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CANADA
MEDICAL & SURGICAL JOURNAL

MAY, 1887.

Original Communications.

FAREWELL ADDRESS

DELIVERED TO THE GRADUATES IN MEDICINE AT THE ANNUAL CONVOCATION OF THE MEDICAL FACULTY OF McGILL UNIVERSITY, MARCH 29TH, 1887.

BY F. BULLER, M.D., Professor of Ophthalmology, McGill University.

Gentlemen Graduates :—In commencing, I will give you a few original lines of poetry—at least they were original some time ago. (Laughter.)

> "The lives of great men all remind us
> We can make our lives sublime,
> And departing leave behind us
> Footprints on the sands of time."

The author of these lines, great himself in the possession of a truly noble nature, as well as of the heaven-born gift of poetry, has left us many footprints of his own engraven, not in the sands of time, but cut deeply in the trunk of the thriving young tree of American literature. A tree which is destined to spread its branches and expand its foliage not only over the length and breadth of this broad continent, but east and west across the wide oceans and around the circle of the civilized world. A tree which in time must bring forth the best of fruit, because it has been grafted from the very best stock of the greatest nations of Europe, just as these are the literary scions of ancient Greece and Rome. But we may go a step further in the same direction and, I think, safely predict a brilliant future for art and science in this Western world. By and by the physical and mental

energy that has placed America in the front rank in all that pertains to practical and applied science will surely develop its latent powers in the direction of the higher forms of culture. Year by year, with the accumulation of wealth and the extension of facilities for the acquirement of higher education, we are gradually approaching an era of intellectual life which will in all probability transcend that of the present day, as this does the intellectual life of the dark middle ages. In the growth of this wonderful tree of knowledge—literature, art and science—let us hope, and I think we have good reason to expect, that some of its thriftiest branches and some of its richest fruit will be found springing from Canadian soil. The good seed is sown in thousands of common schools throughout the land; here we see the swelling buds—youthful minds in the spring of life drinking in the vernal sap of knowledge. In our higher schools and colleges the tender leaves have become unfolded, and in our universities the choicest buds have burst forth into full bloom. In this last cast category belong all our undergraduates, and some of them, I am sure, are blossoms of great beauty and promise. But you, gentlemen of the graduating class, who are here to-day to say farewell to your Alma Mater, you have now advanced a stage further; you have shed the petals and are now the young and tender fruit. As such you are about to be exposed to trials and difficulties of a different order to those that have hitherto beset you. Now the cold bleak winds of distrust and worldly indifference will have to be faced, a blighting influence that works discouragement in many a sensitive nature, and one which weighs especially heavily upon our profession. For some of you there will be a long and weary period of waiting for work that you have carefully prepared yourselves to do, and which you feel you ought to be doing, but it will not come to you. With this period of enforced idleness you will be exposed to a thousand temptations that ever beset the unemployed. This is the time when much of the young fruit is stung with the busy moth of vice and intemperance, cankerworms which, once having penetrated the pericarp of the human soul, rob it of all proper nutriment, blighting all its noble powers of development, so that

the withered fruit drops early from its stem and sinks forgotten into the abyss of eternity. This is the time when, grown restive of long delay, some may be tempted by the hope of speedy reward to actions which pave the way to ruin and disgrace. Would any of you obtain the love and respect of your fellow-men? Believe me, there is but one sure way to attain your object, and that is to remain steadfast in the good resolves you all will make at the outset of your career. Be not faint or weary in well-doing. Above all, do not imagine that the time and attention you bestow upon the poor and needy who come to you for relief is labor and time thrown away. It is bread cast upon the waters which will surely return to you after many days. In every occupation in life all men should study attentively the sayings and doings of illustrious ones who have trodden the same paths before. For this reason I have looked up the records of some great names in British medicine, men with whose names and great deeds you are all more or less familiar, and if you will kindly bear with me for a short time I will endeavor to give you a few brief results of my researches in this direction. Aikin, in his Biographical Memoirs of Medicine in Great Britain, speaking of Harvey, says: "The private character of this great man appears to have been in every respect worthy of his public reputation. Cheerful, candid and upright, he was not the prey of any mean or ungentle passion. He was as little disposed by nature to detract from the merits of others or make an ostentatious display of his own as necessitated to use such methods for advancing his fame. The many antagonists whom his renown and the novelty of his opinions excited were, in general, treated by him with modest and temperate language, frequently very different from their own; and while he refuted their arguments he decorated them with all due praises. He lived on terms of perfect harmony and friendship with his brethren of the profession, and seems to have been very little ambitious of engrossing a dispropriate share of medical practice. To complete his character he did not want in that polish and courtly address which are necessary to the scholar who would also appear as a gentleman." Of Thomas Sydenham it has been said: "What Harvey and Newton did for the sciences

of inorganic matter Sydenham did for the art of healing and of keeping man whole; he made it in the main observational." His nobleness of character is best illustrated by an extract from his own writings. He says: "In all points of theory where the reader finds me in error I ask his pardon. In all points of practice I say that I speak nothing but the truth, and that I have propounded nothing except what I have properly tried. Verily, I am sure that when the last day of my life shall have come upon me I shall carry in my heart a willing witness that shall speak, not only to the care and honesty with which I have labored for the health of both rich and poor who have entrusted themselves to my care, but also to those efforts which I have made to the best of my power and with all the energies of my mind, to give certainty to the treatment of diseases even after my death, if such may be. In the first place, no patient has been treated by me otherwise than I would myself wish to be treated under the same complaint. In the second, I have ever held that any accession whatever to the art of healing, even if it went no further than the cutting of corns or the curing of toothaches, was of far higher value than all the knowledge of fine points and all the pomp of subtle speculation—matters which are as useful to the physicians in driving away disease as music is to masons in laying bricks." In another place he says, "I have always thought that to have published for the benefit of afflicted mortals any certain method of subduing even the slightest disease was a matter of greater felicity than the riches of a Tantalus or a Crœsus." Again he says, "My fame is in the hands of others. I have weighed in a nice and scrupulous balance whether it is better to serve men or to be praised by them. I prefer the former. It does more to tranquilize the mind; whereas fame and the breath of popular applause is but a feather, a bubble, and a dream. Such wealth as fame gives, those who have scraped it together and those who value it highly are fully free to enjoy, only let them remember that the mechanical arts (and sometimes the meanest of them) bring greater gains and make richer heirs. A hundred and fifty years ago William Cullen gave advice to a young man just starting out in life which any

young man would do well to take heed of to-day. He says: "Study your trade eagerly, decline no labor, recommend yourself by briskness and diligence, bear hardships with patience and resolution, be obliging to everybody, whether above or below you, and hold up your head both in a literal and figurative sense." Of Benjamin Brodie it is said: "It was impossible to see him acting in any capacity without instinctively feeling that he would do his duty and do it well." Nor could he be imagined in a false position. A gentleman, according to his own definition of the word, he did to others that which he would desire to be done to him, respecting them as he respected himself. Simple in his manners, he gained confidence at once; accustomed to mix with the poorest in the hospital and with the noblest in private abodes, he sympatnized with the better qualities of each —valued all and despised nothing but moral meanness. Richard Bright is said to have been remarkable for consideration towards the failings of others, but severe in the discipline of his own mind. He was sincerely religious both in doctrine and in practice, and of so pure a mind that he never was heard to utter a sentiment or to relate an anecdote that was not fit to be heard by the merest child or the most refined female. Of Liston we are told that he never had a patient that was not anxious to become a friend, and a voice which was sometimes discordant amid the petty annoyances of daily life was music to the sick man's ear. Into the scene of suffering he never brought a harsh word or an unkind look, and the hand which was hard as iron and true as steel in the theatre of operation, was soft as thistledown to the throbbing pulse and aching brow. But we need not go beyond our own university and school for bright examples of nature's noblemen, some of whom have only been taken from us within a recent period. Such were William Sutherland, George W. Campbell, and, later still, one who had a special gift of endearing himself to all who had the good fortune to know him; few of you, perhaps, knew him personally, but I am sure all who did will agree with me there never was a nobler nature than that of Dr. Joseph Drake. A large-souled, genial man, possessed of a refined and cultured intellect, he has left in the

minds of all his confrères an impression of loving regard such as few can inspire, and which they will carry with them to the end of their existence here and, perhaps, renew in the infinite beyond. Such were a few of the men who have adorned the medical profession in the past, and I could give you many similar examples of illustrious lives worthy of your emulation. I do not know exactly why, but the world seems to expect all those who have adopted the profession of which you now are members, to be above the vices and failings of ordinary mortals, and in this, as in everything else, the nearer you can come to the world's ideal the greater will be your success in life. On the duties and responsibilities you are about to undertake, perhaps the words of Sydenham on this subject, though spoken long ago, are as appropriate as I can find. He says: "Whoever takes up the profession of medicine should seriously consider the following points: Firstly, that he must one day render to the Supreme Judge an account of the lives of those sick men who have been entrusted to his care. Secondly, that such skill and science as, by the blessing of God, he has attained, are to be especially directed towards the honor of his Maker and the welfare of his fellow-creatures, since it is a base thing for the great gifts of Heaven to become the servants of avarice or ambition. Thirdly, he must remember that it is no mean, ignoble animal that he deals with. We may ascertain the worth of the human race, since for its sake God's only begotten Son became a man, and thereby ennobled the nature that He took upon Him. Lastly, he must remember that he himself hath no exemption from the common lot, but that he is bound by the same laws of mortality, and liable to the same ailments and afflictions with his fellows. For these and like reasons let him strive to render aid to the distressed with the greater care, with the kindlier spirit, and with the stronger fellow-feeling."

CHRONIC NASAL CATARRH—ITS NATURE AND TREATMENT.*

By George W. Major, B.A., M.D., &c.,
Late (1877) Clinical Assistant, Hospital for Diseases of the Throat and Chest, London, Eng.; Fellow of the American Laryngological Association: Specialist to the Department for Diseases of the Nose and Throat, Montreal General Hospital; and Instructor in Laryngology and Diseases of the Throat, McGill University, Montreal.

Chronic nasal catarrh or chronic rhinitis is commonly met with in three distinct and separate stages. The first is simple chronic Rhinitis, the second Hypertrophic Rhinitis, and the third Atrophic or Fetid Rhinitis.

Simple chronic rhinitis is simply an inflammation of the nasal mucous membrane that has lasted some time, entitling it to be considered chronic. It is usually the result of a single attack of acute rhinitis, or of a number of acute attacks which have resisted Nature's spontaneous cure. Simple chronic rhinitis is not uncommon in infancy, in extreme age, and in cachectic persons. This condition may be recognized by the general redness of the mucous membrane lining the nasal chambers, and is, as its name implies, unassociated with structural changes of any kind, if we except a softened and diminished contractile power of the vessel walls, the result of oft-repeated and continued distension. The amount of swelling varies with the individual and modifying circumstances. The pharynx is commonly implicated, and laryngeal extension is not infrequent. After this simple form of chronic rhinitis has lasted for some time it gives rise to structural changes, the products of inflammation become organized, and connective tissue is formed in the mucous membrane proper as well as in the submucous layer. The walls of the veins become thickened and remain in a constant state of distension, causing a general increase in the amount of blood present, with the usual results. The glands of the nasal passage become involved, and the nasal secretion becomes thick and tenacious. Gradually the turbinated bones participate in this state and overgrowth of the osseous tissue is the result.

* A clinical lecture delivered at the summer session of McGill University in the Clinic for Diseases of the Nose and Throat, Montreal General Hospital, April 21st, 1887.

It is only when the breathing becomes much obstructed by the occlusion of the nasal chambers by the now hypertrophied turbinated bodies that relief is applied for. These bodies usually are red, but may be pale in color; on pressure with a probe they pit, but on withdrawing the pressure they return to their former shape. They may be so enlarged as to impinge upon each other, producing obliteration of the meatus or may exert such decided pressure upon the septum as to produce severe discomfort, if not actual pain. Meantime the secretions accumulate, the drainage of the nose is seriously interfered with, and the already unhealthy state of the chambers is further aggravated. The greatest enlargement occurs in the lower turbinated body, which becomes particularly hypertrophied at its anterior and posterior extremities, with usually an excessive development of loose tissue on its lower surface dipping into and obstructing the inferior meatus. This last condition interferes with proper aeration of the inner ear and causes accumulation of secretion on the floor of the nose, which flowing backwards gives rise to the uncomfortable dripping so often complained of by patients suffering from this annoying but curable condition. The posterior hypertrophy occurring in a region particularly rich in vascular tissue of an especially erectile character, becomes the source of much annoyance to the patient, and is aggravated when in the recumbent position. The middle turbinated body generally develops a spongy growth on its anterior face, and not infrequently shuts off the olfactory region from contact with odoriferous particles, producing a temporary loss of the sense of smell, besides becoming the focus for the accumulation of foreign bodies intimately commingled with the unnaturally adhesive secretions.

The pharyngeal vault becomes by extension very much congested, and its glandular tissue takes on proliferative action, further embarrassing nasal respiration, which necessitates the baneful practice of mouth breathing.

The buccal pharynx is also, in the natural order of things, involved, the mucous lining undergoes retrograde changes, and follicular disease is established, with an almost certain extension to the larynx. Healthy respiration and digestion are interfered with, and the general health suffers.

The third form of this disease—atrophic or fetid rhinitis—follows in the wake of the second or hypertrophic stage. The length of time required for the development of this wasting varies very much; it may develop rapidly, slowly, or not at all. It is not unusual to find far advanced wasting catarrh in a child of six or eight years of age, and it may occasionally be encountered much earlier in child life. It is not unusual to find the disease much further advanced in the vault and pharynx than in the nose, or to have a different stage of development in each nasal chamber. Fortunately this form of nasal catarrh is not as common as the hypertrophic variety. Now how does this wasting occur? We have already seen that in the second stage or that of hypertrophy an amount of connective or elastic tissue is deposited in the deeper tissues of the turbinated bodies; and we have also ascertained that the stage of atrophy may occur early or late in the course of hypertrophy. To put it plainly, the atrophy is the result of pressure. When atrophy occurs early it is directly the result of the crowding of the glands, etc., produced by the newly-formed tissue deposits; and when occurring later on, it is the result of the pressure produced by the contraction of the elastic and connective tissue in course of organization. This is the simplest explanation, and the one generally accepted. The turbinated bones themselves undergo absorption, and frequently disappear altogether. This process is brought about by the pressure just now alluded to, aided by the pressure of dried secretions on their surface. The natural result of this wasting disease is abnormally large and spacious nasal chambers lined with dry red and shining mucous membrane, covered with crusts of inspissated secretion of a yellow or greenish-yellow color. Under these crusts the secretions are poured out, and having no means of escape, they undergo gradual decomposition and aggravate the already unhealthy local state. On breaking or attempting the removal of one of these scales, the unpleasant odor of the patient's breath is very much intensified. The secretions in this stage of the disease are very scanty and lack liquidity, tending to accumulate at favorable points. The sense of smell is usually impaired, if not lost, the

result, no doubt, of implication of the olfactory filaments in the general waste. As the disease advances the fetor increases, when fetor becomes really an index of long standing disease.

