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CANADA

48.

MEDICAL & SURGICAL

JOURNAL.

A Monthly Record of

MEDICAL AND SURGICAL SCIENCE.

EDITED BY

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INDEX TO VOL. XI.

LIST OF CONTRIBUTORS TO VOL. XI.

ALLOWAY, T. J., M.D., L.R.C.S. & P., EDIN.
ARMSTRONG, GEO. A., M.D.
BLACK, DR.
BLACKADER, A. D., M.D., F.R.C.S.
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GOODWILLIE, D. H., M.D.
GRANT, J. A., M.D., M.R.C.S.
HOWARD, R. J. B., B.A., M.D., M.R.C.S.
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OSLER, WM., M.D., F.R.C.P., LOND.
PREVOST, DR.
RODDICK, T. G. M.D.
RODGER, T. A., M.D.
ROSS, GEORGE. A.M., M.D.
ROSS, G. TILLERIE, M. D.
SHEPHERD, F. J., M.D., M.R.C.S., ENG.
SMITH, D. F., M.D.
STEWART, JAS., M.D., L.R.C.P. & S.
VINEBERG, H. N., M.D.
WILLIAMS, JAS. M.D.
WOOLVERTON, A., M.A., M.D.

CANADA
MEDICAL & SURGICAL JOURNAL
AUGUST, 1882.

Original Communications.

REMARKS UPON A CASE OF ULCERATIVE ENDOCARDITIS OF RHEUMATIC ORIGIN.

RAPID SEPTIC FORM.

By GEORGE ROSS, A.M., M.D.,
Prof. Clinical Medicine, McGill University; Physican to the Montreal General Hospital, &c.

[*Read before the Medico-Chirurgical Society of Montreal.*]

B. M., æt. 22, was admitted into the Montreal General Hospital on 4th January, 1882, under care of Dr. Ross. Was a healthy girl till three weeks before admission, when she was taken with a tender and painful swelling of both wrists and one ankle. From history of friends, she had undoubtedly an attack of acute rheumatism, though it does not appear to have been very severe. Received no treatment. No history of a previous attack of rheumatism. One week after the attack of rheumatism, or two weeks before admission, began to have severe chills, sometimes several in a day, and her friends thought she was more feverish, with bad headaches, but no delirium. Rheumatism getting better. From this time till her admission, had occasional chills, fever, headache, and altogether appeared so sick that her friends had her taken to the hospital. No delirium before admission.

Jan. 5th.—Patient has been delirious since her admission; at times delirium is wild, and she appears quite frightened, but the greater part of the time lies quietly in bed, and will answer questions, but does not appear to remember anything of her previous history. Takes a fair amount of liquid nourishment. Tem-

perature 100°F.; pulse 120 to 140, is full and collapsing. Heart apex beat is very strong, and felt in 4th interspace, just under nipple. A double murmur heard up and down sternum, and as far out as apex one can hear the systolic murmur; it is soft and blowing. No murmur at apex. Distinct pulsation of all the superficial arteries of any size, even to dorsalis pedis. Abdomen full and flaccid; no spots or tenderness. Tongue red, not coated. Lungs normal. No albumen in urine.

Jan. 6th.—Last 24 hours has been mostly delirious, at times wildly; at other times lies quietly, moaning lowly, as if in pain. Part of time was perfectly quiet. When asked, says she has no pain in head. No paralysis. Pupils moderately dilated, and when exposed to light oscillate a great deal. Pulse 135; temperature 102°F. To have Tr. Digitalis ℥ v: Pot. Brom. gr. x, every six hours, and an ice cap to be applied to head.

Jan. 7th.—Not so delirious last night. Pulse 130; temperature 101 1-5°. Point of max. intensity at third left costal cartilage, very distinct over whole precordial area, and as high as right sterno-clavicular articulation. No murmur at apex. Pupils about normal, and not dilating so much.

8th.—Still delirious, though getting quieter. No change in heart. Pupils widely dilated and oscillating very much.

9th.—Delirium last 24 hours of a more restless character; patient getting out of bed. Pupils oscillate from a pin's point to widest extent. Had three loose, dark stools, passed in bed. Slight vomiting. Pulse 125; respirations 20; temperature 102°F. No change in pulse or murmur. Has considerable diarrhœa.

11th.—Delirium the same, though she still appears conscious when spoken to. Murmurs considerably louder, though confined to same area. Pulse 128, and is failing in strength; respirations 28; temperature 101°F. Last evening patient was found to have some difficulty in swallowing, and on examining the throat a greyish membrane was found covering the edge of the soft palate and base of uvula. A quantity of secretion in the back of throat and the restlessness of patient prevents a good view of tonsils and pharynx.

12*th*.—Membrane on soft palate rather more extensive. Was very restless during the night, but to-day lies very quiet, with head turned towards right side, and eyes staring straight ahead. This has been noticed for a couple of days. Pupils oscillating. Temperature 103°F.; pulse 148; respirations 44.

13*th*.—Patient was not so restless during the night, and to-day appears more rational than she has been yet. Great difficulty in swallowing, and some of the liquids regurgitate through the nose. No change in membrane in throat. Pulse is 136 to-day, but decidedly weaker; respirations 42. Pupils not oscillating. No change in murmur. Urine examined every day, no albumen. Not much change noticed in her condition during the day, but towards midnight appeared to have some difficulty in her breathing, and died very suddenly.

Autopsy.—Body well nourished; no petechiæ. Heart not enlarged. The affection was confined to the aortic valves; the left anterior segment presented most extensive loss of substance, the greater part of the body was gone. Between the base of this segment and the attachment of the anterior flap of the mitral was a large ulcerative excavation, into which the tip of the thumb could be inserted. This passed back to the left auricle, where it was shown by four tuberous elevations near the septum. No infarcts in spleen, moderate enlargement. None in kidneys. In brain, eight or ten infarcts size of peas and one the size of a cherry in the right sulcus calloso-marginalis. The others were chiefly in the frontal lobes. Extensive diphtheritis of pharynx, larynx, and trachea.

Remarks.—There are a few points arising from this case which may, I think, be brought to the notice of the members. First, the *diagnosis* was here perhaps unusually difficult, for several reasons. One was that when first seen the patient was delirious, and we knew absolutely nothing of the nature of the onset of the severe symptoms witnessed. I then found this: a young, healthy-looking woman with high fever, flushed face, quick pulse, and active delirium. She was first naturally examined with reference to either typhoid fever or cerebral inflammation, or an acute pneumonia. Against the idea of fever was

the absence of any local abdominal signs. The belly was not full, and she did not flinch from pressure upon it, and there were no spots; the tongue presented none of the usual furred condition. As against an acute meningitis, as far as we could get from her, she had no pain in her head, nor did she cry out or moan like a person so affected, nor had she vomited since the hour of her admission. Examination of the chest showed no signs of pneumonia; but examination of the heart showed a moderately loud double blowing murmur in the aortic region. The condition of the circulation also showed that there was decided aortic regurgitation. The pulse was markedly collapsing, and even distant arteries could be plainly seen lifting from their beds and falling back. As soon as this was found, suspicion at once fell upon the heart as the organ primarily at fault. Still, without a history of the attack a positive opinion could not be formed. The heart disease might have been of old standing—(the only thing against this was the absence of dilated hypertrophy of the left ventricle). From the friends we learnt the following day, as I have already stated, that three weeks previously she had a well-marked, though not at all severe, attack of rheumatism; at the end of the second week of which, and when the pains were much relieved, the fever set in—repeated chills were a marked feature at the outset, and fever, weakness and general disturbance had continued from that time. We also learnt another specially important fact, viz., that she had never suffered from rheumatism previously. Well, then, we argued, if this patient has developed such well-marked valvular disease in such a short time, it must have been produced by the destructive form of endocarditis, and that diagnosis was made. Even then another question arose, and one which I found it rather difficult to decide positively: Was there any meningitis associated with it? I know how frequently this condition is associated with it, and, in fact, it occurred in the first case of this kind I met with. And in the present case you may have noticed in the report that a day or two later, as the delirium subsided somewhat, she lay with her head in a fixed position, and with eyes staring at a fixed spot. The pupils also oscillated exceedingly; but in the absence of the

more marked cerebral symptoms already alluded to, I was always inclined to doubt the existence of any meningeal complication, and the autopsy showed that such did not exist.

Second, The *form* of the disease. The two forms of this disease which are commonly described by writers are the *pyæmic* and the *typhoid*. Of the latter form I recently reported a case to this Society, which no doubt many will remember. In the *pyæmic* type, the range of fever-heat simulates that of pyæmia from traumatic causes. Shiverings—these often at regular intervals, like ague. Metastases are very common. Petechiæ or pustules are seen. There are diarrhœa, swelled spleen, albumen in the urine, and generally some of the physical signs of valvular disease. In this case the range of temperatures was continuously pretty high; there were none of the fluctuations which are so often characteristic of it. In this disease there is no doubt a poisoning of the general system, as in septicæmia, from various causes, and the symptoms of this systemic infection will vary according to the manner in which the poison is introduced. If slowly, then a gradual typhoid state is induced, with perhaps occasional exacerbations as a rather larger dose is thrown in. If suddenly in large quantity, then violent indications of this toxic state are produced at the outset, and a rapid pyæmia soon brings about a fatal termination. It is to be noted also that even this most rapidly fatal course may be taken without any of the local internal derangements brought about by the detachment of emboli and the consequent infarctions in various organs. I am not aware that any attempt has yet been made to show, if possible, upon what local differences these two forms depend: Why one man with an extensive valvular lesion and immense fungous growths lives for many weeks, dying only in a state of utter exhaustion and emaciation; and another, with perhaps much less local trouble, is cut off very quickly, with indications of an overwhelming poisonous dose having been received.

Third, The association of this disease with acute rheumatism. The statement is made by nearly all the authors that septic endocarditis is *often* the direct result of acute rheumatism. But it is a singular fact that when Dr. Osler came to analyse all the

reported cases he could find, it was shown that only a very small per cent of the whole were so associated, from which he inferred that this statement could not be supported. However, three cases which have recently come under my own notice were certainly directly preceded by inflammatory rheumatism. There would seem, though, to be no kind of connection between the severity of the rheumatism and the outbreak of this septic disorder. In this case the attack was said to have been mild—so much so that she had no treatment for it.

Fourth, I would note that this patient never had rheumatism before, and had been in excellent health; had therefore had no known symptoms of valvular disease; and then that the autopsy showed that all the parts of the valve-segments, except that directly involved in the fungating and ulcerating disease, were quite normal. It affords us therefore an example of a *primary* affection. Several cases which I have seen in the practice of the General Hospital have been subsequent to diseases of the valves of old standing, and this fact has again been recently insisted upon by Dr. Goodhart in a discussion at the Pathological Society of London.

Fifth, The occurrence of *Diphtheria*. During the course of this autogenous pyæmia, well marked diphtheria was seen—on the soft palate, tonsils, pharynx, and inside the larynx. Did this sick woman contract the disease in the Hospital? Several cases were there, and some in the next ward had recently suffered from it. It was therefore possible. But I do not think it was likely. Diphtheric exudations do occur in persons the subject of septicæmic states. They may occur in a great many parts, and, of course, amongst these, upon the parts usually the site of the contagious disorder. Coming on as it did here, this was most probably the case in our patient. If this explanation be the correct one, was that throat a source of contagion? It *may* have been, but as it was particularly inconvenient to have her isolated, this was not done, and, certainly, no ill effects followed from it.

The following case, previously observed, is worth recording, as furnishing for comparison a good example of the typhoid type sometimes assumed by this disease:—

Case of Ulcerative Endocarditis—Typhoid symptoms, somewhat prolonged duration—Death—Autopsy.

H. M., æt. 38, admitted under Dr. Ross, 8th Sept., 1881. Good family history: no tubercular antecedents. Always had good health until his present illness. About one month ago began to complain of chilly feelings, with fever and sweating; weakness, pains in the knees, loss of appetite, and some vomiting. During second week had one attack of epistaxis. Kept going about until ten days ago, when a physician told him he had fever, and ordered him to bed, with low diet. He then had increased weakness, and began to suffer from severe pains in the joints. For this he used a strong liniment of hartshorn and oil, with which he severely blistered the skin around them. His wife thinks that the parts were not swollen or red. During the whole time he has had almost constant fever and general feeling of *malaise*; a relaxed condition of the bowels, but no diarrhœa.

