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CANADA

MEDICAL JOURNAL.

ORIGINAL COMMUNICATIONS.

Notes of a case of Diabetes Mellitus admitted into the Montreal General Hospital under the care of DR. D. C. MACCALLUM. Reported by G. C. BUTLER, M.D.

James Boroughs, æt. 40, married, a native of Ireland, was admitted into the Montreal General Hospital on the 5th of December, 1864, and placed under the care of Dr. MacCallum.

He is quite emaciated, stands about five feet nine inches, and weighs about 130 lbs., though he says he has weighed 170 lbs.; his countenance is vacant; he has a habit of imperfectly articulating his words; his hearing is a little obtuse and his memory not very reliable. He has resided in Canada since his boyhood, and, for the last ten years has followed the occupation of a sawyer. His father and mother died some years ago, the former of ship-fever and latter of liver complaint, both having previously enjoyed good health.

He always enjoyed good health until about nine years ago, he suffered from a severe attack of typhus or typhoid fever, which lasted for a long time, followed by a slow and tedious convalescence. Having completely recovered, he again enjoyed excellent health till about two and a half years ago. At this time he observed himself to be growing thin and paler; about this time also, or soon after, he noticed that he had more frequent calls to micturate, and that he passed larger quantities of urine.

This condition continued, gradually becoming more and more aggravated until the date of his admission. A few days previous to his admission he contracted a severe cold which, added to his existing debility, caused him to apply for relief.

PRESENT CONDITION.

At this time he was found labouring under the following *symptoms*: Sallow dusky complexion, in fact almost ghastly appearance of the fea-

tures with an œdematous condition of the eyelids; body very much emaciated; skin dryer than natural; has a depressed disposition with great want of energy; has a slight cough with no expectoration; mouth and tongue quite dry, and at times experiences great thirst which causes him to drink largely; appetite good; rather inordinate, and appears to digest his food well; bowels rather costive at periods, but have not been so for a long time; micturition easy and frequent, urine increased in amount, light yellowish green colour, with a characteristic hay-like odour, and is perceptibly sweet to the taste, acid reaction; specific gravity 1040—no deposits.

Diagnosis. The symptoms enumerated are sufficiently characteristic to render the diagnosis comparatively easy. The patient is undoubtedly suffering from diabetes mellitus.

Treatment. 1st *Dietetical*—Bran bread, half a pound per day, celery, tea night and morning, with no sugar; four eggs per day and two ounces whiskey.

2nd *Medicinal.* Ordered tr. ferri. sesquichlor. mxx et ol. morrh. $\frac{z}{3}$ ss. ter die.

PROGRESS OF CASE.

Dec. 8. Found the patient to-day in his usual state, but fearing there might be pulmonary complications present Dr. MacCallum made an examination of the chest with the following results:

Inspection. Considerable wasting of the thoracic parietes, and a slight twisting downwards of the right clavicle; movement of the chest slightly more marked on the left side.

Palpation discovers that the vocal fremitus is much more perceptible on the right side than on the left.

Percussion. In right supra-clavicular space the percussion note is heightened in pitch, shortened in duration, diminished in mass of tone, and offers increased resistance. In right infra-clavicular regions, almost wooden quality of sound; passing down from this the sound increases in violence, same dulness being still present. In right axillary the pitch rises and the duration decreases.

Auscultation. In the right infra-clavicular is heard diffused blowing almost tubular breathing; heart sounds are quite distinct, a few moist crackles are also to be heard. Bronchophony also heard here. In the right supra-clavicular space blowing respiration is well marked; on opposite side replaced by normal breathing. In upper part of right axillary region breathing natural, but at lower parts small crepitations are heard, but the crepitations are more marked at the junction of this space with

the infra axillary; still lower down it is heard but coarser in character: behind and on same side we have exaggerated breathing.

Pulse thirty per minute, full and compressible; respirations 32. He has passed during last twenty-four hours ninety ounces of urine, possessing the specific gravity of 1040.

The above examination plainly indicates that, besides diabetes, the patient is suffering from consolidation of upper part of right lung. This consolidation is either solely pneumonic or mixed with tubercle.

Ordered turpentine stupes to chest. Stop the iron, but continue cod liver oil.

Dec. 9. Pneumonic crepitation very distinct to-day in right axillary space; friction murmur in right mammary about half an inch below and to left of nipple; diffuse blowing is also heard here. The crepitation in axillary region is confined to inspiration, and is heard only during forced breathing. Pulse 86, full. Respiration. 26.

Amount of urine passed since last visit ninety ounces, specific gravity 1035.

Dec. 10. Tongue clean, slightly moist, tending to dryness. Pulse ninety, compressible, slightly hard and full; bowels regular; appetite good; cough about same; no sputa; urine, quantity 100 ounces, specific gravity 1040.

The friction-like sound heard yesterday might have been generated in large tubes and sound conveyed by the consolidated lung to the chest wall. It is probable there is infiltration of tubercle as the solidification appears to have begun at the apex.

Dec. 11. Tongue slightly brown and dry; pulse ninety-two, compressible; respiration thirty-three; bowels regular; appetite good; cough worse than before, no sputa. Liquid bubbling rales of medium size heard in right infra-clavicular region and upper part of mammary; crepitation still in right axillary. Passed 112 ounces urine, specific gravity 1040.

Dec. 12. Tongue same as yesterday: pulse ninety-six, rather full and compressible; respiration 32; cough about same, no sputa. Has passed since last visit 116 ounces of urine, specific gravity 1041.

Dec. 13. Pulse eighty-eight, character same as yesterday; respiration thirty-six; cough about same; in right infra-clavicular region there is a distinct blowing; respiration a little metallic with almost gurgling; also large bubbling apparent especially in deep inspiration; friction sound gone; percussion note now natural in infra-clavicular region, upper part; lower down and in mammary space an amphoric note is elicited.

Skin dry to-day; passed 185 ounces urine, specific gravity 1040.

The urine within the last few days has been subjected to all the ac-

knowledge tests for sugar, with all of which it has given a decided affirmative answer. It was also tested for albumen and resin, negative to both. The rapid change during the last few days, from dry to moist sounds would indicate that the pneumonia was tuberculous. From the percussion note elicited and the breathing heard in upper part of right lung, it is probable there is at least a small cavity.

Dec. 14. Amphoric note is still well marked in right mammary space; cavernous breathing is also heard here; gurgling is also heard at this point.

Tongue same as yesterday; pulse eighty; respiration thirty-two; cough much worse but no expectoration; urine passed 160 ounces, specific gravity 1042.

Dec. 15. Tongue not so dry; pulse eighty-four, compressible; respiration thirty-four; cough same, absence of sputa. An examination of left side was made to-day. A slight shade of dulness over the infra-clavicular region; respiration exaggerated. In the axillary region there is marked dulness, but not so much as in infra-clavicular; in axillary space this breathing is of diffused blowing character, here also there is a moist click to be heard occasionally during inspiration. Therefrom softening may have commenced in this lung also. Passed during last twenty-four hours 110 ounces urine, specific gravity 1046.

Dec. 16. Tongue clean and moist; appetite good; pulse eighty-six, character same as yesterday; respiration twenty-nine; cough about same; passed 100 ounces urine, specific gravity 1045. To-day commenced the test for obtaining an indication of the quantity of sugar. Found that patient to-day passed 3400 grs., nearly half a pound of sugar. The patient was to-day ordered a pill containing two minims of creosote, one to be taken each day.

Jan. 25. Yesterday tested for uric and hippuric acid, and also for inosite, but in each case did not find the substance looked for.

Jan. 31. To-day Dr. MacCallum mentioned that for some time past he had noticed that the patient had a peculiar stained appearance of the skin, which led him to suspect the existence of Addison's disease.

Feb. 1. To-day the patient came under the care of Dr. Craik, and was by him placed more immediately under my charge in order to make some experiments to discover the effects of different diets in increasing and diminishing the amount of urine and sugar. The results of my observations I have placed in a plan from which the whole may be seen and perhaps, upon close examination, some facts of importance may be elicited.

The rates for the following thirty-two days have been placed in a tabular form in order to combine them and at the same time show at a glance all the important changes in the case during that time.

At the close of the table in the last line will be found the averages, which give the following results :

Average daily amount of urine 105 ounces, specific gravity 1039½; after fermentation 1012½; amount of sugar per ounce of urine 27½ grains; amount of sugar eliminated each day 2857 grains. Total amount of sugar passed

December, 1864.	Amount of urine passed in 24 hours.	Specific gravity at time voided.	Specific gravity after fermentation.	Amount of sugar per ounce.	Total amount of sugar in 24 hours.	State of Pulse,	Respirations.	Pulse respir. ratio.	State of tongue.	State of bowels.	Remarks.
16	100	1045	1011	34	3400	86	29	1:3	clean & moist.	regular	
17	125	1043	1012	31	3875	82	32	1:2½	furred & dry.	"	
18	100	1045	1015	30	3000	88	28	1:3½	clean & moist.	"	
19	110	1040	1007	33	3630	90	31	1:3+	slightly furred & moist.	"	Cough worse, skin quite moist.
20	110	1040	1012	28	3080	84	36	1:2¼	"	"	
21	108	1045	1013	32	3456	85*	32	1:2½	slightly dry & furred.	"	The thirst during these 3 days was about the same—
22	90	1042	1012	30	2700	86	28	1:3+	clean & moist.	rather free.	diet exactly the same—was all eaten.
23	130	1043	1010	23	4290	88	30	1:3-	clean tend'cy to dryness.	re½alar	The patient also noticed that he did not drink more than usual.
24	100	1045	1015	30	3000	98	32	1:3+	"	"	
25	100	1043	1011	32	3200	90	30	1:3	"	"	
26	100	1042	1015	27	2700	92	31	1:3	clean & moist.	"	During last few days sputa has been raised.
27	110	1041	1010	31	3410	104	40	1:2½	"	"	Sputa more abundant, not rusty.
28	80	1039	1015	24	1920	92	28	1:2½	"	"	
29	100	1041	1012	29	2900	92	31	1:3	"	"	Skin rather moist.
30	125	1039	1018	21	2625	96	31	1:3+	"	"	
31	120	1040	1013	27	3240	94	31	1:3	"	"	

* Full and compres.

January 1st, 1865.	Amount of urine passed in 24 hours.	Specific gravity at time voided.	Specific gravity after fermentation.	Amount of sugar per ounce.	Total amount of sugar in 24 hours.	State of pulse.	Respirations.	Pulse respir. ratio.	State of Tongue.	State of Bowels.	Remarks.
1	oz. 110	1041	1016	grs. 25	grs. 2700	86*	29	1:3	clean & moist.	regular	
2	100	1040	1012	28	2800	88	29	1:3	"	"	
3	100	1040	1015	25	2500	90	31	1:3-	"	"	
4	100	1043	1016	27	2700	92	30	1:3+	"	"	
5	105	1041	1013	28	2940	94†	30	1:2½	furred & dry.	rather free.	
9	105	1038	1012	26	2730	84	31	1:2½	moist & clean.	"	During these days patient still was the same — thirst was not increased — he each day drank same quantity of fluid.
10	65	1031	1012	19	1235	88	32	1:2¾	"	regular	
11	100	1038	1010	28	2800	85	32	1:2¾	moist.	"	
12	105	1036	1012	24	2520	88‡	32	1:2¾	"	"	
13	115	1035	1110	25	2875	90	33	1:2¾	"	"	
14	110	1031	1009	22	2420	98	31	1:3‡	"	"	
15	100	1036	1010	26	2600	94§	31	1:3+	clean tend'cy to dry.	"	
16	105	1037	1011	26	2730	90	31	1:3	clean & dry.	"	
17	75	1033	1012	21	1575	86	39	1:2½	clean & moist.	"	
18	115	1039	1012	27	3105	92	38	1:2½	clean red and moist.	"	
21	110	1037	1011	26	2860	92	33	1:2½	"	"	
Avg	105	1039½	1012½	27½	2857				Total amount sugar for 36 days 220¼ oz.		

* Full and compres. † Compres. ‡ Full and compres. § Less full but compres.