Now under the head of nasal catarrh or rhinitis, let us review what we have attempted to describe.

Chronic nasal catarrh was divided into the three great progressive stages in which it is met with in actual practice. It does not follow that all these stages are developed in each case, for we are fortunate to be able to cut short the disease in its early stages. The three stages named are—1, Simple Chronic Rhinitis; 2, Hypertrophic Rhinitis; 3, Atrophic Rhinitis.

There are an endless number of synonyms used to express these conditions; these have been avoided, as they only would tend to confusion. The division given you is simple and, above all, practical; it represents to you the disease as it is and as it will present itself to you, and as you must recognize it in order to correctly diagnose or prognose, or successfully treat it.

You will observe that I have avoided mentioning all the multitude of complications that beset an ordinary case of nasal catarrh. I have not mentioned deviations of the septum, simple sigmoid or multiple, nor exostoses, nor ecchondromata, nor polypi, nor tumors, nor vegetations of any kind. These will all be dealt with hereafter. I have described so far simple, uncomplicated, non-specific chronic rhinitis, and shall now proceed to the treatment appropriate to the different stages.

Before doing so, however, it may be well to briefly refer to a few points in the general or constitutional treatment of these cases applicable to any stage of the disease. In the first place, remove, if possible, the cause, whatever it may be, if you are so fortunate as to find it out. The occupation may have something to do with the production of the disease, or the habits of life, or some constitutional dyscrasia, or some diathesis. Improve the general health, as far as possible, by administering suitable remedies. Pay particular attention to frequent bathing of the surface of the body and other hygienic measures. Stop the use or abuse of alcohol, as tending to congest the vessels of the head. In the specific treatment of this disease by internal

remedies, you need not look for much, if any, return. Cubebs I have found occasionally serviceable, but not to the extent of being a specific by any means. The disease usually is local, requires local treatment, and in local improvement you will have a general constitutional gain.

The principle of cleanliness so essential to the success of modern surgical measures is most essential in this disease. Whether cleanliness be obtained by simply blowing the nose with the handkerchief, or by some liquid capable of clearing the nasal chambers of accumulated secretion by virtue of a solvent action, it matters not, so long as the desired end is attained. Some judgment is necessary, however, in the selection of proper ingredients for the composition of these local washes, and particular care should be devoted to securing a proper density.

Many of you have doubtless observed that at my clinic in this hospital I very frequently order a cleansing solution. This solution is composed of—Carbolic Acid, No. 1, Calvert's, gr. i; Borax, gr. iii; Sod. Carb., gr. iii; Glycerine ʒi; Water, ʒvii, and is the Collunarium Boracis of the Pharmacopœia of this hospital.

Now, it will not do to let you suppose that the cure of this disease consists in simple cleanliness. Cleanliness is essential to a cure, but is not curative in itself. Of what value would any medicated application be if applied over a layer of adhesive mucus or over an indurated varnish-like pellicle of secretion. The application intended to cure would never reach the diseased surface and your treatment would be a failure, and you would ignorantly condemn the means employed as useless—little thinking that it was your *modus operandi* that was at fault. Now as to the way in which these cleansing solutions should be used. A syringe should seldom be employed, as the liquid enters the nasal chambers in a stream, with more or less violence, and does not reach all the nooks and corners that most stand in need of being cleared. The force of the stream is very likely also to abrade the delicate and sensitive Schneiderian membrane or to produce more or less swelling by its impact. The nasal douche should be resorted to even less than the syringe. It is occasion-

ally useful, however, in bad forms of wasting catarrh, especially if advanced in character (fetid), to remove the hardened crusts and scales that accumulate in such abundance in this advanced and obnoxious form of the disease. Certain rules are essential for guidance in the use of douches, and if carefully observed, the harm that accrues from their use is somewhat modified. The douche should be raised but slightly above the level of the patient's head so as to give as little force as possible, merely pressure sufficient to cause the liquid to flow. During the use of the douche the patient should avoid the tendency to swallow; breathing should be conducted through the open mouth, and no attempt at speaking should be made.

The special danger attending the use of the douche is the tendency of the liquid to enter the Eustachian tube and possibly give rise to serious ear complications. Too much pressure will produce severe headache and inflame and abrade the nasal lining membrane. A douche, then, is only admissible in the last stage of chronic nasal catarrh, and is here employed to wash away crusts that the patient could not otherwise rid himself of. A large quantity of liquid is usually necessary, and should be employed warm, as, indeed, should all nasal lotions or sprays. Cold liquids used in the nares tend to develop neuralgia of the face, and are to be avoided in consequence. The method of cleansing the nostrils carried out by patients attending my clinic for diseases of the nose and throat is simply to snuff the liquid from a wine-glass and clear the nose by gently blowing with a handkerchief. You notice I say "gently blowing." Violent blowing of the nose produces an excessive flow of blood, with accumulation in the venous sinuses, and is, moreover, liable to do injury to the ear if persevered in. This means of applying by "snuffing" is I find quite as effectual as the use of an atomizer. In private practice I prefer an atomizer however, as more likely to disseminate the fluid throughout all the nasal sinuses, and perhaps more elegant. The atomization of liquids is free from many of the objections urged against syringes and douches; a less quantity of liquid is needed, and as it is in a very fine state of division it enters every region possible.

Before proceeding further with the consideration of cleansing solutions, let me call your attention to the popular abuse of salt used in solutions. I will not say there is nothing worse—for there is—and that one thing is simple water used at any temperature. The membrane of the nose is hygroscopic or capable of absorbing moisture, and that tendency is increased when in contact with a liquid of low specific gravity; the result is that the vessels become loaded, the membrane tumefied, and the surface irritated. A solution of salt in water is not, if of proper density, subject to this grave disadvantage, but it relaxes the membranes in time and produces a genuine nasal catarrh where possibly none previously existed. When speaking of atomizers, it will be well to recommend an instrument that will be found serviceable, and not likely to get out of working order. In the Burgess' atomizer you will find everything that you can desire. I have ordered for the past two or three years no other instruments, and have every reason to be perfectly satisfied with their behavior. They may be obtained with an up, down or straight stream, and are practically indestructible. They require, like all delicate instruments, occasional cleaning with hot water. In addition to the formula for a cleansing solution already given, I frequently modify it by omitting the bicarbonate of soda; by using borax and sod. carb. alone, with water; by substituting muriate of ammonia in less quantity for either or both. I likewise order a spray containing fluid extract of Pinus Canadensis (instead of carbolic acid), and find it answer very well in some cases. The value of a spray in each case can be well judged by the feelings of the patient, not at the time of using, but after an interval of an hour or two.

Insufflation of medicated powders are also employed in chronic nasal catarrh. I employ only two formulæ. The first is—Iodoform, one part by bulk; Boracic Acid, seven parts by bulk, finely powdered and used with an insufflator. The second formula is—Iodoform, ʒi; Pulv. Benzoin, ʒvii, finely powdered. The first is simply antiseptic and the latter combines antisepticism with stimulating properties.

Before proceeding to speak more particularly of the treatment

most applicable to each one of the three forms of chronic nasal catarrh, I wish to say right here that my individual experience of the disease leads me to place very little confidence in any of the various methods of local medication set forth as cures for chronic nasal catarrh. Palliatives they may be; radical cures they certainly are not. It will not do to ignore local medication, as it no doubt assists surgical measures, but in the latter method I look for and obtain good, satisfactory and permanent results.

In simple chronic rhinitis, uncomplicated by any other abnormal condition, I usually order a cleansing spray to be used the last thing at night before retiring and the first thing in the morning on rising. This must be persevered in for some weeks; gradually the membrane will appear less red and less swelled, and may possibly entirely recover. Usually these cases improve up to a certain point and then hang fire completely. I usually then undertake some superficial scoring with galvano-cautery knives, whereby the superficial circulation is reduced to such an extent that the case quickly and permanently recovers. I say permanently, as the tendency to inflammatory action is reduced and the parts are rendered less susceptible to weather influence. These operations are absolutely painless, as they are done under the local use of a four per cent. solution of Merck's cocaïne. My method of proceeding is as follows: After clearing the nostrils of any adherent or accumulated secretion by means of atomization, I dry the surface to be operated upon with a small pledget of absorbent cotton carried on a suitable probe. I then apply the cocaïne to the part on which I am about to operate with a brush or pledget of cotton, after having first sprayed the nasal chamber so as to diminish the general sensibility. When contraction has taken place, and the membrane is somewhat paler, I test the parts with a probe to ascertain if sufficient insensibility has been produced. I then pass in the knife through a nasal speculum, and having arrived at the farthest point I intend reaching, I turn on the current and draw the knife steadily and slowly forward; having reached a point forward beyond which I do not wish to go, I shut off the current and withdraw

the knife cold. I make it a point never, unless under very exceptional circumstances, to operate on both nostrils at the same sitting. It is well to preserve one nostril for respiratory purposes. After completing the operation I dress the wounds with sublimated wool, and am careful not to put in too large a piece nor to pack it too tightly. I find when the latter precaution is omitted that the absorption of moisture by the wool increases the bulk to such an extent as to exert pressure sufficient to produce severe headache. This dressing I change in 48 hours, and may or may not replace it by a second one. In 96 hours the wounds are healed, when we can safely operate on the remaining side, and so on. The scoring as carried out in simple chronic rhinitis is, as I stated, superficial, and is best done with knives made of round platinum wire and at cherry-red heat.

In the hypertrophic variety deep wounds are necessary; a sharp spatula knife, therefore, is to be preferred, and the temperature of the knife requires to be higher.

In the atrophic variety, galvano-cautery should be used as a stimulant to the general surface, and when used, you will find it better than Galanga, Sanguinaria Canadensis *et hoc genus omne.* In wasting diseases I proceed somewhat differently. I apply the flat of a specially constructed and large sized spatula to the bones generally. I observe the exact spots where collections occur; these regions I score thoroughly and destroy glandular masses that are here situated, with the happiest results. This atrophic stage is incurable; by incurable I mean that it is not radically curable, and why? For the simple reason that wasting has taken place. Parts essential to the health of the region are wanting; they are not there, and we cannot put them there. We can destroy, but we cannot always restore. So much improvement follows this method in the last stage that a little care on the part of the patient will be sufficient to keep the chambers in a comparatively healthy and pleasant state. By care I mean cleanliness, for in this stage it is of all means the most essential. The secretions lack fluidity, they cannot drain away, and hence crust and dry up, becoming centres of decomposition. Then wash them away. Time and patience are required, but it is not spent in vain.

There are other methods of a surgical nature to which it is necessary to refer.

The actual cautery is always available, and if carefully handled is no doubt efficacious. It is, however, a rude means to an end, and personally I have no experience of it.

The thermo-cautery is a clumsy appliance for nasal purposes, and rests under the great disadvantage that it requires to be introduced into the nasal passage red-hot. Its action cannot be properly controlled, and it is liable to destroy a large extent of surface. It is not suitable for nasal purposes, and is at best a makeshift.

Chemical agents are occasionally useful, and sometimes to be preferred.

Of the latter class I may mention fuming nitric acid, glacial acetic acid, and chromic acid; and I name them in the order in which they are to be preferred. In employing acids, some precautions against possible accidents are necessary. First cleanse the nasal chamber thoroughly before applying the solution of cocaïne. When local anæsthesia has been produced, proceed to prepare your applicator. Take a metal probe with a roughened end, or, better, a vulcanite acid carrier, if you happen to have one, and wrap the end lightly, but tightly, with absorbent cotton. When properly secured, dip into the acid and squeeze out any excess of acid by pressing the probe against the side of the glass. Introduce your nasal speculum and pass in the probe, exerting a pressure against the part requiring contraction, rotating the instrument on its axis to secure thorough contact. Now withdraw and quickly spray the parts with a saturated solution of bicarbonate of soda, which you have ready at hand. This last-named procedure neutralizes any excess of acid and prevents unnecessary destruction. Then dress the wound as after the galvano-caustic method. I also should state that it is well to direct the patient when the acid is *in situ* to inspire through the mouth only, then shut it and expire through the nose, repeating as often as necessary. This will effectually prevent the entrance of the fumes into the throat and avoid the awkward complication of coughing or sneezing. If you saturate the acid with cocaïne

it will also diminish the pain of the application. Acids are only available for use in the anterior area of the nasal chambers, as, if applied in the back part of the nose, they would not be under proper observation or control. If the head be somewhat inclined forward the flow will be in the same direction, and an additional precaution against any accident will have been taken.

Nitric I prefer to any other acid. Glacial acetic I have used, but failed to find it possessed of any advantage over the first named. Chromic acid I do not recommend, as it is difficult to control and is not clean. Nitrate of silver is too stimulating, too superficial in its action, and as a destructive would require to be repeated too often. It is not to be recommended. The cold wire snare is available in cases of hypertrophy, when there is sufficient redundancy of tissue to enable you to secure a grip. It is specially useful, in fact indispensable, in hypertrophies of the posterior end of the lower turbinated body. The loop of wire, to which a proper outward curve has been given, is passed along the nasal chamber, and when the overgrowth is engaged in its embrace, the wire is drawn home and the mass severed thereby. Cocaïne cannot be used in the last-named operation, as its use will frequently cause the temporary disappearance of the tumor, only to return again in a few minutes. When skilfully performed, the operation is speedy and not very painful. Considerable bleeding, occasionally lasting for several days, may succeed this operation, but it is not likely to be serious. If you direct the patient to keep the head erect, you will probably avoid this annoyance. If the patient finds it necessary to expectorate, do not allow the head to be inclined forward in the least. This rule holds good in all cases of bleeding from the nose. Whether bleeding occurs or not, take the precaution to plug the nasal passage on which you have just operated with a little cotton wool to prevent breathing on that side, as breathing tends to prevent the formation of a clot. The cold wire snare is also available in hypertrophies occurring on the anterior face of the middle turbinated body and on the lower margin of the lower bone.*

* This lecture was profusely illustrated by living subjects, and the various surgical operations detailed were performed in the presence of the class.

