of the gall bladder, and the destruc-

tion of anatomical outlines. Biliary calculi lying in the common duct, in the hepatic or at the mouth of the cystic duct; stricture of the ducts from local ulceration (exceedingly rare), or occlusion of them from external causes, as cancer of the pylorus or the last portion of the pancreatic duct, all require treatment for relief beyond either cholecystotomy or cholecystectomy.

I believe it is possible to freely loosen adhesions that have formed in the region of the gall bladder, and in all cases of severe traumatism we should not hesitate to make use of the tamponade of iodoform gauze and drainage, or employ the method so clearly recommended by one of our Fellows, Dr. Morris.

Dr. H. O. Marcy's paper on "Relief for Biliary Obstruction" defines the steps of the operation very closely, particularly in relation to suturing of the incision made in the gall duct. The operative technique may be varied as follows, by:

1. Dislocation of the calculus *en masse*, either into the duodenum or into the gall bladder.

2. Cholelithotripsy, either by crushing through the walls of the duct with padded forceps or fingers, or from within the gall bladder by means of the needle or fine probe, followed by removal by way of the gall bladder or intestinal canal.

3. Breaking of the calculus by the introduction of strong needles through the walls of the duct, and subsequent dislodgment of the fragments.

4. Cholecystenterostomy according to Von Winwarter, or modifications of it as have been suggested by Gaston in his elaborate experiments upon dogs.

5. Incision of the gall duct and removal of the calculus, with subsequent suturing of the incision in the duct.

The application of these methods conflicts with some notions in surgery which, to my mind, are altogether fallacious. The first is that sutures can never be applied to the gall bladder and ducts with safety. The first cholecystotomy was followed by suture and recovery.

The second notion is that the healthy biliary secretion always causes peritonitis when free in the abdominal cavity. The experience of Schuppel, Bostrom; the cases of Paraisse, Sabatier, Thiersch, etc., demonstrate the falsity of this dogma.

We must put these fallacious ideas behind us, as we have many concerning the technique and management of abdominal section. I believe in a wholesome fear of the peritoneum and of throwing around our patients every possible safeguard. I should not like to complete an operation knowing that bile might flow over the intestines, but I believe that such wounds, by proper drainage and iodoform gauze tamponade, can be made comparatively safe for the patient, much safer than the condition for which the operation was done.

Those cases which present the least difficulties are where the calculus can be removed *en masse* by pushing either into the gall bladder after cholecystotomy (preferable) or into the duodenum. The danger of tearing the duct across its diameter, as has already occurred, must be kept in mind, and will somewhat circumscribe the operation of fracture or incision and removal from the intestine.

The second procedure, together with the third, may be employed in suitable cases, but the choice will lie between them and the fifth procedure, that is, incision and removal.

The fourth method of treatment, by establishing a new communication between the biliary ducts and the intestine, must always have a certain utility, especially where it is found that the seat of obstruction (the common duct) is bound down by adhesions and cannot be made accessible.

To one doing abdominal work, I would advise a careful perusal of Dr. Gaston's paper in *The Atlanta Medical and Surgical Journal* in 1884, entitled "Experimental Cholecystotomy."

In France the operation bearing the name of Von Winiwarter has recently received much attention, and flattering results are reported.

Under the fifth division—that is, incision and suture of the gall ducts—we have, I believe, in many cases a method which promises great success, where heretofore cases have been treated by establishment of biliary fistula, which only relieved for a short time. So far as I have been able to learn, incision of the common duct has been seldom performed in this country. The technique of the operation is as follows: Usual vertical incision from tip of cartilage of tenth rib, made of sufficient length to permit free examination. It may be necessary to complete the operation by making a transverse incision through the right rectus abdominalis. Incision over stone, in line of duct, is made. Fluid behind duct should be withdrawn by aspirator, or sponges placed to protect surrounding parts. First row of sutures continuous, introduced just within serous coat of duct, brought just within the mucous coat, but not involving it; second series Lembert, bringing the serous coat into accurate apposition. Surround drainage tube on all sides with iodoform gauze tamponade, the ends being left in abdominal wound, closing latter with silkworm gut. One or two silkworm gut sutures may be introduced and tied in loop, so that after removal of tamponade they may be tied and abdominal wound more completely closed.