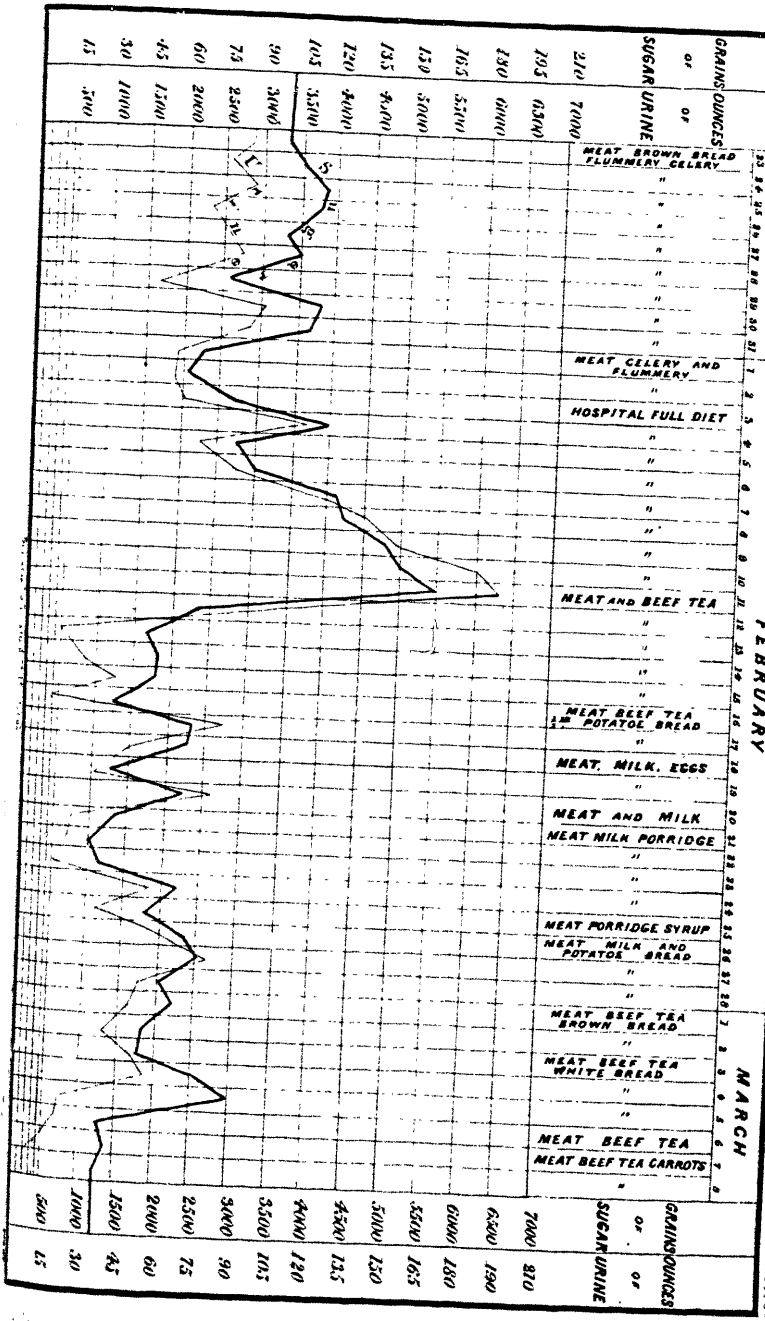
During thirty-six days 220¼ ounces, nearly fourteen pounds of sugar, were passed by the patient.

The heavy line on the plan shows the rise and fall of the sugar. The light line shows the rise and fall of the urine. The lines frequently cross, which shows that the sugar is more easily affected than the urine by the diet.

An important change will be seen to have taken place on the 11th and 12th of February, when the patient's diet was changed from hospital full to a purely animal regimen. On the 16th and 17th of same month potatoe bread was used with but a slight increase in amount of sugar, and great satisfaction to patient's appetite. Its use was more satisfactory on the 26th, 27th, 28th.

A PLAN.

SHEWING THE VARIATION IN THE DAILY AMOUNT OF SUGAR AND URINE PASSED UNDER DIFFERENT DIET BY J.BOROUGH.



The following is the composition of this bread: Take of rasped potatoes, washed free from starch, 4lbs., mutton suet, 3oz., fresh butter, 2oz., 4 eggs, carb. soda, one drachm, muriatic acid (dilute) half an ounce. Mix into two cakes, and bake quickly till brown. (Taken from Wood's Practice.)

The almost entire absence of sugar indicated at the close of the report attributed principally to the near approach of dissolution. For many observers have noticed in similar cases that the sugar ceases to be eliminated at all for some time before death.

Although it was found in small amount then, about a week after it was not to be discovered at all, even with Tillings' test liquor. I also at this time tested it after Moore's plan and others, but none gave the first indication. The specific gravity and quantity of urine was about normal.

On the use of Permanganate of Potassa in the treatment of Typhus Fever and Patrid Sore Throat. By C. B. HALL M.D., Toronto. Read before the Medical Section, Canadian Institute, May 5th, 1865.

In no branch of our progressive profession has so little advance been made as in that class of pythogenic diseases of which typhus fever stands the representative. Inflammation, or the whole class of sthenic diseases, has not the terror for us it formerly held. Diagnosis has, perhaps, done as much for this as treatment; but certain it is that in the latter there has been a wonderful advance—theoretically, men may widely differ, but practically there is no doubt the cause of inflammation can be cut short by judicious treatment. Whether we admit the theory of the protean compounds of the blood to be the seat of inflammation *per se*, it matters little. Few men will attempt the subjugation of pneumonia or any other acute inflammation without the use of some of the alkalis. But again, whether these substances classed as alkalis act directly as such, or possess, according to the language of the old alchymists, some other solvent power, I will not assume. We know that potash and soda are both classed as alkalis; but when combined with fats produce a very different compound; and so it is equally certain they bear no relative comparison in the treatment of diseases. I premise this far as an apology for bringing a new application of a now well-known remedy for checking the course of a formidable disease, without, possibly, sufficient theory to explain its *modus operandi*.

Idiopathic typhus fever is not at all common in Western Canada; but the marked symptoms, indicating a putrescent state, are frequently met with in pneumonia, typhoid and scarlet fevers. It is not so much the

crisis or critical days of the fever to which I would draw your attention, as the crisis in which the pythogenic symptoms appear: this change may be slower in some cases more than others, but never more than two or three days from the first appearance of the tongue becoming dry, red or brown, till the unmistakable sordes, with parched, cracked tongue, the brown, increasing to black, incessant thirst, increased pulse, pain in the head, dimness of vision, contracted pupils, ringing in the ears, sleeplessness, wandering of the mind, muttering, muscular tremors, and general agitation, follow in rapid succession. I have seen typhus fever change from apparent hopeful convalescence to the most alarming and hopeless state, in twenty-four hours. It is sufficient to allude to all standard authors without quoting from any, that there is a direct tendency to putrescency and waste of tissue in the general cause of the disease, and that the rose-coloured spots or petechia are manifestations of its approach. However, I look upon the state of the tongue with the symptoms already enumerated as far more certain indications of the change from one stage to the other. This then is the stage of the disease in which I would venture to advise the use of the manganates, and chief of these the permanganate of potassa, and this only is the theory I advance. Indeed the only reason that induced me to try this remedy in typhus was the impression that at a certain state, varying several days, it was sure to assume the putrid type, and that if a disinfectant could be found sufficient to counteract the tendency, a sure check could be put to the disease running its course.

The chlorides of lime and soda have been the principal and most active anti-bromic compounds, in general use, though manganese as in Young's, and lead in Ledoyen's disinfecting liquids, have been used as bases; but they at best act only by driving out the fetor by a sort of *vis a tergo* force occupying the place themselves.

The salts of manganese have been long in use, as gentle alteratives, acting quite as effectually and less objectionable than mercury, and in combination with iron extolled as possessing great advantages in the treatment of anemic cases, when iron alone has failed.

Permanganate of potassa was first brought into notice in 1857 by Mr. Candy as a disinfectant, and has since been repeatedly tried in the various forms of sloughing and ill-conditioned ulcers. It has been greatly used in the United States in hospital gangrene, and in all cases sustained its high reputation as the most powerful disinfectant known to the profession. Unlike the chlorides, the salts of manganese act by the escape of oxygen, and thus completely destroying all traces of the poison or miasm or effluvium supplying the most active life-giving principle, the most power

ful restorative, and the most direct stimulant. I trust you will therefore allow me to urge the use of the permanganate upon your attention, and to entreat you to give it a full and thorough trial. I append a few cases in which the effect has been particularly marked.

Case 1.—E. J., male, æt. 20, Dec. 10th, 1864, fourth day of fever,—pulse 98—skin hot, dry—tongue coated white—bowels confined—no pain in head—thirst great. Urine scanty—no sediment—ordered soda pot. tart. ζ ij every four hours. 11th, bowels moved—fæces dark, fetid—urine slightly increased—pulse 90. Prescribed vini. ipecac—liq. am. acet. 13th, complains of pain in the head—pulse 106—tongue clean, red, increased thirst—urine scanty, no deposit—pot. permanganate grs. ij every four hours—soda pot. tart. ζ ij at night. 14th, bowels open, stool offensive,—tongue dry, cracked brown, teeth black—delirium—rose spots on abdomen inclining to purple—continue pot. perman. 15th, tongue moist, clean—urine free heavy deposit—bowels open. 16th, stopped potash—ordered infusion cinch.—convalescent.

Case 2.—M. J., sister of above—æt. 10. The third day—fever much the same—less violent—vini ipeca. liq. am. acet. for two days, when the tongue became dry, clean, brown—urine no deposit—take gr. $\frac{1}{2}$ perman. pot. every four hours—next day—tongue clean, moist, urine free, heavy deposit—in two days more discontinued all medicines—recovered.

Case 3rd. J. R., male, æt. 45, Feby. 12th, 1865—labourer; high liver—drinks spirits freely—tongue heavy coated—pulse 120 full—excessive thirst—urine scanty, dark—constantly drinking water and vomiting—8th day of attack \mathcal{R} hyd. chlorid gr. iv. pulv. ipecac—podo-phill aa. gr. $\frac{1}{2}$ every four hours. 13th, bowels open, thirst continues—pulse same— \mathcal{R} ant. tart. gr. $\frac{1}{4}$ liq. am. acet. ζ i every three hours. 14th, tongue dry—dark brown—cracked—abdomen spotted—urine no sediment—mind wandering—skin dry—pulse 120 small but firm—ordered pot. perman. gr. ij. pulv. ipecac. gr. ij. every four hours. 17th, tongue moist, clean—urine free, heavy deposit—on the eighth day convalescent.

Cases 4 & 5. E. B., & R. B.,—girl 13, boy 10—same house—March 12th, 1865—2nd day of attack, marked febrile symptoms—on the 4th day, 6th of attack, tongue dark—dry—sordes—pain in the head—wandering—prescribed pot. perman. gr. $\frac{1}{2}$ with vini ipecac every four hours—in 48 hours both tongues clean, moist—the boy required nothing more; girl infus. cinch. four or five days.

Case 6th. P. L. male, aged 7, April 28th, 1865, strumous diathesis—scarlet fever with putrid sore throat—fauces inflamed—tongue dry—red—throat swollen, almost closed—bowels confined, pulse 130,—constantly crying— \mathcal{R} hyd. chlorid. gr. ij. every three hours. 29th, bowels open

freely—no better—rash declining—to take pot. perman. gr. $\frac{1}{2}$ every four hours—continued for thirty-six hours, when all violent symptoms abated. May 1st syr. ferri. iodid, and tr. cinch. co. for a few days—recovered rapidly.

Bay Street, Toronto, C.W., May 1865.

NOTE.—In publishing the above important paper we cannot but state that the permanganate of potassa was recommended by our friend and fellow townsman, Dr. G. P. Girdwood, as an excellent lotion in foul ulcers, and also in malignant sore throat, as early as the year 1857. This may be found on reference to the second volume of the London *Lancet* for that year. The permanganate of potassa had before that period been introduced as a remedy in diabetes.—EDS.

Exanthematous Fever at Cacouna, By WILLIAM JAMES ANDERSON, M.D., Quebec.

On the 10th July last, I received from a friend at Cacouna, a telegram as under,—“Come down first opportunity, boy very poorly with sore throat—E.—Measles.” I went, and on arrival was informed that the children were somewhat better. I may here say that G. was a boy aged 14, B. a girl aged 11, and E. a little girl aged 3. The family reside in the vicinity of Quebec, but for several years past, have been in the habit of spending a few of the summer months at Cacouna. The family then at Cacouna, consisted of the parents, eight children, governess, four females, and a boy servant. When at home they spend much of their time in the open air, and have enjoyed a full average amount of health, though they have not escaped the epidemics to which children are prone, and with the exception of the two youngest, all had passed through the ordeal of measles and scarlet fever, and during the prevalence of mumps last autumn, all had very acute attacks of that disease.

On enquiry I found that Dr. Thomas, the resident practitioner, had been in attendance, and had at first pronounced the disease measles.

I first examined G. His countenance was that of one affected with mumps; the parotid glands were very much enlarged; skin very hot and dry; tongue coated with a thick dry brown crust; lips tumid, brown and dry; puffiness about the eyes; tonsils enlarged and ulcerated; breath very offensive; great thirst; urine scanty; severe diarrhoea; erythematous swelling of the left wrist and knee, with great tenderness to touch. I was told that in the morning the right ankle and wrist had been similarly affected, but they were now quite free from swelling or pain; there was

desquamation of the buttocks; the pulse 120, and there was constant restlessness. I was informed by his mother and Dr. Thomas that the eruptions, which had been of a peculiar character, had been chiefly on the buttocks, and had produced great irritation, it presented large red blotches of rose-coloured pimples, with white tops or blisters, containing fluid.

In the case of B. the symptoms had been much milder, the glands had not been so much swollen, nor the throat so sore; the eruption milder, not scarlet but *rosy*, and in crescentic patches; it was this case particularly which had led Dr. Thomas to pronounce the disease measles.

In the case of E. the eruption had been very similar to that of B. and still presented a rosy appearance; the parotids were not so much enlarged, but there was puffiness about the eyes, and the tonsils were swollen, inflamed and ulcerated; tongue very sore, and lips ulcerated, especially at the angles of the mouth; skin hot and dry, great thirst; urine scanty and albuminous; severe diarrhœa; drowsiness during the day and great restlessness at night.

