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(HALIFAX, NOVA SCOTIA.)

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MEDICINE and SURGERY.

VOL. VIII.—No. 12.

DECEMBER, 1896.

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VOL. VIII.

HALIFAX, N. S., DECEMBER, 1896.

No. 12.

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Original Communications.

A MORNING'S WORK AT THE SAMARITAN HOSPITAL FOR  
WOMEN, MONTREAL.

BY A. LAPHORN SMITH, B. A., M. D., M. R. C. S., England. Fellow of the American Gynecological Society, Surgeon-in-chief of the Samaritan Hospital, Gynecologist to the Western Hospital and Montreal Dispensary, Professor of Clinical Gynecology in Bishop's University, Montreal.

The following work was done between the hours of 8 and 10.30 a. m., of the 27th August in the presence of a number of visiting members of the Canadian Medical Association who had expressed a desire to witness some major and minor gynecological operations. As a rule we seldom exceed six or seven operations in one morning, so that this was an unusually busy morning's work. For being able to get through with so many operations in that time, I am indebted to the members of the staff, especially Drs. Wilson, Letellier, Sylvester, MacNamara and Fiske, who assisted me. The hour of 8 a. m. was chosen for two reasons, on this occasion: 1st, in order not to interfere with the sessions of the Association; and 2nd, because I am much in favor of early morning operations. I would like to embrace this opportunity of putting in

A PLEA FOR EARLY MORNING OPERATIONS,

which are the rule nearly all over the Continent of Europe, and which I have advocated ever since my last visit to the European clinics. At Oldshausen's clinics in Berlin, visitors must arrive before 6.45 a. m., sign

the book, remove their outer clothing, and put on disinfected robes, so as to be in the operating room precisely at 7 o'clock, when the first incision is made. The early morning operations have much to commend them; in the first place the operator is fresh both in body and mind for the effort he is called upon to make; in the second place, the light is good, much better than it is at 2 or 3 or 4 p. m., at which hour some operators work: but above all, the patient is saved the mental discomfort of thinking of the ordeal she has to go through hour after hour from early morning till noon, as well as the physical discomfort of fasting all day.

The first patient was Mrs. M., 46 years of age, who had come to the Montreal Dispensary a few weeks previously, in a deplorable state, the uterus hanging outside her body, and the bladder and rectum with it. The vagina had become greatly thickened and quite dry and scaly like the skin. The cervix was ulcerated from bruising and contact with the clothing. The uterus was replaced inside the body, and the patient sent into the hospital for rest in bed, so that the organ which was much enlarged might be reduced in size. It has lately become the custom on the Continent, especially in France, to do vaginal hysterectomy in such cases, but ventrofixation gives such good results with so little risks, that although I have removed the uterus for procidentia and found it very easy, yet I hardly feel justified in doing it. My usual practice in such cases is to amputate the cervix by Schroeder's method, after first dilating and curetting the uterus; then to remedy the cystocele by Stoltz's operation, which consists in denuding an area as large as a hen's egg from the anterior vaginal mucous membrane, covering the bladder, after which a purse string of silkworm gut is threaded around the margin of the denudation underneath it, and drawn up tight and tied. By this means the area of the anterior vaginal wall is greatly lessened and the bladder supported. This cystocele or falling of the bladder is sometimes very distressing, giving rise to much the same symptoms as enlargement of the prostate in men, for owing to the sacculation of the bladder, the latter is never thoroughly emptied, and decomposition of urine ensues. This operation is usually followed by posterior colporrhaphy or Hegar's operation for repair of the lacerated perineum. But neither of these operations was performed on this patient at this time, for several reasons; the principal one being her great weakness, on account of which it was thought better to postpone these two operations to a later period, so she was put on the laparotomy table and prepared to have the abdo-

men opened. These preparations were rendered shorter at the time owing to the patient having been carefully prepared beforehand; the bowels having been well cleared out, strychnine  $1/20$  grain given 3 times a day, and a soap poultice put on the night before; so that all that was required before the operation was to scrub the abdomen with soap and brush and to shave it and the pubis, after which it was washed with 1 in 1000 sublimate solution, and then with plain boiled water so as to save the instruments. But no permanganate or oxalic solution was used, as I do not think that it is necessary to use them anywhere except on the hands. The same reason for using them on the hands does not apply to the abdomen which is always kept comparatively free from contact with infected surfaces. It only required a few minutes to open the abdomen and take up the uterus with a bullet forceps, the ovaries being small and giving no trouble, and the woman past the menopause, were left alone. The anterior surface of the uterus near the top of the fundus was scraped to the extent of an inch, and the corresponding surface on the abdominal peritoneum scarified; a couple of fine sterilised silk stitches were passed through the fascia and peritoneum and through the anterior wall of the uterus, but not going into the uterine cavity. During a recent discussion on the subjection of Ventrofixation, or as some prefer to name it, *Suspensio uteri*, it came out that it was not necessary to include the muscles or their aponeurosis in the ligatures which fasten the uterus to the abdominal wall, all that is necessary being to pass a very fine silk ligature through the peritoneum and uterine wall, whereby the opposing surfaces will be kept in contact until firm adhesions are formed, which is all that we really need. On several occasions I have trusted for this purpose to the silkworm gut sutures closing up the abdominal incision being passed through the scarified wall of the uterus; and the plan seemed to work well until I had a failure, since which I have always left two very carefully sterilised fine silk sutures. Occasionally these have suppurated and have had to be removed, but eventually the patients did well and have remained well ever since.

During the process of washing the field of operation, one of the visitors asked how I sterilized the soap, as he thought it inconsistent to sterilize the water and then to use soap full of disease germs. The answer is that soap is manufactured by boiling it at a very high temperature, very much higher than boiled water, a temperature in which no living thing can live; so that while the outside of a piece of soap

may have bacteria on it, this surface is soon washed off, leaving a layer of thoroughly sterilized material underneath.

The incision was very small, so that only three or four silkworm gut sutures were needed, and the bowels were never seen as the operation was performed with the patient in the Trendelenburg posture. This patient made an excellent recovery, and went out of the hospital in four weeks.

The next patient was a woman 34 years of age who had been incapacitated from attending to her household or other duties since many years by a large, heavy and tender, prolapsed ovary. She had been well treated by tampons and pessaries for more than a year, with little or no benefit, and it was therefore decided to remove the ovary, which was done very speedily; but the uterus was not suspended from the abdominal wall, as it was in good position. The patient made a very rapid recovery, having hardly any pain afterwards and being well enough to get up in a week, although she was kept in bed for nearly three weeks. She has been heard from while writing this two months subsequent to the operation, and was enjoying better health than she had had for many years.

The third patient had a lacerated cervix which had been repaired several times, but had healed by scar tissue, instead of by primary union, one of the scars being situated in the anterior lip, a rather unusual place; there was also much eversion, so that anyone looking at the cervix with a speculum would have thought that it was ulcerated merely; although on examining with the finger, the laceration could be distinctly felt. I might mention here that lacerated cervix should always be *looked* for with the finger, as many lacerations can be easily recognized by touch which would escape detection or be mistaken for ulceration and improperly treated, if the speculum be used. I believe that many cases of cancer of the cervix are due to the irritation caused by frequent applications of nitrate of silver or other caustics. This patient was suffering from dyspepsia and neuralgia, especially of the brain. The advantage of the anæsthetic was taken to make a thorough examination of the ovaries and tubes, and they were found healthy. These organs should always be examined carefully in every case in which it is proposed to operate on the cervix, for it is of little avail to repair a lacerated cervix while we leave a leaking pus tube setting up frequent attacks of pelvic peritonitis; not only that, but the manipulations necessary for a Scroeder or Emmet operation would be sufficient

to rupture adhesions of the tube, and allow the pus to pour out into the general peritoneal cavity. In this cases the uterus was dilated and curetted and Schroeder's amputation of the cervix performed. This is a pretty operation, being performed in such a manner that the hard fibrous tissue full of cystic degeneration is all removed and the raw surfaces covered over with flaps of soft mucous membrane taken from the vaginal surface of the cervix. The suturing material was strong catgut prepared with the juniper oil which holds good for about ten days, at the end of which time union is complete. This patient went home at the end of two weeks, and has also been seen after two months since the operation, looking a very different woman, her dyspepsia is cured, her headaches and neuralgias are gone, she has no leucorrhœa and she is getting fat.