Dr. R. T. Morris, of New York.—There is one method of procedure, in cases of gall stones, so simple that I wonder that anybody has failed to think of it. Gall stones can be dissolved very easily by chloroform, ether, and some of the marsh-gas series. We do not need any forceps. We can remove the greatest element of danger by dissolving them right in place. The operation consists in suturing the gall bladder to the abdominal wall, then waiting for forty-eight hours until adhesion has taken place. The cases of greatest danger after operation are those followed by leakage of bile or mucus or the fermenting contents from the gall bladder into the abdominal cavity. Therefore the ideal procedure consists in first suturing the gall bladder to the abdominal wall, waiting until adhesion takes place, opening the gall bladder, and with a syringe injecting down upon the gall stones, at any time you please, a week or a day or a month after, a chemical that will make a solution of the cholesterin quickly and safely without imposing the grave danger upon the patient of crushing, bruising, or injuring the common duct. I am making experiments in this line to find some non-irritating solution which will dissolve the gall stones easily.

Dr. L. S. Pilcher, of Brooklyn, recognized the fact, as all surgeons do, that the gall bladder has become a fit subject for surgical interference, and that, with the rapidly increasing experience which is being gained in work upon that organ, we shall

soon have well-established indications for not only examining the organ, but also for the different classes of operations which we shall be called upon to do for the relief of the conditions which we find present in it. The ideal cholecystotomy, in which the organ is exposed, is opened, is evacuated, is closed and dropped back into the abdominal cavity, suggests itself as an operation extremely desirable to be done, if the conditions are such as to make it feasible to do it. The extirpation of the gall bladder has been done, and will at times be found necessary if we are to relieve the conditions which have made operation of any kind necessary. The difficulties which attend the operation are great, and it can only be rarely that a surgeon will feel justified in undertaking its accomplishment. The opening of the common duct and the removal therefrom of a gall stone have been described to us this afternoon. The successful performance of the operation has again and again been demonstrated to us. The possibilities of relief which are open by means of that should always be present in the mind of the surgeon. He then presented and discussed some specimens of gall stones.

Dr. Kellogg, of Battle Creek, reported a number of interesting cases of operation upon the gall bladder.

Dr. M. B. Ward, of Topeka, stated that he had done the operation twice on a dog, removing the gall bladder entirely. His first operation was a failure, death occurring from general peritonitis on account of some defect in the operation. The next dog got well and very fat, and was subjected to three other operations on the intestines. He inquired whether the gentlemen found it easy to bring the gall bladder up and attach it to the parietes. He found it difficult unless the gall bladder was enlarged.

Dr. Seymour, closing the discussion on his part, said, with regard to the attachment of the gall bladder to the abdominal wound, the method pursued by Mr. Tait is very satisfactory, particularly in cases of contracted gall bladder. That is, not to attempt to bring the gall bladder up to the level of the skin, but to suture the gall bladder with an interrupted buried silk suture at an intervening height in those tissues, taking a sufficient number of interrupted sutures to give strong and firm coaptation of the structures. He considered the matter of dissolving gall stones within the gall bladder as still *sub judice*. In view of that, the operation of Tait—opening the gall bladder with establishment of a fistula—is the most rational operation. He considered it very possible that there would be a recurrence of the disease with the persistence of the constitutional condition. He considered the silk suture preferable in this operation to any of the animal sutures.

Dr. Vander Veer, closing the discussion on his part, said that, in reference to attaching the gall bladder to the parietes, he would only add this, that before the gall bladder is attached to the incision, and before it is opened, we should make a very careful examination of the common duct and be very certain as to the condition of the pancreas.—*American Journal of Obstetrics*.

(To be continued).