Status Præsens.—Patient looks dull and heavy; face slightly flushed; pupils not dilated; tongue moist and coated of a dirty whitish-brown. Complains of pain, of a stitch-like character, in left lower costal region. Abdomen not distended; no tenderness nor eruption. Heart apex in 5th space, dulness normal; a loud whiffing, somewhat musical murmur is heard at the apex—systolic—and transmitted as far as the mid-axillary line and to the ensiform cartilage. At the base the first sound is indistinct, and the second is sharp and flapping, followed by a suspicious murmurish sound. Temperature 100½°; pulse 102. No swelling in any of the joints. Urine normal.

The condition as thus described continued without material change for some time. No chills are mentioned, but the fever ranged high, with marked remissions—sometimes to normal or even subnormal in the mornings. The state of prostration marked. On the 15th, tongue very dark-brown in the centre. Iliac tenderness (?). Three stools in the day, loose, watery, yellowish-brown. During the next week the temperature ranged from 100° to 103°; no chills; weakness increased; tongue moister; perspires very freely, specially at night; some pain under left ribs, where, also, tenderness is considerable. Pulse 90 to 100, intermittent.

On Oct. 3rd, fever and prostration continue; not so much sweating. The mitral systolic murmur is now heard all round the left side to the spine; it is very loud at the back. The slightly prolonged and altered second sound is heard as before.

Oct. 6th.—Temperature now remains without much variation, about 102°. Slight delirium at night. Small quantity of albumen in the urine. Pulse more irregularly intermittent, getting very weak.

Oct. 10th.—Nocturnal delirium. Great tenderness of skin over toes of left foot. Stiffness and pain in right wrist and elbow. Pulse weak and intermittent.

Oct. 14th.—An eruption of small petechial spots over the abdomen.

From this time rapid exhaustion set in, with increasingly feeble pulse; rather lower temperature, 99°–101°; delirium; stupor; occasional sweatings, and he died on the 23rd.

Autopsy.—Body emaciated; a few cutaneous petechiæ. Heart was a little enlarged. Both mitral and aortic segments presented ulcerative vegetations. On the mitral, the anterior segment was the seat of a recent valvular aneurism the size of a cherry, the orifice on the ventricular face rough and covered with many vegetations. The two anterior segments of the aortic valves were united and thickened; the single segment was the seat of numerous soft, greyish vegetations, one of which hung by a very slender pedicle. Left ventricle a little hypertrophied. Spleen weighed 300 grms., and presented six or eight infarcts; one, the size of a billiard ball, had suppurated. No infarcts in kidneys. No special changes in lungs, brain, or other viscera.

ABSTRACT REPORT OF THE FOURTH ANNUAL CONGRESS OF THE AMERICAN LARYNGOLOGICAL ASSOCIATION.

By GEORGE W. MAJOR, B.A., M.D., &c.,
Instructor of Laryngology and Diseases of the Throat, McGill University;
Out-Patient Physician to the Montreal General Hospital;
a Fellow of the Association.

The American Laryngological Association held its fourth annual meeting in the Hall of the Medical Library Association,

Boston, June 12th, 13th and 14th; Dr. Knight occupied the Presidential chair, the vice-chair being filled by Dr. Shurley, the First Vice-President.

The President opened the proceedings with the usual address and referred at length to the progress of Laryngology during the past year, which he considered satisfactory. At the International Medical Congress in London the subject, though only allowed a sub-section, produced papers and discussions universally admitted to be among the very best of the Congress. Several of the Universities had recognized the study by the establishment of Professorships, though lack of time would prevent much prominence being given to the subject. Though the advance had been satisfactory, it was capable of much greater development. He pointed out two distinct duties that should be held in mind: one to foster the specialty and improve it—the other to the general profession and the community in which we live to make our knowledge of the greatest benefit to mankind. The first of these duties were discharged by our individual studies and researches into the nature of Laryngeal and allied diseases and the proper method of treating them, by our contributions to special journals, and by our papers and discussions in this Association. The second duty involved the consideration of the best means of ensuring that amount of knowledge of our specialty, particularly of the methods of examination which every practitioner of medicine should possess. The community were not slow to learn the real advances in our art, and were now pretty generally aware that a physician was not fulfilling his duty to them when, for instance, he gave an opinion on the cause of hoarseness and prescribed a remedy for it without using the Laryngeal mirror. An important point was to teach the intelligent use of the instrument. If a student neglected the acquisition of the use of the Laryngoscope during pupilage, he would not likely acquire it afterwards. Continual personal and individual supervision was inadmissable. Large classes of men could not be instructed at once, and demonstrations—the most valuable and practical part of the instruction—could not be enjoyed by more than three or four at most at a time, and, consequently, the labor of the teacher became ardu-

ous from its oft-repetition. He advocated the four years' course as sufficiently short a time in which to acquire a well-rounded medical education and deplored the commercial character of too many of our modern schools, and expressed the hope that the rendering of teachers independent of class fees, by the introduction of endowments, would some day remedy the prevailing evil of competition for students, so detrimental to modern medicine.

Among many other topics he referred, in concluding his address, to the Association, its meetings and papers, and the good-fellowship and cordiality that had thus far characterized its gatherings. The Association had limited its fellowship to recognized teachers in leading schools, not to exceed fifty in number, a figure now attained, and he hoped that should vacancies occur by any means that the *personnel* would still be jealously maintained. He then introduced the papers of the day, and wished the Fellows a pleasant and a profitable session.

"Paralysis of Muscles of the Larynx," by Dr. Elsberg, of New York, was the first announced. This paper, like all others emanating from the pen of this talented gentleman, showed great detail and thoroughness of research and originality of thought. He had for many years named the laryngeal muscles from their position as well as main action And in regard to the action of the intrinsic muscles gave it as his opinion that the thyroid cartilage was fixed relatively to the movement between the several parts of the larynx. He gave the muscles influencing the vocal bands as follows :—

1. Anterior muscles, the thyro-cricoid ; tensors of the vocal bands.

2. Interior muscles, the thyro-arytenoid; straighteners of the vocal bands.

3. Transverse muscle, the arytenoid ; transverse adductor of the vocal bands.

4. Lateral muscles, the lateral crico-arytenoid ; lateral adductors of the vocal bands.

5. Posterior muscles, the posterior crico-arytenoid ; abductors of the vocal bands.

Those whose anatomical names were derived from two cartil-

ages, the first two and the last two muscles, were bilateral; those whose anatomical name was one word, was a single muscle. The first four may be grouped together as constrictors, or narrowers of the rima. The fifth comprises the group dilatators, or wideners of the rima glottidis. Paralysis of the constrictors of the rima glottidis caused "phonatory leakage" of air (Elsberg), paralysis of the dilatators "respiratory insufficiency;" in the former case the characteristic laryngoscopic image was obtained in the examination during efforts of phonation; in the latter during respiration. In each of the isolated paralyses of, and in combined paralyses confined to, the constrictor muscles, respiration was not directly interfered with; nevertheless, in all severe cases the patient suffered from easily getting out of breath on account of the leakage of air, while in the isolated paralyses of the dilatators, the voice, though never extinct, is not clear and pure on account of incomplete fixation of the arytenoid cartilages. He proposed a scheme for deciding by the shape of the gape the form of the paralysis and the muscles engaged. Though very ingenious, it would require very deep thought for its mastery. Among other interesting points he further stated, that, when in injury or disease of either the brain or the pneumogastric, spinal accessory or recurrent nerves, laryngeal paralysis is or becomes incomplete, a very curious and yet unexplained fact has been observed, viz., that the abductor filaments are more prone to be affected than the adductor filaments, and that if, in a case in which both the abductors and the adductors are affected, recovery takes place, the adductors are apt to recover first or exclusively, and to be affected with abnormal contraction, so that the patient during the progress of recovery is in danger of a dyspnœa, which might necessitate tracheotomy to prevent death. The relatively greater disposition to implication of the abductor filaments is well known to laryngologists, but the relatively greater disposition to recovery of the adductor filaments under these circumstances seems to have been unnoticed until Dr. Elsberg himself called attention to it. In the discussion that followed some exception was taken to calling the thyro-arytenoid muscle a

straightener of the vocal bands—it was true it was only one of its functions, but as such it had been *tacitly* recognized by every laryngologist. When these muscles were paralyzed the vocal bands were concave, and when in action straight. If one of the functions was not to straighten the cords, Dr. Elsberg was at a loss to account for this fact. Space prevents the minute detail this paper so well deserves, and which, to do the author justice, it would require.

"On Laryngeal Asthma," by Dr. Glasgow, of St. Louis.

Dr. Glasgow claimed that the dependence of bronchial spasm upon laryngitis had not been previously noticed. Several writers on asthma had described such cases without really recognizing the true seat of irritation: and had universally included the condition under the term Bronchial Asthma, presupposing the point of irritation to be located in the bronchi. They had, in some of these cases, noticed that the signs of bronchial inflammation only become apparent after the asthma has existed for some time. Such cases he considered primary laryngitis, with subsequent extension to the bronchi. Under laryngeal asthma he would not include those symptoms so often met with in laryngitis, such as laryngeal whistling, laryngeal râles, and the sensation of suffocation which is often found accompanying an inflammation and œdema of the posterior surface of the larynx, and would also exclude laryngisum stridulus. His attention was first drawn to the occurrence of bronchial spasm as a result of laryngitis through the unexpected results of an application to the larynx in the case of a child suffering from an attack of asthma. Dr. Glasgow reported at length six cases he considered typical, and said he had met with nine in addition; in all he found two prominent factors, a subacute inflammation of the larynx and bronchial spasm. The condition of the larynx was demonstrated by the mirror, and the bronchial spasm by the physical signs—sibilant and sonorous râles and the prolonged expiratory effort characteristic of the asthmatic. He also found an improvement or a disappearance of the asthma as a result of applications to the larynx. Dr. Glasgow had found relief to be instantaneous in some cases, in others more gradual, and claimed

that we should not locate the point of irritation in the bronchial tubes without some evidence of a pathological change of their mucous membrane. He did not deny the dependence of asthma upon bronchial inflammation, nor that it may coexist with a laryngitis; in such cases the spasm continued after the cough had yielded to local treatment. That hay asthma depended upon irritation of the laryngeal mucous membrane he was convinced, as relief quickly and permanently followed laryngeal applications. Laryngeal asthma he held to be reflex, examples of which were numerous—as nasal asthma due to nasal polyps—cases in which the olfactory nerves play an important part, as in asthma arising from emanations from flowers and animals. The presence of food and a loaded condition of the bowels were well known and recognized causes of asthmatic phenomena. The treatment of this asthma consisted in the treatment of the primary lesion—the laryngitis. The usual remedies had recourse to in asthma may also assist, but the relief they afford will be only temporary, and no permanency will be secured until after the disappearance of the laryngitis.

"On the question of Hypertrophy of the Osseous Structure of the Turbinated Bodies," practically considered by Dr. D. Bryson Delavan, New York. Dr. Delavan stated, in introducing the subject, that in all recent contributions attention had been directed solely to the consideration of the soft parts, while the investigation of the fundamental structure of the organ, its osseous tissue, had been ignored. The object of his paper was to establish the proposition, that *the turbinated bones may, under proper conditions, undergo marked hypertrophy.* Theoretically, the process of hypertrophy might occur in almost any tissue of the body. Hypernutrition was, of course, the occasion of hypertrophy in bone as well as in other tissues, and to such structural changes the bones of the skull were particularly liable. The turbinated bones were not formed until a late period in the development of the fœtus; indeed the inferior turbinated bone was ossified from a single centre, which only appears at birth. This tardy appearance implied activity of development later in the history of the child, and it was not unreasonable to suppose

that occasionally actual overgrowth might occur. Atrophy and hypertrophy, though antithetical conditions, there was no part which being susceptible of the one was not equally so of the other. Atrophy of the bones, in atrophic rhinitis, was commonly met with and conceded; then, under conditions of nutrition exactly opposed, why not the opposite condition of hypertrophy of these bones? The probability was increased when we considered the facilities afforded by the intimate relation between the mucous membrane and the bone through the medium of the membrana mucosa, which not only formed a fibrous network for the support of the vessels but also passed into the periosteum. Dr. Delavan gave, as the conditions favorable to hypertrophy of the turbinated bone—1. Unusual space in the nasal fossæ. 2. Long continued hyperæmia of the structures investing the bone. 3. The existence of the above two conditions during the period of greatest constructive activity.