Margaret, the cook, had no eruptions, but enormous glandular enlargement, and extensive ulceration of the tonsils, and when she attempted to swallow any fluid, the greatest portion was discharged through the nostrils.

The mother also had chills and fever, with considerable enlargement and ulceration of the tonsils. In all cases the breath was most offensive.

On consultation with Dr. Thomas, I had the pleasure to concur with him on all points, as to the treatment; but from the absence of bronchitic nasal or conjunctival irritation, and from the presence of angina, and especially from my knowledge that with the exception of E. they had already the disease, I stated that I did not view the cases, either as measles or scarlet fever, but rather as types of rosalia or roseola. Dr. T. then informed me that though at first he had been inclined to consider it as rubeola *sine catarrho*, as it progressed he had begun to doubt, and on learning the facts I have mentioned, had sought to account for it in another way, and as I think, had very properly come to the conclusion that it was a disease "*sui generis*" arising from foul air from the cellar, which he had accordingly directed to be cleansed and ventilated. Dr. T. also informed me that there was not then, nor had there been to his knowledge, any exanthematous disease prevailing in the district, but that the gentleman who had occupied the house the previous summer had been constantly troubled with sore throat—On examining the cellar I found no mode of ventilation, but through a door, the smell was very

offensive, and in a part of the cellar I discovered decaying cabbage leaves, rotten potatoes, and musty straw, but there were no stagnant waters. The cleansing was proceeded with, and chloride of lime freely used, which quickly found its way through the floors to the upper chambers. We agreed that great attention should be paid to the throat and mouth, and that they should be frequently washed with a solution of chlorate of potass, that saline drafts of citrate of potass and lemonade should be freely given, and that the soap bath should be had recourse to. Owing to the acute rheumatic affection of the joints in the case of G., it was decided to give him full doses of the hydriodate of potass and citric acid every fourth hour; and I may here say, that after the administration of the second dose, the tongue became moist and began to clean, the skin had a tendency to moisture, the pulse fell, and the tenderness of the joints was perceptively diminished. I remained at Cacouna till the afternoon of the 13th, when, being satisfied that everything was going on well, I returned to Quebec. Everything did go on well for a time, and the parents came up for some days to their home; but immediately on their return to Cacouna, I received on the evening of the 27th a letter from Mrs.—, as follows:—"When we came down on Saturday we found B., W., E., and baby sick. B. has been in bed for three days, and is better. W. you would scarcely know, he is so reduced; the Dr. says E. has dropsy." B. was the eldest daughter 12 years of age; W. a fine boy aged 5; the baby was a little over 18 months; E. was the little girl already mentioned. I went down to Cacouna on the 28th, and found W. very seriously ill, but the symptoms were not so alarming as were presented in E. In B., the eruption was slight, no swelling of the parotids, and the throat but slightly affected. I certainly never could have recognized W.; the parotid glands were enormously enlarged, the countenance extremely emaciated, like that of a very old man, and the skin hung like loose trousers on his legs. His mouth was brown and the tongue aphthous; lips ulcerated, especially at the angles of the mouth; an offensive brown sanies was discharged from the nostrils; the skin hot and dry; urine scanty; diarrhoea; great restlessness, and pulse 130.

The disease was very slight in B., the eldest, and A., the youngest girl; the eruption was slight and miliary, such as is presented in "Roseola Milians," and in other cases nothing was required but a simple purgative, and the use of the soap bath, and to prevent the indulgence in the appetite, which was very urgent. I had again the pleasure to agree with Dr. T—— as to the treatment, and remained at Cacouna till Monday 1st August, when all the patients appearing in a fair way,

I returned to Quebec, and I several times heard that they were continuing to improve. On the 12th, Mr.—— came up to Quebec, when I learnt that all were quite well with the exception of E., in whom the drosical symptoms had not yet disappeared, and W., who though much better, was still suffering from the enlarged gland, which, it was feared, would suppurate. I may here mention that three years before I had been called in to consult with the late Dr. Fremont in the case of W., who had then, with the rest of the family, been attacked with scarlet fever: on that occasion the parotids had been enormously enlarged and the lungs congested—one of the glands had suppurated, and an early opening had been made to discharge the matters. I now recommended that the matter should be discharged as early as possible, and I learnt that it was and continued to hear favourable accounts of his progress till the afternoon of Monday, the 22nd, when I unexpectedly heard that he had died that morning. All the members of the family and all the servants had either been attacked with the eruptive fever or with sore throat and enlargement of the glands. I believe the governess alone escaped, though exposed in every way to contagion, and almost overcome with the fatigue of watching and nursing. I saw them all with the exception of the last boy; and Dr. Campbell, of Montreal, being in Cacouna, was called in by Dr. Thomas, and he unhesitatingly pronounced this case, scarlet fever. Up to this time no other case had occurred in Cacouna, but at last a groom in the employment of Mr. Ross, of Quebec, was attacked, and Dr. Sewell the attendant of Mr. Ross's family being in Cacouna, was consulted and pronounced it a case of scarlet fever. The man was sent to the Marine Hospital, Quebec; and Dr. Roy has informed me that he viewed it as a case of scarlet fever. I have also been told by Dr. Sewell that he never doubted that it was scarlet fever.

I cannot speak of these cases, not having seen them, but I had the pleasure of calling on Dr. Campbell a few weeks ago in Montreal, and he is still positive that the boy D., whom he saw, had scarlet fever; and moreover I was informed by him that he had ascertained that during the preceding winter, an exanthematous fever, called by the *habitans* "fièvre rouge" had prevailed, and that some of the inhabitants of the house subsequently occupied by my friends, had had the disease, and that they had carefully concealed the circumstance from Dr. Thomas, who, during the winter, resides permanently at Rivière du Loup. I can have no doubt that Dr. Campbell is right in his conviction, since he believes in *second* attacks of scarlet fever many of which he asserts he has seen. Drs. Campbell and Sewell are both, like myself,

veterans in the profession, and are moreover of extensive and enlightened experience; and Dr. Roy, though a much younger man, is a very intelligent practitioner, and I will not venture to say that the cases which came under their observations, were not cases of scarlet fever, but I may be permitted, with equal confidence, to assert that none of the cases I saw were scarlet fever, even though I am prepared to admit that scarlet fever, like small-pox, may be taken a second time.

There can be no doubt that for a long time scarlet fever and measles were viewed only as varieties of the same disease, and that when their distinctive features became so apparent that they were recognized by the profession as two distinct diseases, each possessing its specific poison, still the resemblance was frequently so great that it was utterly impossible for the most experienced to designate whether the case was scarlet fever or measles. Nor can there be any doubt that since the almost suppression of small-pox, both these diseases have become more prevalent, and assumed a more severe type, and that different epidemics, have been of such a character that a family resemblance could scarcely be traced. It is also admitted that within the last thirty years, exanthematous diseases have appeared both as epidemics and sporadically, which cannot be classed either as measles or scarlatina, but which have been variously classed under the head of rosalia, roseola, or rubeola hybrida.

That the medical art is very far from an *exact* science is too clearly proved by reference to the standard authors on this very subject of exanthems. Not only is there great discrepancy in nomenclature, but even when certain terms are recognised as synonymous in reference to a particular disease, the descriptions of it as given by the different writers will be found to differ materially.

I shall refer to a few authorities. Dr. George Gregory of London, treats of measles and scarlet fever under the terms *rubeola*, the *morbilli* of Sydenham or measles and *scarlatina*, that variety of exanthema now known as Scarlet Fever, but which was first described as *Rubeola*, by the Latin Translators of Hali Abbas to distinguish it from *Morbilli*. Measles he describes as "the product of a miasm or morbid poison which in this country is invariably received by the mode of infection." "It occurs to all mankind *once* in the course of life; but having been undergone the constitution remains for *ever* after unsusceptible of the same disease." —It is "a fever with *catarrhal* implication, which, at the end of seventy-two hours, throws out an abundant eruption consisting of minute confluent papulæ slightly elevated above the surface of the skin, and subsiding in three or four days at furthest." There is, also, "an exanthemic

disorder allied in aspect to rubeola, but not exhibiting any initiatory *catarrhal* symptoms." In reference to this latter, Dr. Bulkley of New York says:—"The cases which constitute the largest share of "rubeola sine catarrho" have been those of roseola, between the cutaneous developments of which and of rubeola there is often great resemblance."

Dr. Gregory then describes scarlatina, taken in its widest sense, as a fever sometimes inflammatory, sometimes typhoid, the offspring of a morbid poison gaining access to the body, by the mode of infection only, characterised by a short period of incubation, an eruption rapidly developed, and an *inflammation of the fauces*, having a strong tendency to terminate by sloughing."

It may terminate in a week, or extend over a month. "Such a disease does not, like measles, invade a large proportion of mankind during infancy, *but having been undergone, the susceptibility to future attacks is exhausted.*"

Again: "No doubt exists that in a very large proportion of cases, scarlet fever is the product of a specific miasm; but the question may well arise, whether any combination of circumstances can develop an eruption possessing the characters of scarlet fever. *I am bound to tell you that I believe they can.*" Further; "This much I thought it right to say before approaching the *vexata questio* of secondary attacks of scarlet fever. Observe the conflicting statements of authors on this head. Dr. Wilan (certainly one of the most acute and careful observers of the disease) says that out of 2000 cases which he attended, he saw no instance of recurrence. Dr. Currie, of Liverpool, who devoted much attention to scarlet fever, was compelled, by the results of long experience, to "renounce the opinion he had early imbibed, and to confess that the same individual is liable to scarlatina, *once only.*" Sir Gilbert Blane, on the other hand, met with one instance of scarlet fever occurring thrice, and, as he says, "without the least suspicion of ambiguity." Dr. Burns inclines to the notion of occasional recurrence. Exceptions do occur; nevertheless, the law of exhausted susceptibility, as Dr. Williams calls it, *is very strongly marked in this disease.*" But "medicine is filled to overflowing with false facts of this kind set down without much consideration, and with a scanty knowledge of pathology." Tweedie and Rayer have both met with several well-authenticated secondary attacks of scarlet fever—and during the past month I have met with a very striking case occurring in Quebec. The son of a medical friend was sent home from Lennoxville on the out-break of a scarlet fever there, on the third day after his coming home, he was attacked with scarlatina pretty severely; the eruption and angina being well marked. His little sister, somewhat

his elder, and who had had the disease during a former epidemic, was about the same time attacked with fever and angina, and a miliary eruption on the throat and chest, which only remained about forty-eight hours. Still I have seen many similar cases passed as scarlatina, and would most likely hold this to be one, had the doctor not assured me that she undoubtedly had had the disease previously. Both patients got well, and confidence was felt that the disease would extend no further, when a younger sister was attacked, and had the fever very acutely; and very much to our surprise the first little girl was again affected, the tonsils and cervical glands were enlarged and inflamed, a rosy miliary eruption again appeared, but chiefly on the trunk and lower extremities, followed by desquamation. This third attack might, under other circumstances, have been viewed as scarlatina, but the pulse never rose above ninety; while in the cases of the other two it continued above 120, till desquamation was nearly completed.

Dr. Gregory describes *roseola* in some of its forms as very trivial; but I desire to direct attention to the variety *R. exanthematica*, or *variolosa*, as bearing on the case of G., at Cacouna. "It happens," says Dr. Gregory, "that after one, two, or three days of fever, a rosecolous rash is suddenly thrown out over the face, neck, arms, and back, in irregular patches. In some cases the eruption assumes the aspect of scarlet fever. On the second or third day from the appearance of this rose-coloured or scarlet rash, pimples display themselves in the very midst of these patches. These gradually advance; and in three days more, show the depressed centres of variola. The occurrence is very annoying in practice. The physician first announces that his patient has fever. Two days afterwards he changes his note, and informs the friends that the patient besides fever has the roseola or rose rash,—an affair of no consequence. Two days after that he announces to the astonished listeners, that the patient has small-pox! This once occurred to myself in consultation with Mr. Hammond at Windsor."

I have met with several cases of this type besides the case of G., and have no difficulty in identifying it (the roseola variolosa of Gregory) as the roseola punctata of Erasmus Wilson, who says: "This disease is interesting, not merely on account of its novelty, but also from the questionable shape in which it makes its appearance, and from the variety of character which it subsequently presents. Thus, a resemblance to variola at its outbreak, caused the patient to be sent to the small-pox hospital, while its aspect within the hospital suggested to gentlemen well acquainted with the physiognomy of eruptive disease, ideas of lichen lividus, urticaria, erythema, rubeola, purpura, &c., &c. The name

given to it by Mr. Marson, namely, erythema rubeolosum, conveys a good notion of its erythematous and rubeoloid character; but I have not adopted that designation from the belief that the nature of the disease is better expressed by the term roseola. Roseola, I need hardly say, bears a close resemblance to erythema and rubeola; indeed, in some cases, it seems to be a compound of the two."

The characters of this affection roseola, are generally, according to Wilson, as follows: "Febrile symptoms of a sub-acute type, accompanied with redness of the eyes, slight coryza, redness of the fauces, and swelling of the mucous membrane of the mouth, ushering in an exanthema at the end of three days,—the exanthema appearing on the mucous membrane and skin; on the latter in the form of small red spots around the mouths of the follicles, then becoming diffused so as to cover the greater part of the body, reaching its height on the third day, at first of a bright raspberry-red colour, afterwards acquiring a dull roseate hue—the dulness increasing with the progress of the decline,—the entire attack lasting ten days, of which three belong to the febrile period, three to the exanthema, and four to the decline, the rash assuming a different form on different parts of the surface, such differences being all attributable to roseola."