DR. W. H. B. ATKINS has been appointed Associate-Coroner for the City of Toronto.

Book Reviews.

International Clinics. A quarterly of clinical lectures on medicine, surgery, gynecology, pediatrics, neurol gy, dermatology, laryngology, ophthalmology, and otology. By professors and lecturers in the leading medical colleges of the United States, Great Britain, and Canada; edited by John M. Keating, M.D., and J. P. Crozier Griffith, M.D., of Philadelphia, and Drs. Mitchell Bruce and David Finlay, of London. July, 1891. Philadelphia: J. B. Lippincott Co.

The second volume of this valuable work contains its full complement of excellent clinical lectures. The first chapter is a biological sketch of Dr. Joseph Leidy, who was one of the most highly honored of American scientists. Next comes a lecture in two cases of ulcerative endocarditis by Dr. Pepper, of Philadelphia, which is very interesting and well illustrated. Then follow lectures on general false ankylosis, treatment of typhoid fever, nephritis, angina pectoris, chronic diffuse nephritis, asthma, indigestion, lead colic, hernia in groin, stricture of urethra, tubercular disease of the skull, stab wound of the chest, scirrhus of the breast, sarcoma of the thyroid, litholapaxy, weeping sinew, rapid dilatation of urethra for stricture, ovarian and tubal diseases, management of labor, endometritis, uterine myomata, displacements of uterus, myoma complicating pregnancy, removal of tubes and ovaries, tabes, and many others, by Drs. Bridge, Wilson, Peabody, Sansom, Tyson, Mays, Nathan Davis, Andus, Tiffany, Simes, Roswell Park, Conner, Ashhurst, Bryant, Deaver, Gerster, Sturgis, Reamy, Palmer, Gill, Wylie, Montgomery, Grandin, Munde, Skene, etc. Dr. Skene, in his valuable lecture on the removal of tubes and ovaries, honors Dr. Jas. F. W. Ross, of Toronto, by referring to him as "one of the best British authorities living, one of the very best of the age." The lectures, taken as a whole, are quite up to the standard of the first volume, to which it was our pleasure to refer in a former issue in highly commendatory terms.

A Practical Treatise on the Diseases of Women.
By T. Gaillard Thomas, M.D., LL.D., Emeritus Professor of Diseases of Women in the

College of Physicians and Surgeons, N.Y., and Paul F. Munde, M.D., Professor of Gynecology in the New York Polyclinic. New (sixth) edition, thoroughly revised and rewritten by Dr. Munde. In one large and handsome octavo volume of 824 pages, with 347 illustrations. Cloth, \$5.00: leather, \$6.00. Philadelphia: Lea Brothers & Co., Publishers. 1891.

The early editions of Thomas' book were probably more popular than any of the text books on gynecology which were contemporaneous with them. Ten years, however, forms a long era in modern gynecology, and the fifth edition, having been published in 1881, was old enough to have nearly outlived its usefulness, even though it contained much that was good and much that will never grow too old to be well worth reading. This sixth edition retains all that is valuable in the former book, with sufficient changes and new matter to include ample information respecting all the advances of recent years. The choice of Dr. Munde to revise and rewrite a large portion of the work was a very fortunate one. He is well known as an able teacher and writer on this subject, and he possesses a large amount of good judgment, which has enabled him to separate the chaff from the wheat in things gynecological. We can confidently recommend the book as an admirable one in all respects.

Personal.

DR. LAFFERTY, of Calgary, N.W.T., was in Toronto, on November 6.

DR. OSLER, of Baltimore, paid Toronto a short visit in November.

DR. T. E. BENNETT (Toronto, '91) is practising in Rocklyn, eleven miles from Meaford.

DR. J. F. W. ROSS, of Toronto, attended the meeting of the Southern Surgical and Gynecological Association, as an invited guest, in November, and read a paper, which will appear in our next issue.

Therapeutic Notes.