The fourth case was Mrs. R., thirty-five years of age, who had been complaining for about a year of pain in her right side which was thought to be due to the appendix. About two weeks before admission she had been suddenly attacked with acute pains in the right side and over the bladder and her temperature and pulse ran up. The urine was very red and scanty, and its passage caused great pain, and this attack was diagnosed as an attack of the gravel, although no small stones were found in the urine. She was a very ill woman, lying in bed on her back with her knees drawn up and suffering intense pain necessitating the use of morphine, poultices, &c. On admission to the hospital, however, and on careful examination, a large hard mass slightly fluctuating was found to be filling the right inguinal and part of the umbilical and lumbar regions, and on examination per vaginam the uterus was found to be pushed to the left side by a large tense round body projecting low into the pelvis. But there was another smaller mass beneath this which was slightly moveable and which presented the feeling of a papilloma or a little bunch of wild grapes. This made the diagnosis rather more complicated, especially as the left ovary could not be found at all. I had this patient examined by nearly all the staff and by one or two visiting gynecologists from the United States, and there was quite a diversity of opinion as to what the mass might be. The patient informed us that her period had been profuse the last time, which made us remember the possibility of a tubal pregnancy and tubal abortion, in which case the nodular mass might have been the escaped fœtus, others again thought that it might be a fibroid tumor, as it was very adherent or apparently continuous with the uterus; others again thought that it might be an ovarian cyst,

The fact that the woman had had such a severe attack of pain on the right side with high temperature and rapid pulse two weeks previous to her admission pointed rather to a suppurating appendix or to a pus tube. I mentioned to the visitors that I was not at all sure what the nature of the mass might be, and that I agreed with one of the greatest operators living, who states that the larger his experience the less inclined was he to make a positive diagnosis before opening the abdomen. I was rather inclined to think that the mass was either a papillomatous cyst or a broad ligament cyst. After careful preparation the abdomen was opened, the fingers introduced into the left side where no ovary could be found; but on the right side there was a large, almost black looking tumor as big as an adult's head adherent everywhere; to the abdominal wall, to the bowels, to the bladder, and to the pelvic cavity; the adhesions were rather fresh, so the tumor was easily separated simply by passing the hand over it, which however caused free oozing. During the process of enucleation the tumor burst, and a black tarry fluid escaped all over the field of operation and some of it into the abdominal cavity, in spite of the precaution we had taken to protect the latter with sterilized towels. The tumor was then extracted and found to be an ovarian cyst of the left side which had moved over to the right side and been twisted, and a hemorrhage had taken place into its cavity, owing to the obstruction in the ovarian vein caused by the twisting of the pedicle. In fact, the tumor was depending upon its adhesions with the bowels and parietal peritoneum for its nourishment for the last two weeks, as when I was taking it out the pedicle broke and no hemorrhage took place from it; the ovarian artery however was ligatured an inch away from the pedicle. As soon as this tumor was removed attention was now directed to the right ovary which was easily lifted out, and was about the size of an orange, being covered with papillomatous or warty excrescences. It was also tied and cut off. As the bowels were very much soiled and there was very free oozing from many raw surfaces, the abdominal cavity was thoroughly washed out with three or four gallons of very hot sterilized water, the hand being introduced and paddled about among the bowels, so as to wash them well. A few large oozing spots on the back of the uterus and broad ligaments were tied with fine silk and the bleeding was pretty well stopped. The uterus was then attached to the abdominal wall as in the first case and the abdominal cavity sewed up by through and through silkworm gut sutures placed rather closely together. This patient, as might be expected, suffered a

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"I have used your Liquid Malt Extract, and am highly pleased with it. In cases of mal-nutrition where Malt is indicated, its action is satisfactory. Especially during lactation, however, when the strength of the mother is deficient, or the secretion scanty, its effect is highly gratifying. Its reasonable price brings it within the reach of all."

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ST. ANNE DE LA PERADE, Nov. 27, 1895.

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DR. J. LESPERANCE, St. Denis St., Montreal, tells us that he can express no higher opinion for Wyeth's Extract of Malt than to say that he has at present some sixty patients using it.

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DR. A. R. GORDON, Toronto, writes:—

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"It affords me great pleasure to say that ever since its introduction I have prescribed Wyeth's Malt Extract with gratifying results. I believe it to be a most valuable and reliable aid and stimulant to the processes of digestion and assimilation, in addition to its purely nutrient qualities, which from analysis given must be of a high order."

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"I have often had much difficulty in getting patients to take the semi-solid Extracts of Malt and your preparation of Wyeth's Liquid Malt Extract I think will fill a long felt want, and I see a very large field for its use."

F. WAYLAND CAMPBELL, M. A., M. D., L. R. C. P., Lond.

DR. F. A. MARCOTTE, of St. Anne de la Perade, also writes:—

"I prescribed Wyeth's Malt Extract as a tonic in great feebleness produced by laborious accouchement with excellent results, and I can recommend it above all a tonic to augment lacteal secretions."

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There seems to be little or no doubt from recent investigations and the flattering results of the internal exhibition of this derivative of Turpentine, that it plays a very important part in the therapeutics of the profession. In the treatment of Chronic and Obstinate Cough, Bronchitis, etc., it has proven itself. A number of our medical men most familiar with the treatment of diseases and ailments of the lungs and throat have pronounced it as "the best expectorant in existence."

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Made of two, three and four grains.

Practical physicians need hardly be told how frequently ordinary cough remedies and expectorants fail; the agents that *relieve* the cough *disorder* the stomach. It is a misfortune of the action of most remedies used against cough, that they are apt to distress the stomach and impair the appetite. As in all cases of chronic cough it is of vital importance to maintain the nutrition, the value of a remedy such as Wyeth's Syrup White Pine can be readily appreciated.

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good deal and made a somewhat anxious recovery, owing to the amount of previous peritonitis and the large raw surfaces in the abdomen. But she was able to go home in five weeks, when she took an attack of pleurisy somewhat delaying her recovery; although at the present time, eight weeks from the operation, she is going about her house and doing a little work; and I have no doubt that her recovery will be as good as the others.

There were several other cases of great interest awaiting operation, among them one of pus tubes which had ruptured into the rectum, the woman being much exhausted with septic fever; but the hour being half past ten and the members having to leave for the work in the sections of the Association, the other cases were held over till the next day. This hurried report has been prepared at the request of several of those who were present who have written to ask whether the patients recovered; and I thought it might interest them as well as those who were not present to hear that they not only recovered, but that they made such good recoveries.



## REPORT OF TEN CASES OF APPENDICITIS CAECI, WITH REMARKS.

Read at N. B. Medical Society 1896, by A. B. ATHERTON, M. D.

After rather urgent solicitation from your committee of arrangements, I consented to write a hastily prepared paper on the above subject, to be read at your present meeting. When so much has been presented to the profession by much abler and more experienced men, upon this question, it may seem superfluous for me to add my small quota to what has been written during the last few years. But, as many points in reference to appendicitis still remain unsettled, it is hoped that some benefit may be derived from a further discussion among ourselves in regard to the matter.

I will first relate briefly the histories of those cases which have come under my care during the last four years, and then offer a few remarks upon them and the subject generally.

CASE 1.—On July 4th, 1892, I was called to see Mrs. M., a multipara, aged 33 years, who had been suffering for six days from abdominal pain, at first general and then localized on right side. No vomiting. Took a cathartic the day before, and bowels moved freely before my visit. No menstrual disorder. No similar attack before.

I found her flushed, with a pulse of 100 and T. 101°. On examination a hardish swelling found on right side above anterior crest of ilium, tender on pressure, and somewhat resonant over it. General abdomen moderately disturbed and tympanic. Hot fomentations and  $\frac{1}{4}$  gr. morphia ordered *p. r. n.*

After a week of this treatment, the general abdominal swelling had subsided, but a hard map still felt on right side. T. about 100°.

During the two following days the T. kept at over 101°, and it was decided to explore the swelling.

July 10.—*Operation.*—Four inch incision over part, and after getting in 2 or 3 inches I reached fetid pus with some bubbles of gas behind cæcum. Counter opening made in loin and drainage tube passed through from front to back. Also some iodoform gauze used to loosely plug cavity. Patient did well for three days, when suddenly a large swelling

developed in right parotid gland, followed within a few hours by the same on left side. Pus found in both in five days and evacuated. Within the next week four openings were required in right parotid region and three in left. Also pus was discharged freely from both ears. Subsequently some large sloughs separated, and by Aug. 26th patient was about the house with wounds all healed.

Incidentally, I may mention that I attended patient again on August 1st, 1893, when a ten pound boy was safely delivered.

CASE 2.—On Oct. 26th, I was called by Dr. Cuthbertson, of Toronto, to see a young man with him in consultation

*History.*—Generally healthy till two years ago, when after a blow on right side of abdomen was seized with a severe pain there, followed by peritonitis. This laid him up two weeks in bed. Convalescence, though slow, was satisfactory, and he considered himself quite well till three days ago, when a few hours after rather severe exertion, he was attacked with a sudden cramp-like pain in right abdomen, which has continued in spite of opiates, etc.

I found him with a pinched countenance, thoracic respiration, belly hard and tympanitic, and pain and tenderness over caecum. P. 128. T. 101.4°.

