

Technical and Bibliographic Notes / Notes techniques et bibliographiques

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

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

- Coloured covers /
Couverture de couleur
- Covers damaged /
Couverture endommagée
- Covers restored and/or laminated /
Couverture restaurée et/ou pelliculée
- Cover title missing /
Le titre de couverture manque
- Coloured maps /
Cartes géographiques en couleur
- Coloured ink (i.e. other than blue or black) /
Encre de couleur (i.e. autre que bleue ou noire)
- Coloured plates and/or illustrations /
Planches et/ou illustrations en couleur
- Bound with other material /
Relié avec d'autres documents
- Only edition available /
Seule édition disponible
- Tight binding may cause shadows or distortion
along interior margin / La reliure serrée peut
causer de l'ombre ou de la distorsion le long de la
marge intérieure.
- Additional comments /
Commentaires supplémentaires:

Continuous pagination.

- Coloured pages / Pages de couleur
- Pages damaged / Pages endommagées
- Pages restored and/or laminated /
Pages restaurées et/ou pelliculées
- Pages discoloured, stained or foxed/
Pages décolorées, tachetées ou piquées
- Pages detached / Pages détachées
- Showthrough / Transparence
- Quality of print varies /
Qualité inégale de l'impression
- Includes supplementary materials /
Comprend du matériel supplémentaire
- Blank leaves added during restorations may
appear within the text. Whenever possible, these
have been omitted from scanning / Il se peut que
certaines pages blanches ajoutées lors d'une
restauration apparaissent dans le texte, mais,
lorsque cela était possible, ces pages n'ont pas
été numérisées.

CANADA

MEDICAL & SURGICAL JOURNAL

JANUARY, 1885.

Original Communications.

CHARCOT'S JOINT DISEASE.

By C. L. COTTON, M.D.,
COWANSVILLE, QUE.

(Read before the Canada Medical Association, at Montreal, August, 1884.)

Mr. President and Gentlemen,—As the subject of Charcot's joint disease has recently attracted a good deal of attention, I trust a few notes of a case, which I have under observation, may prove of some interest to this meeting :

H. G., aged 42, a native of England, engaged in the dry goods business in New York during 14 years. He has a good family history, no case of nervous disease that he can discover. He had convulsions when a child, but enjoyed generally good health until 1876 when he noticed strabismus of both eyes. He had one eye operated on in Glasgow and the second in Paris, since which time he has had no further trouble with his eyes. In looking back he can notice some failure in his gait in 1879, which was soon followed by neuralgic pains in his legs. These began quite suddenly. He can remember distinctly the place and hour when he had the first attack. He describes them as the usual pains of locomotor ataxia are described—as lightning-like pains. These have continued until the present, each attack lasting two or three days, and then an intermission of two or three weeks. He also had a cord-like feeling about his waist and a weakness in the knees.

He first came under my notice in December, 1879, when he presented very typical symptoms of locomotor ataxia. His walk

was quite ataxic, could not stand with his eyes closed. Patellar reflex absent; complained severely of the feeling of girdle pains; some loss of power over the sphincters and diminished cutaneous sensibility in the legs. He continued in very much the same condition, but with a gradual failure of co-ordination until July, 1883, when one day after using a saw in such a manner that his right leg was put into a swinging motion over the edge of a box, the under surface of the thigh coming in contact with the box, he noticed immediately afterwards his knee very much swollen, and during the day the leg, foot and toes were involved in the swelling. There was a slight purple discolouration on the under surface of the thigh. My attention was called to it about ten days later; there having been no pain about it from the first, it had been looked upon as a simple sprain. I found the knee and leg as far as the ankle much swollen, the joint full of fluid and crackling on pressure. It had the appearance of a joint undergoing rapid disorganization. His present condition one year since the knee was first affected will be seen by the appearance of these photographs. The joint is enlarged; the lower end of the femur appearing to be much enlarged. There are no apparent bony outgrowths. Both bones of the leg are dislocated outwards, though they can be readily replaced, and in doing so give rise to a sound as if the ends of the bones were quite worn away. There is no fluid in the joint, no crackling feeling present. The veins are much enlarged over the knee. Both legs are much wasted; patellar and plantar reflexes absent; cutaneous sensation entirely absent in the feet, legs, and lower half of the trunk. He can support part of his weight on the diseased knee, but is afraid to do so; consequently he does not attempt to walk, but gets about comfortably in a wheeled chair. Appetite good. Digestion sometimes at fault, but generally fair. Sexual power lost during the last twelve months. The sphincters are weakened. At times he can control his bowels and bladder; at other times he finds it impossible to do so. Has never had gastric crises, and never felt any pain in the affected knee. Girdle pains have disappeared. In reference to the loss of sensation, it is curious to

note that he has a large corn on one foot which often causes him severe pain. He complains of much numbness in his fingers.

The question of the relationship of joint affections occurring during the course of locomotor ataxia with the especial lesion of the spine has been very freely discussed during the last few months; giving rise to papers at the clinical and pathological societies of London. Charcot, whose name has been associated with this disease, in his earlier observations attributed it to the anterior cornua of the spinal cord becoming involved in the diseased process. But further post mortems showed that the disease could be present without disease of the anterior cornua being demonstrated. Dr. Buzzard is strongly inclined to the opinion that the pathological centre is to be found in the medulla oblongata and brings forward as evidence the frequent presence of laryngeal, gastric and intestinal affection (more than 50 per cent.) associated with bone joint troubles. Sclerosis attacking the vagus centre is in short his pathology. Thus far there has been no discovery of a joint centre in the nervous system, and it would seem that, with the close pathological study that has been given to "centres," if such a centre existed, the question would have been set at rest before this. Charcot depends chiefly on the clinical features and pathological changes in his assumption of this being a distinct specific arthropathy. Another view of the pathology of these cases is that they are an ordinary arthritis modified by the conditions of the patient. In support of this view are the very similar joint changes noticed after injuries to nerves. Weir Mitchell, Sir Wm. Gull, Ziemssen and Charcot have all noticed cases of arthritis due to nerve lesions, and it is a question whether rheumatism has its origin in the nervous system. These lesions are usually ascribed to the inhibition of the trophic influence of certain nerves. The third view of the pathology of these joint cases is that they are ordinary rheumatic or other forms of arthritis occurring in ataxic patients independently of their nervous disease. My experience of these cases being limited to the one under discussion, I must leave the question of pathology to others who have had more experience. But I must observe that the course of this case

has been different from any joint affection that has come under my notice. The entire absence of pain, the rapid disorganization of the joint, with the history of a slight injury, would incline me to the view, that, firstly, there must have been a predisposition to joint affection, otherwise so slight an injury could not have caused such a serious effect; and secondly, that the trophic nerves, and I think it is generally admitted that certain nerves have trophic influence, must have become seriously impaired in their function. If these joint affections occurring in locomotor ataxia are not specific arthropathies, and I do not think that this has yet been proved to a certainty, yet there is no question in my mind that they are strongly modified by the diseased nerve influence.

PUERPERAL ECLAMPSIA—INDUCTION OF PREMATURE LABOR—DELIVERY WITH FORCEPS—SUCCESSFUL TREATMENT WITH PILOCARPIN.

By J. CAMPBELL, M.D.C.M., AND L.R.C.P., EDIN., OF SEAFORTH, ONT.

(Read before the Huron County Medical Association, October 7th, 1884.)

About 11 a.m. on the 2nd of September last, was called to see Mrs. B., æt. 30, pregnant for the third time. Found her in bed complaining of severe frontal headache and pains in the epigastrium. She appeared to be quite rational. She had been washing and sawing her own wood the day previous. Asked her if her urine was scanty or high-colored, and received a reply in the negative. Wished to see some, but could not procure any. Having no catheter with me, I asked her to keep some of her urine for me. Ordered cold to the head, heat to the feet, enjoined perfect rest and quiet, gave a dose of chloral, and left. At one p.m. was called in haste, the messenger saying that she had taken a fit. When we reached the house she had recovered from the first seizure, but within half an hour took another. Endeavored to control them by inhalation of chloroform, and gave a drop of croton oil in a teaspoonful of castor oil. The convulsions were severe, and about thirty minutes apart. Began to give chloral in gr. x doses, but the convulsions came so close and were so deep that she was unable to swallow the medicine.

The bowels now began to operate freely, which prevented us from giving chloral and bromide per rectum, as otherwise we would have done. The chloroform merely modified and somewhat retarded the seizures. The os, which at first was not dilated in the least, now began slightly to relax. The question of inducing premature labor and emptying the uterus now occurred to me, but I asked for the assistance of another medical man. After a consultation, we agreed to continue the anæsthetic and wait until the os was somewhat dilated and dilatable. Moreover, in the meantime we aided the dilatation with the fingers—a method that is condemned by some and advocated by others. By 4 p.m., finding the os slightly dilated, I passed up a uterine sound and succeeded in rupturing the membranes. Some time after this we gave a full dose of ergot. The convulsions, however, becoming deeper and deeper, with shorter intervals between, and finding the os dilatable, though not sufficiently dilated, I attempted to apply the forceps cautiously, and after some manœuvring succeeded, and soon delivered a male child, which we were fortunate in resuscitating. The placenta came away without much difficulty, and, contrary to our expectations, we had no hæmorrhage. Passed a catheter, and found only two teaspoonfuls of urine in the bladder, though she had not made water for twelve hours. Upon testing for albumen, found it nearly solid. My medical assistant now left me to watch the case alone. The fits continued, and grew deeper and deeper, with shorter intervals between, and at 9 p.m. I felt that my patient must go unless something more was done for her than had yet been attempted. I remembered that I had never regretted dosing too much in a serious case, but had often been sorry that I had done too little. I therefore injected gr. $\frac{1}{4}$ of pilocarpin (Wyeth's preparation) under the skin of the arm, and in fifteen minutes afterwards the most profuse sweating and salivation took place. Her clothes were as wet as if she had been dipped in the river, and the saliva fairly poured out of her mouth and nostrils, almost suffocating her. The nurse and myself kept taking it away with a towel, and raising her up betimes to prevent her being choked. We observed that in point of time the

salivation came on first. The convulsions at the same time moderated, and they were longer in returning, while we observed that she passed water involuntarily. By 11 o'clock the effect of the medicine had, in a great measure, subsided, and the fits began to return with their usual vigor. I injected the same quantity again, with the same result. My consultant now arrived, and said the patient would die; and certainly appearances were in favor of his prognosis. However, as I felt certain she would have died at any rate, if left alone, there was nothing to be lost, and there might be something to gain, in trying the pilocarpin, as we had already done, and I felt sure there could be no reflections from the friends. At the time my medical friend came in, the pulse was weak and rapid, the lips and nails were blue, the patient was tossing to and fro in great distress, the perspiration was pouring from every part of her body, and the saliva was issuing from mouth and nose in great lumps of foam. The fæces and urine were passed involuntarily, and everything pointed to a speedy death by collapse. However, this did not take place. She took no fits after the last injection, and by 4 o'clock next morning she had rallied to a remarkable degree, and by 8 a.m. had, to all appearances, recovered, with the exception that she was still weak and was out of her mind. A period of maniacal excitement now supervened, which continued for over 24 hours, and complicated matters very much. By testing the urine, we found that the albumen was rapidly diminishing. At first it had been nearly solid; next it was one-third; now it was only one-sixth albumen. We now gave a diuretic with the happiest results, the albumen gradually, but steadily, diminishing until, within four days of the attack, it had disappeared altogether. The third day the temperature, which had all along remained either normal or below the normal, rose to $101\frac{1}{2}^{\circ}\text{F.}$, but it gradually subsided, the milk was secreted, the woman became quite sensible, but felt weak. She had no recollection whatever of what had happened, not even my first visit two hours previous to the first eclamptic seizure, when she talked apparently so rationally. When she recovered her senses, she said that she could not see us, but could tell us by the sound of our voices.

After a time she could distinguish our faces, and, still later, tried hard to read the time of day on a clock about twenty feet from her bed, but failed. She did not say that she only saw half of an object, as some people are said to do after having taken pilocarpin. The disordered vision continued through the third and fourth day, but whether this was the effect of the albuminuria, or of the pilocarpin, or of both combined, we could not say. By the fifth day I discontinued my visits, but heard from the friends daily for some time afterwards. Both mother and child did well.

Remarks.

Gentlemen, I feel certain that Wyeth's pellets of pilocarpin saved my patient, and it was a fortunate circumstance, to my mind, that the medicine was in my pocket at the time, or, probably, I would not have used it.

2. Under similar circumstances, I would use the pilocarpin as I did in this case, only not in such large doses. Probably one-eighth of a grain is enough to begin with, to be repeated when its effects are passing away. There was extreme danger of death at one time in my case from the excessive salivation, which could likely have been avoided by using a smaller dose.

3. Though I believe pilocarpin to be a valuable remedy, at the same time it is a somewhat dangerous one, and should be used with caution until the action of the drug is better understood. I would first use the chloral-hydrate, potas. bromid., purgatives, sweating, hot baths (if convenient), chloroform, cold to the head, &c., keeping pilocarpin in reserve, as we did in the case which has just been reported. When better understood, it will no doubt come to be used with greater freedom, and will, we believe, prove to be a valuable acquisition in the treatment of the frightful malady we have just been describing.

REMARKS ON CLINICAL CASES.

BY WILLIAM OSLER, M.D.,

Professor of Clinical Medicine, University of Pennsylvania.