Too free inspiration of air through the nares will produce turgescence of the nasal mucous membrane, and when long continued, chronic hyperæmia. Persons whose nasal cavities were unusually large were, preferably, subjects of nasal catarrh. In the normal nasal chamber the erection of the tubinated corpora cavernosa was limited by the boundaries of the nasal cavity. The greater the possibility for expansion and the more exposure leading to congestion, the less likely were the soft parts to return to their normal conditions of size and nutrition, and, of course, the greater the hyperæmia of the soft parts the greater the hypernutrition of bone. Commencing early in life, the maximum would not be reached until the adult period. With a spacious nasal fossa, a turbinated body abnormally stimulated, a turbinated bone excessively nourished, and a subject preferably rachitic, in whom the constructive process is at its height, there is no reason in theory why the bones should not increase in size equally with the hypertrophy of the soft parts. The conditions which would best furnish these factors would be congenital, and would be found in cleft palate and in deviation of the nasal septum. Cleft palate was, however, as rare as deviation of the septum was common, so that we may devote our attention to

this latter condition. Deflection of the septum may result at any time during life as the result of fractures or dislocations, or from intro-nasal growth pressure, but these causes were rare. Deviation had been supposed to be due to habitual blowing of the nose. This was not likely, as it occurred in races, especially the negro, with whom the use of the handkerchief was uncommon or unknown; moreover, the curve was seldom, single, confined to the front, but usually double, and extending too far back to be affected by lateral pressure upon the anterior aspect. Reasoning by exclusion, then, the congenital origin of a large number of cases of deviation was evident. The middle turbiated bone was the one most commonly enlarged; and since the septum was in a plastic condition some time after birth, the question might arise, Was the turbinated enlargement due to a deviation, or the deviation the result of the hypertrophy? The latter was negatived by two facts: in the first place, nature is rarely asymmetrical, so that enlarged turbinated on one side would be accompanied by the same condition on the opposite side; and in the second place, the greatest enlargement was found on the side of the greatest concavity. By a very extensive and minute investigation in craniological museums, dissection of fresh subjects, and exploring in the living, Dr. Delavan had been enabled to verify the foregoing conclusions. The middle turbinated was most commonly affected, and the enlargement extended throughout the whole antero-posterior course of the bone; it had nothing about it of the nature of exostosis; the bony plates were of about the same relative thickness as in the normal organ, the whole resembling a natural turbinated magnified in size. In some instances the bone was thinner, when the general symmetrical hypertrophy was by no means constant, but rather seemed to follow the course of the deflected septum. It would be seen that any operation for the relief of the stenosis referred to the septum would only aggravate the condition by increasing the tendency to hypertrophy. Removal of the turbinated bone itself was essential, and must first be effected, then the septum may be corrected, but the reverse order of procedure must not be followed.

Zuckerkandl of Vienna speaks of "a bladder-like expansion"

of the turbinated bone, which would correspond to one of the forms of *dilatation* referred to by Dr. Delavan. Dr. Delavan's paper was timely, and its practical nature cannot but recommend it for perusal and careful consideration, and has undoubtedly the merit of priority.

"On Photographing the Larynx," by Dr. T. R. French, Brooklyn, N.Y. Dr. French has succeeded in securing some very good results. He used sun light—a small camera, mounted on a tripod. The throat was illuminated with a plane mirror with central aperture §in. in diameter. The throat mirror was attached to a flexible rod fixed to the top of the camera. The plates were exposed from one to four seconds; none of the pictures showed the entire larynx. Dry gelatine plates were used, which simplified the matter very much. The great trouble was that when one portion of the laryngeal image was in focus the rest of it was out, so that it was impossible to get a really perfect picture. Schmidt and Stein had both photographed the larynx, but Dr. French's results were superior. The burning magnesian wire or electric light might have been used with some advantage. Field, lately of Montreal, with my assistance, produced, three years ago, some very good pictures of laryngeal cancer. The results were shown to the Medico-Chirurgical Society at the time of my reading my paper on the case.

"Ozæna," by Dr. Bosworth, New York. Dr. Bosworth opened the discussion, for the object of his paper was such, by asking, What was meant by ozæna? The term simply conveyed the idea of a stink—to use a forcible but not an elegant term; a single symptom gave rise to the name, much in the same way as "dropsy" gave rise to confusion in early medical nomenclature. The term ought either to be abolished (the better plan) or else confined to one well known condition attended with offensive odor, rhinitis atrophica. Fetid discharges from the nose occurred under five conditions—1. Syphilitic ulceration and necrosis. 2. Scrofulous ulceration and necrosis (rare). 3. Presence of foreign bodies. 4. Disease of one of the accessory nasal cavities. 5. The late stage of atrophy of the nasal mucous membrane, the rhinitis atrophica

of the Germans. Syphilis and scrofula give rise to typical and characteristic symptoms and morbid conditions, hence he held that whether in the nose, larynx, skin or elsewhere, it was to be considered under its original name. Cancer and lupus give rise to offensive discharges, as do also sometimes diphtheria, scarlatina and typhoid fever, &c., but as the origin of the discharge was easily recognized they should not add to the general confusion. There come under notice very frequently cases of nasal catarrh with a fetid odor, in which there is seen, on inspection, a nasal cavity large and very roomy. The turbinated bones, especially the lower, have nearly all disappeared, and the cavity is lined with greyish green crusts adhering closely to the mucous membrane. The odor is fetid and offensive, but by no means so penetrating as that of syphilis of the nose. If we thoroughly detach these crusts and clean the cavities we find the odor removed, and furthermore we find the mucous membrane intact and unbroken. There is no ulceration, no abrasion and no necrosis. Nothing more remains to recognize the disease but a roomy cavity and shrunken turbinated bones; it is rhinitis atrophica—it is a purely local disease, a catarrhal inflammation of the mucous membrane, and atrophic from the first. The disease commences in early life, in an inflammation characterized by a desquamation of the epithelial lining of the acinous glands. There ensues a marked diminution in the number of glands, and the membrane is deprived of its normal supply of mucus. What is secreted is scanty and soon dries, leaving a thin pellicle, which closely adheres, and is removed with difficulty; it then decomposes and gives rise to fetor. The secretion beneath the pellicle going on is imprisoned, and a new source of fetor is developed. The mucus held becomes purulent and infects the membrane, and a still further secretion of pus results. Under the process of drying, contraction occurs, and the circulation is interfered with, and is still further obstructed by the fresh secretions of pusy mucous under the pellicle. Thus atrophy takes place.

The extent of the atrophy of the turbinated bone may be looked upon as a measure of the duration of the disease. As to the cause

of the disease, Dr. Bosworth knew of none. It occurred, as a rule, in patients in good health; it might involve one or both nostrils, or a portion of one, or both. The treatment Dr. Bosworth would employ might be foreshadowed by what has already been said. While disinfection of the cavities is important, a stimulating treatment will be called for. The fluid used for cleansing should be alkaline, for its solvent effect on mucus; and it should be disinfectant, to correct results of decomposition. Carbolic acid 1 grain with 3 grains each of bicarbonate and biborate of soda to each ounce of water is about the best cleansing fluid. This should be used with a post-nasal syringe, and should be employed twice daily; if syringing will not dislodge the crusts, they must be removed with cotton wool pellet on a proper probe. After cleansing thoroughly, stimulating applications should be made. A radical cure is doubtful if the disease be old. The extent of the atrophy of the turbinated bones is always an evidence of the curability, as it is of the chronicity likewise. For ordinary use, after all fetor has been corrected, common salt is a good and useful adjunct to what has been already recommended.

This paper was one of the most clearly written, most simple as an exponent of the author's views, and as thoroughly in accordance with rational ideas on the subject as any produced at the congress.

BI-MONTHLY RETROSPECT OF OBSTETRICS AND GYNÆCOLOGY.

PREPARED BY WM. GARDNER, M.D.,

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The Treatment of Puerperal Convulsions.—Breus, assistant at Prof. Gustav Braun's Obstetrical Clinic at Vienna, in a paper in the *Archiv. f. Gyn.*, Bd. 19, Hft. 2, gives the results of the treatment of puerperal eclampsia in the clinic by hot baths and packing. The cases selected for this treatment were those in which the presence of albuminuria and dropsy indicated copious sweating. This treatment was not used to the exclusion of nar-

cotics. These were used when necessary to control the convulsions. The results were most favourable. Of six cases so treated, only one died. In this case the kidneys were found in the second stage of Bright's disease; œdema of brain and lungs and cirrhosis of the liver were also present. In some of the favourable cases in which the convulsions came on before the expiration of the full period of gestation, the œdema and albuminuria ceased or greatly abated, and the patients went on to full term. No ill results were observed from the treatment. It appeared in no wise to excite or affect the progress of labour, nor when administered after delivery did the baths have the least tendency to relax the uterus or favour hemorrhage. The puerperium, moreover, was not at all unfavourably affected.

The baths and pack were administered in the following manner:—The sick-room was kept at 20°C. The patient was put in a bath at 38° to 40°C, and this was then warmed up to 42–45°C. by the addition of hot water. The body was immersed to the chin, and kept in the water for half-an-hour; while in the bath, copious sweating of the head and face was noticed. The bed was prepared for the "pack" in the following manner:—Two blankets were spread on it, and over these a warmed sheet. As soon as removed from the bath, the patient was wrapped in a warm sheet, put into bed, and there covered with several blankets, the face only remaining exposed. Copious general perspiration soon resulted, and the pack was continued from two to three hours and repeated daily for as many days as might be necessary. As a result of the treatment, the author concludes that since no ill results followed in these cases, the induction of copious diaphoresis by hot baths and packing is as much indicated in the treatment of puerperal eclampsia as of Bright's disease, in which its value has been long recognized.

Case of Basilysis, by Prof. A. R. Simpson, Edinburgh.—The report of this case appears in the *Edinburgh Med. Journal* for last March. A description of the operation of Basilysis, as proposed by Professor Simpson, will be found in the October (1880) number of this Journal. Briefly, it consists in perforating first the vault of the skull, and subsequently the hard and un-

yielding base, by a suitable instrument, the "basilyst," in order to facilitate the delivery of the head through a contracted pelvis. In this case, after the comminution of the head, its delivery was easily accomplished; extraction of the body was, however, more difficult. Dr. Simpson believes that the result justifies his preference for this operation over cranioclasm or craniotomy. He believes basilysis to be an easy, safe and satisfactory operation. This is the first opportunity he has had of trying the instrument on a child in utero.

Ligatures around the Extremities as a means of Hæmostasis in Uterine and other Hemorrhages.—Dr. J. W. Pryor of Lexington, Ky., in a short paper in the *Amer. Jour. of Obstetrics*, July, 1882, calls attention to this method of arresting hemorrhage. Dr. P. does not claim priority or novelty for this treatment, but asserts that it has been forgotten or neglected. He believes that not only is it a means for hæmostasis, but also for prevention, almost infallible, in cases where, from facts in the previous history, hemorrhagic diathesis, &c., there is reason to fear flooding. The material used by the author is elastic web, one inch wide (taking a somewhat narrower ligature for the upper extremity), with a buckle similar to that found upon the common Arctic overshoe. Unbleached cotton or any heavy material may be used. The mode of application, either as a preventive or as a remedy when hemorrhage has actually set in, is to tie the ligatures around each extremity as close to the body as possible, drawing them tight enough to arrest the return of the venous blood, without materially affecting the arterial circulation. Two cases are given in illustration of the good results of the treatment in puerperal hemorrhage. In three other cases, one of repeated pulmonary hemorrhage and two of intractable epistaxis, the bleeding was speedily controlled by ligatures around the arms until internal remedies had time to act in permanently arresting it. In the case of hemoptysis, several recurrences of the bleeding took place when, by way of experiment, the ligatures were omitted and internal remedies alone given, until the exhausted condition of the patient demanded prompt action. The ligatures were then applied, and the hemorrhage was immediately checked.

The Relation of Lateral Cervical Lacerations to Catarrh of the Cervix Uteri and the Necessity for Emmet's Operation.—This is the title of what I believe to be the most important paper on these subjects that has appeared since Emmet's original papers on Laceration of the Cervix. The author is Prof. Carl Schrœder, of the University of Berlin. He first adverts to the fact that there is a great want of uniformity of good results after the now very frequently performed Emmet's operation, showing, in his opinion, that the indications for the operation are not yet clearly defined. In the great majority of cases, cervical catarrh exists as a complication of the laceration. What is its relation to the laceration? Emmet says it is usually a consequence. Schrœder says, on the other hand, that it is usually the cause. In support of this he argues that deep lacerations, not rarely extending into the vaginal junction, are often found completely healed when we are searching for other conditions. No one would think of performing such an operation with a view of curing cervical catarrh. Any gynecologist of experience knows that the most obstinate cases of catarrh to cure are those in which the cervix is narrow. Emmet himself insists on getting the parts into healthy condition, and devotes, if necessary, several months to this object before he operates.