The improved angular nasal snare and écraseur introduced by the author is especially adapted to the needs of the general practitioner, possessing many advantages over the straight instrument ordinarily used by specialists.

After the removal of hypertrophies by the means above referred to, you will find that there will be no redevelopment; in other words, the cure is radical. Many of these operations, simple though they appear, require far more than the average skill of the general practitioner, and are best referred to those whose opportunities best fit them for the work, when such persons are available.

You will observe that I have here carefully confined myself to the consideration of simple chronic nasal catarrh, free from complications, and these remarks are to be so considered.

TRAUMATIC SUPPURATIVE MENINGITIS.

By W. A. DeWolf Smith, M.D., New Westminster, B.C.

On Thursday, March 17th, '87, I received an order from the Police Magistrate to make a post-mortem examination of the body of a Chinaman. The previous history of the case, as given me by Dr. Cooper, is briefly as follows:—

On Monday, Feb. 21st, Dr. Cooper was called to see a Chinaman who had been hurt, and was taken to a building used as a Chinese gambling-house, where he found a man lying on the floor, bleeding profusely from a wound in the forehead. On examination, a wound over the left eye, about an inch in length and reaching to the bone, was seen. Over the right parietal bone a severe contusion was present, which presented clearly defined edges, and over the occipital bone was another contusion. The man, when first seen by Dr. Cooper, was unable to move or speak. His friends being unwilling that he should stitch the wound, he contented himself with cleansing it and drawing the edges together by a couple of strips of rubber plaster. The man recovered his senses, and when seen by Dr. Cooper a couple of days after the row, was able to walk about. In another day or so he was again seen by Dr. C., who found that a "chemical doctor" had visited him, had taken off the

plaster, and stuffed the wound full of a powder for which they claim considerable virtue. Dr. Cooper thereupon intimated his unwillingness to co-operate with the Chinese doctor, and did not see the man again until a day or so before his death, when he again cleansed the wound and drew the edges together with plaster. Notwithstanding, the man died on the 14th March, three weeks after receiving the injury.

On the 17th of March, then, I was required to make a post-mortem examination of the body of a Chinaman, Lim Bos. I found the body on the floor of the Chinese hut, where he had died. It was fully clothed. On stripping the body it was seen to be that of a Chinaman of a little more than the average height, well-proportioned and well-nourished. His age was said to be thirty-six. The front of the neck, part of the chest and sides, and the back were discolored in places from post-mortem staining. The abdomen was distended and tympanitic. In each groin were patches of greenish discoloration. On the forehead were two strips of adhesive plaster, and when these were removed an open wound was visible. It was about one inch in length, and commenced at a point two and a half inches above the inner canthus of the left eye, and extended in a direction outwards and a little upwards. With a probe, bare bone could be felt through its whole length. There was a slight bloody discharge from the nostrils.

A crucial incision having been made in the scalp, it was reflected, a considerable quantity of bloody serum being underneath. Over the whole frontal bone the periosteum peels off easily, and over the left frontal bone surrounding the situation of the above-mentioned wound the periosteum is entirely absent. The edges of the wound on the inner surface of the scalp show signs of inflammation, and are very unhealthy looking. Above, and communicating with the orbit of the left eye at its external angle, is an abscess containing about half an ounce of pus. Over the right parietal bone there was a large contusion.

The skull-cap having been removed, the membranes were found to be not adherent at any point, and a little dark blood, which came from a tear in the longitudinal sinus, escaped. The

vessels of the dura mater were much congested. On the interior of the cranium the sutures were particularly well marked. No crack or fracture was visible beneath the site of the wound, either on the exterior or interior of the frontal bone. A large quantity of purulent matter was spread over the dura mater, beneath the site of the wound, and for some distance around. The membranes over the whole left anterior lobe were much thickened, except at a point immediately beneath the site of the injury, where they were absent. Beneath the membranes, bathing the whole of the anterior lobe, was a large quantity of pus.

Brain removed. Between the under surface of the left posterior lobe, of the cerebrum, and the adjacent surface of the cerebellum, was a moderate quantity of creamy pus. Otherwise the base of the brain and the arteries of the base were healthy. Over the anterior three-fourths of the upper surface of the left hemisphere there was an intense degree of inflammation, and in places the membranes were adherent to the brain. Along the middle two-fourths of the convolution of the longitudinal fissure on the right side there were evidences of a lesser degree of inflammation. The hemispheres were adherent along the whole extent of the great longitudinal fissure from inflammatory exudation. The lateral ventricle of each side contained a small recent blood-clot. The right hemisphere was of normal consistence. The anterior portion of the left hemisphere was softened by inflammation to the depth of about half an inch. The cerebellum appeared normal. The fourth ventricle was empty.

On opening the abdomen, the bowels, much distended with gas, came immediately into view. On the left side there was a hernia of the omentum into the scrotal sac—evidently of old standing, as it had become adherent to the bottom of the sac. There was no other evidence of disease, inflammatory or otherwise, about the abdomen. In the thorax the heart was free from any signs of disease, and the valves were normal. The lungs were not adherent to the chest wall at any point, and were, in fact, quite healthy.

REMOVAL OF A NUT-SHELL IMPACTED IN THE LARYNX.

By George W. Major, B.A., M.D., &c.,
Specialist to the Department for Diseases of the Nose and Throat, Montreal General Hospital; Instructor in Laryngology and Diseases of the Throat, McGill University, Montreal, Canada.

On Monday, April 11th, Dr. Roddick referred an infant of eleven months in whose larynx a portion of nut-shell had become lodged a couple of hours before. The child was suffering from very difficult breathing, and was altogether in a very critical condition. An attempted examination with the laryngoscope proved a failure owing to swelling and a continued state of spasm. On passing the finger into the larynx an irregular body was found in the posterior commissure of the larynx, firmly held between the vocal cords, then in a state of spasm. An attempt at removal with forceps of many sizes and patterns proved fruitless, as the small size of the passage would not allow of the opening of the blades. Before deciding upon tracheotomy, I took an ordinary laryngeal probe and bent its tip outwards at a right angle. After finding the body with the forefinger of the left hand, I introduced the probe bent as described between the vocal cords and in front of the shell, and pressing upwards and backwards, succeeded in dislodging the body and carrying it into the upper pharynx. On turning the child on her face, the body was ejected and breathing restored. On the following day some slight hoarseness remained and the sputum was tinged with blood. No other untoward result was observed.

Correspondence.

HEREDITY.

To the Editors of The Canada Medical & Surgical Journal.

Dear Sirs,—When Dr. Johnston's paper on "Heredity," published in the April number of this Journal, was under discussion in the Medico-Chirurgical Society of this city, I suggested that medical men might possibly be able to throw some light on that part of Prof. Brooks' theory of heredity which refers variations to one parent rather than the other, viz., to

the male. By way of starting discussion on this subject, I beg to refer to a communication in *Science* for August 20th, 1886, in which Prof. Joseph LeConte reports a case of inherited polydactylism, which he renders clear by the following diagram :—

Maternal Grandfather.	*Maternal Grandmother.*	
Father.	*Mother.*	
(Case Reported)—*Peter Weitner.*	Sisters.	Brother.
	a, b, c, d.	a.
	Children.	

It is seen that the deformity was inherited from his mother's maternal grandmother; that, besides himself, it has affected one sister out of four, and one brother, and has been transmitted to the children of the sister, thus affecting at least four generations. Besides, it will appear that the peculiarity began on the *female* side and descended first along that line, and affected, on the whole, as many females as males.

According to Prof. Brooks, variations *originate* with the male. His view has been much disputed, and it seems important to determine whether it be true or not, for if so, many momentous practical conclusions will flow from it. This single case is against the theory.

Hoping that this communication will stimulate others of your readers to communicate cases, bearing on the theory, that they have met either in reading or in practice,

I am, yours truly,

T. Wesley Mills.

McGill College, Montreal, April 23rd, 1887.

Hospital Reports.

Medical and Surgical Cases Occurring in the Practice of the Montreal General Hospital.

Excision of Tongue, with preliminary Ligature of the Lingual Arteries. (Under care of Dr. Shepherd.)

(Reported by Dr. A. W. Campbell, Acting House-Surgeon.)

Thomas T., aged 63, laborer, was admitted to hospital on December 1st, 1886, complaining of a painful sore on his tongue.

History.—Patient states that he has always been a healthy man, with the exception of an attack of yellow fever many years

ago. Knows of no ill health among any members of his family. Father and mother died, aged respectively 64 and 72. He has been a sailor in the U. S. navy. Last February he obtained employment in an oil-house on the C. P. R. at Chapleau. He lived there in comfortable circumstances with his family. Has never used alcohol nor tobacco in excess, but has been in the habit of smoking an old wooden pipe, which he held on the left side of his mouth. Lost some teeth on that side ten years ago, but has had no trouble with his teeth lately. About the first of May last he noticed a small ulcer on the edge of the left side of the tongue, about half an inch from the tip. This became larger and painful, and on going to a doctor he was given a gargle which, he says, took the skin all off his mouth, blackened his teeth, and made his tongue worse. The ulcer continued to grow in size and the pain increased. He began to lose strength and flesh, and could not eat solid food on account of the pain. Continued to work until a few days ago, as his work was not hard, when he was advised to enter the hospital.

Present condition.—Patient is a well-built, intelligent man, thin and weak, having lost 20 lbs. since last May. His appetite is good. The ulcer extends along the left edge of the tongue, from the tip to opposite the last molar teeth, and also on the dorsum of the tongue. The surface of the ulcer is irregular, depressed, and sloughy, the edges ragged and everted, and the base firm and indurated. A second ulcer, oval and more deeply excavated, is situated on the middle of the dorsum of the tongue, about 1½ inches from the tip. The rest of the tongue appears healthy. The floor of the mouth is not affected. The submaxillary glands are enlarged and firm. No other glands are enlarged. The teeth are blackened, but not decayed; the bicuspids on right side have been removed. Heart and lungs normal. Pulse 72. Respirations 16. Urine normal; no disorder nor frequency of micturition.

Operation (Dec. 4th.)—The patient was etherized, and the *right lingual* was first tied. The incision made was a curved one reaching from near the symphysis menti to near the angle of the lower jaw, with the convexity downwards, having its

lowest portion parallel to the great corner of the hyoid bone. After cutting through the platysma and deep cervical fascia the tendon of the digastric was exposed, and in the angle formed by it with the great corner of the hyoid bone the artery was found running *over* the hyoglossus muscle. The artery was tied with two silk ligatures and divided between them. The submaxillary gland of that side, which was enlarged, was then removed and the facial artery tied. The *left lingual* was tied by a similar incision, the artery being found in its normal position beneath the hyoglossus muscle. On this side the temporo-maxillary vein was also tied. The submaxillary gland, being enlarged, was taken away and facial artery tied as on opposite side; several small lymphatic glands were also removed. The mouth was now kept open with a Whitehead's gag, and the tongue drawn out by a double ligature passed through its substance about an inch from the tip, and completely removed with scissors, after Whitehead's method. There was very little hemorrhage. The wounds in the neck, which had been filled with antiseptic sponges, were then closed by continuous silk sutures and dressed with iodoform and jute pads. The mouth was packed with a sticky iodoform gauze.*

Dec. 5th.—Temperature 100°; pulse 80; respirations 16. Has been fed every four hours per rectum with three ounces of beef juice and one ounce of brandy. As there was considerable ropy mucus in the mouth, the gauze was removed and mouth washed out with a solution of Condy's fluid and again packed with the gauze.

Dec. 6th.—Had a comfortable night, slept well; temperature 99½°; pulse 80. Mouth again washed out, as gauze would not remain in. Wound healthy-looking and covered with the iodoform mixture with which gauze is charged. Not the slightest fœtor.

Dec. 7th.—Temperature 98½°; pulse 70. Wounds in neck dressed and drainage-tubes removed. Mouth still sweet. Stopped

* The gauze was prepared after a formula of Dr. Robert Weir of New York. (*Medical News*, Jan. 30th, 1886.) Resin, 10 parts; Castor Oil, 6 parts; Alcohol, 15 parts; Iodoform, 5 parts.

the rectal injections and fed patient through mouth with a catheter attached to a glass funnel by means of a rubber tube.

From this time the patient progressed most favorably; the wound in mouth rapidly granulated, and was sweet throughout. The wounds in neck did not heal so rapidly, and the wound made for tying the right lingual communicated with the mouth. The stitches on this side gave way, and the wound healed by granulation. The patient was up at the end of the first week. When discharged, December 23rd (nineteenth day), the wound in mouth had completely healed. The wound in right side of neck had not yet closed. Patient could swallow well, and could talk so as to be understood.

He wrote January 12th to Dr. Shepherd and stated that the wounds in neck had completely healed, and that since his return home he had gained seven pounds. When last heard from, the end of March, patient was attending to his business as usual, and was feeling well.

Remarks.—Excision of the tongue with preliminary ligature of the linguals is an operation which has many advantages over removal of the tongue by the écraseur. The removal of the tongue is complete and bloodless, and there is no fear of secondary hemorrhage. Few instruments are required, except scissors, knife and forceps, and by means of the incisions made for ligaturing the linguals the diseased glands in the neck can be easily detected and excised. In excision of the tongue it is very important to keep the wound in the mouth sweet, and so avoid the great danger of septic infection of the lungs. The gauze used did not stick well to the wound, but rolled up into a ball owing to the quantity of ropy mucus formed in the mouth. The antiseptic preparation with which the gauze was charged, however, coated the wound well and prevented fœtor. In another case, it would be perhaps as well to use the preparation without the gauze. A microscopical examination of the tongue by Dr. Johnston, pathologist to the hospital, showed that the growth was an epithelioma.

Reviews and Notices of Books.