Gentlemen,—The case of *Typhoid Fever* which you saw at the last clinic died on Monday. The prominent features of the case were: Illness of over three weeks' duration before coming to hospital—fever, headache, and diarrhoea; in bed on and off during this period, but up and about for days at a time. Came to Dispensary on the 8th, and was admitted. The temperature was 103°F.; pulse 90, dicrotic. He was bright mentally, and did not present the appearance of a man who had been ill three weeks with fever. When you saw him on Thursday last he had all the appearance of a man with typhoid; the symptoms were not grave; temperature not high; pulse not over 100. There were two unfavorable features in the case,—the fact of his having been neglected for three weeks and allowed to be about while the fever was on him, and the nervous twitchings of the muscles. An unfavorable prognosis was given. The subsequent course was briefly as follows: On Friday evening the temperature rose to 105°F., and throughout Saturday and Sunday there was a constant tendency to elevation, kept down but feebly by quinine in 15 and 20 gr. doses, and cold sponging every hour or two. On Saturday the lowest temperature was 101.2°, and the highest 105°. On Sunday it rose to 106.2°. He retained consciousness in a remarkable and unusual manner. He took stimulants and nourishment every alternate hour. The diarrhoea was never troublesome, but the stomach became a little irritable on Saturday and Sunday, so that the quinine had to be given at times by the bowel. It is exceptional for cases such as these to get well, and when a man walks into your office complaining of fever, headache, and malaise, says he has been ill a couple of weeks and has been fighting against it, and you find his temperature 104° or 105°, you may expect a case of severity. As I mentioned at the last lecture, there is no worse feature than such a history. The nervous or rather muscular twitchings are also of evil omen, indicating implication of the nerve centres.

They may even amount to convulsive jerkings of the head, trunk and extremities, and I remember one case in which the muscular spasms were so prominent that the disease was thought to be spinal meningitis.

Heart Disease: Action of Digitalis.—This old man, aged 75, you also saw at the last clinic, and he is brought in to-day to demonstrate to you the beneficial effects of digitalis and rest. He has mitral disease, which probably followed an attack of rheumatism in 1854. On Thursday last, three days after his admission, he was, as you remember, very short of breath, the feet and abdomen were dropsical, the pulse was small and exceedingly irregular, and the amount of urine was reduced. He has had 10 m of the tincture of digitalis every four hours, day and night, and has been kept quiet in bed. The changes are: 1st, The pulse is slower, fuller and only occasionally intermits. Those of you who saw him in the ward-class the day after his admission will recall the extreme feebleness and the irregularity of the pulse. 2nd, The breathing is quite relieved; he can lie down comfortably, and walking is not an exertion. 3rd, The dropsy has disappeared entirely from the legs, and has almost all gone from the abdomen, which, as you see, is relaxed, and only gives indication of a small amount remaining. 4th, The urine has increased from 3 and 3½ pints to 6 and 7 pints in the 24 hours. He has been taking the digitalis ten days, 3i in the day—not a very large amount, but has served our purpose.

Caisson Disease.—The man, J. Farrell, aged 30, who came to Hospital yesterday (17th) with a heavy cold in his chest, is also—or rather has been—the subject of an interesting disease to which the workers in the compressed air of the caissons are liable. Two months ago he went to work at Perryville, on the Susquehanna, where they are building a bridge, and in sinking the piers the workmen are in caissons, as they are called, in which the pressure may amount to two or three atmospheres. Until Sunday last (13th) he had never suffered any inconvenience, beyond occasional “bends,” as he calls them, to which I shall refer later. At 4 a.m. on Sunday he came up from work feeling all right, but before he could get to his boarding-house

the left leg became numb, cold and dead, as he puts it, from the hip down, so that he could not walk, and had to be carried home. It did not appear to be painful, but he says the sensation in it was gone. It remained in this state all day, but towards evening he could move it a little, and on Monday morning the power was quite restored. He did not attempt to go to work again; was too much scared! There were some pains about the legs and arms for a day or so, and a feeling of dizziness, particularly if he looked up or looked from a height. He has now quite recovered, except that on walking, if he looks up, he staggers, and there is a tendency to sway when the eyes are shut. The patellar tendon reflex on both sides is a little exaggerated; no ankle clonus; skin reflexes normal. No other special features. He says that the workmen are much subject to what they call "bends," which, so far as I can make out from his imperfect account, are attacks of pain in the arms or legs, often about the joints, but whether accompanied by spasm or cramp of the muscle does not appear very clear from his statements. These attacks never come on while in the caisson, but *always* a few hours or less after they have come up. So also with the more severe attacks; they invariably come on after leaving the caisson, never in it. He states that two men have died of the affection, and that one man is now in hospital paralyzed in both legs. In the building of the Brooklyn bridge, many cases of this curious disease occurred, and Dr. Andrew H. Smith of New York made a special study of it, and was, I believe, the first to give the name by which it is now generally known. According to his description, it is characterized by pain in one or more of the extremities, sometimes with pain in the stomach and vomiting. There is paralysis, local or general, but most often in the lower limbs. Headache, vertigo, and coma may occur. Cases may prove fatal with these symptoms, and, *post-mortem*, congestion of the brain and cord has been found. In sinking the piers for the bridge at St. Louis, there were many cases, and there were twelve deaths among the 352-men employed. The disease has been known to French observers for many years, and has also been met with in miners working

in compressed air, and in sponge divers in the Mediterranean. There appears to be no difficulty, in the majority of the workmen, in standing a pressure of two or three atmospheres, and, as a rule, no inconvenience is felt further than the temporary pain in the ears, due to the pressure on the drums, which disappears gradually. Naturally, there is a tendency for the blood to be driven into the deeper parts, the superficial vessels are compressed, there is less blood in the skin and more in the viscera. The brain and cord, enclosed in solid, incompressible cases, will also have an additional amount of blood. But this does not appear to produce any inconvenience, and men can work for hours under a compression of three or even four atmospheres. The danger is in the transition from a high to a low pressure, and, as this patient has told us, the men are never affected in the caisson, but always on coming up. The occurrence of sudden death, or a rapid paralysis, suggest hæmorrhage as the cause, but it has been shown by Hecpe-Seyler that there may be a sudden development of nitrogen gas in the blood on removal from high to a low pressure atmosphere, and he attributes the symptoms and the fatal result to the evolution of this gas, the bubbles of which plug the capillaries in the lungs and produce dilatation and stoppage of the heart. Bert states that in an animal under very high pressure, the blood, when withdrawn at low pressure of the atmosphere, will foam from the rapid evolution of nitrogen. The paralysis is probably also due to this cause, and in one case Leyden has found, 15 days after the onset of the paraplegia, lacerations in the cord, which he attributed to the action of the gas bubbles, distending and tearing the capillaries. Schultze, in another case—death 2½ months after the onset,—could only find disseminated areas of sclerosis. This really seems to give a satisfactory explanation of the cases, and in this man we may suppose that he has had local development of gas in the lumbar region, limited in extent, probably not destructive, but only expanding the capillaries and inducing a monoplegia, which disappeared with the absorption of the gas. Paul Bert found that if the animals which had been exposed to the pressure of several atmospheres were to be kept alive, the

transition to the normal atmospheric pressure must be slow and gradual, so as to permit of the gradual diffusion of the superfluous gas absorbed by the blood under the high pressure. So also it is recommended that, on the first onset of symptoms in men working in caissons, they should be submitted again to the pressure, which should be gradually reduced to the normal standard.

Emphysema—Bronchitis.—This man, J. S., aged 35, came to hospital complaining of great shortness of breath and cough. When stripped, he carries, as you see, the diagnosis in the form of the chest and the peculiar mode of breathing. Inspection shows a short, well-nourished man, with a full, barrel-shaped thorax, into which the head seems set by a very short neck. Watch the peculiar mode of breathing. The inspiratory act is labored, accompanied with more elevation than expansion of the chest-walls, but the abdomen rises considerably. Expiration seems still more labored, and is fully twice as long as inspiration. It looks as if the air were forced by muscular exertion out of the chest; and so it is. With each act there is very audible wheezing, most marked with expiration. The finger tips are a little livid, but there is no cyanosis of the face. On placing the hands upon the chest, ronal fremitus can everywhere be felt, but most intense at the right apex, in front. Percussion gives a hyper-resonant note over the various regions, except the left base and lower axillary regions, where there is defective resonance. On auscultation, there are innumerable whistling and sonorous râles over the whole chest; nothing else can be heard with both inspiration and expiration. The high-pitched ones are most prevalent. There are two places where there are special features. At the right apex the sounds are extremely hollow, and there may be here either a cavity or, what is more likely, dilatation of the bronchial tubes; at the left base, with the piping rhonchi, there are many liquid râles, and there is possibly here some infiltration—œdema of the lung. The cough is most distressing, frequent, and the sputum is got rid of with difficulty. It is tenacious, thick, and purulent. The area of heart's dulness is covered by lung, and the liver is

depressed. The points in the history are briefly as follows:—He is a jeweller by trade, and has used the blow-pipe a great deal for 15 or 16 years. He tells us that sometimes he would require to keep up the flame for 15 or 20 minutes, only intermitting enough to catch the breath. The family history is good, and he was always pretty healthy until three years ago, when he was laid up with a severe bronchitic attack for three months, and ever since he has been specially liable to catch cold, and has had four or five spells of shortness of breath and severe cough; none have been so bad as the present one, which came on a week ago, with fever, cough and dyspnoea. Two conditions are here present: Emphysema, a permanent and irreparable affection of the lungs; and Bronchitis, a transitory and curable condition, upon which his chief symptoms now depend. Two weeks ago this man could get about satisfactorily, and, if he took it quietly, could go up stairs without difficulty, whereas now he puffs and blows on the slightest exertion. The emphysema has no doubt been caused by the habitual use of the blow-pipe in his occupation, and every such attack as the present one leaves the lung in a worse condition than before. Just now the bronchitis is the main trouble, and the swollen state of the mucous membrane retards the access of air to the alveoli, while the loss of elasticity in the lungs renders expectoration very difficult, and the cough is in consequence hard and distressing. On his admission, he was ordered a relaxing expectorant (chloride of ammonium grs. x, with ipecacuanha wine 20 ℥) every three hours, and already, after two days, he is much relieved. Jacket poultices, frequently changed, are very useful when there is much soreness in the chest. The existence of local trouble at the right apex may delay convalescence, but the bronchitic symptoms should disappear in a few weeks.

Correspondence.

NEW YORK, January, 1885.

The two schools for practitioners—the Polyclinic and Post-Graduate—have each had a successful season ending with the year. Both have men of ability as teachers, who are zealous as well as able. The advantages of each appear to be on a par. If the Polyclinic has a greater abundance of material, it has a corresponding greater number of men among which to divide it. I myself am attending the Polyclinic, and am very well pleased with its practical teaching and the facilities it offers for the personal study of disease. The gynæcological course in both appears to be the most popular—not, as some of your readers may think, from a growing desire of many practitioners “to fumble” with the uterus, but from an inward conviction that on that subject they are weak; and no matter how much they may wish uterine symptoms did not exist, patients will come to them suffering from such symptoms, for which they seek alleviation and cure.

The fees for a three months course, including everything, are \$150. Dissecting material is not included in the above. Board can be obtained for from \$6 to \$10 per week; two together can live very comfortably, in a fair part of the city, for \$8 a week. These schools supply a want that was much felt on this continent. Evidence of this is found in the fact that since they originated, a couple of years ago, there has been almost a constant attendance of a hundred practitioners. The men attending the schools are for the most part well advanced in years. A graduate of six or seven years' standing is merely considered a “youngster.” Most of the men come to “brush up,” others for the purpose of making better men of themselves with a view to changing a country for a town or city practice, while a third class take it in as a part of a holiday well earned after a number of years of hard work in practice.

Through the kindness of Dr. Emmet, to whom I had a card of introduction from my valued friend Dr. Hingston, I have received invitations to nearly all the operations performed at the Woman's Hospital. Dr. Emmet has devised an operation

which more efficiently repairs a lacerated perineum than any of the operations hitherto performed. The operation is the result of close observation, for over twenty years, of those affections. His attention was first attracted by the great disparity often observed between the apparent extent of the laceration in the perineum and the symptoms that followed. The perineum might be torn through to the sphincter with very few ill results, while, on the other hand, an insignificant tear might be accompanied by a train of symptoms consequent on the rolling out of the vaginal walls and dragging down of the uterus and bladder and rectum. On close observation and study of a great number of cases, he arrived at the conclusion that in the so-called "lacerated perineum" the defect is not in the rupture of the "perineal body," but in a separation of the pelvic fascia which holds the vagina suspended, so to speak, from the pelvic roof. That in lacerations, excepting when produced by the forceps, the tear is from within outwards, and not in the reverse direction, as is generally taught. I shall not attempt a description of the operation, for to be understood it must be seen, but after witnessing several being done, and having seen some of the patients after the parts had healed, I can unhesitatingly say that it possesses all the advantages over the old operation that Dr. Emmet claims for it, with one exception—easier performance. The denudation of the parts is simpler, but, to my mind, it requires more skill to pass the sutures, which, by the way, are all passed within the vagina, and are not seen externally. The advantages over the old are: 1, It brings up the posterior vaginal wall more effectually. 2, It makes a more firm perineum that is not so likely to be torn in subsequent labors. Every one knows that the result of the old operation often is merely the union of the external integument, which, as Dr. Emmet forcibly expressed it one day, "is like sewing up a woman's drawers to give support to her generative organs." 3, It is not necessary to withdraw the urine, hence a trained nurse can be dispensed with. 4, The stitches are not so painful. 5, Easier performance. This, however, is open to doubt, as I have already stated.

It may seem that I have dwelt with undue length on this sub-

ject, but, in my opinion, the importance of the matter demands even fuller treatment than I have been able to accord it in a communication of this kind. The operation is being pretty generally adopted by the gynæcologists of this city. Every day Dr. Emmet operates at the Woman's Hospital; a host of men from Philadelphia and other parts are to be seen closely observing the operation. All go away well pleased with it, and with the determination to perform it on the first opportunity.

New York is proud of its Woman's Hospital, and one need only to have a slight acquaintance with the working of the institution to become fully convinced that there are just grounds for pride. I believe one can safely assert that it has not its equal in the world. Its statistics may not offer as good a showing as some others of a similar nature beyond the ocean, but, in judging of these, one must take into account that cases are operated upon here that would be left untouched in other parts of the world. A case in point occurred a few weeks ago.