I advised immediate operation as the only chance for him, and with Dr. C's assistance made the usual incision, and after some considerable difficulty, from firm adhesions, reached foul pus. General peritoneal cavity washed out with plain warm water, and drainage tube and iodoform gauze put in. At close of operation P. was 140 and patient gradually sank and died in 36 hours.

Autopsy revealed an old pus cavity about appendix, with thick walls, containing a faecal concretion. This old abscess had ruptured into the general peritoneal cavity, producing suppurative peritonitis. The distal end of appendix was blackish and gangrenous-looking, but no opening found in it.

CASE 3.—F. L., aged 23, female. Never very strong. Was laid up for two or three weeks about a year ago with "inflammation of the bowels."

I was called to her on Dec. 14th, 1894, at 1.30 in the morning. Severe abdominal pain had come on the previous evening, and as no improvement had taken place from domestic remedies, I was sent for. There had been no vomiting. I found her lying in bed with lower limbs straight. Belly soft and not much distended. Pain and tenderness most

marked in right epigastric region. P. 72. T. normal. She had had a constipated motion thirty-six hours before.

I administered  $\frac{1}{4}$  gr. morphine hypodermically, and ordered the same dose to be taken *p. r. n.* by the mouth. During the day the pain and tenderness settled down to McBurney's point, and the right abdominal muscles became more resistant to pressure. Vomited two or three times. P. rose to 90 and T. to 100°.

At 4 p. m. she was operated on at the Woman's Hospital, Toronto. Three or four ounces of turbid serum escaped and the appendix covered with lymph was found at back of cæcum. Ligatured with silk and removed, the stump being cauterized with carbolic acid. This was then dropped and the peritoneum sponged out. Wound closed without drainage.

Convalescence good. Left hospital well in exactly four weeks. On examination the mucous membrane of appendix was quite black looking and the peritoneal coat at one spot was distinctly gangrenous.

CASE 4.—J. W., aet. 30, male. Nothing remarkable in family history, except that a twin brother was laid up about three months at the age of fourteen with what was called peritonitis. He himself, has suffered more or less from "cramps" for years, which lasted usually only a few minutes. Nine months ago he had what his physician considered to be inflammation of the bowels. It confined him to bed only three days.

Jan. 12, 1894.—Present illness began suddenly with abdominal pain two days ago. His physician, Dr. Bryan, treated him with morphine and calomel. Bowels moved this morning from latter. I found him with a flat belly but tender and hard, especially over cæcum. T. 100°.

Operation advised and done in afternoon. A coil of small intestine found attached by old adhesions to the inner side of cæcum. Appendix hanging down into pelvis and adherent there. Separated and removed as in Case 3. It was covered at distal half with purulent lymph and dark in colour. No concretion or foreign body in it, but it was distended with foul pus. Iodoform gauze drain used. Silk-worm gut sutures. Did well after operation, and was about in a few weeks.

On June 15th, five months after the operation, I was again called by Dr. Bryan to see the patient with intestinal obstruction, for which I opened him and divided a band in pelvis, which had constricted a loop of intestine. Recovery.

CASE 5.—B. W., aet. 30, male. One brother had "inflammation of the bowels" several years ago. Patient himself has never had any such attack until the present.

On Dec. 22nd., 1894, while out of Toronto, was suddenly seized with abdominal pain. Attended for two or three weeks by Dr. Charlton, of Weston. Then returned home to the city. Since his return has not felt so well, and I was called to see him on the afternoon of Jan. 17th, 1895.

I found P. 100, T. 101.1°. Some soreness and pain in right groin and loins. Bowels regular. Not much tenderness on pressure.

I advised rest in bed and care in diet. Under this he improved somewhat, but P. and T. never became quite normal. On Feb. 3rd. he had a discharge with stool of about half an ounce of what was taken (to be pus) by his attendants. Next day he felt better and his T. was normal.

Feb. 22.—T. soon rose again after last report, and has run from 99.5° to 100.5°. Gets out on couch every day. Has some difficulty in fully extending right limb, because of its hurting him in the groin. As he remained much the same, it was thought best to explore right side, and on March 1st. this was done. After considerable search the appendix was found behind and below caecum, buried in firmly organized adventitious tissue. It was dug out and removed. Two faecal concretions were found in it. Iodoform gauze drain, etc.

Did apparently very well until towards next morning, when he was seized with agonizing pain and went into collapse which ended in death the following night.

On *post-mortem* examination, about eight ounces of pus found free in abdominal cavity. This had proceeded from rupture of a peri-renal abscess. A map of thickened indurated inflammatory tissue led directly up from stump of appendix behind caecum to abscess above.

CASE 6.—W. S., aet. 23, male. On telephone message from Brampton August 31st., 1895, I left Toronto on midnight train to see patient in consultation. Dr. Moore, who had attended him, reported a sudden seizure of abdominal pain forty-eight hours before. Relieved by opiates for a time. Pain became intense the afternoon before my visit, and T. run up to 105°, but has since dropped to 102°. P. has never been over 105. Recti muscles rigid, and tenderness at McBurney's point.

Operation done by lamp-light. A small grape-like faecal concretion found free in peritoneal cavity. Appendix found with perforation near

base. Removed. No other concretion seen. Iodoform gauze drainage and usual sutures.

Patient did well, with the exception of an attack of quinsy from the 14th to 17th September. On the 23rd Dr. Moore reported the discharge of another faecal concretion of size and shape of a bicuspid tooth, and in a few days the wound closed.

CASE 7.—Nov. 23rd, 1895.—G. M., aet. 42, male. Had several attacks of "colic" during the last nine months. Supposed cause, errors in diet.

Present illness began a day or two ago. Took carthartic pills at the outset, and bowels moved well. Vomited once or twice. I found him with considerable pain, P. 96, T. 99.4°. Tongue was dry, and may have prevented the thermometer registering more. Abdomen somewhat distended and tender. Skin dusky, and blood did not return quickly after removal by pressure of finger.

Ordered rest in bed, hot fomentations, and  $\frac{1}{2}$  gr. ext. opii. p. r. n. for pain.

Under this treatment the symptoms subsided, and in a few days he was able to be about.

CASE 8.—Ap. 22, 1896.—L. P., aet. 25, male. Was asked by Dr. McLearn, of Fredericton, to see the patient in consultation. Dr. McLearn reported that he came to his office two days before, complaining of pain in the belly, and a carthartic was given. Bowels were moved well next day, but patient felt no relief. Has vomited several times.

When I saw him in the evening his P. was 100, T. 102°. Slight abdominal distension. Rigid recti. Pain and tenderness over caecum. I agreed with the diagnosis of appendicitis and advised immediate operation. I was kindly asked by Dr. McLearn to operate, and he was removed at once to Victoria Hospital, and with the assistance of Drs. McLearn and Bridges, he was operated upon by lamplight. Finger first came upon a faecal concretion loose in peritoneal cavity of size of white bean. Appendix found running up behind caecum towards loin. It was firmly bound down by adhesions, and on getting it free we found a gangrenous looking tip, perforated just at its extremity, the opening pouting and its edges black. Removed in usual way. Iodoform gauze drains. Sutures.

Ap. 29.—During the first week P. ranged from 80 to 100, and T. from 100° to 101.8° (in rectum). Wound looked and did well. For a day or two, however, the belly has been considerably distended, especially in epigastric region, and a looseness of the bowels has come on. P. is now 80, T. 99.5°.

May 4.—Yesterday considerable pus was discharged from wound, and the abdomen became less distended. Looseness of bowels continues, but stools not so frequent. A drainage tube put in.

May 15.—Diarrhoea has ceased. Belly back to normal size. P. 64, T. nearly normal.

June 10.—Left hospital with wound healed.

CASE 9.—Ap. 23, 1896.—T. McN., aet. 30, male. Generally healthy. Eleven days ago had an attack of abdominal pain with vomiting. Got better after a few days, and left home two days ago to stream-drive. He scarcely got to his work when pain began again, located on right side. He was brought to my office from twelve miles in the country, in a wagon.

I found a firm swelling on right side close to anterior superior spinous process of ilium. Unable to straighten right limb. P. 64, T. 96°, probably due to chill from riding so far in wagon in rather cold weather.

I sent him home, and next day visited him, and cut down upon swelling. About half an ounce of stinking pus let out. Large rubber-drainage tube put in upwards and backwards for three inches. Antiseptic dressings.

Ap. 27.—Visited again. P. and T. normal. Discharge growing less.

May 1.—Doing well.

May 15.—Going about.

CASE 10.—R. Q., aet. 28, male. During the last four months has had two attacks of what seemed to be appendicitis. They were not severe.

On April 23rd, 1896, abdominal pain came on for the third time. Was better in a day or two and went out. Became worse again, and a hard swelling developed near anterior superior spinous process on right side. P. and T. nearly normal, and patient is going about.