A Practical Treatise on Obstetrics. (Four Vols.) Vol. I—Anatomy of the Internal and External Genitals, Physiological Phenomena (Menstruation and Fecundation). Vol. II—The Pathology of Pregnancy. By A. CHARPENTIER, M.D., Paris. Illustrated with lithographic plates and wood engravings. New York: Wm. Wood & Co.

One of the best modern French works on Obstetrics is that of Charpentier, for some time head of the Obstetrical Clinic at the School of Medicine, and assistant to Professors Pajot and Depaul. Published in 1882, it is now translated and brought fully up to date by Dr. E. H. Grandin of New York, whose notes and criticisms are numerous and practical. The article on Embryology is by Dr. Milnes Marshall, slightly condensed from Barnes' "System of Obstetric Medicine and Surgery." It is as gratifying as it is unusual to find in a French author thorough acquaintance with, and appreciation of, foreign methods and teachings. Charpentier's book is full of references to German work and extracts from English and German authors, to whom he generally does justice. In some points his teaching is not in accord with generally received opinions in Canada and the United States. For instance, in the delivery of the placenta, he advises traction upon the cord, utterly condemning the Dublin and Credé methods. Delivery according to such methods he claims to be no longer natural, but in the highest degree artificial. Massage applied to a uterus exhausted by previous effort does positive injury, and is apt to set up peritonitis or metritis. Hemorrhage is not prevented, but shreds of membrane and bits of placenta are apt to be retained in utero. Dr. Grandin, in a note, strongly opposes these views and upholds the Credé method, but agrees with Charpentier in recommending the twisting of the placenta upon itself "in order to form, with the membranes, a species of cord more resisting, and therefore less likely to break." Grandin says "the placenta delivered, too much stress cannot be laid on the fact that it must be twisted on itself over and over again, in order that the membranes may be extracted entire.

Inattention to this fact is a very common cause of retained shreds of membrane." This practice now so commonly taught seems highly objectionable, and indeed very apt to ensure the occurrence of the accident which it aims to prevent. If the portion of the membranes inside the uterus be adherent or even firmly gripped, and if rotation of the placenta be practised, the rope of membranes will be far more apt to give way at its weakest part than to detach or disengage the portion remaining in utero. Charpentier's book, although of unequal merit, contains much valuable information, and we can heartily recommend it to the profession.

Handbook of Materia Medica, Pharmacy and Therapeutics. Including the physiological action of Drugs, the Special Therapeutics of Disease, Official and Extemporaneous Pharmacy, and Minute Directions for Prescription Writing.—By SAMUEL O. L. POTTER, M.A., M.D., Professor of the Theory and Practice of Medicine in the Cooper Medical College of San Francisco; author of "Quiz-Compends" of Anatomy and Materia Medica, &c. Philadelphia: P. Blakiston, Son & Co.

The first part of this work is devoted to a description of the materia medica, pharmacology and therapeutics of all the official drugs of the United States Pharmacopœia. In addition, many important and many unimportant unofficial agents of the pharmacopœia are described. The drugs are taken up alphabetically, an arrangement, although convenient, which has very serious objections. Therapeutics and pharmacology cannot be grasped fully unless considered according to a physiological arrangement. It is only then that the student can recognize small, but important, points of difference between agents of the same physiological group. It is only by contrasting agents of different groups that either the student or the practitioner can be saved from being immersed in a sea of physiological imcompatibles.

A physician of our acquaintance, prized for his eminent practicality, has been known to prescribe the following combination in a case of acute myelitis, viz., bromide of potassium, strychnine,

Calabar bean and atropine. We believe that it is only by following a physiological arrangement in the teaching of pharmacology that a physician will be saved from putting together such a mass of incompatibles in the physiological sense.

Dr. Potter has a very good section devoted to prescribing, but in our opinion the best portion of the work is the elaborate therapeutical index. Under the head of the prominent diseases there is a description of the agents usually recommended, with a reference to the author or authors recommending the same. The concluding portion of the volume deals with a number of miscellaneous matters entirely out of place in a work of this character. Several pages are devoted to the differential diagnosis between various diseases by representing the prominent symptoms of each disease in parallel columns. Every physician surely knows that this is certainly not a method to be relied on at the bedside. It is always a method of doubtful utility. A number of other matters are discussed, but as they are found in all visiting lists, we fail to understand why Dr. Potter should make mention of them. In spite of these blemishes, however, the work will be found useful to both student and practitioner.

The Field and Limitation of the Operative Surgery of the Human Brain.—By JOHN B. ROBERTS, A.M., M.D., Professor of Anatomy and Surgery in the Philadelphia Polyclinic; Surgeon to St. Mary's Hospital. Philadelphia: P. Blakiston, Son & Co.

This essay, which was in part read at a recent meeting of the American Surgical Association, is meant to incite the profession to rebellion against the conservatism which has so long reigned in connection with the surgery of the brain. Dr. Roberts is a radical of a very dangerous type, and must be kept within decent bounds. He would have us all going about with our waistcoat pockets full of buttons of bone like the Irish surgeons of old. Dr. Roberts' monograph is, however, well worthy of careful perusal. He believes that in "compression of the brain" the symptoms are due more to incranial inflammation than to displacing pressure exerted on the brain substance. He looks

upon trephining as if attended by little more risk than amputation of a finger, and with our improved methods of treating wounds, asserts that the conversion of a simple into a compound fracture is attended with very little increased risk to life. These with many other statements of an equally extreme character go to make up the author's creed. One chapter is devoted to "Cerebral Localization," and another to the "Operative Treatment of Cerebral Lesions," both very useful for reference. The book altogether has much to commend it.

Handbook of Diseases of the Ear.—By URBAN PRITCHARD, M.D., F.R.C.S., Eng., Professor of Aural Surgery at King's College, London; Aural Surgeon to King's College Hospital; Senior Surgeon to the Royal Ear Hospital. London: H. K. Lewis.

A small manual on diseases of the ear, "intended for the use of students and practitioners," which the reader will find contains a great deal of useful information in a condensed and readable form. A short chapter on the anatomy and physiology of the ear is quite a model of brevity and clearness of description. Then follows a concise and methodical description of the examination of the ear, in which the author has introduced the late Dr. Gardiner Brown's excellent method of testing the degree and kind of impairment of the hearing power. This method has not as yet come into general use, but bids fair to become a valuable aid in diagnosis. In the description of the various diseases of the ear and their treatment the author gives chiefly his own views founded on his individual experience, the scope of the work, of course, not being sufficient to allow any lengthy discussion of disputed points. In speaking, for instance, of the treatment of mastoid inflammations, he deprecates the use of cold applications, though he admits that some aurists, under certain circumstances, attach much importance to this method of treatment; evidently he cannot have had much experience in this direction, or he would not speak so lightly of a remedy which in other hands has proved singularly efficacious.

We cordially recommend the work to all those who are inter-

ested in the subjects of which it treats, but especially to those practitioners—and there are many such—who still cherish the belief that the human ear and its diseases is a subject too difficult and complicated for any but the specialist to deal with.

The Nursing and Care of the Nervous and the Insane.—By C. K. MILLS, M.D., Professor of Diseases of the Mind and Nervous System in the Philadelphia Polyclinic and College for Graduates in Medicine, &c., &c. Philadelphia: J. B. Lippincott Company. 1887.

This small work is the substance of a series of lectures delivered by Dr. Mills at the training school for nurses of the Philadelphia Hospital. A very full and clear account is given of the general management of hysterical and epileptic patients. There is a good chapter devoted to a description of massage and the best way of carrying it out; a long chapter on electricity, which is too technical, covers a field which even to most general practitioners is unknown ground. The work, on the whole, will be found valuable, not only to nurses, for whom it is written, but also to physicians.

Books and Pamphlets Received.

A REFERENCE HANDBOOK OF THE MEDICAL SCIENCES. By various writers. Edited by Albert H. Buck, M.D. Vol. VI. New York: Wm. Wood & Co.

THE PREVAILING DANGERS TO HEALTH IN THE MEDICAL PROFESSION.—Ramazzini (De Morbis Artificum, 1713) says that medical practitioners are comparatively exempt from ordinary diseases in consequence of their good exercise and their *hilarity* of mind, when they go home with their fees in their pockets,—"Dum bene nummati lares suos repetunt." He adds that medical men are never so unwell as when no one else is unwell. The professor remarks, however, that they are subject to hernia from going up-stairs, and catch dysentery from sitting beside their patients. Voltaire has remarked that among centenaries not one was from the faculty of medicine; that the King of France had interred forty of his physicians.—(*Thackrah on the Effects of the Arts, Trades and Professions on Health.*)

Society Proceedings.

MEDICO-CHIRURGICAL SOCIETY OF MONTREAL.

Stated Meeting, January 28th, 1887.

J. C. CAMERON, M.D., PRESIDENT, IN THE CHAIR.

DR. MAJOR exhibited two laryngeal growths, and gave the following histories :

Case 1—A large papillomatous growth, removed from the right vocal cord, near the anterior commisure. This growth involved the cord on its upper, inner and lower surface, and projected into the rima. The origin was catarrhal, and the duration from first indications was three years. The mass was removed with Schrötter's laryngeal guillotine almost in its entirety. The case was still under local treatment.

Case 2—*Cyst of Larynx.*—A well-known gentleman consulted me for an acute tonsillar affection. Knowing well his peculiar voice, I made a laryngoscopic examination, and found a small nodular tumor occupying the free margin of the right vocal cord, yet involved in the substance of the cord. The tumor occupied a position so far forward on the cord that not only was a laryngoscopic examination difficult, but any operation for removal would also be far from easy of performance. The difficulty was further increased by the situation of the body in the substance of the cord. After applying by a laryngeal spray a quantity of a 20 per cent. solution of cocaïne, I passed in Schrötter's forceps and flattened the growth outwards by pressure exerted by the blades acting on the upper and lower surfaces of the cord. I then seized the prominence thus produced with Mackenzie's antero-posterior cutting forceps, and was so fortunate as to successfully remove the tumor. When inspected, it was about half the size of a grain of wheat. Dr. Wyatt T. Johnston, to whom I am indebted for the microscopic examination, made the following report: " Small cyst of larynx. Tumor, received in absolute alcohol, was imbedded in celloidin and cut with microtome. On staining sections with logwood, the cyst was seen to be situated in the submu. us tissue. The boundaries were distinctly formed

of fibrous tissue, with a thin layer of flattish epithelium over inner surface. The laryngeal mucous membrane is slightly thickened, as also is the submucous tissue. The cyst appears to have arisen probably from inflammatory obstruction of one of the mucous glands." The quantity of cocaïne used was very great, and it was with no small degree of hesitatation that it was employed. The voice, which previous to the operation had not been under any control, was greatly improved, and a good speaking voice was produced. This gentleman, who, on attempting to shout or call out loudly, could not be heard at a distance of ten feet, can now emit a good volume of sound. Some after-treatment with nitrate of silver was resorted to, the case progressing satisfactorily.

Tumor of the Ovary and Fallopian Tube.—DR. GARDNER exhibited a friable, irregular tumor about the size of a child's head, removed by him a few days before from a maiden lady of 43 years. On opening the abdomen, the tumor of the right ovary and tube was found firmly adherent to the intestines, omentum and floor of the pelvis. The operation was a very formidable one. The patient, however, recovered well from the effects of the operation, having experienced no severe shock, and was apparently making a rapid recovery.

Myxœdema.—DR. JAMES STEWART read a paper on a case of myxœdema, which will appear in our next issue.

Discussion.—DR. R. L. MACDONNELL said that the patient had been under his observation in the General Hospital at different times. It was generally regarded there as a case of tetanus. He had never been able to find that the patient had any tetanic spasms in the hospital, though these were carefully looked for. He did not think that the thyroid in the patient was altogether absent. In many it is difficult to make out the gland by external manipulations. Finally, he asked if Dr. Stewart had ever seen the patient in a tetanic spasm.

DR. MERRILL said he had known the patient some years. He had never seen any tetanic spasms, but the patient had complained about frequent attacks of severe colicky pains. He was always a very badly-nourished, dyspeptic-looking man.

DR. SHEPHERD could not agree with Dr. Stewart's suggestion

that the reason myxœdema or cachexia strumipriva follows excision of the thyroid is because of the disturbing damage done to the sympathetic system, as the affection, so far as he knew, never followed extensive operations in the neck (as removal of chains of enlarged glands and tumors), when the sympathetic trunk is quite as much interfered with as in the removal of the thyroid. When no myxœdema follows the operation of removal of the gland, it is supposed to be incomplete removal.

DR. REED asked if Dr. Stewart could give the average temperature of the patient.

DR. MILLS said—To believe that any gland or other organ existed to *prevent* the formation of a substance, whether normal or abnormal, was inconsistent with general physiological principles. True, the removal of certain glands, as the testicles in the young, arrested development, both physical and psychical. In the adult dog, such removal was followed by obesity, which could be largely accounted for by the inactivity of the animal, associated with the psychical shrinkage—the curtailment in the number and variety of the afferent impulses reaching the nerve centres. It had been asserted that after the removal of the thyroid in children there was stunted development, especially intellectually. It is likely metabolic changes follow removal of the thyroid; owing to the influence on the nervous system there is a loss of balance. All healthful life implies balance of function. It was not yet clear how the balance was destroyed by removal of the thyroid; but we were on the way to knowledge, for we had learned, experimentally, that this organ was not a blood-former. If, as had been suggested, the changes following experimental or surgical removal were due to injury to the sympathetic, one would expect to observe vaso-motor symptoms, which had not been the case, though such an objection must not be too strongly urged; for though dilation follows section of the cervical sympathetic, such is not permanent, and if transient, might be overlooked.

DR. STEWART, in reply, stated that he had seen the patient in tetanic spasms many times. When first seen the patient he had an attack. With regard to the average temperature, it was low—about 97°. The patient always complained of cold.

The whole question of the function of the thyroid was still in a very unsettled state. He did not wish to be understood as saying that atrophy or disappearance of the thyroid had nothing to do with myxœdema. There is certainly evidence pointing strongly to both myxœdema and tetany being due to neurotic changes.

Stated Meeting, Feb. 11th, 1887.

J. C. CAMERON, M.D., PRESIDENT, IN THE CHAIR.

DR. ROE of Rochester and DR. SHUFELDT of New York were the guests of the Society.