Dr. Thomas operated upon a patient who was very much emaciated, and whose general condition was extremely low. For a fortnight prior to the operation the patient's temperature ranged from 101°F. to 103°F. It was a question if she would not succumb to the anæsthetic. The operation proved a double one, for after removing a large ovarian cyst with considerable adhesions, the uterus was found to be involved by a fibroid the size of a child's head. This was also removed, the whole operation occupying a little more than 25 minutes. In its performance, Dr. Thomas illustrated his maxim in these cases, where each minute, during which the patient is under the anæsthetic, means one chance less for the success of the operation, "operate quickly, but don't be in a hurry." Of course the assistants, Drs. Chambers, Ward and the staff of the house, left nothing to be desired; every gesture of the operator was understood, and every wish anticipated. The patient has made a good recovery, and is about in the wards.

The other day I was present when Dr. Hunter cut down on an abdominal tumor, expecting a simple ovarian cyst, but found an immense fibroid of the uterus, with very extensive adhesions.

He coolly set to work to battle with the unexpected foe. The abdominal incision was enlarged, the adhesions carefully separated, those existing between the bladder and tumor were very firm, and necessitated the greatest care and caution. Having freed the tumor, he firmly encircled it by rubber tubing, then cut it away, with no loss of blood; the surface of the pedicle was quite blanched. The pedicle was slightly cauterized by hot irons, and retained projecting through the abdominal wound by a couple of knitting needles. The house surgeon, Dr. Vaners, (to whom I am indebted for many acts of courtesy), tells me the patient is progressing favorably, and he expects to have her in the wards in a few days.

At the last stated meeting of the Academy of Medicine, December 18th, the capacious hall and adjoining room were filled to overcrowding, and intense excitement prevailed. The ostensible object of the meeting was to hear the report of the Committee on Ethics on a charge of no less than dishonorable conduct and perjury of a Fellow, the Fellow being none other than the venerable and distinguished president of that august body—Dr. Mordyce Barker. The charge was preferred by six Fellows, the leading spirit being Dr. A. Flint, jr., and was to the effect that Dr. Barker, on becoming a Fellow in 1856, had signed his name on the books of the Academy as a graduate of L'Ecole de Medecine, Paris, and also that in accordance with a by-law passed in 1880 had registered and sworn before the City Clerk that he was a graduate of the above-named school. Sharp at eight o'clock p.m. the president, who is of erect stature, firm physique, possessing a beautiful cast of features, and with silvery locks and snowy-white side-whiskers, walked up the aisle to his chair amid great applause. He opened the meeting and then vacated the chair for the vice-president, Dr. Weir. The report of the committee was read by its chairman, Dr. A. H. Smith, and gave in full the evidence *pro* and *con*. It was the unanimous conclusion of the committee that the charges were not sustained. This decision was accepted with great enthusiasm, and a motion passed that the report be recorded in the books of the Academy. Several motions were then moved, beginning

with censure and winding up with expulsion of the Fellows that made the charge ; but on Dr. Dalton moving that the motions be laid on the table, and Dr. Barker saying that he thought the Academy acted wisely, and that he was pleased to let the matter rest where it now stood, the former motions were all withdrawn. On resuming the chair, Dr. Barker said : " Here endeth the second lesson. The Academy will now resume its scientific work, which it has continued zealously, efficiently and harmoniously for thirteen months, until the present interruption by this supreme effort to elevate the character of the medical profession."

At a prior meeting of the Academy, a very important discussion took place on a paper read by Dr. Winters—" Is the operation of Tracheotomy for Diphtheritic Croup dangerous ? " The reader of the paper urged the early performance of tracheotomy, and thought that its difficulties and dangers were over-rated ; that every physician should be prepared to perform the operation on a moment's notice. Drs. Wright, Jacobi, Lewis Smith and Ripley took part in the discussion.

Dr. Jacobi, whose utterances on this subject always command the greatest respect, while agreeing in the main with the reader of the paper, thought that the operation should not be hurriedly performed, and that the greatest care should be exercised. He would deprecate incising the thyroid gland unless the urgency of the case demanded immediate entrance into the trachea. He considered the operation was demanded equally as much in diphtheritic laryngitis as in membranous croup. In the former, one source of systemic infection was thus avoided by the inspired air not having to travel over the diseased surface of the pharynx and larynx. In laying down a guide as to when to operate, Dr. Jacobi would operate in any case in which there was considerable laryngeal stenosis, recession about the supra- and infra-clavicular and ensiform regions, particularly if these symptoms increased in the morning, and if the pulse was becoming frequent and irregular. With extended experience, he would reiterate his remarks made at a meeting last May as to the value of Bichloride of Mercury in these affections. He felt certain that he had cured many cases of diphtheritic croup by that drug.

H. N. V.

Reviews and Notices of Books.

The Elements of Physiological Physics. An outline of the elementary facts, principles and methods of Physics and their applications in Physiology.—By J. MCGREGOR-ROBERTSON, M.A., M.B., C.M., Muirhead Demonstrator of Physiology, and Assistant to the Professor of Physiology in the University of Glasgow. Illustrated with 219 wood-engravings. Philadelphia: Henry C. Lea's Son & Co.

The modern teaching of physiology, and especially the demonstrations in that branch, presuppose and require a considerable acquaintance with the subject of physics. There is hardly to be found a good text-book on physics for medical students which, together with the elementary facts, gives their physiological applications. That is the purpose of the above volume, which forms one of the series of manuals. It is very complete in all its parts, profusely illustrated, and clearly written. It is a good and useful book, and will add to the popularity of the series to which it belongs.

Doctrines of the Circulation: A history of Physiological opinion and discovery in regard to the Circulation of the Blood.—By J. C. DALTON, M.D., Professor Emeritus of Physiology in the College of Physicians and Surgeons, New York, and President of the College. Philadelphia: Henry C. Lea's Son & Co.

The fact of the circulation of the blood in our bodies is such an elementary one, that it requires some effort of thought to conceive or fancy what our ideas would be without any knowledge of it. And yet there was a time—all the time before Harvey—when complete ignorance on the subject was universal. The men of those days were able and cultivated men, equal, undoubtedly, in intellect to those that came after them. They were also ardent and original investigators, and yet the truth did not come to them. It is certainly one of the most interesting chapters in the history of medicine which traces out the glimmerings which the ancients had as to the functions of the

different blood-vessels and the behaviour of the blood contained therein—the various and conflicting notions upon these subjects—then leads up to the great discovery of Harvey, and shows the extraordinary opposition he met with in introducing his explanation of the true circulation through the heart, lungs and vessels. Prof. Dalton has presented to us this chapter in a most readable form. That which must have been the result of a vast amount of research is condensed within the space of a small volume. Beginning with Aristotle and his philosophy, we are consecutively introduced to Praxagoras, to the School of Alexandria, Galen, Mondini, Carpi, Vesalius, Servetus, Colombo, Cesalpinus, Fabricius, and Harvey. Amongst those of highest standing who fought the arguments of Harvey, we find Primrose, Riolan, and Bartholinus. For those wishing to follow up the subject, an appendix, giving numerous quotations and a bibliography, have been added. Every one will be interested in, and instructed by, the perusal of this admirable historical work.

A Text-book of Practical Medicine, designed for the use of Students and Practitioners of Medicine.—By ALFRED L. LOOMIS, M.D., LL.D., Professor of Pathology and Practical Medicine in the Medical Department of the University of the City of New York, Visiting Physician to Bellevue Hospital, &c. With 211 illustrations. New York: Wm. Wood & Co.

The exceeding good reputation enjoyed by the author of this work as a good observer and a sound practical physician—added to the favor with which his previous writings on medical subjects have been received—would of itself lead us to expect to find in this more comprehensive treatise the stamp of the writer's originality and industry. Nor have we been disappointed. Numerous as are the text-books on medicine at the present day, still there will always be room and a place for books such as this. Dr. Loomis, in all his lecturing and writing, is nothing if not clear and concise, and in these two cardinal virtues lies the chief merit of the treatise. The classification adopted is simple, yet not

obscure, and the separate articles are composed in such a way as to give the reader quickly the generally accepted views of the profession, along with the result of the author's own experience. Controversy and disputed points are specially avoided. It is unnecessary to say that in every case the statements are carefully made, and are in accordance with the very latest writings. The questions of treatment are brief, and to the point—never complicated or prolix. They carry on their face Dr. Loomis' practical good common sense. From a perusal of a large number of the chapters, and with the impressions formed of it as given above, it may readily be supposed that we cordially recommend this new 'Practice', and think that students will find it peculiarly suited to their wants. The illustrations are original, and assist very materially in the comprehension of the text.

Manual of Chemistry: A Guide to Lectures and Laboratory-work for Beginners in Chemistry.—By W. SIMON, Ph.D., M.D., Professor of Chemistry and Toxicology in the College of Physicians and Surgeons, &c. With sixteen illustrations on wood and seven colored plates, representing fifty-six chemical reactions. Philadelphia: Henry C. Lea's Son & Co.

This is a well-arranged text-book of chemistry, both organic and inorganic. It is condensed and made specially suitable for students of medicine or of pharmacy. From an examination of its chapters, we are prepared to fully recommend it as meeting well the requirements of those for whom it is intended. It has one special feature which will no doubt tend to make it popular, viz., the plates representing the exact colors produced by various chemical reagents. These have been prepared with the greatest care, and are very beautiful.

The Elements of Physiological and Pathological Chemistry. A Handbook for Medical Students and Practitioners.—By T. CRANSTOUN CHARLES, M.D. Illustrated by 38 woodcuts and a chromo-lithograph. Philadelphia: Henry C. Lea's Son & Co.

With the author's views on the relations of this subject; on

its importance for the student of medicine ; on the difficulties in this way owing to imperfect knowledge of chemistry in most cases, as expressed in the preface, we most heartily agree. The task of writing a work that should serve as a guide for the advanced student and a book of reference for the practitioner at once complete, compact and readable, as well as suitable for use in practical laboratory work, has been so well accomplished as to render reference to foreign text-books almost superfluous. The book is in every respect up to date, including the formulæ for organic chemical compounds ; indeed, it is a pleasure to feel that the work is written by one combining the physician and the chemist. The work is so complete that few important omissions are to be noted. We should have liked to have seen an account of Landweke's method for the preparation of glycogen, inasmuch as it is so much superior to older ones, and a really good method was a *desideratum*. The general appearance and entire get-up of the book is excellent, and it deserves much consideration from different classes of students.

Books and Pamphlets Received.

A PHARMACOPŒIA FOR THE TREATMENT OF DISEASES OF THE LARYNX, PHARYNX AND NASAL PASSAGES. By George Morewood Lefferts, A.M., M.D. Second edition. New York and London: G. P. Putnam's Sons.

A MANUAL OF DISSECTION OF THE HUMAN BODY. By Luther Holden. Fifth edition. Edited by John Langston. Philadelphia: P. Blakiston, Son & Co.

THE PRINCIPLES AND PRACTICE OF GYNÆCOLOGY. By Thomas Addis Emmet, M.D., LL.D. Third edition. Philadelphia: Henry C. Lea's Son & Co.

FIFTH ANNUAL REPORT OF THE STATE BOARD OF HEALTH, LUNACY AND CHARITY OF MASSACHUSETTS. Boston: Wright & Potter.

THE LAW AND MEDICAL MEN. By R. Vashon Rogers, Jr. Carswell & Co., Toronto and Edinburgh.

Society Proceedings.

MEDICO-CHIRURGICAL SOCIETY OF MONTREAL.

Stated Meeting, October 24th, 1884.

T. G. RODDICK, M.D., PRESIDENT, IN THE CHAIR.

Missed Abortion.—DR. ALLOWAY read a paper on this subject. (*See December number, page 257.*)

DR. KENNEDY said he did not like this new name, "Missed Abortion," especially if applied to the retention of a dead foetus over five months old. He said it was well recognized that the foetus might die, become mummified, and be retained, or, after its death, it might be expelled and the membranes alone be retained.

DR. CAMERON also took exception to the term "missed abortion," as not being precise. He mentioned that McClintock made fun of the term by saying that when a woman went to full time it was a case of missed abortion. He prefers calling a blighted ovum a *mole*.

DR. TRENHOLME said there was no question as to a dead foetus being retained in some cases for several weeks or months. The only point was as to whether the specimen exhibited was so retained or not. The indications led him to question its long retention, and to regard it as one of a series of early abortions. In those cases of retained foetuses which had come under his observation, he had found an abnormal condition of the decidua—the reflex decidua being distinct and separate from the uterine decidua, which is strongly adherent throughout. In this way the enveloped foetus became a sort of tumor, frequently causing hæmorrhage, and its growth being interfered with, the subsequent death of the foetus is due to the compressing force of the reflex decidua. In his cases he found the decidua very strong indeed, a good deal of force being required to rupture it and allow of the removal of the foetus. Dr. T.'s theory is that there is sufficient vital union existing to prolong the retention, while the pressure is such as destroys life. It is only when the contents of the uterine cavity become separated to such an extent

that the contained mass acts as a foreign body that uterine contractions ensue. This is true whether the contents to be expelled is an early or late product of conception. The fact of the non-union of the reflex and true deciduæ accounts for menstruation during pregnancy; also for the well known fact that frequently no harm follows the use of the sound, nor even the application of remedial agents to the cavity. Of course the separation of any part of the placenta would be apt to be followed by uterine contractions.

DR. CAMPBELL said he had a patient with symptoms indicating treatment by means of applications to the interior of the uterus. He first passed a probe and afterwards painted with a solution of iodine and also acid. nitrate of mercury. This was done four or five times before the real cause of her trouble was found out by her aborting.

DR. ALLOWAY said, in reply to those gentlemen who took exception to the term "missed abortion," that if a better one could be suggested he would gladly accept it. Dr. McClintock's little joke was simply an *Irishism*, and was not intended to convey any literal meaning. Dr. A., however, drew attention to the error of confusing the terms Missed Abortion and Fleshmole. He referred to his definition of the terms relatively, as given in the body of the paper, which distinctly shewed that the term missed abortion alluded to "*a condition*," and that a mole was "*the product*" of this condition—in fact, a pathological specimen; and that the terms could not be used with any other meaning or relationship. In conclusion, Dr. Alloway said he felt much gratified with the kindness shown by the members who had discussed his paper, more especially for their complete recognition of the correctness of his views relating to this interesting subject,

PATHOLOGICAL SPECIMENS.