Dr. Marshall Hall, in drawing the distinction between rubeola, measles and scarlatina, says: "In reference to the indoles of these two diseases, I would remark that rubeola principally attacks the parts of the respiratory organs *below*, whilst scarlatina is chiefly situated *above* the glottis. This important point appears to be the boundary of the internal affections, in both these affections respectively."

Dr. Hall believes in the recurrence of rubeola, but says nothing of second attacks of scarlatina.

McIntosh says, "The rash in scarlet fever appears somewhere between the first and sixth days of fever, *appearing first on the face and neck*, and progressively spreads over the body, terminating between the seventh and tenth days. The inflammation of *the throat is the prominent symptom.*" He says nothing of recurrence, but that it "occurs only *once* in a lifetime." Measles is marked by the crescentic eruptions and *bronchial* symptoms. Roseola "has often been confounded with measles and scarlet fever, and I have seen the wisest heads baffled in determining the point.

In 1838 Nova Scotia was visited with a wide-spread and very fatal epidemic of scarlatina which very often became hybrid in November, December, and January; in February, March, and April, 1839, measles followed by whooping-cough prevailed; and in August and September

following, rosalia or roseola in a very severe form attacked many of those whom I had previously attended in both scarlatina and rubeola. Roseola was in this epidemic generally attended with enlargement of the cervical glands, and extensive desquamation, *invariably* in patients of a strumous diathesis.

Copeland says, "The eruption in scarlatina appears on the second day, *on the fauces, face, and neck*, spreading subsequently over the body, terminating from the fifth to the seventh day, and *occurring only once in a lifetime.*"

Roseola, rose-rash, rosalia, rubeola spinosa, has several varieties. Roseola *autumnalis* is attended with desquamation. Roseola *cholericæ* presents more the appearance of scarlet fever and measles than roseola. About the sixth or seventh day, the epidermis cracks, and is thrown off in large scales, and Rayer has seen it complicated with inflammatory affection of fauces and tonsils, sometimes terminating in death.

In scarlatina, according to Watson, the eruption begins on the face, neck, and breast, and extends to the extremities, pervading almost every part of the skin, standing out for three or four days, when it declines and disappears before the end of the seventh day. It is distinguished from measles by the *affection of the throat and skin*, only one of which may be well marked. It seldom comes on a second time.

Willan and Bateman say, it is difficult, if not impossible, to distinguish roseola from scarlatina. Dr. A. Thompson says, in scarlatina, rash attacks the *face* first; in roseola, the *extremities*. I may here remark that it is very singular that in the several cases of scarlatina which I have lately seen in Quebec, the eruption did not first make its appearance on the face and neck.

Wells and Begbie say, that the urine in scarlet fever *always* contains more or less albumen, which generally appears a few days after commencement of desquamation, lasting three or four days, and is not to be viewed as invariably a precursor of dropsy, but frequently disappears without such a sequel. I have noted this, and also albuminous urine in parotitis.

Grant's "Hooper" says, Roseola appears *first* on head and neck, and, in course of a day or two, is distributed over the whole body in patches larger and more irregular than measles. There is itching and tingling. The eruption is first red, then deep roseate; fauces tinged with the same; toughness of tonsils. The eruption wholly disappears on the fifth day, but in some cases it continues more than a week appearing and disappearing. There is desquamation in roseola *autumnalis*. It has sometimes been called rosalia, which name has been also applied to measles and

scarlet fever. It is most severe in scrofulous habits. Dr. Hooper has seen dropsy after measles.

Dr. Maunsell saw *rubcola sine catarrho* epidemic in Dublin during the latter part of 1839. One family of four children all underwent eruption accurately resembling measles, and they were all again attacked within a week of its disappearance, and went through measles regularly.

Dr. Drake, in his work on the the "principal diseases of the interior valley of North America," says: *Roseola* is often confounded with scarlet fever, especially when it is accompanied with throat affection. *Scarlatina*, with *catarrhal* affection superseding *anginosa*, was epidemic in Cincinnati in 1811-2-3, and did not present the decided characteristics of either scarlet fever or measles. In Jacksonville, Illinois, in 1813, morbilli prevailed as an epidemic and *angina* was the prominent feature. The *angina* supervened on *catarrhal*, and the crescent-shaped spots assumed a scarlet hue. In Louisiana, in 1844, an *androgynous* or hybrid epidemic of similar character prevailed from January to June, and Dr. Ames had occasion more than once to change the name which he had entered in his book. Drake, as the opinion resulting from thirty years' experience, submits that measles and scarlet fever are merely *varieties* of one species, and may unite in the formation of a new variety, or that they may be two distinct *species*, but likely to concur in the production of an hybrid, which, therefore, would not be contagious.

Aitken adopts a new terminology; he accepts *scarlatina* for scarlet fever, resumes *morbilli* for measles, and adopts *rubeola* to denote hybrid of measles and scarlet fever, or *rothelis*; pointing out that Kutness, of Dresden, declares the "androgynous cases calculated to embarrass the most experienced diagnosticers;" and that Schönlein classes measles as a peculiar exanthematous form of *catarrhal*, and *scarlatina* among the group of *crispelatosus* diseases." Aitken says of the prognosis of *rubeola* or hybrid: "It requires to be as guarded as in scarlet fever, for, like scarlet fever, *rubeola* is often an extremely and rapidly fatal disorder, though, in general, it is a mild disease. Copious secretions of mucus in the back of the throat, is always a bad symptom, as is regurgitation of fluids by the nose. The condition of the urine requires to be daily examined. Treatment is similar to that of scarlet fever. The accompanying febrile symptoms distinguish the disease from *roseola*. Dr. Aitken considers that scarlet fever may be taken a second time, but believes that death from a second attack is *unknown as a fact*.

Should this latter statement be correct, and should Dr. Campbell's opinions of the exanthem at Cacouna be correct in reference to all the cases of the family, then in the case of W. we have to record the first

authentic death from a second attack of scarlet fever. But though, as I have already said, I am free to admit that scarlatina, like small-pox, may, as the exception to the rule, be taken a second time, I think it most improbable that a whole family, and that so large a one, should be attacked a second time together. I prefer, therefore, to view all the cases of which I was a witness, as well-marked cases of *roseola* or *rosalia*, exhibiting unmistakably all the characteristics of that exanthem from its mildest to its most severe and fatal type. But, after all, "what's in a name, the rose by any other name would smell as sweet." Whether we are to view these cases at Cacouna as scarlet fever, produced by infection from fomites remaining in the house since the previous year, which we know is quite possible, or whether we may consider them as varieties of *roseola*, arising from the foul airs from the cellar, it is of very little consequence, as there ought to be no doubt as to treatment.

I may have been led to form the strong opinion I entertain from my having no doubt of all the family, with the exception I have mentioned, having previously had both measles and scarlet fever; but I believe, from having carefully watched all the cases, and having marked the different types which they offered, I should have been disposed to have viewed them as *roseola* from my distinct recollections of the characteristics of the epidemic of 1839. I may add that I think it remarkable that though the disease extended from the first week in July to the 22nd August the disease, with the single exceptions I have mentioned, did not go beyond this one family.

I shall conclude with an extract from Marshall Hall: "The science of medicine is not so simple as it has been made to appear. When our books present a faithful portraiture of nature, we shall discover that during the course and after the course of many diseases, we have still to watch the patient if we would early detect diseases which only require to be over-looked and disregarded in their beginnings, to be placed beyond the reach of remedy. The eye, the mind will speedily become familiarized with the multitude of events which occur, and then the principal difficulty will be overcome."

PERISCOPIC DEPARTMENT.

—
Surgery.

FIBROUS POLYP IN THE NASAL CAVITY.

D. M., 11 years of age ; has a fibrous polyp in the left nasal cavity, which commenced forming eight months ago. It is firmly attached by a broad base to the posterior nares, to the floor of the nostril, to the side of the ethmoid bone and to the basilar process of the occipital bone. The diseased mass completely blocks up the posterior nares, and has been the seat of repeated hemorrhages so as to produce a certain degree of anæmia. It discharges a thin muco purulent and occasionally bloody fluid. The patient is unable to articulate well on account of the obstruction, and snores most violently during the night, being obliged to lie with his mouth wide open. These tumours are composed of fibres interlacing with each other in every conceivable direction, they are remarkably vascular and rarely occur in any other situation than the posterior part of the nasal fossa in connection with the floor of the nostril or the septum of the nose or of the palate bone, or all of these parts simultaneously. It is likewise remarkable that they occur at comparatively early age. Their growth is usually rapid, and in time they acquire a large bulk sufficient to lift the nasal bones out of their position, producing the deformity called "frog face." They are susceptible of malignity and occasionally take on this kind of action. This tumour is very difficult to remove on account of its being seated so far back, and as its adhesions are so firm there is no method of detaching it, but by dividing its connections with the knife. Attempts have been made to ligate them with a double canula, but in this case the base is so broad and the attachment so firm that failure would be inevitable.

Prof. GROSS devised, many years ago, an instrument for the removal of these tumours. It is shaped like a chisel and bevelled off at the extremity. By means of this instrument the mass was shaved off from its connection with the floor and walls of the nasal fossa: the finger of the left hand being placed in the posterior nares so as to prevent the tumor from falling into the larynx in the event of its being detached. The adhesions to the basilar process of the occipital bone were so firm that they could not be detached with a pair of lithotomy forceps, and an instrument similar to the one described, but having its point bent at an angle, was devised to shave it off from its connections in these situations. The hemorrhage was considerable, but was restrained by plugging the anterior

and posterior nares by the aid of Bellocq's canula. These operations forbid the use of chloroform as it is necessary that the patient should have full control of his palate to prevent the flow of blood into the larynx.—*Surgical Clinic of Prof. S. D. Gross, M. D.*

NOTES FROM DUBLIN.

Two cases of great interest have lately occurred here, which, I think, it will be worth your while to record. Therefore I send you brief notices of them.

The first is that of a fracture of the spine, in which the operation of trephining was performed. The patient was a man named Joseph Collins, aged 38 years, who entered Jervis Street Hospital, December 28th, 1864, suffering from an injury of the spine. Dr. Robert McDonnell, who saw him immediately after his admission, and under whose care he remained, at once diagnosed a fracture of the spine corresponding to the last dorsal or first lumbar vertebra. The symptoms were those of pressure on the spinal cord.

At a consultation held the same day, Dr. McDonnell advocated the immediate performance of trephining. His colleagues, however, not taking his view of the case, the proceeding was negatived.

The idea of trephining was then given up until January 30th, 1865, when Dr. Brown-Séguard, happening to be in Dublin, saw him with Dr. McDonnell. He supported his view, and advocated the operation as a *dernier ressort*. Accordingly, it was performed February 3rd, 1865.

Previously to the operation, sensation existed normally in the thigh and calf of each leg. In the feet, sensibility was much impaired, the sole being quite anæsthetic. Paralysis of motion was almost complete in both lower limbs; no reflex movements could be excited. The bladder and rectum were absolutely paralysed; the urine was alkaline. The penis and scrotum were swelled, and the prepuce ulcerated. Bed-sores existed over the sacrum; and the left foot and leg were œdematous.

After the operation, sensation became normal everywhere. There was a marked increase of motor power in the muscles of the thigh; the patient, however, did not regain the power of moving his toes. After some days, the reflex phenomena as regards movements of the muscles of the thigh reappeared. The most remarkable improvement, however, was in the penis and scrotum, etc. The ulcerations improved; the swelling diminished; and the œdema of the left leg disappeared.

A fortnight after the operation, the bladder had regained considerable power, and the urine could be expelled with some force. However, the

patient sank on the seventeenth day after the operation, when it was found that inflammation had extended from the bladder to the kidneys, purulent depositions having been found in one of those organs.

On *post-mortem* examination, a displacement was found to have taken place between the last dorsal and first lumbar vertebræ, with fracture of a portion of the body of the latter. The theca vertebralis was uninjured; the cord compressed, but not lacerated.

The operation consisted in the removal of the posterior arch of the first lumbar vertebræ; and there is little doubt, had it been performed at an earlier period, there would have been a fair chance of interrupting the chain of sequences which led to a fatal result in this case.

The above is a mere sketch, as the whole details will soon be published in full by Dr. McDonnell.

The second case is one of no less importance than that just described, being the cure of an aneurism implicating the femoral and iliac arteries by compression applied to the common iliac and femoral vessels. The case occurred in the practice of Dr. Mapother of St. Vincent's Hospital, and presented extraordinary difficulties in its management. Among others, I may mention the fact of the treatment being carried out while the patient was under chloroform, and the combination of distal and proximal compression, so as to prevent complete emptying of the sac. This device is the suggestion of Mr. O'Farrell of St. Vincent's Hospital, and is a most valuable one. The prolonged chloroform inhalation was also most remarkable, having been sustained on one occasion for twelve hours. The cure of the disease was complete.—*Dublin Correspondent of the British Medical Journal, April 18th, 1865.*

CASE OF RECURRENT EPITHELIAL CANCER.