May 2.—Seen by me for first time, and the same day, assisted by Dr. Leary, I cut down upon swelling. Only thickened indurated tissue found with a small lump, which, on removal, proved to be a diminutive shrunken appendix, surrounded by hard fatty tissue. The peritoneal coat was stripped off from the proximal end during removal, and as the stump could not easily be got at to ligature I left it, thinking that the stripped up peritoneal coat would be a sufficient protection against escape of contents of bowels. Iodoform gauze drain.

May 25.—Did perfectly well after operation, the temperature keeping about normal. Wound is now healed, and patient able to be up and about.

On July 4th patient presented himself in my office with a small abscess at site of wound. Opened. Probe passed in over an inch. Nothing felt.

In the course of a week discharge had about ceased, a small sinus being left.

I have had two other very mild cases during the last four years, but they speedily recovered, and are scarcely worth reporting here.

#### REMARKS.

In looking over the above report we find three cases which are especially worthy of notice.

First, the young man who, after an attack of peritonitis with escape of a faecal concretion into the peritoneal cavity, was left for a year with a circumscribed abscess containing that concretion, while he went about apparently perfectly well, not feeling any inconvenience from its presence.

Again, the case in which a peri-renal abscess developed in connection with an appendicitis, the pus about the appendix having, as would seem from the history and the condition found at the autopsy, emptied itself into the bowel, while it was retained about the kidney.

Lastly, we notice the rapidity with which, as in case 3, an inflammation of the appendix may lead to gangrene of all its coats, though no faecal concretion or foreign body was present to hasten the process. Then to it is remarkable that, with such acute inflammatory conditions established there, I should have at my first visit, seven or eight hours after the onset of pain, found so little evidence of it either in the local or general state of the patient. The pulse and temperature were normal, and there was little or no change in the abdomen to indicate peritonitis.

This shows the treacherous character of some of these cases, and confirms one in the desirability of early operative measures. If I had waited a few more hours, perforation would have occurred through the sphacelated coats of the appendix, and with the amount of sero-purulent fluid found in the general peritoneum, we would almost certainly have had a fatal suppurative peritonitis.

Now a few words as to the general subject of appendicitis caeci.

Since the exact pathological condition present in any given case must always be more or less a matter of conjecture, no one being able always to distinguish the simple catarrhal or inflammatory cases from the more fatal perforative and gangrenous ones, there will probably be more or less difference of opinion as to just how we should handle them. The

more surgical a man is in his tendencies the more likely he is to resort pretty early to operation; while the physician, on the other hand, will put off surgical measures in hope of recovery, either with or without the formation of a circumscribed abscess.

Again, some surgeons, such as Murphy, of Chicago, and other Americans, believe it is better to operate in every case in which the four cardinal symptoms of appendicitis are present, viz: (1) a sudden attack of pain over that part; (2) nausea or vomiting; (3) elevation of temperature; and (4) local tenderness about McBurney's point. Most European surgeons adopt a more conservative course, and, except in recurring cases, wait for serious symptoms.

Of late years it has become the fashion, in some quarters, to give cathartics in appendicitis. It is difficult, however, to see how such treatment, if used more than to empty a loaded bowel, can do anything but harm, especially in the perforative cases, where the prime object of the medical treatment would seem to be to arrest peristalsis by opiates, in order to give a chance for nature to wall off the extravasated materials and form a local abscess. If I made up my mind to treat a case without operation, I should, after seeing that the lower bowel was emptied by enema, apply hot fomentations, restrict the ingesta to those articles which would give the most nourishment with the least amount of residue to pass through the large intestine, (not giving much even of them) and administer opiates in doses sufficient to relieve *all* pain and keep the patient pretty well narcotized, leaving the bowels unmoved for a week or more if they did not act spontaneously.

I can call to mind a good many cases treated in former years by this method, and with a fair degree of success. I remember that in three of these a circumscribed abscess formed. One of them ruptured into the bowel; another pointed by the side of the rectum, and was opened within the anus; while the third broke into the general peritoneal cavity. The first two recovered, while the last one rapidly succumbed.

At the present time, however, I would trust to medical treatment only in the milder cases, while if more serious symptoms developed, I would resort to surgical measures. The occurrence of previous attacks of a similar nature would lead me to hasten such action.

In those cases which were severe from the start, and continued so in spite of the medical treatment outlined above, I would operate before the end of the third day at the very latest. In hyper-acute ones, especially if other serious attacks had been experienced, I would not wait more than twenty-four hours.

While there is no doubt that a fair percentage of these will and do recover under more purely medical treatment, with or even without a localized suppuration, still I believe an early operation performed by one accustomed to do such work will save a much larger number.

## SOME INSTRUCTIVE MISTAKES OF EMINENT CLINICIANS.

BY the late J. A. COLEMAN, M. D.

(Read before the Nova Scotia Medical Society, July, 1896.)

Prof. Oppolzer, of Vienna, brought two patients before his class one morning and gave a bedside lecture on the differential diagnosis of *Acute Miliary Tuberculosis* and *Typhoid Fever*. At the close of the lecture he diagnosed one as a probable case of *Acute Miliary Tuberculosis*, the other as a probable case of *Typhoid Fever*.

Both died, and at the autopsy his *supposed tuberculosis* case was found to have died of *typhoid fever*, while the case diagnosed typhoid fever had died of *Acute Miliary tuberculosis*.

CASE II.—A woman presented herself at Prof. Albert's clinic, and, upon examination, was found to have a cystic growth lying high up in the abdomen. There was an area of tympanitic resonance below it. It was believed to be a pancreatic cyst.

Prof. Chroback, and his brilliant assistant, Lihotsky, were asked to examine the case, and gave as their opinion that the tumor did not arise from the pelvic organs. At the operation it was found to be a simple cyst of an ovary, with a long slender pedicle, and a loop of the sigmoid flexure adherent to the anterior surface. The position of the sigmoid flexure accounted for the tympanitic area.

CASE III.—A patient presented himself at Prof. Dittel's clinic, complaining of difficulty in swallowing. There was no history of an injury to the œsophagus, though it was asked for. There was stricture, however, and carcinoma was diagnosed. Gastrotony was performed, and the stricture dilated from below. Food was introduced through the opening into the stomach.

The patient soon died of gangrene of the lung due to septic absorption from the œsophagus wounded by the dilating process. The post-mortem revealed cicatrices along the whole œsophagus and in the stomach. They were such as result from the swallowing of caustic acids or alkalis. There was no cancer.

CASE IV.—A patient presented himself to Oppolzer for diagnosis. He had cough and expectoration, raised blood, was emaciated, and had

dullness at the left apex. Prof. O. diagnosed *phthisis* and ordered the patient to the *Mediterranean*. Not being satisfied he went to *Skoda*, *Kussmaul* and *Frerichs*. The four greatest diagnosticians of the time separately made the same diagnosis. One day an *aneurism* burst into the trachea and settled the diagnosis. There was no tuberculosis.

CASE V.—In the winter of 1880, a patient presented himself at Kahler's clinic with shortness of breath, fever, cough, expectoration of pus and emaciation well marked. There was dullness in the left apex, and *phthisis* was diagnosed. At the autopsy the apex of the left lung was found enlarged and contained about three fluid ounces of blood and pus. A large bronchial tube going to the apex was occluded. The lung was adherent to the front wall of beginning aorta descendens. Section through the point of adhesion of lung to aorta revealed a clot of blood one-half inch in diameter which lay in the bronchial tube, plugging it and also plugging a hole in a ruptured aortic aneurismal sac which had first pressed upon, then by an ulcerative process, entered the bronchial tube. From the time the small saccular aneurism first occluded the bronchial tube by pressure, there had been a retention of secretions in the apex, or distal part of tube. After it had entered the tube there were small hemorrhages from time to time, and blood was expectorated from the proximal end of tube at point of ulceration. The resulting bronchitis furnished purulent expectoration. The aneurism finally burst into the tube with fatal effect. There was no *phthisis*.

CASE VI.—Prof. Nothnagle sent a body to the post-mortem rooms with the clinical diagnosis of meningitis. The Professor was present at the autopsy. When the skull cap was removed there was no evidence of meningitis, but the convolutions were flattened and he said it must be an abscess. On opening the brain there was no abscess, but each optic thalamus was the seat of an enormous glioma. The glioma in the right thalamus measured three inches in length, by one and one half in diameter. The one in the left thalamus was one inch and a half long, by one inch in diameter.

CASE VII.—Prof. Maydl diagnosed gallstones and occlusion of cystic duct in an otherwise apparently healthy man. On doing laparotomy for his relief there were no gallstones, but there was a cancerous stomach with adhesions to the liver. There were also metastases in the liver and omentum. There had been no symptoms referable to the stomach in this case. The man had the appearance of perfect health. This mistake occurred to a brilliant surgeon in his private practice.

CASE VIII.—The same surgeon examined a two months old child who had no coccyx and a defective sacrum associated with a non-inflammatory fluctuating tumor in place where the sacrum was defective. The tumor was about  $2\frac{1}{2}$  inches in diameter, and on compressing it for a time became empty, the child crying as it did so. The sac refilled on stopping pressure.