DR. SUTHERLAND exhibited the following specimens:—

1. *An Appendix Vermiformis, containing 14 snipe shot.*—This was removed from a patient who died of chronic Bright's disease, and who had been a lover of game.
2. *Intestines from a case of typhoid fever,* where the patient

died on the ninth day of illness, and before ulceration had taken place. The Peyers' patches were swollen and raised about a quarter of an inch. This patient was admitted into the hospital on the sixth day in an unconscious condition, and remained so until death, three days later.

3. *A Heart, showing calcification of the valves of a congenitally narrowed aortic orifice.*—DR. ROSS said this had been removed from a gentleman, a traveller, stopping at one of the hotels. He had suddenly taken ill with alarming symptoms, and was sent to the hospital. When admitted he was suffering from dyspnoea, and died shortly afterwards.

4. *Abscess of the Liver.*—Patient, a woman, was admitted into the hospital under the care of Dr. Molson, with the following symptoms: Pain and tenderness in both iliac fossæ; worse in the right. Had a quick pulse, and was suffering from dysentery. She died in 48 hours. There was a history of having had an attack of illness, with similar symptoms, about a year ago, and lasting five weeks. The *post-mortem* showed signs of an old peritonitis in the region of the right iliac fossa; also signs of recent peritonitis in right hypochondriac region. Flakes of lymph were adherent to the under surface of the liver. On removing this organ pus was seen oozing from a small opening on its under surface, where rupture had taken place. Fifty or sixty ounces of pus were removed from the cavity in the liver.

5. *Horse-shoe Kidney*, also from a hospital patient aged 32 years. The right half was healthy; left half was filled with pus. A large calculus in the pelvis blocked the exit of urine; several smaller calculi were seen in the calyces. The microscopic appearance of the right kidney was normal. Both lungs were riddled with cavities. This patient had been admitted with phthisis. On admission, the urine contained 50 per cent. of albumen. There was excessive pain in the left lumbar region, with frequent micturition. At first he passed large quantities of water, it became less, and, during the last 36 hours, scarcely any came away.

6. *Pyo-pneumo-Thorax, showing ulceration from a large lung cavity into the pleura.*—This specimen was removed from

a man aged 27, admitted into hospital August 1st, 1884. He was a stonecutter, of steady habits, a moderate drinker, and belonged to a phthisical family. He had typhoid fever eight years ago; had coughed and expectorated ever since. He had failed rapidly during the last seven months, and had suffered with severe cough, fever, and sweating. Four days before admission he took a sudden sharp pain at the left apex, and, shooting downwards, was accompanied with great dyspnoea. There were now present signs of softening tubercular deposit in the right lung; the left was loudly tympanitic, with feeble amphoric respiration. The heart was pushed to the right. Whilst in hospital there was extreme dyspnoea (orthopnoea), with irregular hectic fever and profuse sweating. On Aug. 5th, distinct succussion sounds were heard; breathing amphoric, loud and distinct to the base. Dulness up to the tenth rib on leaning back; loud, clear resonance down to twelfth rib leaning forwards. This condition persisted till death took place from exhaustion on the 17th September.

Special General Meeting, Oct. 31, 1884.

T. G. RODDICK, M.D., PRESIDENT, IN THE CHAIR.

This meeting was called to consider Dr. Tuke's report on the Insane Asylums of the Province of Quebec, and generally to discuss the treatment of the insane in this province.

DR. CAMPBELL, who opened the discussion, strongly denounced the present farming or contract system, and deplored the lack of skilled medical treatment in our asylums.

Several resolutions were read and spoken to, Drs. Trenholme, Shepherd, Kennedy, Geo. Ross, Reed, G. T. Ross, Cameron, McConnell, Mills and the President taking part.

The following are some of the chief objections mentioned by the speakers to the present system of managing the insane poor of this province: That it led to cheap everything—attendants, care, fare, etc.—and to an entire absence of skilled medical treatment, which latter want resulted in a minimum of cures and the excessive use of mechanical restraint.

DR. CAMERON read portions from the Lunacy Act for the Prov. of Quebec, passed last June, and which he characterized as being very loose, incomplete, and apparently drawn by an amateur. No blame was attached to the ladies of the Longue-Pointe Asylum or to Dr. Henry Howard, the onus being placed on the Government.

DR. HENRY HOWARD, who was not present, sent a written communication criticising Dr. Tuke's report and expressing his disapproval of the contract system.

A committee was formed to draw up resolutions embodying the sentiments expressed at this meeting, which resolutions were to be forwarded to the Government. (These resolutions appeared in the November number of this JOURNAL.)

Stated Meeting, Nov. 7th, 1884.

T. G. RODDICK, M.D., PRESIDENT, IN THE CHAIR.

DR. ALLOWAY exhibited the following Pathological specimens :

1. *A Fœtus of two months*, complete in its sac.

2. *A Fœtus three months old*, shewing arrest of development of the abdominal walls, and through which opening the bowels protruded.

3. *A Fibroid growth the size of an almond*, removed by him from the anterior wall of the vagina, just inside the introitus. The woman had suffered from hæmorrhages, and her health was broken down, largely, no doubt, from septic poisoning, as the little growth was sloughing. Since its removal the hæmorrhages have ceased, and the patient's health has very much improved.

DR. TRENHOLME exhibited a *pair of Ovaries* removed by him the day before from a woman aged 28 years, who has suffered from pelvic distress since she was 14 years old. Six years ago she had a child, after a difficult labor, from which time her sufferings have been worse, quite incapacitating her from her duties. On examining her he found in Douglass' fossa a tumor which he took to be a diseased and enlarged right ovary, and decided to operate. On opening the abdomen, the left ovary was also found to be enlarged to about the size of an egg and

filled with fluid. It was first removed, along with its tube. Much greater difficulty was experienced in removing the right, as it was firmly fastened down in Douglass' pouch. It was about the size of a large walnut, and filled with pus. Dr. Trenholme said the patient was doing well; pulse 82, temperature normal.

Perforation of a Typhoid Ulcer in the Colon; Peritonitis.—DR. ROSS exhibited the specimen and related the case. The ulcer was situated about a foot from the ilio-cæcal valve. The patient was sent to hospital on the 21st day, with a good pulse, temperature 99° to 100°, the only bad symptom being tympanites. Dr. R. remarked that it was very unusual to find a perforating ulcer in the situation of this one. They are found much more commonly in the ileum. Tympanites had been a prominent symptom, and resisted all treatment. It did not arise from constipation and retained decomposing fæces, as is sometimes the case, as care had been taken to prevent this, and the autopsy showed the bowels to be nearly empty. It made the prognosis bad. The onset of perforation and subsequent peritonitis were well marked.

DR. TRENHOLME asked why not perforate through the abdominal walls to let out gas.

DR. ROSS said there were no distressing symptoms present, and it was not clear that this was always a safe proceeding.

DR. HINGSTON remarked that it was a common thing for a farmer to open the distended abdomen in cattle.

Sycosis.—DR. WOOD read a paper on this subject, of which the following is a brief resumé:—Much confusion has resulted from a want of agreement among authorities as to a definition of sycosis. It has been defined so as to include pustular eczema, tricophytosis barbæ, and acne indurata, and it is yet a question whether there is a disease which is distinct from these—a true sycosis. Liveing says this is a non-contagious disease of the hairy face, which is neither eczema, nor acne, nor a syphilide. The diagnosis is often difficult, but the microscope ought to discover the mycelium and spores of the *tricophyton tonsurans*, while the moist patches of eczema and the distinctive characters of acne should prevent mistakes. The affection is not common,

is usually obstinate, and only yields to long-continued and persistent treatment. Epilation and the inunction of some simple ointment are all that are commonly required. The hairs should be extracted two or three times a week, and where the pustules and tubercles are the result of the inflammatory changes incident to acne, to eczema, or to ringworm, additional appropriate treatment should in each case be resorted to.

Dr. Wood showed a patient of his recovering from a lengthened attack of sycosis.

Dr. SHEPHERD said it was easy to diagnose sycosis from acne and eczema, and spoke highly of Shoemaker's treatment of parasitic skin diseases with the oleates.

Dr. BLACKADER gave his experience in treating *tinea tonsurans* by means of oleate of copper ointment. Thirty cases occurred among the children of the Hervey Institute during the past spring and summer. Marked improvement and cure followed the use of an ointment of the strength of from 1 to 8 to 1 to 12, very little irritation being produced.

Dr. CAMERON said dermatologists were finding out that vaseline, though very elegant, was not so useful a vehicle as lard for making ointments intended to cure the parasitic skin diseases. Lard, having more affinity for animal tissues, penetrates deeper. The best vehicle for oleate of copper is oleic acid. The oleic acid, of English manufacture, should first be heated, after which the oleate of copper is to be stirred in.

Dr. HINGSTON said it was necessary to make first a correct diagnosis between eczema and tinea sycosis. Tinea sycosis is a simple inflammatory disease, so that parasiticides were not necessary. He uses epilation of the diseased hairs only, a bread and milk poultice, and attendance to the digestion. He always cures this way, and in a few days.

Dr. CAMPBELL had seen six cases of the parasitic form of sycosis, and only one of the non-parasitic. He had been successful in curing six or eight cases of tinea tonsurans lately with the oleate of copper ointment.

The PRESIDENT made a few remarks, in which he said that he had seen but very few cases of this parasitic form of sycosis.

Extracts from British and Foreign Journals.

Unless otherwise stated the translations are made specially for this Journal.

Fracture of the Floor of the Acetabulum.—The following is an epitome of a paper on this subject by Dr. C. C. F. Gay of Buffalo :—

This is a type of cases which fall under the observation of every surgeon, the *diagnosis* of which is very difficult to make out. The two following cases—one a case of Dr. Sands's, the other my own case—illustrate the difficulty experienced in diagnosing this lesion. Dr. Sands styles his case a “perforating fracture of the acetabulum.”

The patient, aged 66 years, had fallen in a dumb-waiter well. When first seen, the patient was suffering severely. In forty-eight hours after the injury Dr. Sands noted the facts already observed by Dr. Levings, viz. : That the limb was not shortened nor everted ; that the heel could be elevated ; the limb was capable of free rotary motion ; the trochanter described the arc of a circle, and there *was no crepitus*. Autopsy revealed the fact that the head of the thigh bone had penetrated the floor of the acetabulum, and that there was fracture of the pelvis.

My own case is reported by Dr. McBeth, house surgeon.

Ella Smith was brought into hospital April 26, 1880 ; single, American. Had been the mother of one or more children ; contracted syphilis in September, 1879. Six hours previous to entering hospital she had fallen from a verandah to the pavement, a distance of 13 feet, striking upon her right hip. Dr. Frederick and myself gave her ether and made an examination, finding slight eversion of the toe, and crepitus. There was no shortening, each limb measuring $39\frac{1}{2}$ inches. We did not consider a diagnosis of intra-capsular fracture positive, but, as relief was afforded by extension, we put on extension with 8-lb. weight.

April 27th.—Patient seen by Dr. Gay, who made an examination and carefully measured the limbs, finding them the same as the night previous. Patient stated to-day that the eversion of toe was natural, having had it from childhood. There was *no crepitus*. Dressings by extension were therefore discontinued,

thus allowing muscular action to shorten the limb if there was fracture.

May 5th.—This is as early as it was deemed advisable to make further examination, on account of dysmenorrhœa, from which the patient suffered. She was etherized, and another examination made. The injured limb measured a trifle longer than the limb of the sound side; there was no more eversion and no crepitus. As the patient was somewhat relieved of pain by slight extension, Dr. Gay advised its continuance with use of eight-pound weight. For a time after this she was in a typhoid condition, and evidently suffering from septicæmia, having chills with fever, temperature reaching as high as 105°F. Tenderness over caput coli, and abdomen tympanitic. She sank gradually with little pain, and died May 19th. Rapid *post-mortem* changes.

Autopsy May 20th.—Present Drs. Gay, Diehl, Peterson and Frederick. In cutting down upon the hip, found large quantity of pus evidently from the abdominal cavity, as it could be forced through the opening in hip by pressure over abdomen. Vagina filled with pus. Found fracture of the acetabulum in three directions following the original line of union, involving fracture of innominate bone.

There is no sign in either of these reported cases that could possibly suggest the lesion revealed by dissection; therefore they confirm the correctness of statements made by writers. My house surgeon thought he detected crepitus when the patient was first examined, but crepitus was not found to exist at the examination made the next morning. It is easier to presume he was mistaken than to believe that crepitus existed. If crepitus is ever observed, it must be in consequence of co-existent fracture of the innominate bone. "There are no signs clearly distinctive of this fracture" (Agnew). If fracture of this bone can only be suspected, then diagnosis of this lesion has for the first time to be made. There is no shortening, no eversion, no crepitus, whether there be displacement of the head of the thigh bone or not; but there is pain in the hip, which is aggravated by movement of the joint, by pressure upon the trochanter, and by attempts to turn the patient upon the side. I have said

that pain is the only sign of this fracture ; it exists with equal severity with that which accompanies fracture of the cervix femoris, but without the evidence of fracture the latter reveals. Therefore, severe and persistent pain, in the absence of positive symptoms of fracture, is a sign of some significance of this lesion. Explorations through the rectum or vagina may assist in determining the nature of the injury.

Prognosis.—Fracture of the acetabulum without displacement of the head of the thigh bone does not constitute a fatal, nor even dangerous, injury, provided the lesion be early suspected and the patient let alone. Fracture with displacement is not necessarily fatal, as may be shown by the following remarkable case under the care of Charles Hewitt Moore, of Middlesex Hospital. This is the case I supposed referred to by authors :

James T. Horsfield, who died at the age of 60, was crushed about the pelvis, several years before, by a piece of timber. The left limb was shortened, and its principal motions were abduction and moderate flexion, while circumduction and extension were impossible. Dissection of pelvis : left innominate bone broken in the acetabulum into three pieces, corresponding to its original segments. These pieces were separated by the head of the femur having been driven through them into the cavity of the pelvis, where it rested upon the sacrum, below the promontory. The trochanter had worn a new socket upon the brim of the acetabulum. The right innominate bone was broken just in front of the acetabulum. Both ischio-pubal rami were broken. None of the fractures had united with ossific matter. Owing to this fact, and to the fact that the pubes had been separated from all connection with the main body of the pelvis, the former (pubes) was displaced upward (possibly by muscular action) and backward, thus materially narrowing the pelvis antero-posteriorly. The pubes was also displaced laterally—*i.e.*, somewhat twisted. As the person, in walking, bore most of his weight upon the right thigh, the corresponding ilium, which had now no support from the pubes, became bent toward the spinal column.