Under the care of Mr. GLASCOTT R. SYMES.

S. M. E., aged 48, admitted into hospital in December, 1864. The lower part of the left side of the face was occupied by a large epithelial open cancer of about three inches in diameter, its edges were everted, the surface raised and of a dusky red colour. In the situation of the submaxillary gland there was a cavity leading beneath the jaw; the whole was constantly bathed in a thin abominably fetid discharge.

The history of the case is very interesting. In the month of August last he was admitted into hospital for a sweep's cancer of the scrotum, which presented the usual features. There was at that time slight glandular contamination confined to the region of the groin; but as the sore was giving him much annoyance, and as the glandular disease when slight

often appears to be kept in abeyance when the local source of irritation is removed, the ulcer was excised by Dr. Tyner. The wound healed well. The cicatrix, five months after, was perfectly healthy. Before leaving hospital, he shewed Dr. Tyner, under whose care he was, a small wart situated near the left commissure of the lips; this was also excised, but there was no enlargement of the glands about the jaw.

When in hospital last he was much run down by the discharge, pain, and annoyance of the cancer in the face: he had enlarged glands in the right axilla; he had enlarged glands in both groins and iliac regions; both the cicatrices were healthy. It is needless to remark that nothing in the way of operative interference was attempted, under these circumstances.

This case illustrates well the recurring nature of cancer although there will be found some who deny that epithelioma is cancer. It likewise teaches us to be cautious in prognosis. There are many of these cases in which the operator can benefit the patient, even though the glands in the neighbourhood may have been contaminated; and on the other hand as in the present instance, there are many in which the knife not only does not afford relief, but even sometimes appears to hasten the recurrence of the disease, if we are to judge by the rapidity with which the affection is reproduced.

ABSTRACT OF A CLINICAL LECTURE ON TORSION, LIGATURE, AND ACUPRESSURE.

By JAMES SYME, F.R.S.E., Professor of Clinical Surgery in the University of Edinburgh.

G. M——, aged 48, came from Wick, in Caithness, suffering under epithelial cancer of the lower lip. It was necessary, as you saw, to remove fully two-thirds of the lip by a V-shaped incision, and then to provide a substitute for supplying the gap by cutting into the cheek on each side from the angle of the mouth, sewing together the skin and mucous membrane of the new lip thus obtained, after the hemorrhage, which was profuse, had been arrested by torsion of the arteries, and then retaining the cut edges in close contact by silver sutures. Three days after the operation had been thus performed, you saw that union had taken place entirely and completely without a drop of matter, and you now see that the patient's appearance is perfectly natural, without the slightest discernible trace of anything having been done to the lip or cheek.

This case and others that you have seen of a similar kind suggest some important considerations with regard to union by the first intention.

In the first place, they show that torsion of the arteries does not interfere with the adhesive process. It has been said that twisting a vessel so as to arrest the bleeding *must* cause sloughing of its extremity, and consequently *must* prevent the primary mode of healing. But, as "a grain of fact is worth a pound of reasoning," you will now know what value to place upon an opinion which has been so confidently expressed and so completely contradicted by experience. It has also been said that if ligatures are avoided in treating wounds of the cheek or lip, they should in consistency be as far as possible avoided upon all other occasions. But in the first edition of my "Principles of Surgery," published in 1832, I drew a distinction between wounds having one orifice and wounds having two orifices, as those of the cheek, joints, and great cavities, since the former, unless very small and superficial, do not admit of having their mouths closed completely without suffering such an accumulation of blood or serum as must effectually prevent adhesion of their surfaces, while the latter may have their edges brought closely together on one side without any effect of this kind, through the bloody and serous discharges finding vent from the other. This principle of practice I have constantly inculcated, and year after year illustrated by cases such as the one which has led to my present remarks; so that the charge of inconsistency which has been brought against me reduces itself into a painful display of unacquaintance with the subject. When the wound is deep, and has only one orifice, ligatures, so far from being hurtful, are eminently serviceable, by maintaining an outlet for the fluids, which would otherwise be pent up, and lay the foundation of troublesome abscesses, while they do not to any further extent interfere with the adhesive process. Of this you have examples at present in two amputations of the thigh, where the stumps were healed within a fortnight after the operation; in two amputations at the ankle, where cicatrization was completed within the same period; in an amputation of the forearm at the advanced age of eighty; in excision of the elbow-joint; and in the removal of a fibrous tumour, nearly as large as his head, from the neck of a patient who had laboured under it for no less than fifty-seven years. I may also remind you of five operations for the removal of mammary tumours, which were lately under treatment at the same time, and in all of which the result was union by the first intention.

Through the careless and incorrect use of surgical language, ligatures have been most unjustly charged with causing gangrene and mortification; and I may therefore remind you that mortification implies, not merely the death of a part, but death through its own living action—in short, a sort of suicidal procedure; while gangrene denotes the form of inflam-

mation that produces this effect. But when a ligature is tied, the texture embraced by it is cut off from all communication with the circulating system, and at once deprived of vitality; so that the only action excited by it is the ulcerative absorption requisite for its separation, which is not attended with pain or disturbance of any kind. When, therefore, extraordinary efforts are used to shake your confidence in the ligature, and induce you to adopt other means for the suppression of hemorrhage, I consider it my duty to warn you against being misled by these representations, just as I have on various other occasions opposed innovations which seemed calculated to impair the practice of surgery. Thus, when it was proposed to abandon what may be truly called the perfect operation for hydrocele by injection with iodine, and to substitute for it the introduction of metallic setons, I expressed disapproval. When it was proposed to abandon the strictly limited and certainly effectual incision for fistula in ano, and resort in its stead to useless injections with iodine, I expressed disapproval. When it was proposed to burn out simple tumours with destructive caustic, instead of removing them by the knife, I expressed disapproval. When, instead of a slight incision, it was proposed to remedy fissures and spasmodic strictures of the anus by forcibly rending and roughly tearing through the parts concerned, I expressed disapproval. When it was proposed to suppress hemorrhage by means of needles instead of ligatures, I expressed disapproval, on the ground that such a procedure was uncalled for, inexpedient, and in most cases impracticable; so that, when contrasted with the facility, safety, and efficiency of the ligature, it reminded one of the powders for killing fleas, which required that each of them should be seized by the nape of his neck so as to make him gape and admit a mouthful of the poison. When other objectionable proposals were forced upon attention, I pursued the same course; but while thus defending my own province from the injurious inroads of a would-be improver, I have scrupulously avoided any interference with projects relating to other departments of teaching. Thus, when it was proposed to accelerate the progress of sluggish babies in entering the world by applying sucking-pumps to their tender scalps, however much commiserating the helpless victims of an inventive genius, I left the matter entirely to my obstetric colleague and his pupils. It appears that my example in this respect has not been followed, and that in a pamphlet recently published I have been charged not only with ignorance of my profession, but with want of good faith in teaching it. Such vulgar insolence I treat with the contempt it deserves.—*Lancet*.

Medicine.

REMARKABLE CASE OF PURPURA HÆMORRHAGICA, FOLLOWING SYPHILITIC CARIES OF THE BONES OF THE NOSE.

By HENRY LEE, Esq., F.R.C.S., Surgeon to St. George's Hospital.

A gentleman had suffered for some months with disease of the bones at the back of the right nostril, and a piece of bone at one time had become separated, and was swallowed. A very large number of rupial looking sores formed on different parts of the body. These sometimes extended, sometimes healed, and at other times remained stationary. Occasionally, and generally when the ulcerations were better, he had very severe pains, accompanied by a considerable amount of swelling in different parts. These "rheumatic pains," as he called them, affected principally the elbows, wrists, and knees. The pulse was generally quick, weak, and occasionally irregular; and he had been under the care of several physicians for supposed disease of the heart. He frequently felt faint, and was in the habit of carrying some stimulant in his pocket.

On October 11th, after having been unusually depressed and uncomfortable, hæmorrhage occurred from both nostrils. This was followed by a swelling, which attained the size of a bean, on the lower lip. This swelling was formed of epithelium raised by effused blood. Spots of purpura appeared all over the body, but chiefly upon the arms. Hæmorrhage occurred from the gums, and from the mucous membrane of the eyes. The urine passed contained blood. The nostrils, from which the largest amount of blood passed, were now plugged.

12th: Three chamber-pots, each more than half full of bloody urine, had been kept. Hæmorrhage from the gums continued. The skin was yellowish. The mouth was occasionally filled with blood. There were hiccough and sickness. Some blood oozed from the penis.

13th: Three chamber-pots, each more than half full of bloody fluid, had again been passed. The contents of one of these vessels had become coagulated in one mass.

14th: Fresh spots continued to appear upon the skin. There was a continued sensation of sickness and occasional vomiting. Food and medicine were rejected, mixed with altered blood.

15th: The motions contained a large quantity of decomposed blood. The lips were blanched. Bleeding from the gums continued. The urine contained nearly the same amount of blood. Ruspini's styptic was ordered.

16th: The pulse had become more regular, and rather stronger. The

bleeding from the mouth had stopped. He passed a much smaller quantity of water. His lips had assumed a more natural colour.

17th : There was excessive restlessness. Many of the spots on the body and arms had assumed the appearance of large bruises. The bleeding from the mouth had recurred. He had great difficulty in swallowing.

Dr. Markham now saw the patient in consultation, and gave a decided opinion that there was no disease of the heart. Nothing could, after this, be kept on the stomach in any quantity; and the patient died on the 18th.

Dr. Dickenson was good enough to examine the body on the following day. The bones at the back of the nose were extensively diseased. Spots of purpura of various sizes, and presenting different colours, were scattered over the body. In the chest, the heart was found quite healthy. Spots of ecchymosis studded the surface and interior of the lungs. Similar spots existed on the convex surface of the diaphragm.

In the abdomen, spots of ecchymosis were scattered over the whole of the intestines, and could be seen of various sizes under the peritoneal covering.

The kidneys, which were otherwise tolerably healthy, were mottled throughout their structure and upon their surface with circumscribed patches of a very dark colour. These contrasted strongly with the appearance of the natural structure of the organ, and produced a very peculiar and remarkable appearance.

The pelvis of the kidney and ureter on each side was full of what appeared to be semi-coagulated blood. The intestines were filled with a brownish fluid, evidently composed principally of blood which had been changed by the secretions of the stomach and intestines.—*British Medical Journal*.

ON A SUPPLEMENTARY SYSTEM OF NUTRIENT ARTERIES FOR THE LUNGS.

By WILLIAM TURNER, M.B.Lond., F.R.S.E., Senior Demonstrator of Anatomy,
University of Edinburgh.

It is a well-known fact in anatomy, that each lung has, in addition to the pulmonary artery conveying venous blood, one or two small nutrient arteries passing to it. These vessels, called bronchial arteries, are derived, as a rule, either from the thoracic aorta, or in part from that vessel, and in part from its upper intercostal branches. In this communication I wish to show that these usually described bronchial arteries are not the only nutrient vessels of the lung,

but that it receives, in addition, a number of slender supplementary nutrient arteries from other quarters. If the systemic arterial arrangements in the cavity of a healthy thorax be carefully injected with size and vermilion, or other colouring matter, and the pleural cavities then opened by removing portions of the ribs, and muscles attached to them, the general distribution of the arteries in the thoracic walls may be examined without difficulty. The vessels to which I wish more particularly to direct attention are the internal mammary arteries and the trunks of the thoracic intercostals, as they lie in relation to the bodies of the dorsal vertebræ. From each internal mammary artery, besides other branches to which I need not now refer, arise sundry small arteries known as pericardiac and mediastinal branches, and a long branch accompanying the phrenic nerve and passing along with it to the diaphragm. These vessels are all situated beneath the mediastinal pleura, and lie, therefore, between it and the pericardium. They do not, as is implied in the descriptions usually given in anatomical works, end simply in the fibrous bag of the pericardium, in the fat of the mediastinum, the thymus gland and the diaphragm, but they give off, in addition, branches which anastomose and form an arterial plexus, which from its position may conveniently be termed the sub-pleural mediastinal plexus. The general arrangement of this plexus can be examined without using either knife or forceps, by drawing the lung outwards, and tracing the slender arteries filled with injection beneath the transparent mediastinal pleura. The arteries are elongated, thread-like vessels, of almost uniform calibre throughout, and the mesh work which they form by their intercommunication is open and irregular.

If now the lung be raised from its position and thrown forwards, the thoracic and superior intercostal arteries may be seen in relation to the bodies of the dorsal vertebræ, and from the greater number of them fine arteries arise similar in their characters to those just described. These vessels lie beneath the posterior mediastinal pleura, and supply the fat, areolar tissue, and glands of the posterior mediastinal space, and the hinder part of the pericardium. Those on the right side lie in close relation to the œsophagus and anastomose with its proper arteries. Those on the left side run forwards in close relation to the outer coat of the descending thoracic aorta. These fine arteries also anastomose with each other, and form the posterior portion of the sub-pleural mediastinal plexus. Above and below the root of the lung they send branches forward which inosculate with the division of the plexus lying in front of that structure. In giving a description therefore of the anastomoses of the internal mammary and intercostal arteries,

it is not sufficient to refer merely to those occurring in the diaphragm and costal walls, but the inosculation between the vessels forming the anterior and posterior divisions of the sub-pleural mediastinal plexus must be included. This plexus is interesting, not only because it serves to afford an additional channel of communication between the arteries of supply for the thoracic wall, but because from it the supplementary system of nutrient arteries for the lungs arises.