Arytenoid Disease.—DR. MAJOR communicated a paper on arytenoid disease, illustrated by a number of cases. The author's object was to point out the comparative frequency of disease of the arytenoid joint, and also to emphasize the fact that a proportion of laryngeal cases regarded as paralysis were not the result of paralysis, but of anchylosis of the crico-arytenoid joint. The means of diagnosis and other points of interest were briefly referred to. Dr. Major also exhibited Dr. Dwyer's tubage apparatus, and demonstrated their application and use.

DR. ROE (Rochester), after expressing his grateful appreciation of the kindness he had met with in Montreal, said that anchylosis of the arytenoid joint, especially if only partial, is often overlooked by the general practitioner. Partial or complete aphonia is very often attributed to paralysis of the muscles of the larynx when this symptom is due entirely to arytenoid disease. Any inflammation of the larynx involving the articulations, if at all severe, is apt to leave the joints stiff; and as these inflammations are common, arytenoid disease is common. Aphonia is very rarely due to paralysis of the laryngeal muscles. The speaker then gave the details of a case of arytenoid disease resulting from laryngeal phthisis, where there was no systemic affection. In this case there was a tubercular infiltration of the articulations, resulting in almost entire loss of voice. The left arytenoid was most enlarged and stiffest. It is a fortunate thing that, as a rule, but one cartilage is affected.

Three Cases of Laparotomy.—DR. TRENHOLME reported three cases of laparotomy lately performed for abdominal tumors. The

three cases are of much interest, as they necessitated peculiar methods of operation:

Case 1—Mrs. McD., Kingston, Ont., patient of Dr. Dupuis, suffering for many years; was pale, anæmic and weak; legs œdematous; urine scanty and albuminous; heart weak and quick. Assisted by Drs. Dupuis and Harderson, removed a solid tumor of left ovary 10 inches long, 7½ broad and 5 thick, weighing 8 lbs. Had to make a large incision. Mode of operation, etc., as usual. Patient made an excellent recovery.

Case 2—Mrs. E., St. Hyacinthe, aged 29; has suffered severely for the last eight years with pelvic disease, chiefly in left side and down the leg. Dense, but uniform tumor occupied brim of pelvis and pressed a normal-sized uterus down and toward right side. At present time is suffering from febrile symptoms; sordes on teeth and lips, pulse 165, and temperature from 100° to 102°. Has had severe anorexia for some time. Assisted by Dr. Kennedy, removed a suppurating dermoid cyst of left ovary weighing 12 lbs. Emptied the cyst with patient on left side, and drew out the sac as fast as it emptied in such a way that not a drop of pus entered the peritoneal cavity.

Case 3—Mrs. C., Granby, aged 21; always had pelvic distress since menstruation began. Of late has suffered very much in pelvic region. Pulse 140 to 160; temperature 102°. Can take little food. Lips and teeth show febrile state. Removed a suppurating cyst weighing 4 lbs., which was wedged into the pelvis between bladder and uterus, which was pushed downward. Cyst wall was universally and strongly adherent, and cyst was brought to edge of abdominal incision with great difficulty. The pus was evacuated in a manner similar to the last. The tumor was formed in broad ligament, consequently pedicle was very broad and difficult to tie, not only on account of its size, but because it was so bound down, and connected with fundus of the uterus. One large artery on right side could not be tied, and was secured by porous forceps, which were left sticking out of the lower part of the wound, with a drainage-tube. The forceps was removed at twenty-third hour, and the drainage-tube after the second day. Free bloody, serous discharge occurred for several days, but the patient has made, so far, an excellent recovery.

Discussion.—DR. GARDNER said that Dr. Trenholme was to be congratulated on the results of his operations. He had found from experience that no case was too bad to attack, and this was borne out by the last cited case of Dr. Trenholme's.

DR. ALLOWAY asked if Dr. Trenholme had used a drainage-tube to evacuate the contents of the cyst.

DR. TRENHOLME replied that it was unnecessary, as the cyst was tapped at the incision, and its own walls formed a tube to conduct the contents away.

Dermoid Cyst.—DR. GARDNER exhibited a dermoid ovarian cyst, which he said had nothing out of the common. There was the usual history of such cases up to a short time before operation, when the tumor became very painful and tender. On opening the abdomen, the tumor was found much congested and twisted several times on its pedicle. To this twisting was probably due the congestion of the tumor; it was to a certain extent strangulated.

DR. ALLOWAY referred at length to the different explanations offered for the phenomena of twisted pedicles. The alternate filling and emptying of the bladder or the rectum is the usual explanation, but this is not altogether satisfactory.

DR. BELL reported a case in which the patient, a man aged —, presented a marked prominence in connection with the spine of upper cervical vertebræ, which it was expected would result in post-pharyngeal abscess. The history was one of progressive emaciation, lasting some months, with signs of slight consolidation in both lungs. The case was looked upon as one of tubercular origin. At the autopsy by Dr. Johnston, a large cancerous mass was found in the pancreas, infiltrating the stomach, with extensive secondary deposits in the lungs and liver. Very numerous secondary nodules were found in the vertebræ; the bodies of the sixth and eighth dorsal and seventh cervical vertebræ were found to be extensively softened, and to contain numerous cancerous nodules. Numerous nodules were also found in the ribs; the second and third ribs consisted, near the junction with the cartilages, of a thin shell of brittle bone, surrounding masses of new growth nearly as large walnuts, and when examined were found fractured. The bodies of the upper cervical vertebræ

were healthy. The spines were not examined. There was no suppuration. On microscopic examination the growth was found to consist of epithelial cells of small size arranged in alveoli, with scanty stroma.

TORONTO MEDICAL SOCIETY.

Stated Meeting, February 17th, 1887.

THE PRESIDENT, DR. MCPHEDRAN, IN THE CHAIR.

Pathological Specimens.—DR. MCPHEDRAN exhibited several enlarged suppurating glands which he had removed from the neck. The disease commenced about a year ago. At that time the glands inflamed, suppurated, and were lanced. The openings continued to discharge freely and showed no tendency to heal. The operation for their extirpation was then performed. Each sinus was slit up freely, and was found to be lined by a soft, gelatinous substance. This was scraped out with Volkmann's spoons, the remains of the caseous glands were removed, and drainage-tubes laid in the sinuses. Moderate pressure was then applied over all by means of gauze and absorbent cotton. Healing took place for the most part kindly.

DR. SWEETNAM had used calc. chloride in rather large doses with marked beneficial effect in similar cases.

DR. ATHERTON approved of the plan of slitting up the sinuses and removing the glands. He had not found much benefit from calc. chloride, but had extirpated the inflamed glands with gratifying success in several cases, one of syphilitic origin.

DR. OLDRIGHT had used nitrate of silver as a caustic by heating a knitting-needle or probe and then placing it in contact with the caustic, so that it acquired a thin coating. In this way caustic could be applied to the whole of the sinuses. At the same time he used cod-liver oil and the iodides internally.

DR. REEVE presented (1) a specimen of calcified crystalline lens removed from the anterior chamber of the eye, into which it had been dislocated. Before operation, the pupil was strongly contracted with eserine sulphate so as to prevent the displacement of the lens backwards during operation. Cocaine was also instilled into the eye at the same time to relieve the pain caused by the eserine, and also to obtund the sensibility of the cornea

and prevent spasm of the orbicularis muscle. The incision was made downwards and the lens removed without trouble. (2) A glaucomatous eyeball in which there was dislocation of the lens downwards upon the iris and into the anterior chamber. The surface of the eyeball bulged in some places owing to the localized thinning of the sclerotic and the great tension of the intraocular fluids. The vitreous humor was quite fluid. At the time of operation there was pan-ophthalmitis of the affected eye, and as sympathetic inflammation of its fellow was feared, it was thought advisable to remove the inflamed organ.

DR. ATHERTON had found a calcified lens at the fundus of an eye which he had removed for pan-ophthalmitis of three weeks' duration. The retina was atrophied at and near the dislocated lens.

Cases in Practice.—DR. MCPHEDRAN related a case of syphilis in which, two weeks after intercourse, a number of herpetic ulcers appeared in the sulcus behind the glans. Within a few days four of these formed typical Hunterian chancres. The unusual number of hard chancres and their early appearance are remarkable in this case.

DR. SWEETNAM reported a case of perforation of the soft palate from syphilitic ulceration. After ten days of anti-syphilitic treatment the palate was operated upon in the usual way. It did well for five days, when the stitches tore through from contact with solid food, which had been taken contrary to orders, An ordinary rubber palate-plate was then made by a dentist, with a boss upon its upper surface, which exactly fitted the aperture. This produced great improvement in the voice, and was worn with comfort. The boss was snipped off when granulation commenced, and the plate still worn till complete healing took place. The support and rest given to the soft palate by the plate evidently promoted healing.

Stated Meeting, February 24th, 1887.

THE PRESIDENT, DR. MCPHEDRAN, IN THE CHAIR.

DR. W. H. B. AIKINS read a paper on *The Bacillus of Typhoid Fever*, illustrating the subject by means of some very

interesting cultures of the bacilli on patato, and in gelatine and agar-agar. Several microscopic specimens of the growing and stained bacilli were also shown.

DR. HAMILTON followed with a paper on *Reduction of Hernia*. The methods of reduction upon which he dwelt were: 1, Gravity with succussion, as practised by inversion; 2, Taxis; 3, Application of cold externally, by means of ether-spray, ice-bag, etc., and internally by means of cold-water injections; 4, Digital dilatation of the constricting ring.

Discussion.—DR. OLDRIGHT expressed the opinion that digital dilatation of the ring was in the majority of cases almost, if not altogether, impracticable, as it was found exceedingly difficult, even when the sac was empty and after dividing the skin, to dilate the dense fibrous inelastic ring.

DR. DOOLITTLE mentioned a case in which reduction by taxis occurred in a few minutes, after suspension by the friends of the patient for nearly an hour had failed.

DR. MCFARLANE had always availed himself of the advantages of gravity offered by elevation of the hips. In making taxis, the anatomical relations of the parts should be borne in mind, and pressure made exactly in the course of the axis of the canal.

DR. CARSON thought that both suspension and taxis have their uses in different cases. He illustrated by a diagram how suspension would favor reduction, when the contents of the sac consisted of coils of intestine or a single knuckle with fluid contents. And also showed that if the contents of the sac were solid and firm, suspension would fail.

DR. ATHERTON thought rectal injection might be advantageously used in acute cases—*i.e.*, where the sac of the hernia is newly formed. He had succeeded in reducing a hernia, after withdrawing a small quantity of fluid with a hypodermic syringe.

Cancer of the Breast.—DRS. SMITH and MCPHEDRAN showed a case of cancer of the breast in a woman aged 44. The growth commenced nine months ago. It is now nearly as large as a child's head, indurated in some parts and cystic in others. The surface is quite nodular; and ulceration, giving rise to profuse hemorrhage and serous discharge, has occurred in a few spots. The axillary and supra-clavicular glands are enlarged to such

an extent that the Society thought operation would fail to eradicate the disease.

Stated Meeting, March 31, 1887.

THE PRESIDENT, DR. MCPHEDRAN, IN THE CHAIR.

Rheumatoid Arthritis.—DR. MCPHEDRAN presented a case of commencing rheumatoid arthritis in a young man aged 19. Three years ago the metatarso-phalangeal joint of the left great toe began to get stiff and painful, with crackling on moving the joint. At present there is thickening of the ends of the bones and considerable stiffness of the joint. The interphalangeal joints of the same toe are beginning to be affected. Iodides internally and local applications constitute the treatment. The prognosis is unfavorable.

Pathological Specimens.—DR. OLDRIGHT exhibited a calculus weighing about four drachms, which he had removed from a boy aged six years. The symptoms commenced two years ago, with frequent and painful micturition. Sand was passed at intervals. There was sometimes sudden stoppage of the stream. The lateral operation was performed and two stones removed, one having three facets and the other four.

DR. W. H. B. AIKINS exhibited the brain from a young woman aged 24, who had died a few hours after labor. Bright's disease commenced three years ago. Before labor commenced there was a large amount of œdema of the lower limbs and of the external genitals. Urine loaded with albumen. Bowels moved freely; intellect clear, but slight headache. After labor had been in progress about four hours, the patient gradually became semi-comatose, right hemiplegia set in, the right pupil was contracted, and the patient had several convulsions. Patient was delivered of a dead fœtus, and shortly afterwards paralysis became general, coma ensued, and patient died about twelve hours after labor set in. At the post-mortem examination, the lateral, third and fourth ventricles of the brain were found filled with a recent clot; there was also a diffused hemorrhage into the membranes at the lower and back part of the cerebellum. The kidneys were large and white.

DR. CARSON expressed the opinion that when pregnancy is preceded and accompanied by Bright's disease, the gestation should be terminated prematurely.

DR. CAMERON thought simple albuminuria of pregnancy could be successfully treated if taken early. Abortion should only be induced when treatment proves of no avail. In such a case as the above the hemorrhage could probably be checked by venesection.

DR. OLDRIGHT always administered pulv. jalapæ co., and alkaline diuretics, on the first appearance of œdema.

DR. T. S. COVERNTON presented a specimen of carcinoma of the liver, from a woman aged 59. There was no history of cancer in the family. Patient had suffered from indigestion and hepatic colic. On March 5th an attack of pleurisy set in; the chest became filled with fluid and was aspirated. At the same time a smooth, rounded tumor was felt in the epigastric region, apparently depending from the liver. No fluctuation was detected. After tapping the chest a second time an exploratory incision was made over the tumor. On finding the carcinomatous nature of the growth the wound was closed. Death took place on the 11th March. *Post-mortem:* The surface of the liver presented numerous soft, semi-fluctuating tumors, varying in size from a walnut to a goose-egg. The right lung and pleura also presented nodular growths; there was about a quart of fluid in the pleural sac.

Stated Meeting, April 14, 1887.

THE PRESIDENT, DR. MCPHEDRAN, IN THE CHAIR.