If recovery be possible under adverse conditions such as the report of this case reveals, no one need hereafter despair of recovery in any case.

Treatment.—But little can be said upon the subject of the management of these cases. The surgeon wants less to know what to do than what not to do. Meddlesome surgery cannot be advised. Rest of the joint is of the first importance. Whenever, therefore, a fracture is not made out, but is suspected, the patient should be let alone as much as possible, the limb left to rest in an easy position, with or without moderate extension, according as it is grateful or otherwise to the patient. In the case I have reported, it is quite probable the patient was deprived of her only chance of recovery by repeated examinations, two of which were entirely unnecessary, since they inflicted injury, without leading any nearer to a correct diagnosis.—*New York Med. Journal.*

Diphtheria Spread by Adults.—To elucidate some mooted points connected with the etiology of diphtheria, two cases are cited in which children suffering from this disease had been in the company of adults having sore throats. No permanent spontaneous generation is claimed, or has been proved, for cholera, scarlatina, or variola. Nobody looks for their primary cause in moist walls of houses; in bad ventilation; in the odors of hospital wards; in putrefying kitchen refuse, or in the exhalations of sewers. But both medical men and laymen frequently regard these factors as the main and frequently the sole causes of diphtheria. While house hygiene should not be overlooked, we may live to reach the conviction that there is but one predisposing element, viz., a sore mucous membrane, and but one cause of an individual attack of diphtheria, viz., direct contagion. Diphtheria affects principally the oral and pharyngeal spaces and the respiratory organs. The size of the membrane and its seat determine the character of the disease, *ceteris paribus*. While a tonsillar diphtheria is attended with scarcely any danger, a laryngeal diphtheria destroys a child by strangulation, and nasal diphtheria by sepsis. The character of the epithelium,

whether pavement or cylindrical, the presence or absence, copiousness or scarcity of muciparous glands and lymph ducts, decide the nature of a case. It is also well known that the definition of the term diphtheria, as it does not depend upon the size or seat of the membrane, is also not limited by the character of the symptoms. A high or a low temperature, muscular or pharyngeal pain, difficulty in deglutition or articulation, sepsis, glandular swelling, may be present or absent in a case of diphtheria as long as the characteristic membrane is met with. A mild case may generate many severe ones, and a severe one need not necessarily be the source of misfortune to others. The so-called follicular tonsillitis implies a catarrhal or suppurative condition of a tonsillar crypt, or several of them. But the large majority of cases which are commonly called follicular tonsillitis do not belong to this annoying but innocent class; most of them are diphtheria. What to-day looks like a point, or four or five points, covering the outlets of ducts, may to-morrow be a confluent membrane. Diphtheria in the adult is not as rare as it is reported to be, but diphtheritic sepsis is not very frequent, as the action of the lymph system is more pronounced the younger the individual. Mild affections in adults, punctate deposits terminating in membranes on the tonsils, membranous streaks extending, vertically in most cases, over the posterior aspect of the tonsils, are frequent. A little muscular pain and difficult deglutition are, perhaps, all the symptoms complained of. The danger arising from the contagion spread by adults affected with mild forms of diphtheria is increased by the fact that in them diphtheria is apt to assume a chronic character without losing its contagious nature. Barthez emphasizes the long duration of membranes; they may last a month before being exfoliated and expelled. Cadet de Gassicourt publishes cases of pharyngeal and nasal diphtheria of 45 and 151 days' duration. The contagion spreading from such cases is of greater importance than the risk run by the individual. A family with children ought to insist upon the occasional inspection of the throats of their help; servants with chronic pharyngeal catarrh must not be hired. If there be any class of persons who are constant transmitters of diph-

theria, and require attention and caution, it is nurses and cooks—in fact, all domestic help; also sick-nurses, teachers, hair-dressers and barbers, shopkeepers, restaurant-keepers, and all those people who are in constant contact with all classes and ages. There is as much diphtheria out of bed as in bed; nearly as much out of doors as indoors. The following are the main conclusions reached: There is probably no spontaneous origin of diphtheria any more than there is a spontaneous origin of cholera or scarlatina; diphtheria is contagious; severe forms may beget severe or mild forms; mild cases may beget mild or severe cases; what has been called follicular tonsillitis is mostly diphtheria. It is seldom dangerous to the patient, as the tonsils have but very little lymph communication with the rest of the body, but it is contagious. This form is frequent in the adult, in whom it loses nothing, however, of its contagiousness. Diphtheria in the adult proves dangerous to the community mostly because it does not restrain the patient from communicating the disease. It is apt to last long: Firstly, because most cases occur on a surface covered with pavement epithelium (tonsils); secondly, because of the constant exposure and neglect on the part of the patient. Even without it, diphtheria may last weeks and more; with it, it is subject to sudden relapses. As long as it lasts it is contagious. As diphtheria is but a mild affection in many adults, who frequently disregard it, the question of transmission by means of clothing, and so forth, on the part of third persons is capable of becoming more difficult to answer than it ever was. Many a case which has been believed to be thus carried is probably one of direct contagion from a patient to a second person, from this second to a third.—*Jacobi in N. Y. Med. Journal.*

Mistaken Sex.—Dr. W. P. McGuire (*Medical Advocate*, May, 1884) reports the following case:—"A. B., 35 years of age, and in good circumstances in life, consulted me on January 12, 1884, in order to have the sex to which she belonged determined. She was to all outside appearances a fairly-formed woman about 5 feet 4 inches in height, with long hair curling down her back. Her voice and features were effeminate, and

her demeanor was modest. From birth her dress had been that of a woman. All of her associations had been with women, and her business in life that usually followed by that sex. There was no hair upon her face. He found upon examination that the formation of her thorax was similar to that of a woman, and that her breasts were developed similarly to those of a young girl. The nipple was erectile. Her arms, hands and lower limbs were like those of a man. There was a small penis in the natural position about three-quarters of an inch in length, with a well-formed glans and prepuce. It was capable of erection, but had in the glans no aperture. Following from the base of the penis backwards was a sulcus about half an inch in depth and $2\frac{1}{2}$ inches in length. Lying upon each side of this sulcus, and each enclosed in separate scrotums, were two well-formed and developed testicles, each attached to a moderate-sized spermatic cord, the whole conformation resembling the vulva of the female. There was no opening in this sulcus, but just at its posterior termination was an opening one quarter of an inch in diameter, which was the external opening of the urethra, extending backwards and upwards into the bladder. No prostate gland was found. She stated that all her proclivities and desires had been masculine, and admitted that occasionally in her sleep she has pleasurable sensations followed by ejaculations of a white fluid from the opening of the urethra, which was, of course, an ejaculation of semen. There was no trouble in determining her sex. She was advised to change her dress to that of a man, and to attempt to have, by a plastic operation, a new urethra made from its termination in the perinæum, along the sulcus to the glans penis, in order to produce more effective urination."

Opening of Gall Bladder and Extraction of Biliary Calculi.—Dr. Langenbusch of Berlin (*Independence Belge, Midland Medical Miscellany*) has recently performed this operation upon M. Eugene Anspach, the Deputy-Governor of the National Bank of Belgium, who has for many years been suffering from a collection of gall stones, which have kept him in a state of aggravated suffering, and have lat-

terly defied all measures of relief. M. Langenbusch, summoned specially from Berlin, proposed to lay open the gall bladder, with antiseptic precautions, admitting, however, that he had only performed this operation four times, and that but one of these cases recovered. M. Anspach's family and friends were much dismayed at this announcement, and begged that the operation should not be performed. M. Anspach was firm, and reflecting that without it he would not live long, and that in the meantime his life would be worse than death, decided on the operation. Even at this supreme moment the banking mind asserted itself, and M. Anspach remarked: "After all, one in four is 25 per cent., and that is a fine dividend." "You have had one recovery already, doctor," he remarked, "and I will be the second," an element of confidence which no doubt had something to do with the result. The operation was performed on the 9th of September, and 125 calculi were extracted from the gall-bladder. M. Anspach suffered a good deal, but is now out of danger and in complete comfort.

Lumbar Nephrectomy for Renal Calculus.—Henry Morris, M.A., M.B., F.R.C.S., reported before the Royal Medico-Chirurgical Society, November 25, 1884, a case in which this operation proved successful. (*British Medical Journal*.) A laborer, aged thirty-five, who had suffered from well-marked symptoms of renal calculus of the right side since the end of 1881, and had been under the care of Dr. Douglas Powell at the Middlesex Hospital, came again under treatment in October, 1883. In November, 1882, Mr. Morris had explored his kidney digitally, and with the probing needle, but did not detect the stone. On October 23, 1883, the exploration was repeated, but, again failing, the kidney was removed through the lumbar incision. The patient made an uninterrupted recovery, and at the present time is hard at work as a charcoal-burner—"is as well," his medical adviser reported, "as ever he was in his life, and able to work without the slightest inconvenience." The kidney excised was of normal size and appearance, and its secreting structure was found by Dr. Coup-

land on microscopical examination to be quite healthy. The organ, however, was harder and tougher than usual, and contained a rounded rough calculus, about the size of a marble. Careful daily examination was made of the urine by Mr. Paul both before the nephrectomy and for more than six weeks after the operation, so that the rapidity and power with which one kidney could take on the whole of the excretory function was shown in a table which formed part of the paper. The results were equivalent to those of a simple physiological experiment, because a healthy kidney (so far as its excreting substance went) was removed, and a healthy one was left behind. A comparison was made between the lumbar and the peritoneal methods of nephrectomy. It was shown that the arguments which had been used in favor of the peritoneal operation were more theoretical than practical; and that, if followed out, they were likely to lead to pernicious results. The conclusion arrived at was that lumbar nephrectomy was, as a rule, the better operation, though there were exceptional circumstances and certain diseased conditions in which the abdominal method was preferable. In nephro-lithotomy, the lumbar incision, and that only, ought to be employed. In judging of the condition of the kidney opposite to the one to be removed, we had to depend upon the general symptoms of the case, and upon the amount of urea daily excreted. But it was not correct to infer that the kidneys were diseased because they excreted a daily average quantity of urea even less than half the standard quantity. Persons who had long been living an invalid life, and who had lost much flesh, might, with perfectly sound kidneys, eliminate not more than from .8 to 1.8 per cent of urea in the thirty to thirty-five ounces of urine that they passed in a day.

Mr. Bryant congratulated Mr. Morris on his success, and proceeded to touch on the many interesting points in his case. In the first place, as a physiological experiment, as showing that a patient might do nearly as well with one kidney as with two. Again, the difficulty of diagnosis of the calculus, even after handling and probing of the kidney, showed that nephro-lithotomy must, in all cases, be at first an exploratory operation.

It would certainly have been better to have taken away the stone and left the kidney; hence he felt the importance of Mr. Morris's suggestion to incise the pelvis of the kidney in future cases in order to make the search for the stone more complete. In excision of renal calculus, he thought the lumbar operation preferable to the peritoneal, as giving a better access to the pelvis of the kidney, which lay behind the vessels, and was, in many cases, the most important point for incision. A more general and more important point was, what was sufficient to justify the removal of the kidney. In pyonephrosis and hydronephrosis, he was inclined to think it was hardly ever necessary; by washing out and draining the tumour through the loin, the cyst withered, and generally a small discharging sinus was left, which was not enough to have justified a larger operation. He had himself never removed a kidney, but he had drained three fluid tumors of the kidney, with results which showed that more would not have been justifiable. In one case there was still a sinus discharging about four ounces daily, but that was comfortable and no further operation was thought of. In some cases of very slow improvement, he had at first regretted that he had not removed the whole kidney, but afterward had lost his regret on seeing them slowly recover.

Successful Treatment of Chronic Hydrocephalus by Tapping.—By J. G. Palmer, M.D., of Oakbowery, Ala.—I wish to report a case of successful treatment of congenital hydrocephalus. The patient was a negro baby, seven months old. I was called to see the child in July last. I diagnosticated the case as one of congenital hydrocephalus, and told the parents that the only hope for cure was in tapping. To this they would not consent. The accumulation continued until the head reached the enormous size of twenty-six inches in circumference—the bones of the head having become very thin by reason of the pressure from within. There was a space of two inches between the bones. The eyes were turned up under the upper lids from pressure upon the brain. In consultation with Drs. Garrison and Spratling the

importance of tapping was urged and the parents consented. A small hydrocele trocar was inserted at the posterior portion of the anterior fontanelle, the head having first been shaved at the place of insertion of the trocar. The fluid flowed freely. About eight ounces were drawn off, the trocar withdrawn, and a piece of absorbent cotton placed over the place of puncture, and held in place by a piece of adhesive plaster. The bones of the head were pressed into position, and held in place by a tightly fitting bandage. Next day bandage, plaster and cotton were removed, and more fluid was allowed to drain off, though much had done so during the night by the plaster's coming off and the cotton being moved out of position. The fluid was allowed to drain off at intervals until all was removed. The child was then put upon iodide of potash, which was kept up for several weeks. The eyes soon regained their normal position. The child nursed well and fattened rapidly. There were some febrile symptoms for several days after the operation, but they soon subsided. The head is yet big from the large size of the bones, they being very thin. The bones seem to be rapidly uniting, and the child is still fattening and growing.—*Medical Record.*

Is Pneumonia an Infectious Disease? —

Within a comparatively short time the literature on the infectious nature of pneumonia has grown to considerable dimensions. Most of these recent communications are of French or German origin. In England, but quite especially in our own country, original contributions to the subject continue to appear rather tardily, and, as it were, with considerable hesitancy of conviction. There can be no doubt, however, that the current drift of the most competent opinion in the profession is toward an acceptance of the specific and infectious nature of the malady. The October number of the *Revue des Sciences Médicales*, contains a good *résumé* of the entire subject in its various aspects, theoretical, clinical, and experimental. It must be confessed at the outset, that some confusion has been created by the mingling of cases well-observed and equally well-recorded with those of a decidedly contrary kind. One point is quite incon-

testable, namely, the fact that lobar pneumonia may assume the proportions of a quickly-spreading epidemic. Moreover, such epidemics are by no means of quite infrequent occurrence. Now, it is impossible to explain them through the sole agency of meteorological influences. Nor is "taking cold" an adequate explanation of the origin of single cases of pneumonia. If, therefore, we can dismiss cold, if we accord to hygienic conditions, acclimatization, and general surroundings only their proper share in the etiology of the disease, which is the production of predisposition, then we must seek for other causative agents. Something outside of the body must, after entering the organism, be capable of suddenly setting up a typical disease, with a well-marked natural history. The assumption of a specific microbe is a very natural one, and the discovery of the same and its repeated observation by competent physicians are already matters of record. When the question is put: Is pneumonia directly transmissible from man to man? clinical experience answers that the contagion of the disease must be a feeble one. In this respect the pneumonia microbe would seem to resemble the supposed germ of malaria in manifesting the properties of a telluric poison.