Are cervical lacerations alone, uncomplicated with catarrh of the cervical mucosa, of sufficient importance to render the operation necessary? In the author's experience, as a rule, they are not. There are exceptions chiefly belonging to the following type: Deep, double-lateral lacerations, with complaints of pelvic pains, increased especially by exertions and straining, and functional disturbances in the use of the lower extremities. In such cases there is usually a pronounced tenderness of the angle of the fissure when touched with the finger or the sound. Ectropion is also considerable, and the author believes that in the main the pains are due to the dragging at the angles of the rents. In a few cases manifold nervous symptoms attend. In such cases it is imperative to undertake the repair of the cervical lacerations. But these are not numerous. It is more difficult to decide in regard to cases in which cervical lacerations and

catarrh are present at the same time. As already mentioned, Schrœder does not believe that the cervical catarrh is due to the laceration. It must be admitted that catarrh of the cervix is common when the os is intact. All that we see before the os is incised is a ring of erosion, with a string of mucus hanging into the vagina. Again, the exposed cervical mucosa does uot tend so much to catarrhal affections as to transformation of its cylindrical into pavement epithelium. This latter condition is frequently observed in prolapsus, in which the lips, to the extent of their eversion and exposure, are often covered with pavement epithelium exactly resembling that of the remaining vaginal mucosa. In support of his position, that the cervical catarrh causes the laceration, the author argues as follows: During childbirth, lacerations of the margin of the external os are of regular occurrence; they are sometimes only superficial, but sometimes they extend deeply into the cervix. As a rule, these heal during the involution, because their margins lie together and adhere, leaving only slight cicatrices. But if their edges do not lie in contact, they will not unite. This non-apposition is produced by the catarrhal, hyperplastic, and therefore everted mucous membrane, which inserts itself into the gap and prevents union; and this is the cause of the great frequency of the complication of cervical lacerations with cervical catarrh. For these reasons the author holds it to be incorrect to neglect the catarrh and to cure the laceration at once by Emmet's operation, and maintains that the catarrh is, pathologically, of the greater importance, and that its treatment must be placed in the foreground. For the same reason Emmet's operation is to be contraindicated while the cervical catarrh persists, because the gaping cervix greatly facilitates the local treatment of the catarrh, and the closed cervix renders it more difficult. He then goes on to say: "The treatment of chronic cervical catarrh, complicated with great tumefaction, deep indentations of the mucosa, and manifold glandular proliferations, however, is difficult, and requires a protracted length of time." Astringents and caustics temporarily improve, but do not readily cure the condition. The hot iron may cure if used energetically. The author has not

tried it, dreading the destruction of the mucous membrane, with the quite uncontrollable cicatricial contraction that may result. He therefore recommends his own operation of excising the diseased mucous membrane, by which chronic intractable cervical catarrh may be quickly and safely treated. The uterus is drawn down as far as possible by inserting a double tenaculum forceps into both lips. A stream of three per cent carbolic solution is allowed to flow over the field of operation during the entire time of its performance. The two lateral lacerations are then incised with scissors even when they extend as far as the vaginal vault. If now the two lips are widely separated, the diseased mucous membrane may be excised to any extent. To this end a transverse incision is made near the level of the internal os, terminating at the lateral incisions on both sides. This incision should divide not only the mucous membrane, but penetrate some distance into the wall-proper of the cervix. A similar transverse incision is then made, likewise extending from one lateral rent to the other, externally, at the extremity of the vaginal portion, or rather in the mucous membrane, at the junction with the morbid portion, and the piece thus circumscribed is excised in nearly a wedge-shape. Sutures are then introduced in such a manner as that the margin of the wound at the extremity of the vaginal portion is joined to the margin of the wound in the mucous membrane above in the cervix. The posterior lip is treated in the same way. It is now optional with the operator how far the cervix is to be united laterally. By this operation Schroeder claims that the catarrhal mucous membrane is removed, excepting a short stump at the internal os, and the lateral lacerations are made to disappear. Thus both indications are met by one operation. The author says of this operation: "I have performed it frequently; I know it to be easy, certain to succeed, and entirely free from danger, and therefore recommend it warmly." He concludes his paper as follows: "My opinion, consequently, is that in cases where there are only cervical lacerations without catarrh, Emmet's operation is indicated whenever troublesome symptoms appear which are referable to the lacerations. In these, unfortunately

rare cases, it is a beneficial, at times almost magically effective operation, and a very important advance in operative gynæcology always to be linked to the name of Emmet. But in co-existing cervical catarrh the latter is of greater importance, and in these cases it is better, instead of first treating the catarrh and then repairing the lacerations, to excise the morbid mucous membrane and to unite the lacerations simultaneously by one operation"—(*American Journal of Obstetrics*, July, 1882.)

Operations for Restoring Complete Lacerations of the Female Perineum through the Sphincter Ani, by Dr. H. T. Hanks, Assistant Surgeon to the New York Woman's Hospital.—The author, after remarking on the difficulties of the operation and its frequent failure, as exemplified by the experience of the surgeons to the Hospital, proceeds to say that he prefers Emmet's operation for all cases where the perineum and sphincter ani only are involved, but that Simon's operation is the best for closing extensive rents of the rectum and sphincter.

Dr. Hanks believes, and his opinion coincides with that of an increasing number of eminent operators, that the principal cause of failure is in the treatment of the bowels. He urges the necessity for securing daily thorough action of the bowels for a full week before the operation. By this method the bowels are thoroughly emptied, and a knowledge is gained of the dose necessary to liquify the evacuations when laxatives come to be given after the operation. Hypercatharsis is thus avoided. After the operation, on the second day, and on each succeeding day till the tenth, the laxative that seems best suited is given in sufficient quantity to produce liquid evacuations.—*N. Y. Med. Record*, July 11, '82.

The Relation of Anteflexion of the Uterus to Dysmenorrhœa.—This was the subject of a paper read before the Obstetrical Society of London by Dr. Herman of the London Hospital. The author first reviews the generally accepted theory that dysmenorrhœa with anteflexion is caused by constriction or temporary closure of the uterine canal at the point of flexion. With reference to the commonly held opinion that the flexion takes place at a sudden angle, as is often shown in drawings, Dr. Herman,

in four specimens in the London Hospital museum, found a gradual flexion, no sudden angle and no dilatation of the cavity of the uterus. He also sought in vain to discover any case in which the menstrual blood had been retained, and dilatation of the uterus induced, when it could be traced to no other cause than anteflexion. Neither could he find any case of pelvic hæmatocele, depending on stenosis of the uterine canal, caused by anteflexion. The most important, as well as the most valuable, part of his paper is the result of his own experience. He asserts that evidence adduced from observations made on subjects who complain of dysmenorrhœa is one-sided. If it be admitted that in many such the uterus is anteflexed, the question may be pertinently asked: "Is the uterus anteflexed also in other women who do not suffer from dysmenorrhœa." It is only by answering this question—that is, by discovering the proportion of women who suffer from dysmenorrhœa with and without anteflexion, and of those with straight and anteflexed uteri who do not suffer from dysmenorrhœa—that the part played by anteflexion in producing menstrual pain can be determined. With this object in view he examined 110 women who sought relief for suffering, other than uterine. He found that out of 57 women in whom the uterus was only slightly or not at all anteflexed, in 40, or 70 per cent., there was little or no pain at the menstrual period, and in 17, or 29 per cent., there was severe pain. Out of 53 women, in whom there was pronounced anteflexion, in 37, or 69 per cent., there was little or no pain at the menstrual period, and in 16, or 30 per cent., there was severe pain. He concludes, therefore, that menstruation is as often painful when the uterus is straight as when it is anteflexed, and that it is as common for menstruation to be painless when the uterus is anteflexed as when it is not anteflexed. The value of observations of this nature is obvious. If the facts proved by Dr. Herman were generally known and believed, the treatment of dysmenorrhœa, as practiced, would be considerably modified.

Membranous Dysmenorrhœa cured by Mercury.—The writer, whose name is not given, relates five cases of this most obstinate complaint which he cured by the drug mentioned. It was by

a rather unpleasant accident that he discovered the efficacy of mercury in cases which, from the known virtues of this agent in all forms of acute or chronic hyperplasia, might *à priori* have been supposed to be amenable to it. In this case the author had dilated the uterus a few days before the period, with a view of relieving the pain. This set up metroperitonitis. For this she was given calomel and opium, and by mistake a much larger quantity of the medicine was given than intended, with the result of producing salivation, but the menstrual flow had also been started without pain or discharge of any membrane. For five years afterwards the dysmenorrhœa had not returned. In four other cases mercury was given in quantity sufficient to touch the gums for a few days previous to the advent of the period, and with the result of curing each one. The remedy certainly deserves a trial in the treatment of an affection which so generally baffles medical skill.—(*Med. Record*, quoted by the *Cincinnati Obstetric Gazette.*)

Iodoform in Gynecological Practice.—Dr. F. P. Foster recently read a paper before the New York Materia Medica Society on the uses of iodoform. Amongst other results he stated that he had found it useful as a sorbefacient in chronic extra-uterine exudations. He applies it to the upper part of the vagina, and then applies a tampon below. This acts mechanically, retaining the vapor. In dysmenorrhœa the drug gives great relief, but does not control the pain in subsequent menstruations. He has found it of great use in pruritus vulvæ and hyperæsthesia of the vulva. He had considerable confidence in its discutient action in cervical hyperplasia.

Drs. Smith, Mundé, Bosworth and others took part in the discussion. Dr. Mundé stated his practice of using the drug in cervical erosions, endotrachelitis, chronic pelvic peritonitis, erosions of the vulva and vagina, and hyperæsthesia in a case of caruncle of the meatus. In each of these conditions he has found it to be most valuable. Dr. Lusk had found it very successful in fissures of the anus. He applied it to lamp-wick, which he draws through the fissure.

Dr. Fordyce Barker has published a case of membranous

dysmenorrhœa of seven years standing completely cured by iodoform to the interior of the uterus. He first dilated by a seatangle tent and then introduced a cone of iodoform every second day to the uterine cavity. This was continued from November to February. In January following the beginning of the treatment she had only a slight amount of pain. In February she had no pain. In March she did not menstruate, and proved to be pregnant for the first time. She had been married six years. Two other successful cases by the same treatment were mentioned by Dr. Barker. These cases are recorded by Dr. B. in the 4th Vol. of the Transactions of the American Gynecological Society.

Dr. Mundé thought that the most inodorous formula is a drachm of iodoform to half a drachm of balsam of Peru and an ounce of glycerine.

Weissenborg recommends the employment of iodoform in the chronic endometritis of chlorotic and scrofulous women, in whom there is reason to fear tuberculosis, cases in which curetting is not advisable. He has devised an instrument to secure the application of a sufficient quantity to the uterine cavity. This consists of a curved syringe of the size of a medium-sized male catheter. The nozzle is provided with two lateral openings. These are filled with the remedy, and when the instrument is introduced to the uterine cavity it is easily deposited therein. No results are given, but further communications are promised. —(*Berlin Klin. Wochenschrift*, 1882, No. 11.)

Dr. J. Mann of Budapest publishes (*Central. f. Gynäkologie*, No. 7, 1882) the results of the use of iodoform at the University Obstetrical Clinic of that city. It was used in 38 cases. At first it was used only to ulcerated surfaces, the result of contusions and lacerations of the passage, the object being to render them aseptic. But soon the remedy was applied to fresh wound surfaces to prevent them becoming septic. The ulcers or wounds are first washed with a two per cent. carbolized water and dried with carbolized cotton. Iodoform in powder is then sprinkled over the surface and retained by iodoform wadding. The iodoform is deodorized by mixing with powdered Tonquin

bean. The author claims the result to be an efficient antiseptic barrier, which permits of the wounds granulating before it is washed away.