The Irritable Heart of Civil Life.—DR. OSLER of Philadelphia read a paper on this subject. This condition, he said, though not so dangerous to life as organic disease, often gives rise to great discomfort and uneasiness. The prominent symptoms are palpitation, pain, dyspnœa, and slight enlargement. The condition is comparable to the irritable heart mentioned by Da Costa as occurring in military life, particularly among young recruits. As regards the conditions under consideration, the following is the etiological classification: (1) Toxic cases; (2) those trace-

able to over-exertion; (3) those due to sexual excesses; and (4) those accompanying neurasthenia. The toxic agents giving rise to irritable heart are tobacco (which is the most common), tea and coffee. Young men from 18 to 25 years are most frequently the subjects of irritable heart. There is usually some slight enlargement of the organ, and the symptoms accompanythis are palpitation on exertion, more or less pain, and occasionally dyspnœa. Several cases illustrating this condition were recited. The principal points in treatment were removal of the cause, rest in bed, and pot. brom. gr. xv. *ter die*. Most of the cases recovered completely. Irritable heart from over-exertion, otherwise known as heart-strain or heart-shock, is met with in gymnasts, as runners, rowers, etc. Heart-strain has two forms:

(1) Acute dilatation (heart-shock), the result of an individual great and continued effort. In such cases perfect recovery never takes place, and the subjects are thereafter incapacitated for any great effort.

(2) The irritable heart as the result of persistent and repeated great exertions. This is the condition described by Da Costa as occurring in young soldiers. Gradual hypertrophy and dilatation may precede the irritability. These conditions are sometimes classified under the head of idiopathic hypertrophy and dilatation. Cardiac dropsy and murmurs may be accompanying symptoms. Chronic alcoholism and syphilis, as well as overexertion, enter into the causation.

Sexual excess, either in the form of coitus or masturbation, induces irritability of heart. The following is illustrative: A male, aged 26; history good; had chewed tobacco, but never smoked to excess; had lifted a good deal; had been a masturbator, and also of late had indulged in sexual excess with women. The heart-beat was hard, but not rapid when at rest; there was considerable pain in the chest; fluttering at night was a distressing symptom; the pulsations were very variable; in recumbent posture the pulse was 74, and 132 when erect; there was no murmur. Under treatment he recovered in about three months.

The cases of irritable heart, occurring as a result of neurasthenia, are nearly twice as frequent in females as in men. They are accompanied by mental distress, debility, nervous dyspepsia,

and, in women, uterine disease. There is sometimes a peculiar vaso-motor disturbance, causing flushing or even lividity of various parts of the cutaneous surface. A feeling of impending death is a frequent and most distressing symptom in some cases. Two other conditions, tachy-cordia, in which the pulsations reach 180 to 200, and Graves' disease, are forms of irritable heart.

Treatment.—Perfect rest in the recumbent posture, careful feeding, and removal of the cause are important. The application of cold (50° or 60°F.) to the præcordia, by means of Littre's tubes, frequently allay the pain and rapid action of the heart. Galvanism has been used with some benefit in the tobacco heart. Of drugs, pot. brom., in doses of gr. vi *ter die*, has been found signally useful. Nux vomica is also beneficial. Aconite and digitalis seem to have no special influence over this condition.

Discussion.—Dr. Graham considered that among toxic agents might be mentioned those formed in the system, especially in patients of the gouty or rheumatic diathesis. In these cases large quantities of starchy or saccharine foods, or even small quantities of alcohol, give rise to extreme irritation of the heart.

Dr. Bryce had met cases in which saccharine and starchy food caused distressing cardiac symptoms by distending the stomach.

Dr. Wilson had used nitro-glycerine and ammonia in such cases with benefit.

Dr. Zimmerman found that emp. belladonnæ over the præcordia often gave relief. Arsenic and cod liver oil were also found beneficial. In cases of irritability due to distension of the stomach, small doses of ac. carbolic are useful.

Drs. Workman, Covernton, Mullin (Hamilton), McPhedran and Macdonald took part in the discussion, after which Dr. Osler replied.

HURON MEDICAL ASSOCIATION.

Stated Meeting, April 19th, 1887.

The President, Dr. William Graham, in the Chair.

Cases in Practice.—Dr. Taylor presented a case of paralysis following a severe attack of diphtheria in a child of seven years. In this case the disease had manifested itself in a severe form.

The throat was much swollen, and the characteristic patches of diphtheria were very prominent. The constitutional symptoms were severe, and the recovery of the patient was not expected, but he slowly convalesced and the paralysis became very noticeable. It was gradually disappearing under the use of Tr. Ferri Perchl. with Tr. Nux Vomica. A point of interest in this case was the fact that although it had occurred in a family of ten persons living in most favorable quarters for the development of an epidemic, yet no second case had followed in the family. The doctor had ordered isolation of the other members of the family and disinfection, but his orders were not obeyed.

Dr. Chisholm (Wingham) said he had noticed that children who swallowed the membrane when it became dislodged from the throat were more frequently affected with diphtheritic paralysis.

Dr. Graham (Brussels) presented a case of progressive muscular atrophy, in which the symptoms of the disease were well marked. The patient was a man aged 55. The duration of the disease had been about two years, and during that time the patient had been slowly failing in strength. The muscular wasting was most noticeable about the shoulder and hip joints. While the prognosis was regarded as unfavorable, massage and faradization were recommended.

Dr. Smith (Seaforth) related the history of a case of diabetes insipidus under his care. The disease first appeared about five months ago, when the amount of urine passed daily was nine and ten pints. This amount was slowly increased until, in two months, the amonnt voided daily was fourteen pints. No sugar present. Specific gravity in early part of disease was 1003 to 1005. Ergot in 30 minim doses of the fluid extract had been given three times a day, also a pill composed of a grain and a half of extract of belladonna and half a grain of opium, but these failed. Latterly, by using Clement's solution of bromide of arsenic in three-drop doses after each meal, and acid phosphoric dil. in small doses to lessen the thirst, the quantity of urine was lessened to five pints daily, with specific gravity of 1010. The patient's general health was better, but the polyuria still continued, though not to as great an extent as formerly.

Dr. McKenzie (Belgrave) read the notes of an interesting

case of rheumatoid arthritis occurring in a woman aged 50 years. The knee was the joint involved. Although the treatment of these cases was generally unsatisfactory, a very favorable result was reported from the use of arsenic, in gradually increased doses of Fowler's solution until eight minims were taken after each meal. The faradic current was also tried with satisfaction in this case. The treatment in the latter part of the disease consisted of the administration of potass. iodide combined with liquor arsenicalis, and the case might now be pronounced cured, as the patient had been for some time free from any symptom of the disease.

Pathological Specimen.—DR. MACKID (Seaforth) presented a specimen of a fibro-cystic tumor removed from the superior angle of the neck of a woman who had previously appeared at a meeting of this Association. The case was then considered to be one of Hodgkin's disease, but latterly no improvement taking place in the health of the patient, a microscopic examination was made of a small section, and the growth proving to be fibro-cystic, its removal was decided upon. The wound healed nicely by first intention, and the patient is now going about and attending to her usual duties.

Puerperal Fever.—DR. WORTHINGTON (Clinton) read a paper on puerperal fever preceding delivery, and gave an interesting account of three cases which he had met in practice, one of them being of recent occurrence. He was called to a lady in the end of third month of pregnancy, and found hemorrhage had been going on for ten hours, but without any labor pains. After prescribing complete rest and giving ergot in small doses the hemorrhage was lessened, and on making a digital examination the following morning found fœtus in a position to be removed, but the os uteri rigid and undilatable. During the day the hemorrhage was slight, but during the following night it was increased so that when he called in the morning he found a marked change in patient's countenance. Nothing had come away and nothing more could be detected upon examination, the os being still rigid. While considering what course to pursue, a severe chill came on and lasted for about three hours. He decided at once to dilate the os, first using, without success, Barnes' dilator, and then

inserted two small-sized sponge-tents. After waiting a short time and administering a full dose of ergot, he had the satisfaction of seeing the fœtus and placenta discharged. The patient's pulse was then 130 and the temperature 105°F. At once gave quinine, and prepared and used a sublimate solution (1 to 3000) to wash out uterus and vagina. Gave the quinine every three hours and repeated the uterine irrigation every six hours. In a short time the pulse-beat had fallen to 105 and the temperature to 102°. She slowly convalesced, making a good recovery. The questions arose—(1) Could not the septic action have been prevented by the early use of sublimate or carbolic injections? (2) Could not the hemorrhage have been more completely restored? The other two cases which Dr. W. related were also interesting. One of them occurred three weeks before labor was expected, and by the use of opium in full doses and the application of turpentine stupes to the abdomen the symptoms of a severe attack of puerperal peritonitis slowly abated, and the patient went on to full term. The other case was similar to the last one mentioned, with the exception that the attack was nearer to the time at which confinement was expected.

The discussion which took place was mainly on the use of antiseptics in these cases.

Dr. Williams (Clinton) related the history of a case at present under treatment which he had diagnosed as a mild case of typhoid. In the latter part of the disease a slight swelling was noticed in the right iliac region, in which fluctuation was detected, and from which, on opening, a small amount of blood and a quantity of healthy pus discharged. There had evidently been no absorption of the pus, as the temperature was not increased. There was considerable induration at the site of the opening, which was still continuing to discharge. The question arose as to the most probable cause of this interesting sequel to the disease.

Question Drawer.—It was decided to have a question drawer at future meetings. Each will have the privilege of depositing questions with the secretary any time before the meeting, the answers to be given by the Association during the session. This will likely be an interesting feature of future meetings.

HAMILTON MEDICAL AND SURGICAL SOCIETY.

Stated Meeting, April 5th, 1887.

THE PRESIDENT, DR. MCCARGOW, IN THE CHAIR.

Pathological Specimens.—The PRESIDENT exhibited a specimen of disease of the vermiform appendix, with part of ileum, and gave some history of the case. He also exhibited a specimen of *cancer of the penis*, from a negro aged about 60 years, of some months standing. Dr. Malloch removed the penis. In this case the disease had extended so high up, and being complicated with a swollen gland in the groin, amputation close to the pubes was necessary; the gland was also removed. To obviate the irritation which would be caused by the flow of urine over the scrotum and adjacent parts the scrotum was split, the spongy portion of the urethra dissected down to the triangular ligament and brought out in the perineum, and the corpora cavernosa cut off close to the bones. The incisions were then brought together with sutures and the necessary dressings applied.

Perineal Section.—DR. MALLOCH reported two cases of perineal section which occurred during the past week. One from retention due to hypertrophy of the prostate, complicated with a false passage; and commenting on the operation for its relief, he expressed an opinion in favor of Harrison's method of puncturing through the prostate, but not having the necessary instrument, he cut into the membranous portion of the urethra and established communication with the bladder. The second case was one of extravasation of urine resulting from a traumatic stricture of two years standing. The patient, when first seen, had not passed any urine for four days. When examined, the scrotum was found enormously swollen and the bladder much distended. Very little pain was complained of. Wheelhouse's operation was performed. A grooved, straight staff was passed into the urethra until it came to the stricture; the incision was then made in the perineum, the stricture divided, the staff then turned so that the knob on the reverse side hooked on the urethra, and by gentle traction the urethra was put on the stretch. A sufficient opening being made in the anterior aspect

of the urethra, a No. 12 gum elastic catheter was passed into the bladder, the catheter was then bent, and the other end inserted into the part of the urethra above the stricture and carried up till it appeared at the meatus. The scrotum was then freely incised to allow of the escape of urine, and a large quantity was passed from the bladder through the catheter. The last account states that the case is doing well.

—A curious mixture of bad pathology and good surgery is presented by a case reported in the *Virginia Medical Monthly* for October by Dr. Wilkerson, under the following startling caption: "Incision into the pelvis of the kidney and treatment topically through the drainage-tube for the cure of Bright's disease." The patient, a man aged 30, had received an injury of the back, and six months after began to fail in health, became emaciated, had hectic, and passed blood and pus in the urine. Deep palpation on the right side gave an indistinct sense of fluctuation. Lumbar nephrotomy was performed, over a pint of matter was discharged, the sac was swabbed out, and a drainage-tube inserted. The man made a good recovery. The case was evidently one of pyelonephrosis, and the treatment pursued most judicious and successful. It is remarkable how deep-rooted is the idea that all affections of the kidney belong to Bright's disease; fortunately for the patient, the doctor's surgery was at least half a century in advance of his pathology, and it is a pity that the report of so interesting a case should be marred by a title both misleading and erroneous.—*Medical News.*

CANADA

Medical and Surgical Journal.

MONTREAL, MAY, 1887.

THE ROYAL VICTORIA HOSPITAL.

It is with no ordinary degree of pleasure that we record the truly munificent gift to Montreal of $1,000,000, for the building and permanent endowment of an Hospital, to be known as the "Royal Victoria Hospital." Sir George Stephen, Bart., and Sir Donald A. Smith are the donors of this princely gift. They each contribute half a million to this purpose. The "Jubilee Year" will no doubt be characterized by many liberal donations in Her Majesty's wide dominions, but is unlikely that none will even approach that of the noble-hearted act of Sir Geo. Stephen and Sir Donald A. Smith. It is an act that will render the year memorable for all time.

THE COAGULATION OF THE BLOOD.

One of the latest investigations intended to throw light on the conditions which determine the coagulation of the blood is that of Holtzmann. His conclusions may be stated briefly as follows:

1. A body called fibrinogen, belonging to the class of globulins, can be obtained from horse's blood, and solutions of fibrinogen neither coagulate spontaneously at ordinary temperatures nor upon dilution with water.

2. Defibrinated blood, blood serum, watery extracts of the albuminous coagulum formed in blood-serum by the addition of alcohol or the extract obtained from egg-albumen coagulated in the same way, the putrescent fluids obtained from cooked egg-

albumen, and long-continued passage of oxygen, all cause typical coagulation of the solution of fibrinogen at ordinary temperatures, with the production of fibrin.

3. *Fibrin-ferment is not peculiar to the blood*, but occurs among the decomposition products of albumen.

4. It is probable that fibrin is the product of the oxidation of fibrinogen.

5. When a dog is rapidly bled to death (one and a half to three hours), the last portions of blood drawn clot quicker than the first, though the amount of fibrin found does not markedly vary.

6. Venous blood clots more slowly than arterial blood; suffocation delays coagulation. Curare, chloral hydrate, chloroform, quinine and sodium carbonate also delay coagulation.

If this view of coagulation—the oxidation of fibrinogen—be accepted, what, then, becomes of the previous theories and their so-called confirmations? No doubt this theory will give place to another and another until the utter barrenness of the problem, as we pointed out in the December number of the JOURNAL, is realized. We still maintain, as stated then, that it is likely "that coagulation may take place under a variety of circumstances, and, at all events, that the method, as we prefer to call it rather than the cause, is not the same in all animals, and possibly not the same always in the same animal—*i.e.*, that certain events may at one time take a larger share in the process than at another, and that the question is at any rate a comparatively fruitless one."