In a healthy well-injected thorax, these vessels may be seen without any difficulty, passing to the lung in the following manner:—Some proceed from the anterior division of the sub-pleural mediastinal plexus in front of the root of the lung, to its inner aspect; others from the posterior division of the plexus pass behind the root of the lung, and others reach it by running between the two folds of the pleural membrane, known to descriptive writers as the *ligamentum latum pulmonis*. Having reached the lung by one or other of these three routes, the fine thread-like arteries are distributed as follows:—Some pass deeply into the root of the lung, and run along with the bronchial tube into its substance; others again, and these apparently the greater number, are more superficially placed, and may be readily traced beneath the pulmonic pleura for a considerable distance; not unfrequently they accompany those branches of the pulmonic vein which lie near the surface of the lung. From the mode of origin and general distribution of these arteries, there can, I think, be no doubt that they are fine accessory nutrient vessels, and supplement, therefore, the bronchial arteries in their distribution. I am unable to state, with certainty, the exact mode of termination of these vessels in the lung; but from their close analogy to the bronchial arteries in their distribution, it may, I think, be safely assumed that those which pass any distance, either in the substance or on the surface of the lung, end in the pulmonary system of vessels, either arteries, capillaries, or veins.

The sub-pleural mediastinal arterial plexus from which these vessels arise presents several interesting relations, of which it may not be amiss to say a few words. From the circumstance that, on the one hand, it anastomoses with the arteries which supply the parietes of the thorax, and, on the other, that it is in communication with the vessels of the lung, it serves to place the vessels of the latter in direct communication with the arteries of the wall—a relation the importance of which will be readily recognized. In a paper published in the *Medico-Chirurgical Review* for July, 1863, I recorded the results of some observations on the arrangement of the arteries in the abdominal cavity, and I pointed out that there existed in the fat and areolar tissue behind the peritoneum

a well-marked arterial plexus to which I applied the term of sub-peritoneal arterial plexus. Through it, not only are the arteries of one viscus in vascular communication with those of another, but the arteries of the abdominal wall are in communication with the visceral arteries, so that one set of vessels may be injected through the other. The sub-pleural mediastinal plexus now described, so far at least as it affords a medium of communication between the visceral and parietal arteries, has in the thoracic cavity an arrangement closely comparable to that of the sub-peritoneal plexus in the cavity of the abdomen.

I believe that in certain cases of malformation of the heart this sub-pleural plexus would, if carefully examined, be found to have assumed a size and relative importance greater than that which it possesses under ordinary conditions. I refer to those cases in which the pulmonary artery is obliterated, and the ductus arteriosus closed, so that the supply of blood to the lungs is derived from other sources, and would suggest that those who may have opportunities of examining cases of this kind should inject this system of vessels.

In conclusion I may state, as a general result of my injections in these and other localities, that though the area or domain appropriated to each artery is, as a rule, clearly defined, yet that where adjacent areas are in contact, the arteries of one almost invariably inosculated with the arteries of another, and under some conditions, actually encroach upon the domain of another.—*Medico-Chirurgical Review*.

THE ACTION OF THE LIVER ON FOOD, ETC.

What is the function of the liver, is still an unanswered question. The researches of Bernard, Dr. Pavy, and others, have not yet told us the whole of the physiology of that organ, although they have told us very much of it. Bernard's theory of the glycogenic power of the organ is denied by Dr. Pavy; and Dr. Pavy's view is now supported by Dr. Robert McDonnell.

That the liver secretes bile, all the world knows, and has long known; but what it does in addition to this, is what we have yet to learn, and want to know. Modern discovery seems to indicate that the mere secretion of bile is probably the least important part which the organ plays; or rather, we should say, that the secretion of the bile is only one part of its complex function; that, while it is secreting bile, it is also forming some other important materials—perchance some blood constituents. Its power of making and storing up an amyloid (starchy) substance in the liver is certain, as Bernard showed; but Bernard, we are now told, erred

in supposing that this glycogenic (amyloid) matter is converted into sugar, which passes into the hepatic veins, and is consumed in the lungs, producing heat. Dr. Pavy denies this, and has given very strong experimental facts to show that during life, and under natural conditions, the amyloid matter is never converted into sugar. And, in support of this view, it has been argued: Let those who assert that the amyloid matter is converted into sugar, and used up as a heat-producer in the respiratory process, tell us what becomes of the amyloid matter which is formed and used up in the tissues of the foetus before respiration begins. Dr. McDonnell agrees with Dr. Pavy that, during life and health, the liver does not convert its amyloid matter into sugar. He holds that its conversion into sugar during life is a deviation from the healthy process. What, then, becomes of this amyloid matter in the liver? Dr. McDonnell believes that the liver is

“A great blood-making organ, in which there is constantly going on a reconstruction of certain ingredients of the blood; that in it the fibrine, etc., which has done its work, is disintegrated; the hydro-carbons of the bile abstracted; and the nitrogen combined with amyloid substance, which, instead of being normally changed into sugar, emerges from the liver as a constituent principle of the protoplasma.”

This is the theory which Dr. McDonnell discusses experimentally in his pamphlet. He first of all examines and corroborates Dr. Pavy's facts tending to show that the amyloid substance is not transformed into sugar during health and life. He then inquires into the physiological relations of the amyloid substance; and, lastly, into the characters, etc., of the blood which enters, and of the blood which leaves the liver; and from his experiments deduces the conclusions above given.

One very important practical lesson is to be drawn from these physiological investigations. Bernard, Dr. Pavy, and Dr. McDonnell are all agreed in this, that amyloid substance may be formed in the body out of nitrogenous articles of food. Also it appears, if Dr. McDonnell's views be corroborated, that not only can this body of man convert albuminous, nitrogenous, food into starchy, carbonaceous food, but that it can also, through the liver's aid convert amylaceous matter into a nitrogenous base. Enough, at all events, is taught us by these valuable experiments; and it is this—that the fascinating theories of Liebig on food, which have now so long and still so firmly possess the minds of the public and the profession, require reconsideration. Look only at one single article of diet, so largely used in our hospitals; we mean beef-tea. Consider, its enormous consumption, and, therefore, its immense cost; and then let us ask ourselves: Are we sure—have we any sound basis on which to rest the

conclusion which we seem so unhesitatingly to have embraced—that in using beef to make beef-tea, and feeding the sick on it, we are acting wisely and economically—using all the nutrition in the beef, and giving the sick the best kind of food? We beg to suggest that, in the matter of this one article of diet, there are very fair reasons to believe that we are, in fact, yearly squandering away the funds of our hospitals; in other words, that we are wasting very large and very expensive quantities of food, and deluding ourselves as to the food—we mean really nutritive matter—which we give our patients. If, for example, a pound of beef, free from bone and fat, is to be converted into a pint of beef-tea (which, if boiled down, would not contain, perhaps, more than half an ounce of solid matter), is it not reasonable to suggest that the greater part of the *meat* is absolutely wasted? Are we really to believe that all the solid materials—the *bouilli*—left after the manufacture of the soup, is useless as food? More than this: Are we sure that this beef-tea is really the best and most agreeable nutriment which we can give to the sick stomach? We sincerely trust that some of our large hospitals, where the consumption of beef-tea is very large, and where it must figure as a very serious item of expenditure, will seriously take this question into consideration. We verily believe that, in this matter, the professional and the public mind is labouring under the charm and delusion in which they have been caught by one of Liebig's fascinating formulae. We will venture to say that it has never yet been *proved* that the beef-tea à la Liebig, or any other way manufactured, really does possess those highly nutritive qualities usually ascribed to it. And we may add, that the way of using meat now so extensively employed by physicians in St. Petersburg, and especially for sick children, is well worthy the general attention of the profession; we mean, as raw meat chopped up very fine, and made into a savoury mass. Trousseau and other Paris physicians employ and speak in very high terms of meat thus administered.—*British Medical Journal*.

ON THE TREATMENT OF ANEURISM BY LEAD.

By G. OWEN REES, M.D., F.R.S., Physician and Lecturer on the Practice of Medicine, Guy's Hospital.

The following case may perhaps be read with interest, as illustrative of the treatment of aneurism on a new plan—viz., that of introducing lead into the system, as a remedy possessing the power of facilitating the coagulation of the blood, a full diet being given at the same time. My chief object in publishing the case is to induce others to treat aneurism in like manner, in order that the fact I have observed may assume its

proper value, and be regarded either as a mere accident or as an effect of the treatment employed. The case was carefully watched and reported by my young friend, Mr. Benjamin Duke.

W. F——, aged 27, residing at Greenwich, was admitted into Stephen ward, Guy's Hospital, on the 26th of Oct., 1864, under the care of Dr. Owen Rees. He was the subject of popliteal aneurism, and had been taken in by Mr. Poland, who transferred the case in order that Dr. Rees might have an opportunity of making a therapeutical experiment.

The patient states that seventeen days ago he was out walking when, on standing still, he felt pain under the left knee. The pain was relieved by flexing the knee-joint. He then observed a tumour over the seat of pain, which has increased in size up to the present date, but has never caused him much trouble. He has ulcers and varicose veins on both legs, the left being the worse. He is a strong, healthy-looking man, single, and a teetotaller, and has always enjoyed good health. Has worked very hard lately. The heart-sounds may be considered normal, if we except a slight prolongation of the second sound. The bowels are generally costive. A distinct bruit is heard over the seat of the aneurism, and pulsation is well-marked.

Mr. Poland's description of the tumour is as follows:—"The aneurism was of the size of a duck's egg, and its contents were perfectly fluid. The walls were excessively thin, so that it was feared rupture would take place. Arrangements were made to commence compression at once, and a failure ensued. Deligation of the artery to be performed. Pressure on the artery above readily commanded pulsation, and was attended by complete emptying of the sac without apparent trace of coagulation. It was considered that the opening of the artery into the sac was of large diameter."

Oct. 29th: Ordered three grains of acetate of lead and one grain of opium powder three times a day; to have full diet, and a chop for breakfast.

Nov. 1st: A slight blue line on the gums. 4th: Complains of loss of appetite, and has frequent calls to stool; the bowels, however, do not act. 5th: Ordered five grains of acetate of lead and one grain of opium powder three times a day. 18th: He complains of loss of appetite. His condition is much the same as on the 4th. Ordered an ounce of castor-oil immediately. 24th: The swelling in the popliteal space has been gradually hardening and enlarging, apparently owing to the deposit of fibrin within the sac of the aneurism. 26th: Ordered two drachms of castor-oil immediately.

Dec. 2nd: Is obliged to discontinue taking the pills on account of

the colic produced. The pulsation in the tumour is very much less. 3rd: Feels easier; has had pain in stomach. Ordered the magnesia and salts mixture twice a day. 5th: Slept badly, having pain in his stomach; his appetite has much diminished. 12th: The pulsation has ceased, but the tumour is larger and more tender, and he cannot straighten his leg on account of the mechanical obstruction caused by it. 15th: Mr. Hilton found that by pressing the femoral artery he could effect the sac, but thought the aneurism was almost cured. The patient has now a clear, well-defined blue line on the margins of the gums, and feels no pain in the stomach. The articular arteries of the left knee-joint can be seen pulsating very distinctly. 17th: The tumour, which almost fills the popliteal space, is diminishing in size. He can nearly straighten his leg. The left leg is flabby, and swells if he stands much upon it, and it measures two inches more in circumference than the right. 20th: The tumour is fast diminishing in size. 31st: He has left the hospital to return to his work.

On Jan. 17th he came to the hospital to be examined by the surgeons, and was seen by nearly the whole surgical staff, amongst the rest by Messrs. Cock, Hilton, and Birkett. He was considered to be perfectly cured. He states that he cannot walk far without feeling a numb sensation over the calf of his left leg, circulation by anastomosing branches being not yet freely established. He has been able to do his work. There is still a clear, well-defined blue line on the margin of the lower gum; the upper is less affected. There is also some enlargement in the popliteal space, which he feels somewhat inconveniently when walking.

It will be observed that the doses of lead were large and continued. Thus three grains of the acetate were given three times a day for six days, and then an increase was made to five grains, a grain of opium being given with each dose. This five-grain dose was continued for twenty-six days. With regard to the pains in the abdomen, they never amounted to colic, and my surprise is that the patient did not suffer more. His attention was directed to the probable occurrence of such pains, and latterly he was inclined to exaggerate them. Though rest was enjoined, the patient would not submit to it. He walked about the ward as it pleased him, and, I am informed, danced on one occasion for the amusement of his companions. It is worthy of remark that when the lead had been taken for three weeks the aneurism had hardened very obviously, and my belief is that we might be content to discontinue the lead should an aneurism begin to change as above described. The system is charged with the metal, and the deposit once begun, we may fairly expect it will continue to the filling up of the sac.

It may be well to mention that the only other case of aneurism in which I have exhibited lead was in that of a man the subject of so advanced a stage of thoracic aneurism that spinal absorption had occurred and paraplegia had been produced. The tumour was clearly visible on the left side of the spine. The case was obviously hopeless, but I gave the lead, in order, if possible, to ascertain what effect it might produce on the structure of the fibrin in the sac on post mortem examination. The man, however, left the hospital, and, I hear, died shortly afterwards. —*Lancet*.