The diagnosis lay between *spina bifida* and *teratoma*. Prof. Kumdrat, of the pathological institute, was called in and decided it was a *spina bifida* with a small opening in the spinal canal. During the operation of enucleation of the sac there came a gush of about a quart of lymph. The child became collapsed and the operation was readily completed. At the post-mortem, three days later, it was found to be a teratomatous sac which entered the abdomen by a narrow opening and spread out into a sac which held over a quart.

This sac passed upward behind the peritoneum to a point above the diaphragm. There was sarcomatous degeneration of parts of the sac.

CASE IX.—During the winter of 1890 two cases were seen in the autopsy rooms at Vienna. Each had had an abscess in the mastoid cells on one side. Prof. Politzer had operated on one, Prof. Geuber on the other. Both of these distinguished aurists had accidentally opened the lateral sinus during the operation, with fatal effects.

CASE X.—A year ago Prof. Olshausen diagnosed double ovarian cyst, and operated. After one cyst was removed, it was found to be an enormous cystic kidney, the other kidney was nearly as large but was not removed.

CASE XI.—A man suffering from chronic bronchitis placed himself under the care of Prof. Schrotter. After he had been in the hospital a few weeks, he complained of difficulty or pain in swallowing, a symptom which had not annoyed him before. An œsophageal bougie was introduced, and in forty-eight hours the patient was dead of pneumonia.

The autopsy showed perforation of the œsophagus and trachea through an ulcerated carcinoma, which had its seat just below the cricoid cartilage, and had perforated the œsophagus and attacked the trachea.

CASE XII.—A patient presented himself at Prof. Abert's clinic, with a large sore on the under lip, and enlarged glands under the chin.—He denied the possibility of syphilitic infection by kissing.—He was sent to Prof. Kaposi, who believed it was carcinoma, a piece was excised and sent to the pathologists for microscopic examination, and they reported a probable carcinoma. The growth and glands were excised and the wounds healed.

Soon the patient presented himself with secondary syphilitic eruption, which proved the nature of the sore. He then remembered that a barber had cut his lip a few weeks before, this man was probably inoculated with syphilis by a barber's razor.

CASE XIII.—A lady presented herself at Prof Bigelow's clinic, with a tumor much the shape and size of a goose egg, just with, but not involving the right nipple, Dr. B. diagnosed the case as one of fatty tumor and advised its removal. Before being aetherized he introduced a scalpel into centre of growth, when thin and apparently laudable pus spurted forth most profusely. One of these cases only was seen by the writer, the others have been noted down when related for illustration. None of the cases have been related to discredit those who were concerned with them. They are related here to illustrate what sometimes happens to men of the greatest reputation, ability, experience, industry and learning, and because it is just as valuable to every practitioner to know the mistakes that are made, as it is to learn of the successes that are achieved.



# MEDICAL PROGRESS.

NOTES, ABSTRACTS, SELECTIONS.

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## Retrospect of Surgery.

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REPORTERS—J. STEWART, M. B., Halifax,

MURRAY MACLAREN, M. D., M.R.C.S. St. John.

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### ANTITOXINS IN SURGERY.

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A review of the progress of treatment by antitoxins belongs rather to the department of therapeutics than surgery, yet in some points it touches us closely. The efficacy of the diphtheria antitoxin, now so generally admitted, will render less frequent than formerly the necessity for tracheotomy. The results of tracheotomy in laryngeal diphtheria have never been brilliant, this is doubtless due largely to the fact that the operation has almost always been a last resort. Especially poor have the results been in very young children. But it is precisely in these that the antitoxin treatment is most successful. Dr. Sidney Martin, of University College Hospital, London, in a most interesting address (*Lancet*, Oct. 17,) on this subject, shows that while the general average of mortality is much less under antitoxin treatment, it has been reduced nearly *fifty per cent.* in children under five years of age.

Of more direct interest to surgeons is the antistreptococcic serum of Marmorek, which promises wonderful results in septic conditions. Blood-poisoning is now, fortunately, a rare sequence of surgical operations, but accidental cases occur from time to time, and three Canadian surgeons at least fell victims to the disease during the past year. Dr. Peters, in the inaugural address of the present session of the Toronto University Medical School, in discussing this treatment, makes a feeling allusion to the death of Professor McFarlane, and to the fact that since his death, cases of an exactly similar nature have recovered, under the use of Marmorek's antitoxin.

The tetanus antitoxin is also giving satisfaction. In the *Lancet* of Oct. 10th, there is a report of a case. A lad sustained a gunshot wound of the hand, there was much laceration and sloughing. Tetanus declared itself on the fourteenth day. The treatment was begun on the second day of the disease, and was continued for one week. The dis-

tressing symptoms were soon relieved, and recovery was complete in three weeks. One must however distinguish between the milder cases of tetanus, and the more acute forms which set in early.

Medical treatment of thyroid extract, is taking away cases of goitre out of the hands of the surgeon, and the same extract is also proving beneficial in lupus. But for surgeons the most interesting development in this direction is the treatment of malignant growths, not by anti-toxin, but by the toxin of erysipelas, as practised by Dr. W. B. Coley, of New York. In the *Retrospect* for last January, we gave a brief review of Coley's method. In March, 1895, the N. Y. Surgical Society appointed a committee consisting of Drs. Stimson, Gerster and Curtis, to report upon the use of the erysipelas toxins in the treatment of malignant disease. Their report which was handed in on March 25, 1896, is not favourable. They say (*Annals of Surgery*, Feb'y, p. 53), "in no case have we found any amelioration which held out a prospect of ultimate cure." In cases of reported cure, they doubt the diagnosis. And they submit:

1. That the danger to the patient from this treatment is great.
2. That the alleged successes are so few and doubtful in character that the most that can be fairly claimed for the treatment by toxins is that it may offer a very slight chance of amelioration.
3. That valuable time has often been lost in operable cases by postponing operation for the sake of giving this method of treatment a trial.
4. Finally, and most important, that if the method is to be resorted to at all, it should be confined to the absolutely inoperable cases.

On the other hand, Dr. Coley has been working steadily and carefully accumulating cases which support his views. In a paper read at the Johns Hopkins Medical Society last April, for a copy of which we are indebted to Dr. W. S. Muir, of Truro. Dr. Coley gives details of twenty cases, among which were some pronounced inoperable by such well known surgeons as Bull, Bangs, G. O. R. Fowler and Maurice Richardson, and in which a diagnosis of sarcoma was made after microscopic examination by Hospital pathologists like Prudden, Ferguson, Durham and Whitney, and which have been relieved, and to all appearance cured, by the toxin treatment, in which at least there has been no recurrence at intervals of two, three and four years after cessation of treatment.

A very interesting case is one shown by Dr. Coley at the N. Y. Surgical Society on May 27th of this year. It was a recurrent fibro-sarcoma

of the palm in a young lady. After the second operation there was return of the growth in the palm and a secondary growth above the wrist, with contraction of the fingers. It was decided to try the toxin treatment before submitting the patient to amputation. Treatment was begun on Feb. 15 by the local injection of the toxin, in a fortnight there was decided improvement, and when the patient was shown in May the humours were entirely gone and there was normal power of flexion and extension of the fingers.

From a consideration of Dr. Coley's work, we should be inclined to reply to the above findings of the Committee that Dr. Coley recommends his treatment *only* in cases unfit for operation, and that consequently he cannot be blamed for the postponement of feasible operations. Also that in cases where surgical interference is negatived we are justified in subjecting the patient to some danger if there is any prospect of cure, and also that the method, as now carried out with a filtrate of mixed cultures is much less dangerous than when the organisms themselves were injected. To the second finding of the committee, which is really the most important one, we would reply with a quotation from Dr. Coley's paper, already referred to. He says: "I am conscious that there are men who will remain skeptical as to the value of the toxins *in spite* of the evidence here presented. They either fail to see any logical connection between the action of accidental erysipelas and the toxins, or they even go so far as to deny that there are any authentic cases of malignant tumours that were cured by accidental erysipelas. The only explanation they have to offer for these results, which cannot be questioned, is that in all of the successful cases there must have been an error of diagnosis. Such an explanation might be entitled to some consideration were only a single case involved, but to propose it seriously as a satisfactory explanation of the result in twenty cases is, I believe, unworthy of any one who claims to be guided by scientific principles."

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## TREATMENT OF ENLARGED PROSTATE.