This part of the question is still quite obscure, which is due in no small measure, perhaps, to insufficient knowledge concerning the micrococcus of pneumonia. Friedländer, Talamon and Fränkel each claim that their particular bacterium is the true pneumonia producer. But it is well to remember in all such contentions, that it has yet to be shown that pneumonia may not arise from various kinds of microbes. This brings us to the question of the unity of the disease. And here again we are met by strongly opposite views. Thus, at the recent German Medical Congress, Jürgensen and Fränkel upheld it, Friedländer doubted it, while Rühle, Bäumlér and Rosenstein emphatically denied it. Secondary inflammation of the lungs should certainly be distinguished from the primary variety. For the acute lobar pneumonia of asthenic type can hardly be considered to be identical with those asthenic forms that so frequently complicate typhoid fever, chronic nephritis, or cerebral disease.

Again, the unicist view is not upheld by the clinical history of the disease as well as it might be. The physical signs may be the same in all cases of pneumonia. Yet that merely shows that there is fibrinous inflammation in the lungs. Now, it seems that the pulmonary parenchyma responds to irritation in a certain way, just as mucous tissue does. But we should not, therefore, conclude that there is only one cause which sets up this reaction. Pathological identity of lesion should not be used as an argument in favor of identity as regards etiology. There are pneumonias and pneumonias, just as there are different kinds of catarrh. For the present, therefore, it seems best to distinguish two principal varieties of pneumonia, and to call one simple, the other, specific pneumonia.—*N. Y. Med. Record.*

Sleep, Trance and Death.—Occasionally we meet with instances in which death is simulated by some deep degree of stupor. The case of a laborer, living at Bridgewater, which was lately recorded, appears to have been one of this kind. The trance-like state developed quite suddenly, and was mistaken by the relatives for death. Some slight degree of warmth in the apparent corpse induced the clergyman in attendance to refuse burial in spite of the decided wish of the relatives that it should take place. After eight days, the signs of animation were re-established, and the subject of this singular experience slowly recovered. In all such cases, there is an element of mystery; and one cannot always decide how much of this is due to physiological or pathological conditions, or to some external agency. The *British Medical Journal*, in commenting upon the above case is led to make the following remarks: "The relationship between sleep, 'the cousin of death,' and death itself, is probably real as well as apparent. The distance which separates them is great, but there are intermediate connections, grades of dissolution as of development. Among these the similar states of trance and hibernation are worthy of special notice. For sleep and for trance one cause, the exhaustion chiefly of nervous matter, but more or less of every organ and tissue, is assignable. The hysterical stupor is the sleep of nerve

centres, worn out with the assault and conflict of stormy reflex action. Healthy sleep is the rest of physical elements wearied with the same strain applied more gradually. Cases have been recorded in which somnolence, continuing for days without cessation, has resembled trance in its duration, while preserving all the ordinary features of natural sleep. Various facts support us in associating the hibernation of animals with the same train of organic or functional changes as the other unconscious states which we have been considering. It comes like a habit; it has, one may say, annual return; its apparent cause is the oppression of external cold, and the animals it affects are mostly those which, from their bodily structure or habits, are subject to great periodic variations of temperature. Vital tissue is exhausted, and function is in part suspended, probably because the numbness of cold has taken hold upon the radicles of the outer circulation, and of that of the brain-surface which is connected with it by numerous anastomoses. In such a case anæmia would seem to be the cause of the winter sleep, as there is evidence to show that it is also the cause of that temporary starvation of brain which lulls without arresting its action, in the natural repose of each night. We may even regard the lethargy, ended by death, into which man falls when exposed to great cold, as a short and mortal hibernation. The same influence acts upon him as upon the bear or fish, but the power of its shock is greater on his finer and less accustomed senses than on their comparatively coarse organization. So, likewise, in other regions and forms of life, in the weariness, paralysis, atrophy, and gangrene of limbs, in the leafless hibernation of trees, and in their decay, beginning in the terminal twigs, the same teaching is evident, that vascular nutrition, in its periodic variations, is the parent of activity, and of rest, as its absence is of death." *N. Y. Med. Record.*

Charcot's Joint Disease.—A very important discussion of this subject has recently occurred at the London Clinical Society. The names of the prominent men who participated in the debate are a sufficient assurance that the ques-

tion was illuminated with the light of the best minds of the profession. The general tendency of the meeting was to consider the affection not as a distinct disease, but rather as a form of chronic rheumatic arthritis occurring in patients with locomotor ataxia. There was a disposition on the part of the surgeons present to regard the nervous theory of its production as rather an imaginative way of explaining a gross surgical condition. Professor Charcot was invited to be present at the discussion, but was unable to attend.—*N. Y. Med. Journal.*

Contribution to Jacksonian Epilepsy and the Situation of the Leg Centre.—

Dr. William Osler, of the University of Pennsylvania, records, in the January issue of the *American Journal of the Medical Sciences*, the history of an instructive case of Jacksonian epilepsy, the main points of difference between which and true epilepsy are, the slow onset, local in character, beginning in, or in mild attacks confined to, one limb or a single group of muscles; the gradual extension until the side is involved, or, in severe attacks, the entire body; loss of consciousness late, not early and sudden, as in true epilepsy; and, lastly, the muscular contractions are clonic. His case lasted over fourteen years, the convulsions beginning in the left hand, at first monobrachial, then extending to the leg, afterwards becoming unilateral, and finally general; at first without loss of consciousness. For the first nine years of the illness, there were remarkable intermissions, lasting for six or seven months, once an entire year. Six years after the onset the left leg got weak and stiff. For four years, the tenth, eleventh, twelfth and thirteenth of the illness, the seizures were frequent. During this period there were six weeks of unconsciousness in which the spasms were very frequent, fifty to eighty in the day. Ten months prior to the final attacks there was freedom from convulsions. The intellectual faculties were unimpaired.

The case is unusual in the limitation of the lesion to the ascending frontal convolution and to its fasciculus of white matter, scarcely involving the gray substance which is commonly affected in cortical epilepsy. The accurate localization

and the remarkable absence of tissue changes in the immediate vicinity give the case the nature of an exact physiological experiment. With this limited lesion of the motor area there was permanent paralysis with contracture of one extremity and epileptiform convulsions. Another feature of interest in the case is the light it throws on the situation of the leg centre. The fibrous mass was situated entirely within the anterior part of the paracentral lobule limited in extent, confined chiefly to the medullary fibres of the superior frontal fasciculus, and only touched the gray matter in places. A point to be referred to is the absence of the paralysis of the leg for the first six years, for, if the convulsions and monoplegia were caused by the same lesion, how explain the late onset of the latter? From the fibroid state of the tumor it might reasonably be inferred that it was originally larger and had shrunk, but the absence of puckering on the surface and the way in which the margins merged with the contiguous parts make it probable that the growth was always small, so small in fact that at one period of its development it may have caused sufficient irritation to induce the convulsions, and yet at the same time not involve the special fasciculi of white fibres to the extent of producing weakness of the leg, or monoplegia.

An Obscure Case of Popliteal Aneurism Simulating Sarcoma.—

The diagnosis of popliteal aneurism is not generally a matter of great difficulty, still some of the cases of aneurism simulate other diseases so closely that mistakes are occasionally made. Many able surgeons have opened aneurisms, supposing them to be abscesses; and others, again, have tied the femoral artery for malignant growths, mistaking them for aneurisms. There are not a few cases recorded where an old consolidated aneurism has been mistaken for a sarcomatous tumor. In the January issue of the *American Jour. of the Medical Sciences* Dr. F. J. Shepherd of Montreal reports an obscure and instructive case of popliteal aneurism, which was under observation for several weeks, and in which there was a total absence of aneurismal symptoms, and the rational symptoms

pointed to sarcoma, either of the periosteum, or the parts about an old popliteal aneurism, for which the patient had been successfully treated some years before. Amputation was performed, and an examination of the tumor showed it to be solid throughout and composed of fibrin, solidified *en masse*. The orifice of the aneurism was at the distal end of the tumor, and the blood therefore flowed from below up, with, of course, a lessened stream; the circulation, owing to the obliteration of the femoral above the tumor, being carried on by collateral branches. As there was no cavity in the tumor, the absence of pulsation and bruit is explained. As there was not a single symptom which pointed to aneurism, an accurate diagnosis seems to have been impossible.

Fatal Puerperal Infection in the Male.

Dr. Gandor reports this case in the *Revue de Médecine*, Nov. 9, 1884: A healthy man waited on his wife after her confinement. The woman died of puerperal septicæmia; the man developed a lymphangitis, preceded by chills, simultaneously, in one arm and leg. Soon all the symptoms of septicæmia appeared, and the patient rapidly sank, but rallied at length and made a tedious recovery. No wound or scratch of any kind had existed on his hand or foot to account for the origin of the lymphangitis. The author concluded, therefore, that the case was one of puerperal infection in the male. But he fails to explain in what manner the poison entered the system.

Intermediate Hospitals for the Treatment of Acute Mental Diseases.—

The nervous system has of late years claimed the attention and study of the best medical minds of all countries, and it is now an evidence of a still further progress in this direction, that mental diseases are no longer allowed to remain in the hands of asylum-superintendents, but are beginning to demand the care and investigation that they undoubtedly deserve from a larger and more active class of specialists. It is by the medium of this development that Dr. John Van Bibber, of Baltimore, has been led at various periods, during the past five years, to investigate the plan of

treatment and the management of insane asylums, both in this country and in Europe, the results of which are given in a most interesting paper in the January number of the *American Journal of the Medical Sciences*. It is a curious tradition, which is blindly accepted by most people; that insanity differs entirely from any other form of disease, that it must be removed from sight, and if possible, from remembrance, and treated only by medical men who live within the walls of an asylum, and devote their lives to the care of this class of patients. No less is it a matter of general belief that the institutions in which this malady is treated are not hospitals, but asylums, that their use and purpose, though known, are in some way mysterious, and that their existence stands outside and apart from the ordinary ministrations of men:

This uncanny reputation is clearly the result of prejudice, and to some extent the result of the present system of treating and caring for a most unfortunate class of sufferer. It is the remnant of that feeling which, years ago, built prisons for the safe-keeping of lunatics, and which employed chains and manacles in the treatment of their disease. We have developed safely beyond that dark period, and, with rare exceptions, we have even passed the epoch of restraint.

But there are other changes which are as necessary and imperative to secure the better and more successful treatment of cases of acute insanity. These changes must affect many of the characteristic arrangements of insane asylums, the medical officer in his double rôle of physician and superintendent, and the crowding of large asylums with acute and chronic cases. This reform must also bring about the establishment of intermediate hospitals for the treatment of acute cases, and the gradual development of large asylums into homes for incurables and chronic cases.

These points Dr. Van Bibber ably discusses separately and in detail, and he comes to the conclusion that many of the evils to be complained of in our asylum system arise from the unwise association of the curable with chronic cases, and the remedy is to be found in the establishment of the intermediate hospital which is to stand between acute insanity and the asylum. This

is the hospital which is to develop the ambition of the specialist, which is to enlarge his horizon, and to bring him out of an asylum into the active world of thought and progress. This is the hospital which is to teach the treatment of insanity as it has not yet been taught, and to educate, under active clinical instruction, the men who are to be the guardians and promoters of a most important reform. The possibility of making a hospital and a school out of what has been heretofore an asylum without educational power, or without the means of using valuable clinical material, is a proud future to look forward to. It means much to the profession. It is of deep significance to the public. It means an assurance that patients confided to the care of the intermediate hospital are to have every advantage of active treatment and good nursing. It means a course of treatment which will divert and distract the patients as much as possible from their sufferings, forcing them by activity to brood as little as possible over the dreary melancholy of their disease. It means the exclusion of every factor that can militate against the recovery of a patient, and the least possible detention after recovery.

The Diagnostic Value of Tubercle Bacilli in the Urine.—So difficult is the positive diagnosis of tubercular disease of the kidney and urinary tract, that, where tuberculosis of the lung does not co-exist, it has frequently been regarded as impossible. A further contribution to our knowledge of the subject recently appeared in the *Pester Medico-Chirurgicale Presse*, No. 39, 1884. Dr. Arthur Irsai claims that the presence of Koch's bacillus in the urine establishes beyond question the diagnosis of urino-genital-tuberculosis. He gives two cases in illustration of his views, in both of which the bacillus was found in the urine by the method of Ehrlich. The autopsies showed tubercular deposits in some portion of the urinary system. In one case there was also phthisis, and bacilli were found in the sputum a month before death. Here the symptoms had pointed to a cysto-pyelitis, but the excessive loss of flesh and strength caused suspicion of a severe disease of the urinary organs. This was confirmed by the discovery of the bacillus in the urine.—*N. Y. Med. Record*,

CANADA

Medical and Surgical Journal.

MONTREAL, JANUARY, 1885.