TREATMENT OF TYPHOID FEVER.—M. Hayem (*Concours Médical*) gives, in one of his lessons on therapeutics, a new method of treatment of typhoid fever, which he has used with excellent results for several years. It consists in the exhibition of lactic acid as an intestinal disinfectant, and as a means of controlling the diarrhœa. He rejects all internal antipyretics, but reserves the use of baths. Lactic acid, with or without baths, according to the indications, is the regular treatment followed by M. Hayem. He prescribes the acid in the form of lemonade:

℞ Acidi lactici 15.0–25.0 grms. (ʒiv-vj).
Syrupi simplicis 200.0 grms. (ʒviss).
Aquæ 800.0 grms. (ʒxxvij)—M.

Sig.: To be taken in the course of twenty-four hours.

If there is gastric intolerance, the lemonade may be diluted with seltzer water.

In slight cases, M. Hayem prescribes 15 grammes (ʒiv) of lactic acid daily. When the evening temperature reaches 40° C. (104° F.), the dose is increased to 20 grammes (ʒv). In grave cases, with hyperpyrexia, 20 to 25 grammes (ʒv to vj) of lactic acid are given with cold baths (20° C.—68° F.), or baths in water gradually made cold. Brandy is given if adynamia is present. When the fever declines the daily dose of lactic acid is gradually diminished, but is given in daily doses of 5 grammes (gr. lxxv) even during the first days of convalescence.—*Journal d'Accouchements*.—*Satellite*.

A TREATMENT FOR THE LARYNGITIS OF SINGERS (M. Faulkner).—This treatment according to the author, is intended for the acute laryngitis of persons who fatigue their voice.

A purgative is administered, we then use inhalations of cocaine, spray 1 per 100, and give internally a mixture of ammonia and tincture of aconite.

From time to time the patient should make use of the following pastille:—

℞. Morphine $\frac{1}{60}$ grain.
Hydrochlorate of cocaine $\frac{1}{60}$ "
Tincture of aconite . . . 3 drops.
Powdered althæa . . . 4 grains.
Sugar, q. s.

For one pastille.

When the acute symptoms have subsided, we prescribe strychnine, in doses of $\frac{1}{120}$ grain, before meals. The author even repeats this dose at the time that the actor enters *en scene*. The action of the strychnine is efficacious, nevertheless we can understand that this medicament should be used with caution.—*La Méd. Moderne*.—*Times and Register*.

SCHMIEDEN has found diuretin useless in the dropsy of cirrhosis of the liver, and in tubercular peritonitis. In valvular heart disease and in arterio-sclerosis it proved itself a very useful diuretic, increasing not only the water, but also the solids of the urine. It may possibly cause vomiting. In two cases of nephritis, hematuria occurred. In a not inconsiderable number of cases, there was observed increased frequency of the pulse, with a tendency to irregularity; this should cause discontinuance of the drug.—*Centrbl. f. Med. Wissenschaft*, 1891.

DR. E. L. KEYES, of New York, says, in *Jour. Cutaneous and Genito-Urinary Diseases*, that he now uses diuretin in every case of urethral or bladder operation. He gives 60 grains of salol a day for forty-eight hours before operating, and on the day of the operation begins giving 10 grains of diuretin every four hours, continuing it for forty-eight hours. Since using the diuretin he has never seen a chill or suppression of urine following an operation.

MATTISON, in the *St Louis Medical and Surgical Journal*, recommends cannabis indica for the opium, chloral, and cocaine habit. Failure with hemp is largely due to inferior preparations. It should never be called inert till full trial with an active product proves it. Another cause of failure is too timid giving. For many people small doses are stimulant and exciting, large ones sedative and quieting.

DEODORIZATION OF IODOFORM BY CREOLIN.—A patient, suffering from a bone-felon, applied for treatment to Dr. L. Vazci (*Rundschau*, May, 1891), who wrote for a salve consisting of iodoform, two parts; creolin, one part; vaselin, twenty-five parts.

On visiting the patient the next day, there was not the slightest odor of iodoform.—*Virginia Medical Monthly*.