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Few ailments give more distress to the patient and more anxiety to the practitioner than the urinary troubles consequent to this disease. Ever since the suggestion by Prof. White of Philadelphia, of removal of the testes with a view to atrophy of the prostate gland, and especially since his address last year to the American Surgical Associa-

tion, with its table of 111 cases, great hopes have been raised that in this simple operation we might find an easy and permanent cure. But as is almost always the case with new methods of treatment, expectation has been greater than realization. Many cases have been reported, with most gratifying success, but as time goes on, we find that as compared with other modes of treatment, orchidectomy, though a simple and easy treatment, is not so rapid, nor so complete, nor so safe a cure as some were led to hope. Two sources of information are available to us, statistics, and individual experience. Without wishing to detract from the known value of the statistical method, we must remember that few things are so difficult to assess at their true value as the statistics of operations. The great variety of conditions affecting the patient, the care with which cases are selected for operation, as well as the technical skill and experience of the operator, all combine to make the argument from statistics misleading. No better illustration of this can be found than we have in the *Annals of Surgery* for September of this year, in which we have a most careful, and upon the whole, soundly critical paper by Dr. A. T. Cabot, of Boston, in which he reviews Prof White's paper and statistics, and presents another table of operations of the same kind, and draws conclusions which favour prostatectomy rather than orchidectomy, and, a few pages further on an editorial by Prof. White himself on Dr. Cabot's paper, in which he very naturally, and in our view, as to the main points successfully rebuts Dr. Cabot's argument. The main differences in the conclusions of the two writers, depends on the way in which they review statistics, eliminating certain cases and criticising the various conditions present before and after operation.

A more reliable basis for opinion is probably found in the individual experience of surgeons. This is no doubt found to vary, but the causes for variance are more easily found than in tables of statistics. The most valuable expression of opinion of this kind, as regards White's operation, and none the less valuable because the opinions vary, is found in the discussions on prostatic hypertrophy at the recent meeting of the British Medical Association at Carlisle. The attitude of the Surgeons present, was on the whole favourable to the operation, but deprecated too hasty or too hopeful a resort to it.

One fact brought out in the statistics and in the various reports of cases, is that the mortality after this operation is much greater than could have been expected of so simple a proceeding. But it does not follow that the mortality is due to the operation. In fact the ease and simplicity of the operation has probably led to its having been frequently performed on patients already too much weakened by disease to stand even the simplest operation, persons on whom no one would think of performing prostatectomy. Dr. White puts the mortality down as about 6.5 per cent., while Dr. Cabot, in his article, places it as high as 18 or 19 per cent. This is surely an extreme instance of a statistical variant. Dr. Cabot in fact, makes out that in the point of mortality, castration compares unfavorably with prostatectomy. We think few surgeons will

agree with him. And more than this, there can be no doubt that in many cases in which septic urine and an irritable bladder, or perhaps dilated ureters and pyelitis forbids prostatectomy, or at least make it extremely dangerous, the simple aseptic wound of a castration scarcely adds any risk to the patient's condition.

But another point to be borne in mind is that the atrophy of the prostate, which is expected to follow the operation, and which is certainly a most interesting pathological process, does not occur, and a certain amount of residual urine remains. Even in many cases in which the patient's suffering has been entirely relieved and urine can be retained for several hours at a time, the use of the catheter, with all its risks and annoyances, has still to be kept up.

There is another objection to the removal of the testes, which may perhaps be looked upon, in the case of elderly men, as a sentimental one. It is not to be lightly considered. Not on sentimental grounds alone, but on physiological grounds there are objections to removal of the testes. In cases where such objections are strongly felt, the operation of excision of part of the *vasa deferentia*, proposed and carried out by Reginald Harrison, may be employed. It has yielded good results. Mr. Harrison read a short paper embodying his experience of this operation, at the Carlisle meeting, and produced a very favourable impression.

Professor Chiene, of Edinburgh, was opposed, on principle, to the removal of the testes, and thought this operation should be reserved for cases in which everything else had failed. There is certainly much to be said in favor of his advice, that when "catheter-life" has become unsatisfactory or has failed to relieve symptoms, the first thing in the way of an operation should be suprapubic cystotomy. For this operation is a very safe one; it gives immediate relief to the most prominent symptoms, it permits thorough exploration of the bladder, when possibly a stone may be discovered, or an enlarged middle lobe, or intravesical growth the removal of which is a comparatively simple thing. Mr. Chiene would prefer permanent drainage by a perineal tube, to the removal of the testes. But the fact remains that a great many patients, when the various operations are laid before them, deliberately choose castration. And, while a proportion of these cases are failures, and some are only partially relieved, the great majority are most decidedly improved and that sometimes very rapidly, and they are free from the constant leakage which almost invariably accompanies a permanent tube. And the mortality is not serious. After reviewing the subject and taking what he considers the most favourable statistics, Dr. Cabot concludes that "we may thus express the facts to our inquiring patients. You have eight chances in ten of getting through the operation all right, and if you are successful in this you have again eight chances in ten—or a little better of getting very substantial relief from your urinary difficulties." And Prof. White remarks on this that he "would be quite content, so far as he has a personal interest in the establishment of the operation, if nothing better could ever be said of it."

## Selection.

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### THE PROGRESS OF ANATOMY DURING THE PAST TWENTY-FOUR YEARS.

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By THOMAS DWIGHT, M. D., Boston.

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It has been a rich year for anatomy, which many, twenty-four years ago, would have called an exhausted science, at least considered macroscopically. The grossness of that error is now patent.

Progress is reflected in the pages of text-books. How different is Gray now from that old edition! How much more different is Quain! Morris has appeared to dispute with them the supremacy. Macalister has written an excellent book, and spoiled it by bad arrangement. In this country we have had the text-book of Harrison Allen (deserving we think, a warmer welcome than it received) and the topographical anatomy of McClellan. Cunningham's "Manual of Practical Anatomy" has been a valuable addition, from Dublin. In Germany, Henle's great work was not finished twenty-four years ago. In spite of defective methods of illustration, it has ruled as the highest authority in the world, though certain parts are no longer equal to the demands of the times. In France, Cruveilhier and Sappey, different, but both good, have been held in equal esteem. Luschka's anatomy, to a certain extent topographical, is still an authority for accurate description. But Braune's great "Atlas of Frozen Sections," and Rudinger's "Topographical Anatomy," opened a new field. In France a very successful book has been Tillaux's "*Anatomie Topographique*," which has passed through several editions. The only criticism of his plan was that it confined itself too strictly to surgical relations and applications. In Germany, Pansch began a most admirable book in the form of lectures to practitioners and advanced students, which was a topographical, and applied anatomy in the best sense; but his premature death brought it to an early close. Merkel's "Topographical Anatomy," is a work of a far wider scope, and will be a classic should it ever be finished. The first part appeared in 1885, and it is barely half completed. A new descriptive anatomy to replace Henle has been undertaken by many anatomists, under the leadership of Bardeleben. A wonderfully and deservedly successful book is that by Testut, in three volumes, with excellent illustrations and

diagrams. Any one competent to discuss the question must be amazed at the progress of this period, if he will only compare the books that flourished at its beginning with those now in dominion or entering the field.

One of the greatest changes of anatomical teaching in this period, has been the gradual abandonment of what was formerly called descriptive anatomy, pure and simple, in which each system—the bones, the joints, the muscles, etc.,—was taught as if it were valuable to knowledge to know how each looked when separated from all its surroundings in the most artificial manner possible. Topographical anatomy, what there was of it, was looked upon as merely surgical, and not only that, but as restricted to the so-called classical operations. The true relations of the viscera were practically an unknown field, and what was worse, no one seemed to care to explore it. Frozen sections had been introduced before this period, but it was not till after its beginning that their influence was felt beyond Russia and Germany. The magnificent work of Braune, showed that valuable as dissection must always be for the study of anatomy, by itself it is insufficient, and needs to be supplemented with the sectional method. Still it was not by sections, but by hardening injections that His accomplished his great demonstration of the true shape of the viscera. More recently still these methods have been supplemented by that of reconstruction, which is not as yet fully worked out. Formaline promises to be of much value in this process. The method of studying the body from the standpoint of embryology, has made another series of changes in anatomical teaching. Of course, it is subject to abuse, and, indeed, much that was unauthorized, has been claimed for its use as a basis of classification, because this has been done prematurely; but none the less it has thrown floods of light on the process by which such originally simple, and finely complicated, organs as the brain and peritoneum reach their adult condition.

In our first report, on September 5, 1872, we devoted much space to a discussion of Professor Wilder's views on the archetype skeleton. We committed ourselves to the opinion, that has since proved correct, that the study of transcendental anatomy was on the decline. There was no place for it in the system that, making evolution an affair of chance, excluded plan, design or purpose. But now that sober second thought has asserted its sway, and that it is allowable to say without loss of scientific caste that evolution is in no way antagonistic to design and to purpose, it is not surprising that the idea of a ground-plan of an animal should

again assert itself. Let us hope that should the archetype reappear, he will be studied with more caution than in the days of Oken and MacLise.