Dr. Bayer of Stuttgart (*Central. f. Gynak.*, 1882, No. 10) criticizes Dr. Mann's paper, and recommends in preference salicylic acid and starch, 1 to 5 parts, as a much safer, cheaper, more efficacious, and less objectionable application. The vagina is first carefully washed out with weak Condy's fluid and the remedy then blown in.

Schuking, in a paper, "Ueber Iodoform nachbehandlung und Permanente Irrigation" (*Centralb. f. Gynakol.*, No. 13, 1882), describes his method of treating all gynecological wounds. It consists in washing out the vagina with 1 to 20 carbolic lotion, depositing in it a drachm of iodoform, and washing it out on the third day, after which daily douches are employed. In cases of laparotomy, he rubs the stump and wound surfaces with the drug, leaving in all about one drachm in the peritoneal cavity.

Hospital Reports.

MEDICAL AND SURGICAL CASES OCCURRING IN THE PRACTICE OF THE MONTREAL GENERAL HOSPITAL.

MEDICAL CASES UNDER CARE OF DR. OSLER.

I.—*Cancer of Ascending Colon—Extensive Secondary Growths in Liver.* (Reported by DR. DUNCAN.)

J. R., aged 62, messenger, admitted June 26th with pain in the abdomen, which has continued on and off for about two months, chiefly in the right side. Has been a healthy man. Bowels have been very constipated; no vomiting; appetite good, but he has lost flesh. Pain has been worse at night, and Dr. Blackader, under whose care he was, ordered bismuth and morphia. On admission, patient had a somewhat cachectic look, and the skin is icteroid. Abdomen flattened, and on palpation, there were two specially tender points, one just above the umbilicus and the other in the right lumbar region. In this spot a well-defined tumour could be felt, about midway between the costal margin and the crista ilii. It was tender on firm pressure, im-

moveable, and a clear percussion note was obtained between it and the liver. Right lobe of liver did not appear enlarged, but the left projected considerably below the xyphoid cartilage, and the part was very tender. Hot applications were ordered to the abdomen, and $\frac{1}{8}$ gr. of morphia ter die, and stimulants.

July 7th.—Patient has been losing ground, is more emaciated, and sweats a good deal. Skin still slightly jaundiced. Has a stool each day, copious, soft and clay-coloured. Pain not so severe. Temperature a degree or two above normal. Tumour very evident on right side of abdomen. *10th.*—Has failed rapidly; pulse weak, 108. Enlargement of left lobe of liver more marked, and the tenderness increased. Dr. Ross saw the patient in consultation, and was strongly of the opinion that it was malignant disease of colon, with secondary affection of the liver. On the 12th, abdomen became greatly distended, and there was considerable distress; vomiting became troublesome, and he sank and died on the 13th.

Autopsy.—Body much emaciated. In abdomen, intestines distended and dark-coloured; no peritonitis. Left lobe of liver projected a hand's-breadth below costal border. In right side of cavity was a firm, solid mass, which, after removal of the small bowels, was found to involve the greater part of the ascending colon. The affection began at the valve and extended to within a short distance of the hepatic flexure. When slit open, the whole of the part was a mass of disease, the inner surface in a foul, sloughy state; no narrowing; the calibre of the gut rather increased. The walls were thickened and infiltrated with the new growth. The liver was greatly enlarged, weighed over 6 lbs. The left lobe was nearly the size of the right, and occupied by a huge secondary mass of soft cancer, greyish-red in colour, and very soft. In the right lobe there were four or five masses the size of apples. Fully three-fourths of the organ was involved in the new growth. Nothing special in the other organs.

II.—*Obstinate Quotidian Ague.*

It is not often that such a refractory case of ague comes under observation as the one here recorded.

Lion J, aged 18, a Russian refugee, was admitted on May 31st with chills and fever. Came from a malarious district, but had never suffered before. The attacks began two days ago. Patient is a delicate-looking, anæmic lad. No enlargement of liver or spleen. He complained a good deal of pains in the legs and about the ankles. The attacks came on at first just after noon, and the fever, at its height, usually reached from 104° to 105°. Thus on the 1st, the day after admission, the temperature at 2 p.m. was 105°; at 8 p.m., 95.5°. He was put upon quin. sulph. grs. v t.i.d. On the 4th, 5th and 6th he was somewhat better, chill only slight, and the highest rise of temperature 101°. Dr. Osler was away until the 11th, and the quinine was continued as above. On the 12th he was ordered a single dose of grs. xxv a couple of hours before the onset of the chill. This was continued for five days without the slightest benefit. Each afternoon the paroxysm came on, and the temperature rose to 105° or 105.5° and sank in the evening to 96°. In the intervals he was up and about the wards. No heart murmur; no marked splenic enlargement. On the 18th he was ordered ♏ x t.i.d. of Fowler's solution of arsenic. This was continued without any change until the 21st, when the large doses of quinine, grs. xxv, a couple of hours before the chill, and grs. iii t.i.d., were resumed. Not the slightest effect; every day the temperature reached 105°. On the 26th, ordered eucalyptus, which he took for two days, and then left the Hospital. Dr. G. Tillerie Ross, who attends the Home where these refugees were placed, states that the lad continued to "shake" after leaving the Hospital, and does so still (Aug. 2nd), though the use of ʒi doses of the Fld. Ext. of Eucalyptus appears to be relieving him.

SURGICAL CASES UNDER THE CARE OF DR. RODDICK.*

CASE I.—*Cancer of Tongue—Removal of entire Organ.*

N. W., aged 49, was admitted, giving the following history: Has for years indulged freely in spirituous liquors, and used the ordinary clay pipe, being an inveterate smoker. He has also

* Clinical Clerks—Messrs. Cameron, Bowser, Henry and Nelson.

been in the habit of tasting tea. No history of syphilis or suspicious ulceration of the mucous membrane of the mouth can be obtained. Some years ago he broke the first molar tooth of the right side, leaving a sharp point, which constantly irritated the side of the tongue. About the month of March, 1880, he first noticed a small pimple on the floor of the mouth, under the right border of the tongue; this was cauterized, and apparently disappeared. Some months later, a small indurated mass was felt in the situation of the pimple, and now the decayed tooth was extracted On the 10th September, 1880, Dr. Roddick removed with scissors the nodular mass, together with a portion of the side of the tongue. From this operation the patient appeared to recover perfectly, and did not come under observation again until June 9th of this year.

On admission, the patient appeared in good health; no evidence of cachexia. On examination, a lump of about the size of a pigeon's egg is felt in the vicinity of the original induration, but involving two-thirds of the lateral half of the tongue, and interfering very much with the movements of the latter, preventing its protrusion beyond the line of the teeth. The submaxillary gland of that side is also slightly enlarged.

June 13th.—The patient being etherized, and a ligature passed through the point of the tongue in order to control it, the operator proceeded with scissors to separate the organ from the floor of the mouth, cutting widely; especially on the right side. Nunnelly's incision was then made in the middle line, between the chin and hyoid bone; through this the chain of the écraseur was carried and made to encircle the tongue as far back as possible, being kept in position by means of a long needle transfixing the organ. The entire tongue, with diseased portion, was then readily removed, an interval of a quarter of a minute being made to elapse between each click of the écraseur. The hemorrhage was trifling. As a precautionary measure, a ligature was passed through the stump and held to the cheek by means of adhesive plaster. This was intended to be utilized in the event of hemorrhage or other emergency. The enlarged gland was subsequently removed by means of an incision along the margin of the

jaw. A large drainage tube was passed through the opening, so as to facilitate the removal from the floor of the mouth of saliva and other discharge.

The treatment for some days consisted simply of the application of ice to the stump and the administration of small quantities of milk by means of a spoon. As is usual in these cases, there was at first some difficulty in swallowing, but this became gradually removed. A mouth-wash containing carbolic acid and glycerine was used throughout.

The recovery was uninterrupted, and the patient was discharged cured on the 27th day. He was seen on the 31st July, and could make himself readily understood, although there are many words in which the dentals predominate, which he cannot pronounce. The disease was found, on microscopic examination, to be schirrus cancer.

CASE II.—*Fatty Tumour, involving Biceps Muscle of Right Arm, simulating rupture of the muscle.*

M. F., farmer, aged 68, a healthy, muscular man, was admitted June 2nd, 1882. About three years ago, while in the act of undressing, he first noticed a lump of the size of a walnut on the inner and lower edge of the biceps muscle. As he suffered neither pain nor inconvenience, he paid no attention to it until August last, when he found that he was gradually losing power in the arm. This loss of power increased until he was unable to raise the affected arm above his head without assistance from the sound one. He now began to experience pain both above and below the enlargement, of a gnawing character, and so severe as to deprive him of rest and sleep. The tumour had now reached the dimensions of an ordinary lemon. Exploratory incisions were made on two different occasions, but without reaching the tumour, so that the case was looked upon as one of enlargement of or ruptured muscle.

On admission, a distinct enlargement is noticed involving the inner and lower portion of the biceps muscle. It is moderately firm to the feel, and freely movable when the arm is at rest, but on flexion it becomes hard and immovable; it is not tender; the

skin of the affected part is healthy in appearance; the glands are not enlarged, and there are no constitutional symptoms.

June 3rd.—The patient was etherized to-day, and under the spray a free longitudinal incision made over the enlargement. After dividing a rather thick layer of muscular tissue, the tumour was exposed and found embedded in the centre of the belly of the biceps. It was readily enucleated, and found to be purely fatty, some portions being more condensed than others. The edges of the wound in the muscle were brought together with catgut and drained by means of the same material, while the superficial wound was also sutured and dressed antiseptically.

The wound healed rapidly, and the patient was discharged cured on the tenth day. He has since been heard from, and states that he is now free from pain and rapidly regaining power in the arm.

CASE III.—*Stone in Bladder—Lateral Lithotomy—Recovery.*

A. M., aged 11, was admitted May 18th complaining of irregular and painful micturition. His parents are living and healthy, but five children in the family have died of phthisis. There is no history of stone in the family. He has had none of the diseases of childhood, and has always enjoyed fair health, barring the bladder trouble. As long as he can remember, has had frequent and painful micturition, with burning pains in the bladder and along the urethra during and after the act. He further states that he distinctly feels something in his bladder, which changes position with almost every movement of his body; also that frequently during the act of micturition the flow of urine is suddenly arrested. During the past year his urine has been frequently tinged with blood. There is no history of the passage of a renal calculus, but about eighteen months before admission he passed a calculus about the size of a pea during sleep; it was white in colour and crumbled easily. The boy is of average stature for his age, but is anæmic and pasty in appearance.

May 23rd.—A sound was introduced to-day under ether, and the presence of stone readily determined. In one direction it measured one inch and an eighth. It gave the impression of being a soft stone.

May 27th.—The operation of lateral lithotomy was performed to-day, resulting in the extraction of a soft stone, which broke under the forceps. The nucleus, composed of uric acid, was first extracted, and the body (phosphatic) in several large fragments. The bladder was then thoroughly washed out with tepid water. The entire calculus weighed 391 grains.

The patient recovered from the effects of the anæsthetic very slowly, remaining profoundly insensible for more than an hour after the administration had ceased. Hypodermic injections of brandy were resorted to. The hemorrhage was trifling, but the wound became filled with a firm clot, preventing the egress of urine. On this account a gum catheter was introduced through the wound for a few hours. The case went on to recovery without interruption, and the patient was discharged on the twenty-ninth day after operation.

CASE IV.—*Reflex Closure of Jaws—Cure effected with the assistance of Ether.*

Catherine F., aged 20, housemaid, was admitted June 13th, 1882, complaining of inability to open the jaws. It appears that about three months ago she had toothache on the right side, in the last molar. This continued for three days, and on the morning of the fourth she discovered that her jaws were firmly closed. About a week after this they slightly opened spontaneously, and remained opened for about three days, when they again closed, and have remained so ever since, now over two months. During all this time she has been obliged to live on liquid food. The patient is a stout, rather phlegmatic subject, but with no hysterical tendency. The lower jaw cannot be made to separate from the other for more than an eighth of an inch.

June 15th.—Ether was administered to the stage of profound insensibility. The jaws were pulled apart by means of blunt hooks a distance of two inches, and then Smith's gag was introduced. The latter was left *in situ*. She is to be fed on milk alone.

June 16th.—The patient complains of soreness in the teeth and gums from pressure of the gag, but does not direct attention

to the masseters or other muscles of the jaw. The gag was removed and a cork substituted, properly secured.

18*th.*—Much better; all soreness has disappeared. Patient can retain jaws open for an inch and a half, and can close them readily. The cork is retained by the patient herself. To the angles and over the articulations of the jaws an ointment of iodide of potash and belladonna is ordered to be rubbed.