HYDROCHLORATE OF COCAINE.

The *hydrochlorate of cocaine* seems to be holding its own as a local anæsthetic. The ophthalmic surgeons are those, however, who still find it most serviceable. It has failed in a few instances, but this was probably due to deterioration of the solution from age. This might readily be avoided by keeping on hand only as much of the solution as is required for immediate use.

Our friends the gynecologists are employing it largely in the removal of small painful tumours about the vagina and urethra, in cases of abscess, and where minor operations of any kind have to be performed in nervous hysterical women. A writer in one of our exchanges (*N. E. Medical Monthly*) speaks highly of its use in a case of painful menstruation, where before he was obliged to administer morphia hypodermically. He saturated a small piece of cotton with the solution and applied it against the os by means of a speculum. The pain ceased in half an hour, not to return, while the menses began to flow in three hours after the application was made. The editor of the exchange referred to, in a similar case, applied several coats of a four per cent. solution by means of a camel hair brush, and then hastened the drying process by blowing into the vagina with an ordinary hand bellows. The pain here also shortly subsided and the menses came on in four hours. We have not yet heard of its employment in vaginismus, but we can well imagine of what immense service it would be in this painful and troublesome complaint. In the case of the newly married it will be found often of great value, preventing the necessity for calling in

foreign aid in the shape of thumbs and speculum. The chapter of accidents described so graphically in a recent number of the *Medical News* by Dr. Egerton Y. Davis, as having occurred in his quiet home at Pentonville, might have been easily avoided by the previous application of a small quantity of the four per cent. solution of the new local anæsthetic.

In genito-urinary surgery in the male also, the muriate of cocaine is largely used. By previously injecting the urethra with the solution, catheterization is made less painful. In the case of painful and multiple chancroids where the application of nitric acid or other strong caustic is demanded, it is recommended to paint these previously with the solution, as the subsequent pain is thereby deadened if not entirely prevented. To facilitate the removal of venereal warts the new anæsthetic will be found also of service. Its use hypodermically has not yet been much practised. In a letter published in the *New England Medical Monthly*, Dr. J. W. Wright describes the removal of a small fatty tumour from his own forehead, the anæsthetic employed being the one at present under discussion. Six minims of a two per cent. solution of the cocaine were injected hypodermically in the immediate neighbourhood of the tumour. This was followed in two minutes by a sensation of numbness. Then in ten minutes more a second quantity of four minims was injected and which was scarcely felt. "Five or six minutes later Dr. Weir began the operation which was practically painless, the only sensation being a slight pain at the first incision like a pin scratch or less. I could feel the tension as he pulled, and hear the grating sound of the cutting, but felt no other pain." The incision made was about an inch and a half in length. Such scientific testimony as that given by Dr. Wright is of great value in assisting the profession to arrive at definite conclusions regarding the various actions and methods of application of this remarkable drug.

THE UNDERGRADUATES' DINNER.

[We regret that we were unable to publish the following report in our last number.—ED.]

The Undergraduates in Medicine of McGill University held their annual dinner at the Windsor Hotel on Thursday evening, December 4th. About 140 men were present, including many members of the Faculty and University officials, and distinguished guests.

The chair was occupied by Mr. Harkin, who, in an amusing introductory speech, traced the history of dining from the primitive *al fresco* repasts of the Garden of Eden to those of the present day, with an exhaustive treatment of the archæology of gastronomy.

After the loyal toasts, the second Vice-Chairman, Mr. A. D. McDonald, proposed *The University*.

The Principal, Sir William Dawson, who, upon rising to respond, was enthusiastically received, alluded gracefully to the programme and to the quotation opposite the name of the toast, "Thanks for the lessons of this spot" (*Wordsworth*). He would divide his remarks into two heads as to the lessons to be learned—viz., those of the classes, and those which might be gained from the dinner. As to the former, he would ask what did the University expect of the Undergraduates, and what the Undergraduates might expect from the University. The *Alma Mater* said to them in her generosity, take as much as you like; she expected them to make good use of their opportunities. The interests of the University and her Undergraduates were identical. The latter were the hope of the University; on their example much rested. Every man who distinguished himself was a builder up of the University. From their venerable Chancellor to the youngest Undergraduate their interests were the same—to keep forward and build up old McGill. He would say a word as to the lessons of the dinner. He thought it would be a good thing if the Undergraduates could dine together oftener, and this brought him to thoughts of the necessity of a dining hall. He hoped they would get that greatly to be desired

advantage ; they would have to get it sooner or later, and the well known perseverance of McGill towards the attainment of her needs would yet result in the gratification of their wishes and their wants in this respect. With a few remarks in warm commendation of the work of lady students, Sir William closed, sitting down amid another warm outburst of cheers.

The Dean and Professors was given by Mr. R. T. Irvine in a short speech, expressive of the esteem and veneration entertained by the students for their teachers, and bestowing a well-earned encomium upon labors which, he feared, obtained scarcely a tithe of the praise they deserved.

The heartiness of the cheers that greeted Mr. Irvine's speech testified to the sincerity of the undergraduate feeling toward their professors.

Dr. R. P. Howard, Dean of the Medical Faculty, in reply, thanked the students for their cordial reception of the toast, stating his conviction that it was no conventional tribute born of the occasion, but the expression of a regard that had evolved into an affection, based upon the mutual interests of professors and undergraduates. The interests of the professors, he said, were to give the best foundation in medical science to their pupils, to enkindle in them a love of learning for its own sake, and to inculcate those higher principles by which men of science should be actuated ; and that the interests of the students consisted not only in individually availing themselves of these advantages, but to co-operate in maintaining them by perpetuating the dignity and importance which has always characterized McGill, and that standard of excellence, both among professors and undergraduates, which had made the University what it is, a result obtainable only by co-operation. Let them strive to make the possession of a McGill degree as enviable a passport to society as the magic *Civis Romanus sum* of the Romans. In an eloquent reference to Dr. Osler's departure, he expressed his sorrow for a loss which no one could appreciate so fully as himself, a loss which, however much may have been professionally repaired by his able successor, could never be personally compensated for. After an allusion to the project of a Univer-

sity dining hall, mentioned by the Principal, and pledging his assistance to the scheme, the Dean took his seat amid prolonged applause.

Professors Girdwood, Shepherd and Wilkins, and Dr. Mills, also responded.

Mr. J. W. McMeekin proposed, in a humorous and loudly-applauded speech, the next toast, that of *Our Hospitals*. In eulogizing the advantages of the Montreal General Hospital, "where," he gave as his serious opinion, "many patients got better in spite of the treatment," he called attention to the many and marked improvements recently added to facilitate the courses in clinical medicine and surgery.

Mr. Andrew Robertson, in response, regretted the insufficient accommodations for patients in the General Hospital, but announced the news that a site has already been obtained for additional buildings which, after certain pecuniary obstacles had been overcome, might be soon expected to supplement the existing ones. He hoped that the higher education of women would have a beneficial effect in producing a superior class of nurses.

Sister Universities was then given in a short speech by Mr. H. E. Kendall, who extended a hearty welcome to such of the guests as represented other Universities.

In an eloquent reply, the Rev. E. J. Hill traced the analogies that exist between his own *Alma Mater*—Edinburgh University—and McGill. It was the pride that his fellow-students took in their University that had raised it to the standard of excellence which it occupied then and to-day; let a similar love and pride among McGill undergraduates characterize their actions towards the Canadian University. He closed by urging the necessity for a more complete pecuniary equipment of the chairs in the Medical Faculty.

Other responses were made by Mr. Gray of the Toronto School of Medicine, who attributed the cordiality of the present intercollegiate courtesies to the presence of a large number of Ontario students among the McGill undergraduates, and, after an allusion to the advantages possessed by the medical students of Montreal in the superior (?) police supervision in vogue here,

gave place to Messrs. Lyndsay, of the Trinity School of Medicine, Toronto; Houlé, Laval; Grandpré, Victoria; and England, Bishop's College.

The toast of the *Graduates* was then proposed by Mr. G. C. Stephen in a short speech, and responded to by Dr. Rodger, who contrasted the annual dinners celebrated in his day with the present one. He echoed the sentiments expressed by the Dean, that it was the duty of graduates, as well as undergraduates, to work together to promote the interests of the University, and called attention to the fact that many of the students of past times were professors of the Faculty to-day—a fact, he remarked, that should be a stimulus to the labours of all undergraduates.

Dr. Shepherd then proposed the *Class of '85*. He explained that it was a theme which he should be peculiarly fitted to do justice to, as he had been connected with that class more than any other, and, after mentioning, as a cause for congratulation, the increase, instead of decrease, in numbers which the system of a four years' course, with compulsory summer session attendance, had induced, concluded with a cordial hope that the class would "weather the March gales of 1885."

Mr. M. C. McGannon responded in behalf of '85 in an exceedingly eloquent and graceful speech. He traced the history of the class from its first year to the present day; described the aspirations with which they met together for the first time, the unanimous agreement that an M.D., C.M. was the *summum bonum*—their motives being probably as many and varied as their numbers and characters, that while some saw incident to that degree a life of ease and enjoyment, others took it but as a rung in the ladder of ambition and wealth, while others, again, for the higher reason that "nothing so nearly pertains to the gods as to relieve suffering." In proceeding with the annals of the class he alluded to its agency in rectifying the defects in the chair of *Materia Medica*, and made a touching reference to the loss that the Faculty had sustained in the deaths of two of its oldest members. He concluded by a graphic contrast between the former dinners and those of the last three years, upon which the Faculty have shed the lustre of their presence.

The *Freshmen* were then proposed by Dr. Stewart, and their importance to the college as a class of the gentlemen who annually "go, to leave mama and see the show" was demonstrated. From the unprecedented numbers of the present class he augured a brilliant outlook for the prospects of McGill, and gave some good advice as to the object and direction of their reading, pointing out that it should tend to a wider knowledge of medical research than would barely suffice to enable them to scrape through their examinations.

Mr. Holden responded to the toast. After returning thanks for the complimentary reception of the toast, he expressed the feelings of all the students present, we are convinced, by a strong advocacy of the merits of a University Dining Hall, the want of which, he contended, robbed the daily intercourse of students of much of that sociable character which it should possess. After a passing tribute to the advantages to be gained from a more decided interest in college sports, especially football, and also from the Medical Society, he referred to the lack of interest which appeared to be taken in the *College Journal*, a neglect which he advised the students to rectify.

The toasts of the *Ladies* and the *Press* were then duly honored, and a very successful entertainment was brought to a close.

—The well-known and justly celebrated physician, Dr. For-
dyce Barker, of New York, has recently been subjected to considerable annoyance at the hands of certain members of the Academy of Medicine, of which he happens this year to be President. The charge made was that he had been in the habit of signing himself "M.D., Paris, 1845," and that he had sworn falsely to that signature, having no right to the title. Dr. Barker proved, however, most conclusively that while in the midst of his examinations in Paris in 1845, he was called home owing to the alarming illness of his wife's mother. He had done so well, however, that Prof. Orfila, Dean of the Faculty, informed him that a diploma would be forwarded to him. It was lost sight of, however, till 1861 when his friend Trousseau looked the matter up and found the missing parchment in the office of the Minister of Public Instruction. Fortunately a number of

Dr. Barker's personal friends saw and examined the diploma after its arrival in New York, because by some misadventure this with other valuable papers was lost in the following year when moving from one house to another. Although over twenty years had elapsed, two of Dr. Barker's friends who saw the diploma, Drs. Smith and Doremus, could recall many of the facts and circumstances connected therewith, and both declared positively that the date of the diploma was either 1844 or 1845. Dr. Doremus was struck with the name of Orfila on the diploma because he was so familiar with it in his toxicological studies. The committee, after a lengthy and impartial investigation "decided unanimously that the charges were not sustained."

This attack is an outcome of the unfortunate Code troubles of a year ago. The amount of venomous spite and undying malevolence which these seem to have worked up in the bosoms of certain of the leaders on that occasion appears absolutely incredible. However we trust that this is an end of such baseless slanders, and meantime we take the opportunity of congratulating Dr. Barker heartily on the handsome vindication he has received.

—We have received the prospectus of a new medical monthly called the *Annals of Surgery*. It is to be devoted entirely to surgery and is intended to be representative of the "Surgical thought and work of the present day." The journal will appear on the first day of each month, simultaneously in the United States and Great Britain. It is in a way a successor of that admirable periodical which appeared for several years, the *Annals of Anatomy and Surgery*. It is to be edited by L. S. Pilcher, M.D., of Brooklyn, N.Y., and C. B. Keetley, F.R.C.S., of London, Eng., assisted by a large staff of collaborateurs. Among these latter are many well-known British and American surgeons. This is the first attempt, as far as we know, to publish in the English language a periodical exclusively devoted to surgery. We wish the enterprise every success and feel sure that it will be supported by both British and American surgeons. The American publishers are J. K. Chambers & Co., at St. Louis, Mo. Subscription, \$5.00 per annum.

As we proceed to press, the first number of the "Annals" has been received, and will be noticed in our next.

—The columns of our contemporary, the *Atlanta Medical & Surgical Journal*, for the past few months have afforded its readers some *lively* reading in the form of a discussion between Dr. Hammond of New York and Dr. Hopkins of Thomasville, Ga. Dr. Hopkins took a patient to see Dr. Hammond, and in the October number gave a description of the visit, mode of examination, &c., which certainly places the New York consultant in a most unenviable light. He came out also with several of the stories which are current about the doctor, and referred to his unfortunate army experiences. In the November number Dr. Hammond makes a pretty fair defence, to which Dr. Hopkins rejoins, asserting the truth of his previous statements, and using very strong language, too strong, indeed, for a man with a very good case. Indeed this Hopkins-Hammond controversy bids fair to illustrate again, as in the Hammond-Grissom quarrel, the richness of the English language in expletives and denunciation.

Obituary.