In the same report various methods of preserving anatomical material were discussed. Carbolic acid was then fashionable, and glycerine received due recognition. It is surprising how little improvement there has been in this respect since then. For certain purposes formaline promises much. There has been no other new agent worth talking of. Wickersheimer's fluid is fairly efficient, particularly if enough carbolic acid be added. A new method, however, has arisen, that though not taking the place of preservative injections, has yet done much for preservation, namely, cold storage; which is used in several of the leading schools.

A great deal of work has been done on the mechanics of bones and joints, and of the skeleton as a whole. Hermann von Meyer is easily first in this branch, though to him does not belong the credit of showing that the cancelli of bone represents studs and braces. Doubtless he made the discovery for himself; but it had been made long before him by Harvard's anatomist, the lamented Jeffries Wyman. Perhaps the idea had occurred to others before him.

Professor Heiberg's work on the elbow deserves mention. He demonstrated how a combination of flexion or extension with lateral motion of the ulna accounted for the changes in position that the lower end undoubtedly undergoes when the hand is twisted. The only blemish was the unfortunate use of the word "rotation" as applied to that bone, which implied an error he had not really been guilty of.

The name of Jeffries Wyman brings back a remarkable piece of anatomical work in connection with a celebrated trial, when that anatomist put together such pieces of a murdered man's body as could be found, and pronounced on the height. Since then the studies of Topinard, Rollet, Manouvrier, with some poor contributions by the writer, have added much to our knowledge of our facts concerned in a question that may be of such importance. A competent anatomist should be able to put together very accurately the pieces of a skeleton if they be present. If important parts be wanting he can calculate the height from the long bones, sometimes with surprising accuracy, but in more than half the cases the error exceeds one inch. Unfortunately in one quarter of the cases it is as great as two inches, which is enough to discredit the method, except with certain limitations, or as merely confirmatory evidence.

With regard to individual variations of the bones and of other parts of the body much has been done. The practically universal adoption of the doctrine of evolution as a working hypothesis has entirely changed the mode of anatomical thought, both for good and for evil. It has given a great impulse to study. Anomalies that were formerly dismissed with contemptuous interest as "freaks of nature" have since been studied as having a scientific bearing. The result of this has not been merely an increase of scientific interest: much practical advantage to surgery has arisen from the knowledge of the possible variations of important structures. What surgeon twenty-four years ago would have thought of a cervical rib in connection with a tumor at the root of the neck? The large series of statistics which were first in the country gathered at the Harvard Medical School, and are now being collected still more extensively at other places, are likely to prove of anthropological value. The surgical importance of several is undoubted. It is curious that the study of anomalies has proved disappointing in a connection from which much was expected of it, namely, as throwing light on the ancestry of man's body. While numberless animal peculiarities have been found, they point in no single direction, and are of such diverse significance that they have confused instead of elucidating the question. As an example of their misuse, now happily less common than it was, we may mention that some months ago we saw in a treatise on the appendix vermiformis, the statement that the cases of double appendix said to have been observed, are presumably to be explained by the double caeca which occur in many birds! While such sham science is still exploited by its votaries, serious thinkers find the question more and more difficult.

The knowledge of the viscera has increased most remarkably. Twenty-four years ago the presence of adenoid tissue at the top of the pharynx was, indeed, known to anatomists: but the third or pharyngeal tonsil as a well defined entity was not recognized. We wrote of Treves' excellent lecture on the intestines, that we believed it to contain for the first time in English the statement that the cecum is entirely covered by peritoneum. The fact was, indeed, known in Germany, and some of us may have thought we knew it too; but unfortunately, so far as we know, no one said so, and the stupid error of a posterior wall of the cecum connected by areolar tissue to the iliac fossa, was allowed to live. His' discoveries of the relations of the viscera have been hardly less important. They were accepted, but slowly. If we do

not mistake, Luschka described correctly the position of the stomach in 1868 or 1869, but it was many years before it was generally received. The position of the ovaries, of the kidneys, the exact lines of the upper and lower limits of the pleura and their relations to the sternum, have all been discussed, and in most cases settled.

Aseptic surgery has given a great impetus to abdominal anatomy. Numberless measurements of the appendix have been made, and the folds of the peritoneum thoroughly investigated. Of far more value than the endless repetition of measurements, are the many observations on peculiar arrangements of the intestines and peritoneum, which cannot but be of great help to the surgeon.

The anatomy of the brain has been transformed. The Golgi method has revolutionized the minute anatomy, and immense work has been lavished on the course of the fibres. The developmental method of teaching has been of practical use in instruction. The convolutions, of which many professors of anatomy knew practically nothing a generation ago, have sprung into perhaps even a greater prominence than they deserve. A host of anatomists have described them most thoroughly and compared them with those of animals. The great difficulty of determining how far a common plan can be made to serve for the primate and carnivora brain is still unsolved. Professor Wilder is laboring conscientiously to note the characteristics of the brains of law-abiding, educated and intelligent men and women. He has the nucleus of what may become an unique collection of known brains. But if the arrangement of the convolutions still is somewhat unsatisfactory as a basis of scientific work, enough has been done on localization to make the situation of the great motor cortical centres in relation to the skull a matter of vast interest. Many methods of quickly placing these centres have been presented, the too cumbersome are being ignored; and practically the question may be held to be closed.

The veins have to a great extent been rediscovered, chiefly through the labors of Brauer, who died too soon for science, and of a few others, among whom Debière and Lejars may be mentioned.

Valves in veins of the portal system, especially in the fetus and infant, have been shown by Hochstetter and, here, by Bryant. The remarkable fact has also been pointed out by Klotz, in regard to the veins of the lower extremity, that there is a marked destruction or degeneration of the valves during life, beginning probably in youth. Is it possible that the want of the suction power of respiration in the

embryo, makes the presence of valves more necessary than in later life, and that thus there is a continual retrogression? Bardeleben has also formulated a law as to the distance between valves.

The anatomy of childhood is a branch that till the present generation has received lit. attention. Henke, Symington, Ballantyne, Chipault and others have done much for it, but there is still room for more investigations. The application of frozen sections to this study has been very fortunate.

The subject of nomenclature has been widely discussed. The Anatomische Gesellschaft appointed a committee a few years ago, comprising members of other than German nationality, which has recently reported, to the great satisfaction of the German contingent. Whether the terms suggested will be very generally adopted remains to be seen, but it is probable that being the standard in Germany, it will have much influence. In this connection Professor His made the error of alluding to the "American system," meaning that of Professor Wilder. In point of fact the Association of American Anatomists has adopted but few of Dr. Wilder's suggestions. On the other hand, that gentleman, through the influence of his position and the support of his colleagues and pupils, has certainly made considerable progress; and it will indeed be surprising, if with his patience, determination and single-mindedness, he does not make more. Some of his principles, such as the abandonment of proper names in favor of descriptive ones, will undoubtedly be successful at most points. Still the acceptance of his system as a whole is a long way off. As one who does not incline to accept it, the writer is happy to bear witness to the good it has incidentally done.—*Boston Med. and Surg. Jour.*

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**EDITORS.**

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J. W. DANIEL, M.D., M.R.C.S. .... St. John, N. B.	JOHN STEWART, M.D. .... Halifax, N.S.
MURRAY MACLAREN, M.D., M.R.C.S. .... " "	G. M. CAMPBELL, M.D. .... Halifax, N.S.

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DR. D. A. CAMPBELL,  
130 Göttingen Street, Halifax.

*Business correspondence to be addressed to*

DR. G. M. CAMPBELL,  
407 Brunswick Street, Halifax.

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**Editorial.**

The meeting of the British Medical Association at Montreal next year, will be the most memorable event in the annals of Canadian medicine. Everyone, we trust, realizes the importance of the meeting and is inspired with the hope that the reception to be accorded to the British representatives will be no mean affair. The labour of making the reception a grand one must fall on the shoulders of the Montreal profession, and we feel assured that they will receive an enthusiastic support by the profession from Halifax to Vancouver. It is pleasing to note that considerable progress has been already made in the way of preparation for the event. Various committees have been appointed and are actively at work.

A fund of at least \$16,000 is in sight, the Dominion government having promised \$5,000, the balance will likely be obtained from the Quebec legislature, the corporation of Montreal, and private subscriptions.

It has been determined that there shall be at least twelve sections, viz.: Medicine, Surgery, Obstetric Medicine and Gynaecology, State Medicine, Pharmacology and Therapeutics, Pathology and Bacteriology, Anatomy and Physiology, Psychology, Diseases of Children, Ophthalmology, Laryngology and Otology, Orthopaedics and Dermatology. These will meet in the buildings of McGill University and the surrounding theological colleges. All these are within three minutes walk of each other, and it is doubtful if ever the Association has met in a series of halls and theatres so close to each other or so admirably adapted for the needs of the various sections.

So as to guard against the unsatisfactory crowding and confusion resulting from having too small a reception room, it has been determined to erect a temporary building of large size, about 100 by 50 feet, in the grounds of McGill, which will serve not only for the issuing of tickets and daily programmes, for letter delivery, post, telegram and telephone offices, but also during the meeting will contain the Secretaries' and enquiry offices.