20*th.*—Jaws can be readily, but slowly, opened and closed without pain. She is yet unable to chew any substance firmer than bread, and is warned not to attempt to do so for some time. Asks to be discharged.

The patient was seen four weeks after above date, and found to be suffering no inconvenience, but could masticate almost any ordinary food.

Reviews and Notices of Books.

The Philosophy of Insanity, Crime, and Responsibility.—By HENRY HOWARD, M.R.C.S., Eng. For the last twenty-two years connected with Asylums for the Treatment of the Insane; an ex-President of the Medico-Chirurgical Society of Montreal; author of "Howard on the Anatomy, Physiology and Pathology of the Eye." Montreal: Dawson Brothers.

The subject of the medical jurisprudence of legal criminality has been one to which, especially within the past year, widespread attention has been directed owing to several celebrated cases which have come to trial both in the neighbouring States, in this country, and in Europe. Almost every time that the plea of insanity is raised in a criminal case, we are led to see what diverse views are held by experts upon what constitutes responsibility in the eye of the law. And this will no doubt continue to be so until some more definitely fixed principles shall be laid down, based upon sufficiently scientific data, whereby a true test can be applied. Dr. Henry Howard has been interested in this matter for many years, having been an asylum medical officer, and having taken part in several trials for criminal offences where

the defence was founded upon the prisoner's insanity. The last of these was the trial of Hayvern for the murder of a fellow-prisoner named Salter in our Provincial Penitentiary. Dr. Howard was called by the defence, and gave very strong evidence in favour of the mental unsoundness of the prisoner, urging that the crime was committed through "uncontrollable impulse." In spite of this Hayvern was convicted and executed. A great deal was written in our local journals at the time, both *pro* and *con;* and able reviews of the entire case appeared in some of our American medical papers and in the leading English magazines devoted to affections of the mind and nervous system. It is only right to say that the best of these, in the main points, decidedly supported the arguments of Dr. Howard. The present little work has been put together in order to explain more fully the views held by the author upon this much-vexed question. It is divided into two parts: the first treats of Insanity and Imbecility, especially with relation to the material condition of the brain in these abnormal states; the second deals with Crime and Responsibility, inferences being drawn on this point from the views advanced in the introductory portion of the work. We do not purpose entering upon a criticism of Dr Howard's views. Suffice it to say that they are strongly materialistic, imbecility being looked upon as the result of a teratological defect, and insanity of a pathological defect in some part or structure of the brain. We have found it somewhat difficult to follow the author in his explanations of the supposed pathology—*e.g.*, when he speaks of the possibility of chemical changes in the molecular nerve fluid causing "turbidity of the electric fluid," and of lesion of the sensory nerves rendering "the electric vital fluid turbid or opaque, causing insanity." Some pure hypotheses are startling, *e.g.*, "It requires no very great stretch of our imagination to conceive a germ in the fluid of the different nerves propelled by molecular motion to the organ of consciousness, and while in that organ producing violent mania." On the contrary, we think our imagination must be considerably stretched to admit all this. Some observations are given on the important matter of the temperature in insane persons. The plates of the

brains of Hayvern and Moreau have been reproduced from this Journal. Dr. Howard claims that the result of the examinations of the brains of Guiteau and of Hayvern has shown that both these men were insane. He speaks of this as "an established scientific fact." On the contrary, there is great diversity of opinion even yet upon this very point.

In conclusion, we are given twenty pages from Mr. Serjeant Ballantine's "Experiences of a Barrister's Life," the tales in which make pleasanter reading, but it is difficult to perceive that they are always *à propos*.

Homœopathy, what is it? A Statement and Review of its Doctrines and Practice.—By A. B. PALMER, M.D., LL.D., Professor of Pathology and Practice of Medicine in the College of Medicine and Surgery in the University of Michigan. Second Edition. Detroit: Geo. S. Davis.

This little book is one which it would be well for every one to read. It is absolutely necessary at the present day to know something of the actual standing of the exclusive sect who style themselves Homœopathists, and of the doctrines which they now undertake to teach compared with those of the original founders. All this and much more is brought together here by one who has paid considerable attention to the subject during several years. The writer has visited most of the medical centres in Germany, Austria, Switzerland and France, enquiring as to the standing of the Homœopathic system in those countries. "He has found that nowhere has it any position or recognition in any government institution or in any great hospital or medical school, except in the single case of the University of Pesth, in Hungary."

The doctrines of *similia* and of infinitesimals are somewhat elaborately considered, and from the most modern publications it is shown how far the practitioners of the present day really adhere to or depart from their fundamental principles. The gross absurdity of the so-called "provings," which are still laid down in the therapeutical works of the Homœopathists, is once more pointed out and illustrated by several of the most glaring

examples. It is one of the most wonderful psychological problems how men, otherwise possessed of the ordinary common sense of their fellows, can bring themselves to credit, or think they credit, such arrant nonsense. It is also shown that though Homœopathy has been in existence for more than three-quarters of a century, its adherents can yet not point to one single improvement in science as the result of their labors. One of its own journals speaks of Homœopathy as being here a *humiliated beggar* to Allopathy. "Produce," it says, "produce! Were it but the pitifulest infinitesimal fraction of a product, produce it, in God's name!" "But," says the writer, "this cry, like the calling upon Baal, though like his priests they cut themselves with stones, will be in vain. Men who believe, or pretend to believe, in such doctrines as we have been discussing, will never produce such works as are called for. Never."

Dr. Palmer takes strong and, we think, the right ground against association of any kind between regular practitioners and Homœopathists. This subject, of course, is a burning question in the United States just now, owing to the recent action of the New York State Medical Society. He says:—"Every impulse of a legitimate professional pride, every sentiment of fraternal allegiance, every feeling of self-respect, and every principle of honor, impel us to refuse professional associations with such a system and intimate professional and fraternal relations with such men."

We recommend a perusal of this book. It is written fairly, without exaggeration or distortion, and may reasonably be accepted as presenting a picture of the present status of this misleading system of dogmatic errors.

The Physician Himself, and what he should add to the strictly Scientific.—By D. W. CATHELL, M.D., late Professor of Pathology in the College of Physicians and Surgeons of Baltimore; ex-President of the Medical and Surgical Society, &c. Baltimore: Cushings & Bailey.

This is an essay on "Personal Questions in Medical Practice."

It is a chatty book, supposed to let the young practitioner into all the secrets which have led to the envied success of those who have gone before him. All sorts of good advice is given him on all sorts of subjects, and we must admit that it contains a great many useful hints—hints which, if taken note of, might prove invaluable to him in after life. The young man fresh from the Hospitals, full of the latest and newest professional and scientific knowledge, and replete with zeal for his patients, is not long, however, in finding out that he lacks many little things which make it difficult for him to avoid troubles with his patients and possibly discord with his *confrères*. Most of these little things, if he be a man of sense and judgment, he finds out for himself, and is able then to escape from. There are a great number of little questions concerning his conduct in a variety of directions which a medical man at the outset of his career would like to have answered for him. We know of no book in which he might look for just such information. It is not a code of ethics he wants so much as the kindly words of a sufficiently shrewd physician of long experience to guide him in the right direction. The author is evidently such an one, and he has taken the trouble to bring all these things together into book-form in the shape of a series of short paragraphs, explanatory and didactic. It is principally intended for those commencing practice, but it will be found both useful and entertaining to all. We confess to having derived both advantage and amusement from its perusal. Perhaps exception could justly be taken to some of Dr. Cathell's views—*e.g.*, he advises the cultivation of æsthetic tastes in the furnishing of one's office, bouquets and flowers being specially mentioned as in order (sunflowers not alluded to), whilst at the same time he considers it "proper and advisable" to display your library, microscope, &c., also your diplomas, certificates of membership, anatomical plates, &c., the human skeleton, either entire or in parts, anatomical specimens and mementos of dissections, &c. To the latter part of this we cannot subscribe, and besides, is there not some inconsistency here? or would really the school of Oscar Wilde approve of skeletons and dried limbs amongst the decorations? Again, "Do not let your office be a

lounging place or a smoking room for horse-jockeys, dog-fanciers, gamesters, swaggerers, politicians, coxcombs and others whose time hangs heavily on their hands." We should hope not. The Doctor is not too hard on the bachelors of the profession; he says, "If you are unmarried, it will often be quoted against you, but the truth is, there is no great professional advantage gained by being married. The objection to most unmarried doctors is really not their being unmarried, but their youthfulness." Regular relaxation and holidays are properly strongly advocated. A caution is given not to adopt the "habit of presenting your photograph to every one enamoured of your professional skill," as it will "cause many awkward dilemmas." Directions are given concerning the views of various religious bodies, on infant baptism, and the duties of the practitioner in connection therewith. "A study of mental therapeutics is one of the necessities that the regular profession is still very deficient in. Remember that Dr. Diet, Dr. Quiet, Dr. Hope and Dr. Faith are four excellent assistants whose aid you should constantly invoke. Dr. Time is also, in some cases, very necessary, but he is slow and unreliable, and unless Dr. Aidwell is called in to assist, occasionally permits a patient to sink into his coffin instead of restoring him."

These are a few points taken quite at random from different pages. They show the gist of the book, which we find almost entirely original. We strongly advise every actual and intending practitioner of medicine or surgery to have the "Physician Himself," and the more it influences his future conduct the better he will be.

Electricity in Surgery.—By JOHN BUTLER, M.D. Boericke & Tafel, New York and Philadelphia.

It is claimed that very few surgeons indeed could reply, if asked, how much electrical force was needed to accomplish a certain object, whilst an electro-plater, or telegraph mechanic, or an electric light man always knows precisely the quantity of force he requires to employ in any given case. Greater accuracy is certainly to be desired, for, no doubt, success often de-

pends upon the knowledge and experience of the operator of this powerful agent. In a compact little book of little over 100 pages, the author reviews the different surgical disorders in which electricity has proved beneficial. In one of the most important of them all—aneurism—it is stated that the recommendations are entirely derived from other writers, but in most of the others the results given have been obtained from the author's own experience. Though strongly in favor of using electricity more frequently than is commonly done, we do not find that this enthusiasm has led to claiming for it more than is its justly due. A large section is devoted to galvano-causty and its application in surgery. We have no doubt that this treatise will be found useful by surgeons in helping them to greater precision in the use of one valuable means connected with their art.

Books and Pamphlets Received.

SYPHILIS. By V. Cornil. Translated, with Notes and Additions, by J. Henry C. Simes, M.D., and J. William White, M.D. Philadelphia: Henry C. Lea's Son & Co.

THE RETROSPECT OF MEDICINE. By W. Braithwaite, M.D. Vol. LXXXV. Jan.-June, 1882. London: Simpkin, Marshall & Co.

THE VEST-POCKET ANATOMIST (founded upon "Gray"). By C. Henri Leonard, A.M., M.D. Detroit: The Illustrated Medical Journal Company.

TRANSACTIONS OF THE AMERICAN GYNECOLOGICAL SOCIETY. Vol. VI., for the year 1881. Philadelphia: Henry C. Lea's Son & Co.

LA LITHOTRITIE DOIT ETRE FAITE SANS TRAUMATISME. Par le Dr. Reliquet. Paris: Delahaye & Lecrosnier.

WHAT TO DO IN CASES OF POISONING. By William Murrell, M.D. Detroit: Geo. S. Davis.

Extracts from British and Foreign Journals.

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

The Hypodermic Administration of Amyl-nitrite.—J. J. Frederick Barnes writes as follows to the *British Medical Journal*:—I have administered amyl-nitrite hypodermically thirty or more times during the past eighteen months. In all cases, a ten per cent. solution in rec-

tified spirit was used. In no case did any untoward inflammatory or suppurative symptoms occur afterwards. The action of the drug was immediate in every case, the subjective phenomena being like those experienced when using the ordinary methods of administration. The spirit solution appears to be an excellent preparation for use, as a small quantity kept in an ordinary stoppered bottle for some months retains its full efficiency at the present time. The dose usually administered has been ten minims of the solution, equal to one minim of amyl-nitrite. In lumbago, where the patient is seen at the commencement of the attack, and the disease is not of long standing, the drug given in this manner instantly relieves the symptoms; a patient who is unable, previous to its administration, to bend the trunk without the most exquisite pain, five minutes afterwards can do so quite readily. In a case of paraffin-poisoning, where the patient was in a state of collapse and almost pulseless, one administration (inhalation having been ineffectually tried) brought on an immediate resumption of cardiac function, the man speedily recovering. Its action in this case would, I apprehend, be due to the relief momentarily given to the congested centres by the peripheral hyperæmia induced. In another case, one of duodenal colic, the patient was found rolling on the floor from the acuteness of the pain; when, on injecting fifteen minims of the spirit solution, the pain disappeared as if by magic, and the patient was at once able to resume his ordinary position. The value of this drug by ordinary methods of administration has already abundantly demonstrated how great a boon the discovery of Dr. Lauder Brunton is in the hands of the profession, notably in cardiac angina; and I feel confident that its utility may be still further enhanced by giving it as here recommended, hypodermically.