IS IODOFORM AN ANTISEPTIC?

Iodoform has always been ranked so high among antiseptics that to question its efficacy seems rank heresy; yet recently Drs. Heya and Rovsing of Copenhagen have published researches throwing doubt upon its antiseptic properties. The experiments chiefly consisted in mixing iodoform powder with about equal parts of sterilized gelatine or serum, and inoculating with various bacteria, notably the Staphylococcus Pyogenes, further inoculating through a thick layer of powdered iodoform or through

a solution of iodoform in oil. The result showed that the contact of iodoform, as such, is absolutely devoid of significant properties, the cultures growing quite as well when it was present as when absent. Injections of cultures of staphylococcus mixed with iodoform produced suppuration.

The experiments seem to have been carefully and impartially made. The authors call attention to the fact that while the claims of iodoform as an antiseptic have never been disputed, its properties have never been established by experiment. They think it possible that though iodoform itself is inert, yet that in the body it may form iodides, or by combining with the fat in the tissues iodine may be set free, and in this way it may be indirectly an antiseptic. They also call attention to the fact that in surgical cases wounds treated with iodoform have been previously treated with sublimate or carbolic solutions. It is to be regretted that the experiments they performed upon animals were ridiculously few; certainly it will be difficult to convince surgeons that their confidence has been misplaced by any manipulation of test-tubes and sterile gelatine.

As things stand at present, it has been conclusively shown that pure iodoform has no disinfectant power over cultures of bacteria in the usual media, but it still remains to be seen whether, under the conditions under which it is applied in surgery, it may not act as an antiseptic. However this may end, it must be remembered that to the already recognized dangers attending its use these experiments show that since the powder has itself no effect upon bacteria, it is always possible to introduce infective material into a wound through the use of impure iodoform.

ACUTE ASCENDING PARALYSIS.

In the year 1859, Landry described a form of paralysis to which he gave the above name. He looked upon the disease as an essential paralysis—that is, a paralysis not due to any recognizable lesion of the nervous system. The disease, which is a very fatal one, begins generally in the lower extremities, and rapidly extends upwards, involving, in quick succession, the muscles of the upper extremities and those of respiration. Death

is due to paralysis of the latter muscles. It is very rare to find the order of involvement of the muscles reversed, the bulbar symptoms being nearly always the last to make their appearance. The paralysis is always hypotonic. There is never disturbances of nutrition in the paralyzed muscles, and, therefore, no change from the normal electrical reactions. There is loss of both cutaneous and tendinous reflexes. Disturbance of sensation is no essential feature of this disease, its chief feature being pure motor ascending paralysis, with flaccidity of the muscles. As a rule, it is unattended with fever, but almost invariably there is enlargement of the spleen. It runs an acute course, terminating usually within a week or ten days, and even sometimes within forty-eight hours.

The most careful examination of the spinal cord in a large number of cases has given decidedly negative results; no changes having been found that would in the least degree be sufficient to account for the grave nature of the disease. Owing to these negative results the disease was generally considered to be of a functional nature. The profound nature of the paralysis, however, could not be explained by any such view. Since the important *rôle* played by changes in the nerves as a cause of paralysis has been recognized, particular attention has been directed to this portion of the nervous system in examinations of patients who have died from acute ascending paralysis. The most important contribution of this kind has just been made by Pitres and Vaillard (*Archives de Physiologie*, Feb. 15, 1887). In a case running an extremely rapid course (24 hours), they found marked changes in a number of peripheral nerves, while there were no morbid alterations whatever in the spinal cord, medulla or pons. The change in the nerves was not of the nature of the ordinary Wallerian degeneration (the changes that take place in a nerve when it is separated from its nerve centre), but consisted in a primary affection of the myeline and cylinder axis. Emulsification of the myeline was found, and the cylinder axis was so swollen and changed that functionally it was useless.

It is a very striking fact that such profound changes should be induced within twenty-four hours. It is a strong testimony

to the hypothesis that these changes are brought about by the action of a poison (chemical ?). Whether all cases of Landry's paralysis will be found to be due to changes in the peripheral nerves or not, it is impossible to say, the case quoted only proving that a profound and rapidly fatal paralysis (clinically inseparable from Landry's) may be caused by alterations (non-inflammatory) in the peripheral nerves. In this case, unfortunately, there was no examination of the phrenic or other respiratory nerves. The paralysis developed during convalescence from typhoid fever, but the patient had not wholly recovered from a broncho-pneumonia which came on about the tenth day of the fever.

THE TREATMENT OF PHTHISIS.

The treatment of phthisis with gaseous enemata has already a very extensive literature. It is, unfortunately however, built on such a flimsy foundation as to be practically worthless. The eagerness to rush into print with crude and half-digested observations is one of the crying evils of the day. Its influence is more pernicious than beneficial. Why can't we "learn to labor and to wait."

McGILL UNIVERSITY—ANNUAL CONVOCATION.

The annual convocation of McGill University for the conferring of degrees in medicine took place in the William Molson Hall, on Tuesday afternoon, March 29th. There was a large attendance of the friends and patrons of the University. The Hon. Senator Ferrier, Chancellor of the University, occupied the chair. Among those present on the platform were: Messrs. John H. R. Molson and Samuel Finlay; Dr. R. P. Howard, Dean of the Faculty; Dr. Geo. Ross; Prof. H. T. Bovey, Dean of the Faculty of Applied Science, Queen's College, Cambridge; Hon. Judge J. S. C. Wurtele; Sir Wm. Dawson, Principal of the University; Drs. G. E. Fenwick, G. P. Girdwood, Francis J. Shepherd, Frank Buller, Jas. Stewart, Geo. Wilkins, C. E. Cameron, T. Wesley Mills, R. J. B. Howard, Wm. McConnell, Principal McEachran, Montreal Veterinary College; and a few others.

DR. R. P. HOWARD, the Dean, then read the following report:—

The total number of students enregistered in this Faculty during the past year was 231, of whom there were from

Ontario	112	P. E. Island	6
Quebec	56	Newfoundland	2
New Brunswick	23	Manitoba	1
Nova Scotia	19	England	1
United States	11		

The following gentlemen, 46 in number, have passed their Primary Examination, which comprises the following subjects: Anatomy, Practical Anatomy, Chemistry, Practical Chemistry, Physiology, Histology and Botany.

Aborn, W. H	Goderich, O.
Baer, D. C	Summerfield, Ill.
Bell, J. H.; B. A	Kars, O.
Bowen, W.; B. A	Quebec, Q.
Brown, G. A	Charlottetown, P.E.I.
Berry, J. A	Seeley's Bay, O.
Cameron, J. J	Lancaster, O.
Castleman, A. L	East Williamsburg, O.
Campbell, G. G.; B. Sc	Truro, N. S.
Chalmers, W. W.; B. A	Huntingdon, Q.
Creasor, J. C.; B. A	Owen Sound, O.
Delaney, W. J	Peterboro, O.
Dewar, C. P	Ottawa, Ont.
England, W. S	Dunham, Q.
Garrow, A. E	Ottawa, Ont.
Gemmill, E. W	Almonte, O.
Goodwin, W. W	Baie Verte, N. B.
Holmes, A. D	Chatham, O.
Hopkins, F. A	Cookshire, Q,
Lafferty, A. M	Perth, O.
Kincaid, R. J	Fredericton, N. B.
Martin, J. Mc	Brown's Creek, P.E.I.
Mathieson, C. S	Harrington, P.E.I.
Morehouse, O. E	Upper Keswick, N. B.
Mowat, M. M	South Branch, O.
Muirhead, D. A	Carleton Place, O.
Murray, D. A	Pictou, N. S.
McDonald, A	Mongenais, Q.

McDonald, A. L.....Glendonald, O.
McDonald, H. N.....Laggan, O.
McDonald, P. A.....Alexandria, O.
McCurdy, T.....Ormistown, Q.
McIntosh, D. H.....Carleton Place, O.
McLellan, A. A.....Summerside, P.E.I.
McKinnon, T. H.....Lockport, N. S.
McKercher, H.....Stittsville, O.
Porter, J. A.; B. A.....Kemptville, O.
Philp, W. S.....Montreal, Q.
Quirk, E. L.....Aylmer, Q.
Shanks, A. L.....Huntingdon, Q.
Stewart, W. G.; B. A.....Arundel, Q.
Taylor, W. B.; B. A.....Halifax, N. S.
Vipond, A. E.....Montreal, Q.
Whyte, J. J.....Lancaster, O.
Woodruff, T. A.....St. Catherines, O.
Young, H. E., B. A.....Napanee, O.

The following gentlemen, 45 in number, have fullfilled all the requirements to entitle them to the degree of M.D., C.M. from the University. In addition to the Primary subjects mentioned, they have passed a satisfactory examination, both written and oral, on the following subjects: Principles and Practice of Surgery, Theory and Practice of Medicine, Obstretrics and Diseases of Women and Children, Pharmacology and Therapeutics, Medical Jurisprudence, Pathology and Hygiene,—and also Clinical Examinations in Medicine and Surgery conducted at the bedside in the Hospital:

Aborn, W. H.....Goderich, Ont.
Berry, J. A.....Seeley's Bay, Ont.
Blackadder, E. H. P., B.A.....Montreal, Que.
Boone, S. W., B.A.....Fredericton, N. B.
Bowen, W., B.A.....Quebec, Que.
Boyd, Jay.....Vankleek Hill, Ont.
Cameron, K.....Montreal, Que.
Christie, W.....Lachute, Que.
Cowie, A. M.....Montreal, Que.
Dickson, J. A.....Trenholme, Que.
Easton, C. L.....Easton's Corners, Ont.
Edgar, C. J.....Napierville, Que.
Ellis, W. E.....St. Catherines, Ont.
Evans, E. J.....Seaforth, Ont.
Flagg, J. D.....Morrisburg, Ont.
Fillmore, E. W.....Baie Verte, N. B.

Fraser, J. M.	Hawkesbury, Ont.
Gardner, A. W.	Cornwall, Ont.
Hall, A. G.	Franklin, Que.
Hall, W.	Walkerton, Ont.
Hamer, A. L.	Bradford, Ont.
Johnson, J. W.	Farmersville, Ont.
Kelly, J. A. A.	Durham, Ont.
Lafferty, A. M.	Perth, Ont.
Lafleur, H. A., B.A.	Montreal, Que.
Loucks, W. F.	Stirling, Ont.
Macdonald, A. D.	Wickham, N. B.
McDonald, A. L.	Glendonald, Ont.
McDonald, D. D.	North Lancaster, Ont.
McKinnon, H.	Alexandria, Ont.
Morgan, V. H.	Aultsville, Ont.
Norman, T. J.	Schonberg, Ont.
Porter, J. A., B.A.	Kemptville, Ont.
Potheir, J. C.	Woonsocket, R. J.
Reavely, E.	Port Robinson, Ont.
Richardson, G. C.	South March, Ont.
Ross, D. L.	Winthrop, Ont.
Scott, J. M.	Philadelphia, Penn.
Scully, D. J.	Lindsay, O.
Stephen, G. C.	Montreal, Q.
Trapnell, H. E.	Harbor Grace, Nfld.
Warneford, P. H.	Norton, N. B.
Wilkins, H. P.	Toronto, O.
Williams, E. P.	Ottawa, O.
Young, A. A.	Barton, Vt.

The following have passed in Chemistry:

Aylen, W. W.	Esson, F. G.	McManus, H. D.
Burritt, C. H.	Hewetson, J. A.	McEwen, H.
Broderick, E. J.	Kemp, H. D.	Metcalfe, F. T.
Clarke, J. W.	Lang, M. W.	Ross, J.
Campbell, G. M.	Low, D.	Smithson, R. H.
Evans, D. J.	McKee, G. L.	

The following have passed in Practical Chemistry:

Aylen, W. W.	Halpine, A. S.	McNeece, J.
Beers, A. H.	Irwin H.	Ross, J.
Burritt, C. H.	Low, D.	Smithson, R. H.
Broderick, E. J.	Lewin, A. A.	Travers, J. B.
Campbell, G. M.	McManus, H. D.	Weeks, C. M.
Deacon, J. D.	McKee, G. L.	Woodruff, H. E.
Duncan, G.		

The following have passed in Anatomy:

Baer, D. C.
Booth, J.
Esson, F. G.
Haldimand, A. W.
Hewetson, J. A.
Irwin, W. T.
Kincaid, R. J.

The following have passed in Pharmacology and Therapeutics:

Baer, D. C.
Bayne, C. W.
Bell, J. H.
Berry, R. P.
Bradley, W. I.
Castleman, A. L.
Chalmers, W. W.
Clouston, J. R.
Conroy, C. P.
Desmond, F. J.
Fritz, H. D.
Gemmill, E. W.
Goodwin, W. W.
Green, T. J.
Gunne, N. D.
Hewitt, J.
Hoare, C. W.
Hopkins, H. J.
Hubbard, O. H.
Irwin, W. T.
Kemp, H. D.
Kennedy, J. H.
Kenny, F. L.
Kirkpatrick, E. A.
Kincaid, R. M.
Lang, M. W.
Long, C. H.
Metcalf, F. T.
Moffat, R. D.
Mowat, M. Mc.
Morrow, C.
McCarthy, J. G.
McDougall, D. S.
McEwen, H.
Macdonnell, Æ. J.
McKinnon, G. W.
McIntosh, D. H.
McLennan D.
McMartin, D. R.
McFarlane, M.
Orr, A. E.
Orr, J. E.
Park, P. C.
Potts, J. Mc.
Robertson, A. G.
Springle, J. A.
Stewart, A. D.
Stewart, W. G.
Thompson, J. H.
Weagent, A. A.
Westley, R. A.
Wetmore F. H.
Wylde, C. F.