FORMULA FOR WHOOPING COUGH.—Talamon, in the *Méd. Moderne*, gives the following formula for whooping cough:—

R. Terpini hydrati . . .	grammes	1.0-1.5
Antipyrini . . .	gramme	1.0
Syr. aurant cork . . .	grammes	50.0
Aquæ Tiliæ . . .	grammes	60.0

M. et Sig.: One-half to one teaspoonful frequently during the day for a child from one to four years of age.—*Archives of Gynecology*.

FORMULA FOR THE TREATMENT OF UNCONTROLLABLE VOMITING OR GASTRALGIA:—

R. Cocaine	0.10
Antipyrin	1.00
Aq. Destil.	90.00

D.S.: A teaspoonful every one-half to one hour.—*Medical Review*.

TO RELIEVE NAUSEA AND VOMITING.—A writer in the *Therapeutic Gazette* states that a mixture of 1 part of menthol, 20 parts of alcohol, and 30 parts of simple syrup, will relieve nausea and vomiting—sometimes even the obstinate vomiting of pregnancy—if given in teaspoonful doses every hour.—*Archives of Gynecology*.

Miscellaneous.

THE next meeting of the Medical Society of the State of New York will be held at Albany, February 2, 3, and 4, 1892. Dr. Seneca D. Powell, No. 12 West 40th Street, New York, Dr. James D. Spencer, of Watertown, and Dr. Franklin Townsend, No. 2 Park Place, Albany, have been appointed the Business Committee. Any communications regarding papers or any matter pertaining to the business of the Society which should properly come before the Business Committee, should be addressed to Dr. Seneca D. Powell, 12 West 40th Street, New York City.

THE Mississippi Valley Medical Association held its seventeenth annual session at St. Louis, October 14, 15, and 16, 1891, President, Dr. C. H. Hughes, of St. Louis, in the chair. Dr. C. A. L. Reed, of Cincinnati, was elected President; Dr. E. S. McKee, of Cincinnati, re-elected Secretary; Dr. C. S. Bond, of Richmond, Ind., and Dr. J. H. Stucky, of Louisville, Vice-Presidents; Dr. Joseph Ransohoff, of Cincinnati, Chairman of the Committee of Arrangements. The next meeting is to be held in Cincinnati, October, 1892.

THE AMERICAN GYNECOLOGICAL JOURNAL.—The journal, formerly known as the *Journal of Gynecology*, is now published under the name of the *American Gynecological Journal*, with Dr. Charles N. Smith as editor, and an able staff of associate-editors. It is devoted entirely to gynecology, obstetrics, and abdominal surgery, and, although only a few months in existence, shows promise of marked success.

EXCISION OF PART OF THE RIGHT LOBE OF LIVER.—Dr. W. W. Keen, of Philadelphia, removed, October 9, from a patient a considerable portion of the right lobe of the liver for the excision of a cystic tumor, the mass removed being about two-thirds the size of a man's fist. According to the latest reports (*Med. News*) the patient was doing well and was expected to recover.

AN enterprising lady has been making investigations upon the question of matrimony in regard to her sex. She finds that the highest marriage rate is among trained nurses, and impartial observation would rather tend to support the statement that this is the best field for matrimony which the fair sex enjoys.—*Birmingham Med. Review*.

DANGER OF DOMESTIC PETS.—A French scientist says that domestic pets carry at least thirty per cent. of the contagious diseases from house to house. Probably dogs and cats carry the most.

EMPTYING A DISTENDED BLADDER.—Complete emptying of a distended bladder exposes the patient to the danger of vesical hemorrhage. Stop when the urine ceases to escape in a jet.

ARSENIC IN OLD PEOPLE.—Mr. Jonathan Hutchinson, of London, England, has a poor opinion of the administration of arsenic for skin disease in elderly persons and seldom prescribes it for such.

It is reported that the Chambers Street Hospital in New York will be rebuilt and enlarged.

A FACULTY OF MEDICINE is about to be established in Constantinople.