HYPODERMIC MEDICATION.

Under this title Dr. McGugin, of the University of Iowa, gives some interesting cases of the effects of subcutaneous injection of morphia. His list, he says, embraces but a few of all the cases, in all of which the results were nearly as prompt and efficient. 1. In the summer of 1862, a soldier was admitted into hospital who had been wounded in the foot by a rifle-ball. The wound was still discharging, and in a few days several small spiculæ were removed. The wound healed, and he was able to walk with trifling difficulty. In jumping, however, one day, he again injured his foot, which inflamed so much as to confine him to his ward and bed. Trismus appeared during the third night, and by morning the jaws were so tightly closed that speech and deglutition were impossible, and the respiration very laborious. The index finger of the right hand was contracted, and there was some disposition to opisthotonos. Chloroform by inhalation, and endermically applied along the spine, with enemata of tincture of opium, had been the treatment. Very soon afterwards Dr. McGugin saw him. A free incision into the old wound was followed by a discharge of pus, but with no apparent relief. By a small glass syringe, one-third of a grain of acetate of morphia in one drachm of distilled water was injected into the cellular tissue of the arm opposite the insertion of the deltoid muscle. In about half an hour there was some relaxation of the muscles of the jaws. Water was introduced, and a little swallowed with a painful effort. At the expiration of an hour more he swallowed with less difficulty; and in half an hour more, making two hours from the first injection, as he did not seem to improve further, the same amount was injected into the other arm at the same point. In an hour from this second injection he slept soundly, and the respiration was much less difficult. This condition was maintained during the night. He was roused with some effort in the morning, when he asked for water, which was the first word he uttered since the trismus was observed. There was some effort and also some pain in

swallowing the water, nor could he turn his head to either side. He soon sank to sleep again, and slept as profoundly as before. He continued to sleep, at intervals, for two days, when the trismus had entirely disappeared, and the flexors of the index finger were relaxed. In a few days a spiculæ of bone was removed, after which the wound healed permanently. 2. In a case of delirium tremens in a habitual drunkard—a soldier, opiates given by the mouth failed to procure sleep. The hypodermic injection of one-third of a grain of acetate of morphia procured sleep; and a speedy recovery followed. 3. In the case of another soldier who was delirious, and in which nothing could be given, either by the mouth or by injection, which would have any effect in mitigating the symptoms, the hypodermic injection of morphia into the cellular tissue calmed the delirium in less than half an hour, and quiet repose followed. 4. A soldier whose vital power had been much expended by severe duty in the field, and an attack of camp diarrhœa, was seized, since admission, with pneumonia, and sank rapidly. Two days before his death he was wild and frantic, requiring two, and often three nurses to confine him to his bed. His screams were loud, and he was resolutely determined not to take any medicine, nor would he swallow water or any other fluid. Acetate of morphia was injected in the dose of one-fourth of a grain; and in less than an hour he was fully conscious, and continued so until his death, which was easy and tranquil. 5. A washerwoman, aged 45, employed in the hospital, had eaten of fruit too freely, and was attacked with spasms of the diaphragm, stomach, and bowels. The gastric irritation was so great that small portions of morphia placed upon the tongue promptly induced emesis, and were thrown off as fast as given. The injection of acetate of morphia into the tissues of the arm was followed by relief in ten minutes; and in twenty minutes she was asleep, and arose next morning declaring herself “weak, but well.” 6. A lady in this city had for some years been subject to frequent and severe attacks of facial neuralgia. Quinia and morphia and all other appropriate remedies had been resorted to, beside a *quantum sufficit* of potent nostrums, all of which were alike unsuccessful. The paroxysms returned every two weeks, and were more and more severe. Having been sent for in one of her alarming attacks, and finding that reason was suspended, Dr. McGugin at once introduced into the arm the salt of morphia; and in less than half an hour she was entirely relieved of her agonising sufferings, soon was asleep, and has not had a paroxysm since then, which was in May last. 7. Another lady of delicate frame suffered much after her confinement three months previously with sciatica. Hypodermic injection of acetate of morphia on the lower spine, repeated three times,

relieved the pain, and she gradually recovered. After each operation she was entirely relieved, and remained so during a week, when the pain would return again, but not so severely, and finally it disappeared altogether. What advantages are secured by this mode of medication? 1. The remedy does not oppress the brain so much, nor do those unpleasant consequences follow its use by this method as when given by the mouth. 2. Less is required than by the mouth. 3. It requires much less time to produce the same effect. 4. In very many cases in which the effect of opium is desirable, the gastric complications prevent its accomplishment.—*Philadelphia Med. and Surg. Reporter.*

INOCULATION OF SYPHILIS FROM THE DISCHARGE OF A SECONDARY SORE.

THE DISCHARGE BEING COMMUNICATED FROM THE MOUTH OF THE HUSBAND TO THE WIFE'S CHEEK. CLINICAL REMARKS.—The following very interesting and instructive case is given from notes by Mr. Anderson, the dresser of the patient:—

Catherine W——, admitted Nov. 16th, 1864, with an indurated, distinctly circumscribed swelling of the size of a five shilling piece, situated immediately above the left angle of the mouth. It was a reddish purple color in the great part of its area, but had in the centre a patch of excoriation of the size of a shilling, but without any ulceration. Under the jaw of the same side several lymphatic glands were enlarged and indurated. She also complained of sore-throat, but there was no ulceration of the tonsils. These symptoms had lasted for several weeks before the time of her admission. She had been married eight years, but has had no children, and has not miscarried. Never had any primary sore. The pain in the face was very severe, and for this symptom she applied for relief.

Mr. Watson considered the swelling suspiciously like a chancre, and in consultation with Mr. Henry Smith expressed this opinion. It was, however, decided that specific treatment should be withheld until constitutional symptoms showed themselves, especially as the very severe pain in the part gave the appearance of the case being one of facial carbuncle.

The treatment adopted consisted of the administration of tonics and opiates; and this was continued with no improvement in the local condition for several weeks. The swelling increased in size circumferentially, and became somewhat more prominent, and softer in the centre; but no true ulceration occurred; and when punctured on Nov. 28th no pus was found, but the section presented a brawny character, as if infiltrated with fibrin, and very rapidly closed up by primary adhesion.

14th.—Swelling increased in all directions: bulges forward in the centre, where there is indistinct fluctuation.

30th.—For the last ten days she has not presented herself. On inquiry it was found that she had been an in-patient at a large London hospital for a few days, where the surgeon under whose care she was placed proposed, according to the patient's account, to remove the tumour with the knife. At the same time she had been rubbing in mercurial ointment, and her gums are spongy and sore. An eruption of syphilitic lepra has come out on the face and body, and her tonsils are ulcerated. The swelling has increased in prominence, is softer, covered with pale, smooth, moist granulations. More direct questions were now put to the woman, and she stated that her husband was at present attending as an out-patient under the care of Mr. Henry Smith. He (the husband) was at once sent for, and Mr. Smith pointed out a secondary ulcer on the inside of the cheek, for which he had been under specific treatment some weeks past. The man denies having had any primary sore on the penis, but had a urethral discharge in June last.

Mercurial treatment continued up to the present date (Jan. 13th. 1865). The sore is diminishing in size rapidly in all its dimensions, and is cicatrizing at the edges. The eruption has disappeared.

The following clinical remarks were made by Mr. Watson:—

The diagnosis from facial carbuncle was somewhat difficult in the absence of any distinct history, and it was only the very circumscribed character of the induration and the bubo under the jaw which gave a suspicious aspect of syphilis to the case. The chain of evidence subsequently produced was unusually satisfactory, and this case alone would be conclusive as to the transmissibility of secondary syphilis. Mr. Henry Lee, who examined the patient at the Medical Society of London on the 9th January, and made a careful examination also of the sore on the mouth of the husband, was perfectly satisfied of the nature of the case. The history and progress of the case are analogous to those mentioned by several recent authors.

A very interesting case bearing upon the question of the transmission of the poison through secondary inoculation was mentioned at the meeting of the Medical Society of London by Mr. Henry Smith. It was that of a gentleman well known to him, and who had a suspicious sore on the upper lip, which would not heal. Six weeks after the sore first appeared, a well marked secondary eruption came out. The patient was placed under the influence of mercury, and he rapidly got well. This patient strongly denied any illicit intercourse, and there could be little doubt that the sore must have been produced from contact with a secondary ulcer on the tongue or lip of the female.—*Lancet*, Feb. 4th, 1865.

Canada Medical Journal.

MONTREAL, JUNE, 1865.

TO OUR READERS.

With the present number the first volume of the *Canada Medical Journal* is brought to a close. How far we have succeeded in producing a journal worthy of the support of the profession, it is not for us to say—yet we cannot help acknowledging the many kind letters which have reached us from all sections of the Province—letters that have done much to cheer our editorial labour—which, amid the anxieties of a general practice, occupy not a little of our time and attention. Our aim and our ambition is to place our Journal in the hands of every medical practitioner in Canada, and make it to him a valuable monthly visitor. To a certain extent we hope we have succeeded. Our subscription list embraces many of our brethren, but not *all*. May we ask those who now receive it, to aid in extending our circulation? The expenses attendant upon publishing our Journal are large, and the publishers, we may be pardoned for saying, have produced it in a style not excelled by any medical periodical on this continent. To the profession they look for support. Profit they do not anticipate. So far we must say our expectations have been realized; and if those who have not yet remitted the amount of their subscriptions would do so at once, we would enter upon our second volume with the satisfaction of having the first one clear of debt. We have been favoured during the year with many interesting and valuable contributions, and our prospects for the next volume of having the same favour extended to us, is, we are glad to say, encouraging. We have been promised, if the health of the person admit, several valuable papers on syphilis,—a question, we must say, not properly understood by the mass of practitioners. But while we acknowledge the helping hand that has thus been extended to us, we regret that so few of those who have grown grey in the service, have been found to give us information from the abundant store of their experience. We know how heavy are the calls of practice upon them; yet we feel they have a duty to fulfil to the profession, which they

neglect by thus holding back. Elsewhere those similarly situated do not act thus; if they did, the progress of our profession would be slow indeed. The profession in Canada, though now occupying a much better position than it did a few years ago, has not yet attained the position it is entitled to; and to its elevation our best efforts will be directed. It is ever hard to obtain reforms—imagine then the difficulty to obtain our just position from a legislature which legalises almost every system of tom-foolery which exists under the sun. But we will work steadily—perchance some day we may get our reward. With the increase of our population, quackery is getting bold—and for our own protection as well as that of the public, some step must be taken. To this we will give our attention. In a few weeks we will issue the first number of our second volume, and we trust to have all our old subscribers with us, as well as many new ones. Letters on all matters of interest to the profession are requested, and will be answered through the Journal.

QUARANTINE STATION.

We have received information from a source perfectly reliable that the officers in charge of the Quarantine Station at Grosse Isle have received instructions from the Government to exercise special care in the examination of all immigrant vessels, and that in case of the arrival of typhus fever on ship-board, to communicate the fact at once to the head officer at Quebec, so that every precaution may be taken tending to prevent the spread of the disease. This is as it should be. We would gladly see our corporation issue strict orders, and follow them up, of cleaning our back lanes and yards. There is such a thing as typhus fever being generated by local causes, independent of immigration.

MONTREAL GENERAL HOSPITAL.

The Annual Meeting of the Corporation of this noble charity was held on the 16th of May, when the 43rd Annual Report was presented. From it we gather the following items which we know will be of interest to many of our readers. The total amount of moneys received was \$14,925.53, to which may be added the tonnage dues of 1863-4, which were not received till after the close of the fiscal year. They amounted to \$2452.97, making the entire money receipts of the institution for the past year \$17,378.80. The expenditure was a good deal above the receipts, owing

to the high price of provisions, the increased number of patients admitted to its wards, and extensive alterations and improvements which the Committee of Management deemed necessary. The amount disbursed being \$18,042.06, which, compared with the receipts, not including the two years tonnage dues, shows a deficiency of \$3716.53. The amount paid by students for tickets was \$632.00. The number of patients who participated in the benefits of the hospital during the year were 8,694, of which 1,400 were in-door, and 7924 out-door patients. Of the in-door patients 1202 were cured or relieved, the deaths were 94, and at the time of report 104 remained in hospital. We are glad to notice that the Committee have not lost sight of the great necessity which exists for the erection of a separate building for small-pox, and other contagious or infectious diseases, and only await a revival of business to appeal to the liberality of our citizens. We trust they may not have long to wait. We would, before closing, again remind the committee of the great necessity which exists to provide the hospital with a new and improved operating theatre. We trust that much needed improvement will be effected before the session of McGill University opens.

COLLEGE OF PHYSICIANS AND SURGEONS OF LOWER CANADA.

The semi-annual meeting of the Board of Governors of the College of Physicians and Surgeons of Lower Canada was held at the Mechanics Institute, Montreal, on the 9th of May.

PRESENT: Drs. Marsden, Tassé, Marmette, Landry, Blanchet, Weilbrenner, Robitaille, Michaud, Peltier, Munro, Russell, Brigham, Boyer, Foster, Tetu, Robillard, Fenwick, Smith, Howard, Worthington, Gilbert, Boudreau, Hamilton, Smallwood, Tessier, Chervetils, Sutherland, Dufresne, Chamberlin.