The following have passed in Pathology:

Baer, D. C.
Bell, J. H.
Berry R. P.
Berry, J. A.
Bowen, W.
Cameron, J. J.
Cameron, K.
Castleman, A. L.
Clouston, J. R.
Conroy, C. P.
Davis, A. H.
Desmond, F. J.
Ferguson, W. D.
Fritz, H. D.
Gunne, N. D.
Hall, A. G.
Haldimand, A. W.
Hopkins, H. J.
Hubbard, O. H.
Kenny, F. L.
Kennedy, J. H.
Kincaid, R. M.
Kirkpatrick, E. A.
Lafleur, H. A.
Lang, M. W.
Long, C. H.
McCarthy, J. G.
McKinnon, G. W.
McDougall, D. S.
McFarlane, M. A.
McLennan, D.
McMartin, D. R.
Moffatt, R.
Morrow, C.
Orr, A. E.
Orr, J. E.
Porter, J. A.
Park, P. C.
Potts, J. M.
Robertson, A. G.
Quirk, E. L.
Springle, J. A.
Stewart, W. G.
Stewart, A. D.
Thompson, J. H.
Weagant, A. A.
Westley, R. A.
Wetmore, F. H.
Wylde, C. F.

The following have passed in Physiology:

Aylen, W. W.	Irwin, W. T.	McEwan, H.
Booth, J. S.	Kincaid, R. J.	Smithson, R. H.
Hewetson, J.	Low, D.	Wheeler, C. L.
Haldimand, A. W.	Moffatt, R. D.	

The following have passed in Medical Jurisprudence:

Baer, D. C.	Goodwin, W. W.	McEwen, H.
Bayne, C. W.	Hewitt, J.	McFarlane, M.
Bell, J. H.	Hopkins, H. J.	McLennan, D.
Bowen, W.	Hubbard, O. H.	McMartin, D. R.
Berry, R. P.	Hoare, C. W.	Moffatt, R. D.
Clouston, J. R.	Hall, A. G.	Orr, A. E.
Cameron, J. J.	Irwin, W. T.	Orr, J. E.
Castleman, A. L.	Kincaid, R. M.	Porter, J. A.
Chalmers, W. W.	Kenney, F. L.	Potts, J. M.
Conroy, C. P.	Kirkpatrick, E. A.	Park, P. C.
Deacon, J. D.	Kennedy, J. H.	Quance, S. H.
Desmond, F. J.	Long, C. H.	Quirk, E. L.
Dewar, C. P.	Lang, M. W.	Robertson, A. G.
Donald, W. M.	Morrow, C.	Stewart, A. D.
Dickson, J. A.	Mowat, M.	Stewart, W. G.
Fritz, H. D.	Metcalfe, F. T.	Stephen, G. C.
Gardner, A. W.	McCarthy, J. G.	Travers, J. B.
Greene, T. J.	Macdonnell, Æ. J.	Woodruff, E. H.
Gunne, N. D.	McDougall, D. S.	Wylde, C. F.

The following have passed in Hygiene:

Baer, D. C.	Irwin, W. T.	Stayner, S. R.
Bayne, C. W.	Kemp, H. D.	Stewart, A. D.
Bell, J. H.	McDougall, D. S.	Stewart, W. G.
Castleman, A. L.	McEwen, H.	Travers, J. B.
Chalmers, W. W.	McLennan, D.	Vipond, A. E.
Clouston, J. R.	Porter, J. A.	Weeks, C. M.
Deacon, J. D.	Quance, S. H.	Woodruff, E. H.
Dickson, J. A.	Robertson, A. G.	Wylde, C. F.
Donald, W. M.	Shanks, A. L.	

The following have passed in Botany:

Addy, G. A.	Harris, N. M.	McKee, G. L.
Ault, C. A.	Hickey, W. H.	McLennan, A.
Beers, A. H.	Inksetter, W. E.	McNeece, J.
Bisset, C. P.	Jento, C. P.	Noble, C. T.
Bowes, E.	Jenkins, W. E.	Oliver, O. J.

Campbell, G. M.
Clune, P. J.
Coleman, A. H.
Corbin, F. G.
Curtis, J. B.
Esson, A. C.
Evans, D. J.
Garrell, A. S.
Hamilton, H. D.
Kent, H. V.
Liddell, G. L.
Love, A.
Main, C. G.
Morris, O.
Murray, M. W.
Mulligan, E.
McDonald, M, S.
McKechnie, R. E.
Robertson, W.
Smith, A. G.
Thompson, F. E.
Treadwell, H. S.
White, D. D.
Weeks, C. M.
Wilson, W. A.
Yorston, F. S.

The following have passed in Histology:

Ault, C. A.
Addy, G. A.
Burritt, C. H.
Bell, J. H.
Bayne, C. W.
Broderick, E. J.
Bissett, C. P.
Bowes, E.
Campbell, G. M.
Clune, P. J.
Corbin, F. G.
Clarke, J. W.
Chalmers, W. W.
Coleman, A. H.
Curtis, J. B.
Esson, A. C.
Evans, D. J.
Hickey, W. H.
Hewiston, J.
Haldimand, A. W.
Harris, J. W.
Harris, N. M.
Hamilton, H. D.
Irwin. H.
Inksetter, W. E.
Jento, C. P.
Jenkins, W. E.
Kent, H. V.
Liddell, G. L.
Love, A.
Morris, O.
Murray, M. W.
Main, C. G.
Matheson, C. S.
Mulligan, E.
McKee, G. L.
McLennan, A.
McManus, H. N.
McKechnie, R.
McDonald, M. S.
McNeece, J.
Noble, C. T.
Oliver, O. J.
Robertson, W.
Ross, J.
Smith, W. D.
Smith, A. G.
Thompson, F. E.
Wilson, W. A.
White, D. D.
Travers, J. B.
Yorston, F. S.

MEDALS, PRIZES AND HONOURS.

THE HOLMES GOLD MEDAL, FOR THE BEST EXAMINATION IN ALL THE BRANCHES COMPRISED IN THE MEDICAL CURRICULUM, is awarded to Edward Evans, of Seaforth, Ont.

THE PRIZE FOR THE BEST EXAMINATION IN THE FINAL BRANCHES is awarded to Henri A. Lafleur, of Montreal.

THE PRIZE FOR THE BEST EXAMINATION IN THE PRIMARY BRANCHES is awarded to Alexander E. Garrow, of Ottawa, Ont.

THE SUTHERLAND GOLD MEDAL is awarded to John Creasor, of Owen Sound, O.

The following gentlemen, arranged in order of merit, deserve honourable mention :—

In the Primary Examination—H. McKercher, G. G. Campbell, J. A. Creasor, W. S. England, W. G. Stewart, H. E. Young, D. H. McIntosh, G. A. Brown, D. A. Murray.

In the Final Examination :—J. M. Fraser, J. A. Kelly, L. D. Ross, W. Hall, A. L. Hamer, T. J. Norman, A. D. McDonald, W. Christie, E. H. P. Blackader, and J. W. Johnson.

PROFESSOR'S PRIZES.

BOTANY.—Robert McKechnie, Winnipeg.

PRACTICAL ANATOMY.—Demonstrator's Prizes: 2nd year, W. G. Stewart. 1st year, R. McKechnie.

OBSTETRICS.—Ed. Evans, Seaforth, Ont.

PATHOLOGY—O. H. Hubbard, Gilsam, New Hampshire.

After the oath had been administered, the newly-fledged doctors were " capped" by Principal Dawson.

DR. BULLER then delivered the farewell address to the students. (*See page* 577.)

DR. A. D. MCDONALD, of Wickham, N.B., then delivered the

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on behalf of the Class who were about to leave their Alma Mater. After speaking of the vicissitudes and pleasures of college life, he referred to the Class of '87. He said he spoke not of men who were going to the world to make a name, but as friends in the class of '87, whom the tie of friendship, he hoped, would fondly bind them together as long as life remained. (Applause.) In a humorous manner he spoke of the difficulties of a medical student and the trouble they sometimes had in finding a suitable boarding-house ; so serious were those difficulties that some of his class never ventured to say they were medicals when applying to the landlady, but rather preferred the appellation of

theological students of McGill, and they were always received with open arms. (Laughter.) This, he thought, was an injustice to the medical students. (Laughter.) In conclusion, he thanked the Dean and Professors for the kindness they had shown the class of '87, for the trouble they had taken with them, and for the knowledge they communicated to them during their four years at the college. The students of McGill would remember their Alma Mater, and act up to the good example they received. (Applause.)

NOTES AND COMMENTS.

With the return of Spring comes the annual worry of examinations. It has never been my good fortune to be connected with an institution which relieved the teachers of the responsibility of examining the students they have taught. I suppose such a duty should not be a worry, but it is in certain ways, particularly if one has both a heart and a conscience. A class may be divided into three groups: the very good men, who reach 80 per cent. and over; the average men, who get over 60 per cent.; and the indifferent and bad, who fall below 50 per cent. My experience has been that about 15 per cent. of candidates are 1st class, at least 60 per cent. are 2nd class, and from 20 to 25 per cent. 3rd class. With the men of the last group come sorrow and anxiety for the examiner. As a teacher of these men, seeing them for two sessions in his class, knowing them and their defects personally, he is not, as a rule, the proper person to examine. He will either pity and be over lenient, or he will dislike them and be too severe. To mete out strict justice in such cases is a most difficult task, and knowledge of a man and of his circumstances often give a bias to the judgment. If to the task of teacher is added that of examiner, the responsibilities of the two positions should be clearly understood. I have been in the habit of telling my students that with the last lecture my duty to them ceased, and that as examiner I undertook duties for the University and the public which had to be discharged as thoroughly and as impartially as the college work.

To reject a man in his final examination is no light matter. In every faculty there are one or two members so kind-hearted

that they cannot *pluck* a candidate. Sympathy for the man excludes all sense of justice. A lively sense of responsibility to the public admits of no such sentiment, and if there is an occasion which demands strictness and firmness, it is when we are asked to decide whether or not a man is fit to take charge of the lives of his fellow-creatures. In case of doubt, give the public the benefit; better one man to suffer than to allow dozens to run the risks of his incompetency. Yet, as was well said by a writer in the *Lancet* a few years ago, "the rejections at examinations, necessary as they may be in the common interest, represent a sum of lost time, lost labor, wasted money, defeated hopes and poignant disappointment, experienced by candidates and their friends, which no one but an anti-vivisectionist can think lightly of." Fortunately, at a majority of the Canadian colleges it does not rest with the examiners for the *degree* to determine the fitness of the candidate to practice, as the Provincial Licensing Boards relieve the university professors of this responsibility. This is as it should be, and I am glad to see that a Central Board of Examiners is to be established in the Province of Quebec.

The Germans are far ahead of us in this matter. The M.D. degree from Berlin, Leipzic or Bonn carries with it no permission to practice. The candidate must first pass the *Staats-examen*, which he dreads much more than the university test. It corresponds exactly with the examination of the Canadian Provincial Boards. There is this difference, however: in Germany the government appoints the examiners, while under our democratic institutions the incorporated profession nominates. The *Staats-examen* of Germany is a model which medical boards everywhere might follow. It is eminently practical and thorough; the candidate is allowed ample time, and he must show fitness in all clinical details. Take, for example, the examination in medicine, which must be conducted in a hospital by two examiners. The regulations (summarized) are:—1*a*. On each of two following days the candidate must examine a patient in the presence of the examiners, obtain all the details of the case, and the next morning present a critical review of the same. 1*b*. The two patients are to be visited daily for seven days, careful notes

taken, and a supplementary report presented to the examiners. Candidates are also required to undergo a practical examination in diseases of children, mental affection and prescribing. In the other branches the same practical methods are followed. Heretofore at the Provincial Boards there has been a difficulty in carrying out fully the practical examinations. In Ontario, the new and commodious building of the College of Physicians and Surgeons will enable the Council to have suitable rooms for the chemical, anatomical and pharmacological examinations, and the Toronto Hospital will furnish ample material for the clinical tests.

Examining is monotonous, brain-consuming work, relieved only by exceptionally able answers of first-class men and the profoundly stupid replies of some of the third class men. For several years I kept notes of the amusingly stupid answers, but they have been mislaid. I have rarely had one which displayed the man more fully than the following in reply to the question (written) "How to treat hæmoptysis"? "*Plug the cavity with cotton saturated with a solution of Monsell's solutions, dry*"!!

WILLIAM OSLER.

Personal.

Dr. Robert Barnes has been elected an Honorary Fellow of the Chicago Gynæcological Society.

Olshausen of Halle has accepted the invitation to fill the chair of Midwifery in the University of Berlin.

Sir Wm. Jenner has been elected for the seventh time to fill the office of President of the Royal College of Physicians.

Prof. Matterstock has been appointed Director of the Medical Clinic in the University of Wurzburg. He succeeds the late Prof. Geigel.

Medical Items.

—The American Medical Association will meet in Chicago on June 7th, 8th, 9th and 10th.

—Dr. Arlt, the famous ophthalmologist, died recently in Vienna after a lingering illness. He was for half a century one of the foremost of continental ophthalmic surgeons.

—Dr. D. Rutherford Haldane died at his residence in Edinburgh on April 12th. For many years Dr. Haldane was a prominent teacher of medicine in the Extra-mural School of Edinburgh.

—The Ontario Medical Association meets in Toronto on Wednesday and Thursday, the 8th and 9th of June, under the Presidency of Dr. Richardson of Toronto. Dr. Arnott of London will open a discussion on "Phosphaturia." Dr. Taylor of Goderich will read a paper on the "Functional Paralysis of Pregnancy." Dr. Lett, superintendent of the Homewood Retreat in Guelph, will deliver an address on "The Relations of Insanity to Masturbation."

—Professor: "Where do we find squamous epithelium?" Student: "The favorite situation is the squamous portion of the temporal bone." Professor: "Ah, indeed! then what does the professor of dermatology mean when he speaks of squamous skin disease?" Student: "Oh! yes, sir. I forgot. We find that variety of epithelium most common in certain affections of the skin." Professor: "Shades of Dalton!"

—The following exemplifies the advisability of using a special preparation in many cases requiring expensive drugs:—"Four ounces of a mixture of bromide of potassium and chloral, each an ounce, with tincture of hyoscyamus and fluid extract of cannabis indica, in appropriate doses, were ordered, with directions to take one teaspoonful every hour until sleep should be induced. An ugly, muddy mixture was received, which produced nausea and headache, but no sleep. A similar prescription, instead of the above extemporaneous officinal combination, was ordered, only 'Battle's *Bromidia*' was designated, which induced refreshing sleep after a few doses of from 20 to 30 drops had been taken."—*Dr. W. B. Hazard in Medical Brief for December.*