Some Practical Points in the Treatment of Hemoptysis.—Dr. James M. Williamson, of Ventnor, writes on this subject to *British Medical Journal*:—Constipation must not go unrelieved, and is best treated by salines. A quick pulse must be steadied by digitalis, of which

perhaps the most handy form is the digitaline granule of Homolle and Quevenne. Cough is to be soothed, the simpler the mode of accomplishing this the better, but it must be done; and nothing answers better for this than a chloroform pad laid over the sternum. Speaking in a general way, and not alluding to hemoptysis of cardiac origin, I hold that we should keep before our minds the advisability of stopping all blood-spitting in phthisis without delay. To this rule, perhaps, there are two exceptions. The first is trivial. It is that dirty-red, slimy, bad-smelling, never abundant expectoration which hysterical women with phthisis often exhibit at the bottom of their spittoons; this may be left to itself. The other exception is a serious one; it comprises those forms of hemoptysis, usually copious and angry, occurring in advanced and very chronic cases where there is a considerable amount of fibroid induration. In such patients, notable dyspnœa or exertion has for a long time been a prominent symptom, and respiration has been maintained by a very small extent of lung-substance. These cases are open to a special danger, that of fatal embolism in the right chambers of the heart or the pulmonary artery. Not uncommonly the course followed is for the bleeding gradually to abate in quantity, remaining, nevertheless, of the same angry red; then urgent dyspnœa suddenly sets in, and death takes place within forty-eight hours. These are cases calling for extremely careful treatment. Can it be right, where only a small surface is available for respiratory function, to contract those few vessels with ergot? Or can it be good practice to pass styptic medicines into a patient's circulation when his cachectic state, his low vitality, and perhaps some febrile movement, render him specially liable to the formation of thrombi? It is wisest to limit ourselves to external applications, chloroform pads, dry cupping, sinapisms at a distance, or other derivative treatment, with appropriate general management. Perhaps I may be allowed to conclude with two cautions, common-place they may seem, but both of them the outcome of bedside experience. One is, to have some responsible person in attendance night and day, on all cases of severe bleeding, till the attack has com-

pletely passed away. Death in hemoptysis is generally sudden, and it is very appalling to discover too late the consequences of omitting this precaution. The other is, to decline positively to examine a patient's chest while there is any hemoptysis. Irrespectively of the danger of the process, an opinion arrived at by auscultating a chest during or immediately after a bleeding is not a reliable one.

Successful Reduction, after Four Months' Malposition, of a Dislocated Third Cervical Vertebra, Causing Various Serious Nervous Symptoms.—Dr. Landon Carter Gray, of Brooklyn (*Annals of Anatomy and Surgery*), says:—A lad, fifteen years old, was brought to me. Four months before he had attempted to turn a somersault, and had fallen upon his head. There was neither loss of consciousness at the time nor any untoward symptom other than the appearance of a small projection upon the back of the neck. The next morning he experienced some slight difficulty in swallowing, which steadily increased, although varying in degree from day to day. About thirteen weeks after the accident the bladder became distinctly, though not markedly, paretic. About fourteen weeks after, the patient became sensible of a numbness in the left arm. Three days before coming to me, the left upper and lower extremities became powerless, although, singular to say, this lower extremity had not shown any subjective alteration of sensation except a slight itchiness. During the week previous to his visit a slight numbness had appeared in the right leg. At this first examination I found the left upper extremity almost completely paralyzed in motion, the left lower extremity somewhat less so, both these extremities moderately paralyzed in the sense of touch, and the left side of the face paretic. The left upper extremity was decidedly fuller than the other, without, however, presenting any œdema or unusual vascularity. There was occasionally a quick, sharp tremor of the whole body, which came on only while he was standing. The tendon reflex of each quadriceps extensor was greatly exaggerated; but there had not been at any time any symptoms of

hasty micturition. Over the region of the third cervical vertebra there was, on the back of the neck, a projection about as large as a pigeon's egg. Pressure upon it produced some pain around the point of pressure, but none was felt at the front or side of the neck. The spinous process of the third cervical vertebra was devieted markedly to the right. Inserting the finger into the mouth, horizontally backward on a level with the upper surface of the tongue, a distinct depression could be felt in the posterior pharyngeal wall, corresponding to the third cervical vertebra. The attitude of the head was peculiar. The right ear was strongly inclined to the right, the chin directed to the left, but the point of the chin was not elevated. The right sterno-cleido-mastoid was prominent and tense. The point of the left shoulder was drawn up, the acromion process of the scapula being approximated to the median line of the body, and the inferior angle being thus thrown out. The difficulty of swallowing had become so great that the boy was fed on soft and liquid food, and at certain times even this was troublesome; the nervous symptoms were progressing at an ominous pace; nothing but a restoration of the bone to its proper place offered any hope of saving life; and if the reduction were prevented by the callus of a former fracture of the spinous process, no harm could be done by the attempt. In making reduction counter-extension was made by means of folded sheets laid over each shoulder and then brought across the back and shoulder to the opposite side, where the ends of each were placed in charge of an assistant. A gag was used to separate the jaws. The boy was laid flat upon his back on the table, and etherized until all his muscles were well relaxed. Supporting the head by one hand upon the occiput and the other upon the brow, both my hands being covered by those of an assistant, and counter-extension being firmly maintained, I made extension steadily upward to what I deemed a proper degree, and then slowly and cautiously rotated the head from left to right. It was necessary to make this rotatiou three several times before the bone went into place, each rotation, however, effecting evident improvement, althoug no tendinous snap was heard at any time. On

returning to the house about four hours after the reduction I was gratified at finding the boy bright and cheerful, having no longer any difficulty in deglutition,—he had drunk heartily of milk, which he had hitherto taken only by the spoonful—able to lift his hand readily to the top of the head, much improved in motor control of the left lower extremity, and free from numbness anywhere. The patient was not permitted to rise from the table for upwards of three weeks. During this period the head was kept between the prongs of a photographer's head-rest, which permitted of sufficient lateral motion to render the position endurable, and at night a watch was kept to see that the head was not displaced from this support. At the end of this time he was allowed to assume a sitting posture for a couple of days, and then to go about the room. I now noticed that the spinous process of the third cervical vertebra began to deviate again from the line of its fellows, but only to a very slight degree, and a faint depression could again be felt corresponding to the vertebral body; no nervous symptoms, however, were manifested. I was reluctant to interfere again unless it became absolutely necessary, and I contented myself with enjoining great caution and deliberation in the movements, as well as confinement to the house. Notwithstanding these directions, the patient, after a week of this irksome life, started out one morning and walked for several hours. The next day I found a distinct, though not very marked, displacement of the vertebra. I immediately determined to run no risk of pressure upon the cord, and accordingly brought the table and the photographer's head-rest into play as before, and kept him thus until I again reduced the bone a few days after. The reduction was easily made, and the bone went into place with a sharp ligamentous snap. Two weeks more in the supine posture and the patient got up, cautiously at first, and has had no further trouble.—*American Medical Weekly.*

Improved Pharmacy.—The fact is not new, but it has been quite recently made more prominent by Sidney Ringer in his Handbook of Therapeutics, that small doses of

medicine frequently repeated act more efficiently than large doses given at longer intervals. Bartholow, Petero, Desau, and many others also recommend the use of minimum doses in almost every variety of disease. My attention was first called to this subject by my friend and former partner, Dr. J. B. Cook, and by observation and actual experience I have so convinced myself of their efficacy that, with one or two exceptions, I have discarded the larger doses, and by doing so have, I am sorry to say, been charged with practicing homœopathy. The believers in medicine and their efficacy in treating disease do not appear to increase. On the contrary, it is rather refreshing to meet with a practitioner now-a-days with any reliance on drugs. I would say to these doubters, try the small doses often repeated and your faith will revive. Take the first child you have in your practice with catarrhal fever or croup, and give it fourth or half-drop doses of aconite in a teaspoonful of water, repeated every ten or fifteen minutes, and you will see the fever driven off and disappear like frost before the summer sun. But there is an advance yet to be made and a point reached when we shall exclude all save the active principle of drugs. Quinine is far preferable to the bark, morphia to opium, and why should not the alkaloids and their salts, aconitin, veratrin, hyoscyamine, strychnine, digitalin, ergotin, and others given in small doses ($\frac{1}{120}$ or $\frac{1}{60}$ grain of the more potent) at short intervals—every quarter or half hour or hour—and discontinued or given at longer intervals when relief is afforded, be far preferable to the large and oftentimes nauseating compounds which are so frequently prescribed? The thanks of the profession are due and should be extended to advanced pharmacy for rendering it possible to administer medicines in forms which are not only accurate and reliable, but in many instances pleasant to the eye and to the taste of both children and adults. We cannot afford to allow a blind and foolish prejudice against what is called homœopathy to prevent our welcoming any advance which may tend to remove skepticism and restore faith in our healing art, and at the same time render our remedies palatable and pleasing alike to the taste and to the eye. A writer in a recent number

of *The Lancet* says, "No man who has ever used aconitine for the reduction of temperature will hark back to the tincture, Fleming's though it be, or any crude form of the drug; and he who has not used hyoscyamine in trouble of the hollow viscera —stomach, bowels, bladder, etc.—has yet to experience the satisfaction and joy with which he will be greeted after prescribing it for a patient with spasm, retention, dysentery, or hernia; for this last is often spared the surgeon's knife by this beneficent drug." The wise physician is he who has learned to choose the quickest and the best remedy for the relief of his patient, unmisled by superficial differences; who can shun the rocks where others have been wrecked, or from foresight of what is coming can be cool when the peril is upon him.—*Dr. Dixon in Louisville Med. News.*

Aconite in Acute Dysentery.—Dr. W. Owen, Port Blair, India (*Indian Medical Gazette*, April 1, 1882), reports having treated 157 typical cases of acute dysentery with aconite. He was induced to give aconite by the following considerations:—First. Its influence in other acute inflammations. Second. From its relieving internal congestion. Third. It has a marked antipyretic action in febrile cases. Fourth. It has a sedative action on the gastro-intestinal mucous membrane. He gives one minim of the tincture of aconite (British Pharmacopœia) every quarter of an hour for the first two hours, and a minim an hour subsequently, making half a drachm in twenty-four hours. This method has been found by him to be followed by the very best results in the great majority of his cases.—*Chicago Medical Review.*

External Hemorrhoids.—Dr. Pasqua, of Florence, gives the following ointment as infallible:—

Ext. Belladonna, - - - - - -	gr. vss; 0.33 Gm.
Iodoform, - - - - - - - - - -	āā gr. j; 0·06 Gm.
Acetate of Lead, - - - - - -	
Petroleum jelly, - - - - - -	3j; 4.00 Gm.

Make into an ointment, to be applied three or four times a day. —*Druggist's Clerk.*

Corrugated Paper as a Splint.—Dr. Walter Pye gives an account (*British Medical Journal*) of a new splint, which he has found of great value. Its most important feature is flexibility combined with stiffness. It is made of a material known as corrugated paper, and is very cheap and light. Dr. Pye says:—"From the purely surgical point of view, I have found this corrugated paper extremely useful. It can be used in all cases in which the expensive kettle-holding splinting has been employed, and makes about the best angular splint for the elbow I have ever seen. The commercial use to which this paper is put is either that of packing wine bottles in cases, or else of enabling single bottles to be wrapped in a parcel not indicating its contents." The corrugated paper thus used in surgery by Dr. Pye is of American invention.