The President took the chair at 10 o'clock, a. m.

The minutes of the meeting held at Quebec, on the 11th October last, were read.

Moved by Dr. Blanchet, seconded by Dr. Fenwick, and resolved, "That the motion proposed at the last meeting, in October, 1864, on the subject of payment to Drs. Blanchet and Sewell, for travelling expenses to Montreal, be rescinded from the minutes of the College, and that the minutes of the last meeting, so amended, be adopted.

Dr. Blanchet then returned ten dollars to the funds of the College, being the amount paid to him for travelling expenses, and referred to in the above resolution.

Excuses for absence were read from Drs. Von Iffland, Scott, and Turcotte, and received as satisfactory.

The President handed to the Treasurer twenty dollars, being the amount of a fine levied under a judgment against a Mr. Ouellette, for practising without license. Dr. Hamel, of Saint Croix, received authority to prosecute Mr. Ouellette in the name of the College.

The Board was informed of the removal of Dr. Smallwood's residence from the district, to the city of Montreal, and his seat was declared vacant. The Board immediately proceeded to fill up the vacancy by an election by ballot, and Dr. Dufresne was unanimously elected a governor for the district of Montreal, to replace Dr. Smallwood.

The result of the ballot to fill up the vacancy caused by the death of Dr. Jones was filled up by the election of Dr. Smallwood thereto.

The election, by ballot, for a Registrar and Treasurer, in the place of the late Dr. Jones, resulted in the election of Dr. Boyer.

Moved by Dr. Chamberlin, seconded by Dr. Smallwood, and resolved, "That since our semi-annual meeting, in October last, it has pleased Almighty God to take from amongst us our efficient and worthy Registrar and Treasurer, Dr. Thomas Walter Jones, one of the early members of this College; and, while we deeply deplore his loss to us, for his honest, upright, and straight-forward conduct, we do, in all sincerity, mingle our regrets with his bereaved and sorrowing widow, and would, by this resolution, convey to her our deepest sympathy and condolence, and that the Secretary convey to her a copy of this resolution."

Drs. Marsden and Peltier became security, each, in the sum of fifty pounds currency, for Dr. Boyer, the Registrar and Treasurer of the College, and furnished their joint bond to the College to that effect, dated, Montreal, 9th May, 1865.

Dr. J. Louis Bacon, of St. Thomas, district of Quebec, and Dr. John Erskine, of Waterloo, district of Montreal, were elected, by ballot, members of the College.

Applications for membership were received from the following gentlemen:—Dr. L. E. Bardy, of Quebec, Dr. Joseph Godric Blanchet, district of Quebec, and Dr. René Bedard, district of Quebec.

Dr. Peltier read a letter from Dr. Shaver, calling upon the College to reimburse him the costs of an action for libel, instituted by him against a Mr. Linton. Dr. Shaver stated in his letter that Dr. A. Hall promised, as President of the College, to defray his expenses.

Moved by Dr. Gilbert, seconded by Dr. Howard, "That the Secretary be requested to communicate with Dr. Shaver, and ascertain whether he can furnish any evidence that Dr. Hall, as President of our College,

authorized him, officially, to prosecute the action to which his letter refers.

Moved, in amendment, by Dr. Landry, seconded by Dr. Tetu, "That the College of Physicians and Surgeons of Lower Canada does not consider itself, in any manner, responsible for the expenses incurred by Dr. Shaver, in an action instituted by him against a Mr. Linton, for libel; and that Dr. Shaver has no claim against the said College." The amendment was passed unanimously.

Dr. Hall, having entered the room, stated to the President that he had not authorized Dr. Shaver to incur any expenditure on behalf of the College.

The Board instructed Dr. Peltier, the Secretary, to insure the portrait of the late Dr. Arnoldi, senior, the first president of the College.

Moved by Dr. Smallwood, seconded by Dr. Foster, and resolved, "That Drs. Marsden, Tessier, and Russell be named a Committee for the purpose of carrying through the three branches of the Legislature a Bill to regulate the sale of poisons."

Moved by Dr. Gilbert, seconded by Dr. Chamberlin, and resolved, "That Drs. Howard, Robillard, and Smallwood be named a Committee to draft a petition to the three branches of the Legislature, to authorize the formation of a Medical Benevolent Fund for the College of Physicians and Surgeons of Lower Canada, and that the Quebec Committee, on poisons, be requested to assist in the passage of the said petition."

At one o'clock, p. m., the President adjourned the meeting for one hour.

At two, p. m. the Board re-assembled.

Dr. Howard read the report from the Committee on the subject of the expediency of establishing a class of Fellows in the College. The report was read in French by Dr. Robillard, and elicited a lengthy and interesting discussion. It was received, and is to be again brought up for discussion at the triennial meeting in July next.

Here the general business of the College terminated, and the examination of candidates was commenced and continued till five p. m., when the Board adjourned till seven p. m.

The members dined together as the guests of the members for the City of Montreal.

7 o'clock p. m. The Board reassembled. The examinations were continued till 10 o'clock p.m., and then adjourned till 9 a.m., the next morning. The names of the governors present at the time of the adjournment, were ordered to be taken down. Present: Drs. Marsden,

Landry, Tessier, Robillard, Peltier, Tetu, Russell, Blanchet, Foster, Tassé, Dufresne. The meeting then adjourned.

MONTREAL, Wednesday, 10th May, 1865.

At 9 o'clock a.m., the Board met.

Present; Drs. Marsden, Smallwood, Landry, Chamberlin, Brigham, Foster, Tassé, Munro, Dufresne, Peltier, Michaud, Tétu, Weilbrenner, Robitaille, Boyer, Boudreau, Chevrefils, Marmette, Gilbert, Blanchet, Smith, Tessier, Howard.

Examination of candidates was continued. At 1 o'clock, p.m., the Board adjourned for one hour. At 2 p.m., the Board reassembled. The examinations were continued till all the candidates were examined. The last candidate who presented himself was Mr. Thomas Merrill Prime, who claimed his right to be examined by the Board for a license to practise, by virtue of an Act of the Provincial Parliament, passed for that purpose. The validity of the claim was admitted, and five members were named by the Board to examine this candidate in the presence of the Board. The members named were Drs. Landry, Howard, Marsden, Peltier, and Russell. The examinations being now completed, the Board resumed the general business of the College.

Applications for membership were received from Drs. Mayrand and Gariépy.

The Auditors' Report was read and unanimously adopted.

Moved by Dr. Howard, seconded by Dr. Landry, "That in future, the examinations for the license of the College of Physicians and Surgeons of Lower Canada, shall be conducted in writing; and at the first regular meeting, after the triennial, three governors shall be nominated examiners on each of the following subjects,—a different three for each subject,—viz., Anatomy, Chemistry, Materia Medica, Institutes of Medicine, Theory and Practice of Medicine, Surgery, and Midwifery, and two governors shall be nominated examiners,—a different two for each subject,—on Medical Jurisprudence and Botany. That three questions upon each of the subjects shall be proposed to each candidate, except in case of Medical Jurisprudence and Botany, upon each of which two questions shall suffice. Three hours shall be allowed for the written examination. The examiners shall have the option of interrogating the candidates upon their written answers, when it may be thought necessary. The candidates shall attach a motto instead of their real name.

Dr. Tessier moved in amendment, seconded by Dr. Robillard, "That the question of changing the mode of examination proposed by Dr. Howard and seconded by Dr. Landry, be taken into consideration, as

the first order of the day, at the next semi-annual meeting." Amendment passed.

Moved by Dr. Munro, seconded by Dr. Howard, and resolved unanimously, "That the thanks of the governors of the College of Physicians and Surgeons of Lower Canada are due, and are hereby tendered, to the authorities of the Laval University, for the kind manner in which they have placed the University at the service of the College during the last three years.

At 6 o'clock P.M., the business of the College being completed, the President ordered the names of the governors present to be taken down. Present: Drs. Marsden, Howard, Dufresne, Robillard, Smith, Fenwick, Peltier, Boyer, Russell.

The meeting was then adjourned.

NAMES OF GENTLEMEN WHO HAVE RECEIVED THEIR LICENSE.

GRADUATES OF M'GILL COLLEGE.

Malcolm Roscoe Meigs, Edward Payson Hurd, Henry Clinton Rugg, Hannibal Whitney Wood, John Colborne Anderson, Alfred Beaudet, Prosper Bender, John R. Mackie, John W. Bligh, R. Crammond Blair, Cornelius J. F. R. Phelan, N. Mongenais, T. A. Duford, Gilbert Prout Girdwood.

COLLEGE OF SURGEONS OF EDINBURGH.

J. J. Anderson.

AFTER SUCCESSFUL EXAMINATION.

F. X. Valode, René Darche, Edmond Mount, Fred. Gaboury, Joseph Beaudin, Seraphin Gauthier, J. Henri Roy, Dosithée Martel, Edwin Munro, Cléophas Perrault, Henri D. Labadie, Laurent Gignère, George H. Dufresne, Joseph Paquet, Napoléon Hébert, Alphonse Lenoir, Ephrem Chapeleau, J. B. Forest, T. M. Prime, Hermidas Leblanc, Léonidas Lavree, Cleophas Roy.

LICENSE AS CHEMIST AND DRUGGIST.

Esrom Aram Duclos, Wolfred D. E. Nelson, Thomas S. Bulmer.

STUDENTS FOR THE STUDY OF MEDICINE.

Charles Pratt, Julien Guernon, Edward Boissy, Alf. Meunier, L. Proulx, A. Tremblay, Elzéar Plante, Eustache Hurtubise, Emmanuel Lachapelle, Emery Gervais, Wilbrod Ferron, Siméon Aubuchon, Joseph Lanctot, Alfred Larose, Hypolite Moreau, Magloire Archambault, Joseph B. Deguise, Henri G. Hénault, F. X. Trudel, N. Brodeur, H. Neilson, N. Brunette, H. Casgrain, G. Matte, J. Potvin, P. Giroux, J. B. Bélanger.

STUDENT FOR THE STUDY OF PHARMACY.

Charles McDonald.

HECTOR PELTIER, M.D., Edin.,

*Secretary of the College of Physicians and Surgeons
for the District of Montreal.*

COLLEGE OF PHYSICIANS AND SURGEONS OF LOWER CANADA.

The members of the College are especially reminded that the triennial meeting will be held at Three Rivers on the second Wednesday of July next. As business of great moment will be submitted, a full attendance is particularly requested.

At this meeting the election of the Board of Governors for the ensuing three years, will take place.

Those gentlemen who find it impossible to attend should hand their proxies to a friend. Members who have not done so, will have to sign the book of the Registrar, before they will be entitled to vote.

MORTALITY OF CITIES.

The city of Paris in 1841, had 1 death in 36 of its population. In 1864 the number of deaths was only 1 in 40. Wide streets and open boulevards, with public gardens and squares have done for Paris what they will do for any city that is not insane enough to neglect its duty anent the sanitary condition of its inhabitants. What about our public park?

MEDICAL NEWS.

The *Patria* of Naples states that there is at present in the Hospital of Incurables in that city an old woman who is suffering from a strange disease. She every day eats at least five portions of roast meat, seventy eggs, several loaves, and other food, of course including a good quantity of macaroni. When attempts are made to reduce her diet she raves like a mad woman. Professor Zamoglia has recently undertaken to cure the poor woman, but up to the present time her appetite remains unimpaired.

Dr. Watson has been re-elected President of the Royal College of Physicians, London.—Dr. Richardson, an English chemist, according to the American Druggists' Circular, says iodine, placed in a small box, with a perforated lid, destroys organic poisons in rooms. During an epidemic of small pox in London, he saw it used with great advantage.—M. Decaisne of Antwerp treats itch by simply spreading petroleum all over the body of the patient. He has obtained excellent results, and finds that the emanations from the oil purify the clothes which are put on immediately after the operation.

Dr. Valentine Mott, one of the ablest of American surgeons, died at his residence in New York, on the 26th of April last, at the advanced age of eighty years. It is proposed to erect a bronze statue to his memory in the city of New York.—During 1864 there were vaccinated or re-vaccinated 69,560 soldiers of the Prussian army. Of these 59,396 had distinct, and 7,265 indistinct marks, and 2,899 no marks at all of previous vaccination. The result of the vaccination was 43,500 regular, 10,505 irregular, pustules, and in 15,459 no pustules at all. Of the latter on revaccination 4,897 succeeded and 10,392 were followed by no result. From this it appears that in 69,560 men the vaccination produced regular pustules in 48,493 or in about seventy per cent.—Dr. Douglas Maclagan has succeeded Dr. Warburton Begbie (who, having completed his allotted time of hospital attendance, was obliged to retire) as professor of clinical medicine in the Royal Infirmary, Edinburgh.—Dr. Warlomont, of Brussels, is forming an establishment for keeping cows to supply vaccine matter.—The Princess of Wales has signified her intention to become Patron to the Hospital for Diseases of Women and Children in Soho Square, London.—There were thirty-nine medical men in the convention which condemned Louis XVI to death. Of these seventeen voted for his imprisonment, and twenty-two for his death.—The Senate of the University of London have decided upon instituting the degree of Bachelor of Surgery.—The University of Pennsylvania conferred the degree of M.D. upon one hundred and seventeen graduates in April last.