DR. DARLING, F.R.C.S., Eng., died in New York on the 24th ult., aged 82. He was born in Dunse, Scotland, went to the United States in 1830, and, after a life of some years as a tutor, studied medicine at the University of New York, where he graduated in 1842. He had previously, as early as 1824, been a student at Edinburgh, but from some cause his studies were at that time interrupted. He became Demonstrator of Anatomy at his school in 1845, and for years assisted Professors Pattison and Mott. In 1856 he went to England, passed the membership of the Royal College of Surgeons, and in 1866 passed the Fellowship, and the same year was appointed to the chair of anatomy in the University of New York, which position he occupied until his death. He was also Lecturer in Anatomy at the Vermont School. He was a bachelor, and lived a very secluded life in the rooms at the University. As an anatomist, he was a good teacher, but the science has not been much enriched by his contributions; indeed, his papers were very few. In the class-room, a great knowledge of anatomical literature enabled him to make the lectures exceedingly interesting. He had col-

lected a large and valuable museum of osteology, and his rooms reminded one of the descriptions of the dens of old 16th century anatomists. Socially, Dr. Darling was a delightful companion, and at table could monopolize, to the pleasure of all, the conversation for hours at a time. His stories of the olden days in Edinburgh, in 1823 and '24, and of Mott and Pattison in New York in the thirties, should have been transcribed. They cannot possibly be replaced now. But when the "wee sma' hours" arrived, under the genial stimuli of good toddy and good fellowship, he had, indeed, "a ready, swift and tuneful tongue," and would quote from Burns and his favorite poets in a most telling and dramatic manner. He had considerable poetic gifts, but the statement made in some journals that he was the author of the celebrated anonymous poem on a skeleton, beginning

"Behold the ruin! 'Twas a skull,"

must be erroneous, as it was found in 1807 in the museum of the College of Surgeons. He and Dr. Ransohoff of Cincinnati were the only Fellows of the Royal College of Surgeons in the United States.

—Poor Mahomed! cut off at the early age of 35, and in the very middle of his work. Usually in London a man at that age has scarcely yet been heard of, but Dr. Mahomed had been well-known to the profession for the past ten years, so rapidly did he come to the front after his graduation. Being an able microscopist he began early to do original work in connection with the pathology of the kidney, being associated latterly in this line of research with Sir W. Gull and Dr. Sutton. He also assisted materially in bringing the sphygmograph into its present prominent place among scientific instruments. He was originally connected with St. Mary's Hospital, but about six years ago became Registrar of Guy's, and later one of the Assistant Physicians. He married early in life and leaves a widow and five children apparently totally unprovided for. However, the profession in London are subscribing handsomely towards a fund, and already we notice that over thirteen hundred pounds have been raised. Dr. Mahomed died of typhoid

fever contracted in all probability when doing duty at the London Fever Hospital, of which he was one of the attending physicians.

Personal.

We have much pleasure in recording another success scored by our esteemed young colleague Dr. R. J. B. Howard. He has recently obtained the Fellowship degree of the Royal College of Surgeons, England. We congratulate him on the high position he has taken and hope he may long be spared to wear his laurels.

H. V. Ogden, B.A., M.D. (McGill, '82), has been nominated Lecturer on Materia Medica in the new School of Anatomy and Surgery to be opened in Milwaukie, Wis., next March. Dr. Ogden, when a student, gave promise of a fine career, and, we feel sure, will fulfil the expectations of his friends and prove a capable teacher.

Dr. W. T. Duncan, of Fergus Falls, Minnesota, was in the city the other day. He and his partner, Dr. McLean, appear to have the bulk of the professional work to do in that section. Being the only physicians in the place who voted the democratic ticket, they are waiting anxiously for Mr. Cleveland to move into the White House, as they expect him to do the handsome thing by them in connection with two or three fat appointments at present held by republicans. We wish the latter no harm, but we hope our friends won't be disappointed.

Dr. O. C. Edwards, our old and esteemed friend, is now here all the way from his last camping ground, Indian Head, N. W. Territories. He has returned to civilization with his family, intending to spend a couple of months. He speaks feelingly of the weather up there, the thermometer being 50° below zero when he left Indian Head. However, the cold is of that peculiarly dry character which makes it more tolerable than with us. The doctor has been studying the habits and customs of the Indians and is known for hundred of miles around as the "Big Medicine Man." He thinks the country has a great future before it.

Our recent colleague, Dr. Osler, paid a visit to his old haunts last week. His many friends in Montreal were glad to see him. He appears to like his new home, and speaks highly of the profession as a body in Philadelphia. The class of which he has charge in the University of Pennsylvania numbers about two hundred and fifty. As was anticipated Dr. Osler is much missed by the profession of Montreal, but more especially by those members comprising the Medico-Chirurgical Society. Here he was *the* pathologist, and was ever bringing forward something new and interesting in connection with that department. Having also a large clinical experience from his connection with the Montreal General Hospital, his remarks in the discussion of medical subjects always commanded attention. We notice that already he is taking a leading part in the transactions of the Philadelphia medical societies.

Medical Items.

—We note in recent exchanges four fresh cases of chloroform poisoning. Why won't you use ether?

—St. George's Hospital, London, has received a bequest of \$500,000 from the late Mr. William King.

—In some districts of Russia, the number of the blind amounts to two per cent. of the population.

—In Calcutta, during the month of April, there were 486 deaths from cholera.

—A child recently born in West Troy has three perfectly formed legs, the third protruding above the right hip.

—The *Boston Medical & Surgical Journal* has changed publishers, and hereafter will be issued by Cupples, Upham & Co., Washington street.

—Dr. J. Sutherland, of Bedeque, P.E.I., reports a case of triplets. The children weighed 6, 6½ and 7¼ lbs. respectively. Mother and children all doing well.

—We regret to observe in the daily papers the announcement of the sudden death of Mrs. Gerald O'Reilly, of Hamilton. Mrs. O'Reilly was the widow of a well-known and highly respected physician of Hamilton, and three of her sons are now

practising the medical profession in this country, viz. : Dr. Chas. O'Reilly, Superintendent of the Toronto General Hospital ; Dr. Gerald O'Reilly, of Fergus, Ont., and Dr. Edward O'Reilly, of the SS. *Peruvian*.

—Dr. Schweninger, Bismarck's nominee to the Berlin chair of Dermatology, seems to be having a lonely time of it, seeing that not a single student has yet attended one of his lectures.

—A Chinese doctor is practicing with great success at Deadwood. Patients come from all surrounding towns, and their remains are often sent home to their weeping friends by express.

—Dr. Meredith, Thornton's assistant at the Samaritan, has done fifty ovariectomies in the past three years with a mortality of eight per cent. He is in the habit of taking every antiseptic precaution including the spray.

—Dr. Brownlee, of Kansas, treats epistaxis after a novel and most ingenious method. He introduces a condom into the bleeding nostril by means of an elastic catheter. Then he fills the condom with ice water, removes the catheter, and closes the mouth of the bag. The cold and pressure combined never fail to arrest the hemorrhage. The plan looks to be a good one, and certainly deserves a trial.

—The unfortunate Dr. Rabbeth, who recently came to an untimely end from madly attempting to empty a trachea of diphtheritic membrane by sucking it through a tracheotomy wound, is to have a tablet erected to his memory in University College. A "Rabbeth medal" is also talked of. The desire to become immortalized is so strong in the bosom of many that we shall probably now often hear of similar cases. We warn these, however, that they all can't expect a medal or a tablet costing a thousand dollars—times are too hard.

To pass the œsophageal tube sometimes is found very difficult, and dangerous delay may often be occasioned when the stomach-pump is required in cases of poisoning. In such cases the attempt is generally made to pass the tube with the patient in the dorsal position, and its passage is frequently obstructed at some point in the œsophagus. This annoying difficulty usually may be overcome by holding the patient in the upright position during the passage of the tube. We do not know the author of this procedure, but remember having seen it successfully carried out in Bellevue Hospital, when all attempts to pass the tube, with the patient in the dorsal position, had failed.—*Chicago Medical Review*.

—The following “gem of purest ray serene” has been forwarded us from Berhampore, which, we take it, is somewhere in the Madras Presidency. It is the duty of the tahsildar (head man of the village) to send in to the collector or head officer of the district a periodical return of all diseases, births, marriages, deaths, &c., in his village. In one of these returns the collector discovered that there were no births shown and called upon the tahsildar for an explanation. He replied, “Your honour will find the births included under the heading ‘Bowel complaints.’”

—At a recent meeting of the Northumberland and Durham Medical Society (*Med. Press and Cir.*), Dr. Drummond, of Newcastle, demonstrated a new physical sign which is likely to be of great diagnostic importance in thoracic aneurism. When a patient suffering from aneurism of the thoracic aorta is made to draw a long breath (inspire deeply), and then close the mouth and expire slowly through the nose, short puffing expiratory sounds are heard—synchronous with the systole of the heart—on auscultation of the trachea. Dr. Drummond believes this phenomenon to be due to the sudden systolic expansion of the sac expelling air from the chest. He has found it absent in cases of aortic valvular disease simulating aneurism.—*Louv. Med. News.*

—Dr. Oliver Wendell Holmes has been making some calculations, through which the magnifying power of the achromatic microscope may be the more clearly conceived. Estimating from the extent to which it magnifies the minutest piece of human skin placed under its lens, the man of ordinary stature proportionately enlarged throughout, would measure just one mile in height—ten times overtopping the loftiest of the pyramids and twenty times the tallest of our church spires. His weight would be sixty million tons, and he could take up the Massachusetts State House as he would a paving stone, and fling it into the waters beyond the Boston lighthouse.—*Medical Age.*

—A man went to Bristol, Eng., says a daily contemporary, to stay for a few days with some people, and especially to visit a lunatic asylum in the neighborhood, where a large concert for the benefit of the inmates was given. The visitor found the audience, with very few exceptions, intelligent, appreciative, and, to all outward appearance, perfectly sane. The person who sat next to him conversed so delightfully that he felt compelled to remark: “I beg your pardon, but you are surely not

a—a—resident here?" To which the stranger replied meekly, "Yes, I am." "But," insisted the visitor, "you are not—you cannot be—the least mentally afflicted?" And the other replied, "Well, I have an inconceivable predilection. In fact, you see this piece of chalk. Wherever I go I can't resist the temptation to write bad language on the walls. My keeper has nothing to do but walk behind me with a wet sponge and rub it out, but he has a hard time, for I write very rapidly. I was three damns ahead up to 7.30, and I have just written 'hell' five times on your back!"

—The conveniences of our modern inventions are, to an extent, off-set by drawbacks. For instance, the telephone with the mischievous girl at the central office. A secular contemporary reports the following case: A husband calls up a doctor and tells him his wife has "a severe pain in the back of her neck, and complains of a sort of goneness in the stomach." "She has malarial colic," returns the man of medicine. "What shall I do for her?" asks the now anxious husband. The wicked girl at the central now switched off to a machinist who was talking to a saw-mill man about his boiler, and this is the advice which falls on the husband's tympanum: "I think she's covered with scales inside about an inch thick. Let her cool down during the night, and before she fires up in the morning take a hammer and pound her thoroughly all over, then take a hose and hitch it on the fire-plug and wash her out." The doctor and the husband do not now speak as they pass by, and the doctor has found the telephone too expensive a luxury for further continuance.

AN ABBOT AND HIS ERRING PARISHIONER.—*Lyon Médical* quotes the following edifying tale from the *Journal de Médecine de Bordeaux*. The ecclesiastics, as is well known, have fallen into the bad habit of dabbling in medicine and pharmacy, pretending to know them as well as the Gospels. An abbot named X— was lately the victim of this unfortunate propensity. One of his female parishioners, finding herself in great suffering, consulted a physician in the neighborhood, who regretted to find that she had a well-marked gonorrhœa, and accordingly prescribed copaiba and cubebs in liberal doses. Before taking *these poisons*, the fair one thought it prudent to ask the curate what he thought of them. The latter looked at the prescription and exclaimed, "Balsamics, those are used for the chest. Yours is weak. You can take them." And, generous to the last, he wrote these words across the prescription, "Furnish at my personal expense." The story goes on to say that an occasional

sly laugh is still called up at the apothecary's by a perusal of the indorsement on that prescription.

THE OYSTER TUMOR—A NEW VARIETY.—Dr. Theobold of Baltimore reports the removal by a physician, from the nose of a lady, of a suspicious-looking mass which had apparently sloughed off from its former attachments; the supposed neoplasm being regarded as probably of a malignant character. It was examined with the microscope, and at one of the meetings of a Baltimore society, its histological characteristics, together with the clinical facts, were duly presented. An animated discussion followed, and more than one hypothesis was advanced to account for the unusual features of the case. During the heat of the debate, an inquisitive individual inspected the supposed tumor with more care than others had displayed, and announced that it was a harmless specimen of the "bi-valve" order, familiarly known as the *oyster*. It was half-digested, and had become lodged in the nose during a previous attack of vomiting. This is a forcible illustration of discussions, "long, labored and loud," too often held over imaginary "facts."—*Gaillard's Med. Jour.*

PATHOGNOMIC SIGN OF FRACTURE OF THE NECK OF THE FEMUR.—Prof. Bezzi, after showing in the *Spallanzani* the difficulties and uncertainties which often attend the diagnosis of this accident, observes that at the Milan Hospital a traditional practice exists of exploring, whenever fracture of the femur is suspected, the short space between the trochanter and the crest of the ilium. In place of the considerable resistance which there is produced in the sound limb, through the tension of the tensor facię lataę, there is found, when the injury has occurred, a deep depression, due evidently to the diminution of the tension of this muscle, owing to the approximation of its points of attachment.

OZÆNA.—Any simple treatment which is efficacious in so troublesome a complaint as ozæna is a desideratum. Dr. Gottstein (*Berlin Klin.*) believes that ozæna is due not to a congenital narrowing of the nasal fossæ, but to their being too wide. The current of expired air loses its force and becomes powerless to remove the products of secretion, which, being retained, become fetid. The author has always found a condition of atrophy and anæmia of the mucous membrane of the turbinated bones in ozæna. He has always found advantage in plugging the nostrils with cotton wool so as to allow the passage of air. Under the influence of this plugging the mucous membrane resumes its vitality, and the secretions become normal again, and the ozæna is cured.—*Cin. Lancet and Clin.*