The General Meetings and Addresses will be held in the well known Windsor Hall, which is capable of seating 3,000, and is in every way adapted for this purpose. The Museum (instruments, therapeutical preparations, etc.) will in all probability be housed in the Victoria Rink, close to the Windsor Hall, between it and McGill. It is hoped this Museum will be one of the features of the Meeting, and every endeavor will be used to make this attractive to the profession and to the public.

It is already recognized in Montreal, that those intending to be present at the meeting will have to make their arrangements for rooms at an early date. In the beginning of September in any year Montreal is full of visitors. The Hotel and Lodging House Committee have already had reserved for them accommodation for over a thousand members, much of this with the proviso that unless this is taken up before the end of June at the latest, the rooms will no longer be considered as retained for the Association.

The Executive has been greatly pleased by receiving offers of help from the Presidents of the Canadian Medical, Ontario, Maritime Provinces, Nova Scotia, New Brunswick Medical Societies, as also from the President of the Halifax Branch of the British Medical Association, the oldest Branch in the Dominion.

The Excursion Committee are busily arranging for both short and long tours in connection with the meeting. The Chairman, Dr. G. E.

Armstrong, 1127 Dorchester St., Montreal, and the Secretary, Dr. H. S. Birkett, 123 Stanley St., Montreal, will be glad to receive any suggestions of those willing to help to make the excursions successful.

As none but members or specially invited guests are allowed to be present at the meetings, it is desirable that members of the profession throughout the Maritime Provinces, who wish to be present, should take steps at once to secure membership. The steps necessary are as follows :

All properly qualified British subjects can become candidates for membership.

Applications for membership of any branch must be accompanied by certificates of recommendation from three who are already members of the Association, two of whom must certify from personal knowledge of the applicant.

Dr. Carleton Jones, Secretary of the Halifax Branch, will provide the necessary form of application.

The subscription for membership, including the regular delivery of the journal, is \$5.50 per annum.

Medical men in Nova Scotia will find it most convenient to make application for membership through the Halifax Branch.

We trust that the meeting will lead to the formation of local branches in St. John and Charlottetown, thus affording an opportunity for membership to the profession in New Brunswick and P. E. Island.

The experience of the Halifax Branch, now nearly ten years in existence, and the oldest in Canada, has been one of continued success. The advantages are very obvious.

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THE MODERN TREATMENT OF DIPHTHERIA IN PRIVATE PRACTICE.—  
By W. A. Walker, M. D., New York. On the evening of September 14th, a little girl called at my office with a request that I should visit her sick brother. The public schools opened their doors on that day, and Johnny McD., although complaining of feeling sick was sent to mingle with the hundreds of other school children.

An inspection of the case showed all the clinical symptoms of diphtheria, with a muco-purulent discharge from the nostrils so fetid that the odor filled the room. The examination completed, the mother anxiously inquired: "What is it?" "It is a case of diphtheria," I said; and her face blanched, her voice trembled, as she said quietly: "I know what that means—I have buried two children with that."

On the 19th the father called at the office to say that Johnny could not be kept in bed, and they thought he was well.

In a skeleton way this illustrates the results of treatment with anti-diphtheritic serum, and stands in bold contrast with the drug treatment with the bottles of medicine, the cruel swab, the sleepless nights, the futile attempt to force food and medicine, the onset of secondary infection, and death or a tardy convalescence.

The uniform success which I have observed, and had in my own practice, has convinced me that the treatment of diphtheria with anti-toxin is a great advance in therapeutics, and it is my impression that critics who have condemned this treatment have in most instances either observed only hospital patients, or have not persisted in the treatment or perhaps have not had a fresh and reliable serum, or have not used it early enough.

From the standpoint of a general practitioner I confidently expect to cure any case of diphtheria in private practice, seen within forty-eight hours of the onset of the disease.

Take, for instance, a typical case; a previously healthy child, six years of age. The family physician is called in and finds the following conditions: general depression, face pale, pulse accelerated, temperature about 101° F. Inspection of throat shows general diffuse redness, with the characteristic deposit on one or both tonsils. This peculiar deposit once seen is not readily forgotten; the high fever, flushed face, and rapid pulse usually seen in pseudo-membranous tonsillitis are absent; the margin of the inflammatory process is usually sharply defined in diphtheria and not in tonsillitis. In follicular tonsillitis the leading symptoms

are: intense congestion of the tonsils, with small discrete white patches, pulse and temperature high.

If, however, the symptoms are not well defined and the differential diagnosis cannot be clearly made, we should give the patient the benefit of the doubt, and a dose of anti-diphtheritic serum administered at once. Then a culture should be made to verify the diagnosis. If I believe the case to be diphtheria, or have a reasonable doubt as to the diagnosis, I use the antitoxin whilst waiting for the report from the bacteriologist. If the case turns out to be tonsillitis, no harm has been done, as I consider a fresh, reliable serum, properly administered, devoid of danger.

Given, then, a case where the diagnosis of diphtheria is clear, I give as quickly as possible either 1000 units or 1500 units of the serum. The attendant is instructed to keep the throat clean with bichloride solution of 1 to 5000; or a solution of permanganate of potash may be used, 1 to 4000, if the attendant is not a trained nurse. With a young child difficult to manage, it is best to inject the solution into the nostrils: in older children a spray can be used in both the nostrils and throat more advantageously.

At the end of twenty-four hours I expect to find the membrane beginning to shrivel and curl up at the edges. In any event, however, I administer a second injection at this stage of the disease, and in a majority of instances this is sufficient. I advise very strongly that the second injection be given in all cases where the diagnosis of diphtheria is clear. I do not expect a cure from one injection, and rarely omit the second. If the symptoms do not indicate the beginning of convalescence at the end of forty-eight hours, I give a third injection. In fact, I would use a fourth injection if it seemed advisable at the end of another twenty-four hours, but I think this will rarely be found necessary.

I have not used anti-streptococcic serum, but I am convinced that in cases in which the treatment has been delayed, or in cases showing the streptococcic infection, proven by bacteriological investigation or from the peculiar red zone of inflammation which begins to spread from the margin of the diphtheritic process, the anti-streptococcic serum should promptly be used. Not only would I do this, but in cases of severe acute disease in the throat, which present all the symptoms of diphtheria, but where the bacteriological report does not confirm the diagnosis, I would resort to the anti-streptococcic serum. In fact, if I should have a case of diphtheria in which the membrane does not begin to peel up by

the end of the twenty-four hours following say the second injection of antitoxin, I will use the anti-streptococccic serum.

The importance of a fresh, reliable, highly concentrated serum must not be lost sight of, and as I have full confidence in our American products I do not use imported serums. I have used several serums, but have been best satisfied with the effects of that sent out from the biological department of Parke, Davis & Co. I heartily approve of the way this firm now puts up the serum, in bulbs instead of in bottles. It is not only highly concentrated, but, being hermetically sealed, should keep indefinitely. It is put up in bulbs of so many units, 250, 500, 1000, 1500; and, each bulb being a dose, there is no temptation to use a serum that has been exposed to the atmosphere. I append a table giving a report in detail of the last seven cases treated in private families.

TABULAR REPORT OF CASES.

	1	2	3	4	5	6	7
Age of patient .....	8 years.	2 years.	2 years.	11 years.	3 years.	3 years.	8 years.
Other cases in family .....	.....	.....	.....	.....	.....	Yes.	.....
Bacteriological cultures .....	Yes.	Yes.	.....	Yes.	Yes.	.....	Yes.
After first appearance of the dis- ease antitoxin was given.....	1st day.	1st day.	3d day.	2d day.	2d day.	2d day.	3d day.
Doses of antitoxin given.....	3	2	2	3	3	2	3
Units in each injection.....	{ 1500 1000 1000	1500	1500	1000	1500	1500	1500
Total number of units in each case	3500	3000	3000	3000	4500	3000	4500
Antitoxin used.....	Gibier	B of II	B of II	P D & Co	P D & Co	P D & Co	P D & Co
Intubation .....	1st day.	.....	.....	.....	2d day.	.....	.....
Tube retained .....	3½ days.	.....	.....	.....	2½ days.	.....	.....
Recovery.....	Yes.	Yes.	Yes.	Yes.	Yes.	Yes.	Yes.

As to the medicinal treatment, I do not give any drug with the idea of influencing the course of the disease. I treat the conditions as they arrive symptomatically. If I have evidence of the absorption of poisonous secretions, and a coated tongue, I give calomel tablet triturates,  $\frac{1}{4}$  grain every hour, until the bowels move freely. Alcohol is rarely needed in cases receiving the serum treatment, especially if it is used early enough, whereas, under the old treatment, when we were so apt to find profound toxic symptoms, alcohol was more often needed. It is perhaps well to state here that I prefer fluid nourishment, principally milk, during the course of the disease.—*Pediatrics*.

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