Aborting Syphilis.—Some time ago Gantier found that if an intra-venous inoculation of rabietic virus was made upon sheep, this prevented a second hypodermic vaccination from having effect. Hubert (Lyon Mèdicale) claims that something of this kind occurs where a mother secures immunity from syphilis by carrying a syphilitic child, the virus affecting the mother through the blood. He believes that if intra-venous inoculation were done with the secretion and blood of the initial chancre, that systematic infection might be aborted.—*Chicago Medical Review.*

Rheumatism and Syphilis.—Dr. B. C. Lockwood (*British Medical Journal*) has noticed that the prior existence of rheumatism exerts a marked influence on the initial lesion of syphilis, causing it to take on a phagadænic and necrotic character. He believes that this explains the occurrence of many cases of malignant chancre which are from time to time reported by syphilographers. He is inclined to think that in these cases mercury does harm, and that potassium iodide is of very great benefit. His cases certainly appear to indicate that the relationship between the rheumatism and the malignant chancre is more than coincidental, but require further confirmation.—*Chicago Medical Review.*

CANADA

Medical and Surgical Journal.

MONTREAL, AUGUST, 1882.

OUR EDITORS.

A change has been made in the editorial department of this Journal. Dr. Molson, who has for the last three years been associated with Dr. Ross in the work, has been compelled to resign owing to other engagements. We are, however, pleased to be able to say that we have instead obtained the co-operation of Dr. Roddick, the Professor of Clinical Surgery in McGill University. This announcement, we are sure, will meet the approval of all our readers, as the Doctor's energy and literary ability are both sufficiently well known. Since the present senior editor has had charge of the publication, considerable improvements have been made in several of the departments, and, as will be remembered, the size has been increased from 48 to 64 pages. A special series of *resumés* has been established and regularly carried on, viz., on Surgery, by Dr. Shepherd; on Gynecology, by Dr. Gardner; and on Therapeutics, by Dr. Stewart. We are satisfied that these have been much appreciated by our readers, and a further tribute to their excellence is afforded by the frequency with which they have been drawn upon by our exchanges. Our original pages have, we think, been fairly well filled, and several papers of more than common interest and on subjects of great professional importance have first appeared here. We are thus indebted to many of our friends for valuable contributions, and we hope to receive at their hands many similar favors. We think that a good many, especially of our younger graduates, do not yet quite appreciate the importance to themselves of writing for the medical journals. There is no way in which a

well educated medical man can so improve himself, and at the same time enhance his own reputation, as by frequently preparing communications for his local journals. Reports of our Canada association and of our local societies have been made as full as possible, and appear as promptly as possible. In conclusion, it is a matter of great satisfaction to find that our efforts at improving the JOURNAL and maintaining the character it has always held have met with their reward, for our circulation is steadily increasing and we now reach many more readers than ever before.

Under the present management every effort will be made to sustain the different departments of the JOURNAL, to remedy any deficiencies which may have been observed, and to maintain it as heretofore in every respect a first class medical periodical.

COUNTER-PRESCRIBING.

The following account of a most glaring and inexcusable instance of interference with a physician's prescription by a druggist is taken from the *Canadian Pharmaceutical Journal*:—

"Mr. George Mortimer, the defendant, is an old and respected druggist, doing business on York street, Ottawa, in which city he has resided for the past twenty-six years. He holds certificates from the Ontario and Quebec Colleges, and some thirty-five years ago learned his business in Aberdeen, Scotland. On the first of July last, a young man named Thomas Mulrooney called at Mr. Mortimer's shop and presented a prescription from Dr. Cranston, of Arnprior, but, instead of dispensing it, Mr. Mortimer informed the patient that he could give him something better, and on the strength of this statement sold him a preparation of his own. For this he was summoned to appear before the Police Magistrate, on a charge of giving medical advice without being a licentiate of any medical college. Mr. Mortimer, in defence, said that what he sold was a specialty; that he had given the advice entirely gratis, as, he claimed, anyone had a right to do; and that he had done the same thing for thirty-five years past, and that he only did what every druggist in the Dominion was in the habit of doing. The Magistrate de-

cided that the law had been broken, and imposed the lowest fine allowable—$20 and $2 costs. Mr. Mortimer gave notice of appeal, but, on further consideration, has given up the idea; but in conversation with a *Globe* reporter he expressed the opinion 'that the druggists of Ontario should combine together for the purpose of getting the law modified, it being certain that, with proper representation, this could be done.' So far the case is without complication, and it is an easy matter to form an opinion as to its merits. Although we are the mouthpiece of the druggists of Ontario, and are sorry to say a word adverse to the interests of any member of the College, in this particular instance we must confess that we believe the Magistrate's decision was alike in accordance with law, justice and common sense. Mr. Mortimer decidedly overstepped his position as druggist, and had no right whatever to substitute any preparation for that named in the prescription, no matter what his opinion of the merits of the medicine might have been. When, as a tradesman, he sold a preparation of his own, it may be presumed that he disposed of the goods that yield him the most profit, and this renders the case even stronger against him. We feel sure that we express the feelings of the drug trade in condemning this unwarrantable interference and in commending the verdict." The *Journal* clearly states the position which should be maintained by every pharmacist who desires to see his profession holding the high position it is entitled to, and ought to be supported in, by medical practitioners everywhere. The best interests of both pharmacists and physicians are subserved by both adhering strictly to the limits of their respective fields of usefulness. Those druggists who are addicted to the evil practice of surreptitious counter-prescribing are the worst enemies of their class, and we are pleased to find our contemporary actively interested in doing what it can to educate the fraternity to see that, in so doing, they are operating directly against the common good. We are willing to believe that such instances as the above are sufficiently uncommon in this country, and that the publicity given to this case, and the interest it has excited in Ontario, will prove of service in still further diminishing their frequency.

BIDDING FOR STUDENTS.

The following from the New York *Medical Gazette* shows forcibly the loose manner in which, in that free country, teaching and collegiate powers may be assumed by almost any man no matter how illiterate or unfit. We suppose many of our friends in "canady" have received invitations from Dean Petit to send students to Joplin, Mo., for their education—the inducements being very short terms and very small fees:—

COLLEGE OF PHYSICIANS AND SURGEONS,
JOPLIN, MO., 5, 18, 1882.

GENTS.—Please send *price list* of *Doctors* and *Druggists Names* by States as I want to mail *several thousand* Annual *Catalogues* to the *Profession*, all over the U.S.A. and canady. I am starting an embriotic-Pioneer-Medical College and I must, of necessity, noise it around to the world to make it pay me. An early reply will greatly oblige your Respectfuly, &c.,

J. C. PETIT, M.D., Dean.

"The above monument of epistolary art, and record of the aspiring plans of a would-be medical teacher was recently received by the publishers of the *Gazette*. Its unique orthography, displaying, as it does, the untutored mind of the author, untrammeled by the shackles of education, is a silent rebuke to the indifference of a public and profession which permits men of this stamp to usurp the functions of teachers, and teachers, of all arts, all sciences the most exacting, medicine. It is refreshing to see the simplicity with which this would-be Dean unconsciously defines the purpose of his "*embriotic pioneer Medical College*," namely, "to make it pay me." At what expense to good medical instruction, to the interests of his profession, or of humanity, his purpose will be accomplished probably has not occurred to him. But why rail at an individual instance of an evil that is above all else the stumbling-block to good medical instruction, namely, the necessity which makes financial success the condition of existence for our medical colleges. As long as this is so, shall not our most conscientious teachers be obliged to cater to the tastes of their patrons, the students, both in regard to the character and duration of the instruction. What stronger argument for endowed institutions and their independent instruction can

be furnished than this alarming growth of so-called colleges, which are most often, as in this case, business enterprises, money-making schemes, engineered by some ambitious but illiterate and unscrupulous person."

MEDICAL FACULTY, WESTERN UNIVERSITY, LONDON, ONT.

The organization of this Faculty opens a new Medical School for our Canadian youth. London is a thriving young city of 20,000 inhabitants, situated in the best district of the Dominion, and was fortunate enough, a few years ago, chiefly through the exertions of Bishop Hellmuth, to obtain University powers for a local college. Certain members of the profession in the city have been found willing to undertake the arduous duties of a Medical Faculty. We trust they have obtained a full share of the University funds for the purpose, or are prepared to dive deep into their own pockets. From what we remember of the amount of the original endowment, the entire sum would be about what a medical school should start with It is only due to the profession, to which the schools are nurseries, that the teaching bodies should be fully equipped with modern appliances. We look forward hopefully to the time when *all* the theological seminaries in *all* the Provinces have *all* the money they need—then the non-sectarian colleges and the medical schools will begin to get satisfactory endowments, and then only, so far as the latter are concerned, will they be on a satisfactory educational basis. The success of this new school is in the hands of the men connected with it. If they are active and energetic, thoroughly in earnest, zealous in their respective departments, a good share of professional patronage will fall to them. The only serious obstacle we can see to ultimate success is deficient hospital accommodation. It will be a long time before London needs a hospital of 100 beds—the number, by the way, fixed for recognition of tickets by the Ontario Council and the various licencing boards of Great Britain. The Faculty seems to have been judiciously chosen; one arrangement strikes us as particularly good. Mr. W. Saunders—perhaps the ablest pharmacist in Canada, and

one of our leading scientific men—lectures on Materia Medica, while Therapeutics is dealt with from a separate chair. The *personnel* of this school is as follows:

Chas. G. Moore, M.C.P.S., L.C., Principles and Practice of Surgery, Dean of the Faculty; John M. Fraser, B.A., M.D., M.R.C.S., Eng., Principles and Practice of Medicine; R. M. Bucke, M.D., F.R.S.C., Nervous and Mental Diseases; Wm. Saunders, F.R.S.C., Materia Medica and Pharmacy; J. A. Stevenson, M.D., Therapeutics and Toxicology; James Bowman, Theoretical and Practical Chemistry; Charles S. Moore, M.D., C.M., Obstetrics and Diseases of Women and Children; F. R. Eccles, M.D., M.R.C.S., Eng., F.R.C.S., Edin., Physiology; Wm. Waugh, M.D., C.M., Anatomy, General, Descriptive, and Surgical; H. Arnott, M.B., Clinical Medicine; James Niven, M.B., M.R.C.S., L., Clinical Surgery; W. H. Moorhouse, M.D., L.R.C.S., and L.R.C.P., Edin., Histology and Dermatology; G. P. Jones, M.D., Sanitary Science; Alex. G. Fenwick, M.D., M.R.C.S., Eng., Medical Jurisprudence; John Wishart, M.D., M.R.C.S., Eng., F.R.C.S., Edin., Demonstrator of Anatomy. Secretary-Treasurer, J. A. Stevenson, M.D.

REPORT OF ROYAL COMMISSION ON THE MEDICAL ACTS.

The report of this important body is published in the current numbers of the London weeklies. The essential feature is expressed in the following extract: "They propose, in general terms, that there shall be one Medical Council, and that, in each of the three divisions of the United Kingdom, there shall be a Divisional Board, representing all the medical authorities of the division; that the right of admitting to the *Medical Register* and a general control over the proceedings of the Divisional Boards shall vest in the Medical Council; and that, subject to such control, each Divisional Board shall, in its own division, conduct the examinations for licence." The condition will be very similar to what prevails in Ontario, and will, we feel certain, if adopted, give satisfaction. The corporations will feel it hard to have the licensing power taken away, but many of them richly

deserve to have their candlesticks removed. A point of interest to us is the position taken with regard to Colonial graduates. The Commission virtually recommends the proposal of the Government Act of 1880, which provides that persons with colonial diplomas may register without further examination as *colonial practitioners* in the Medical Register. This is quite as much as we want or should ask, considering that the Medical Council cannot possibly supervise the colonial examinations of the 18 members of the Council. It is recommended that four be elected by the registered members of the profession in Great Britain. For this the profession has to thank the British Medical Association, which has for years advocated direct representation.

COLLEGE OF PHYSICIANS AND SURGEONS OF CHICAGO.—The announcement of this new Institution is to hand. It has been organized—like all others—"in the interests of a more thorough and practical education than is usually furnished by the medical schools of this country." We had hoped that from the outset this new college would have demanded three full sessions of six months, and so set a good example to Western Schools. But no; it is a private monetary enterprise, and must be put on a paying basis, and for this the profession must be sacrificed to the demands of impecunious and ignorant students who seek the quickest, cheapest and easiest course to the degree. The board of directors has erected a magnificent building opposite the large Cook County Hospital. Judging from the woodcut and the description, it must be one of the best equipped schools in the country. We are glad to see the name of our old friend, Leonard St John, M.D., (McGill, '72) on the board of directors and Professor of Demonstrations of Surgery.

CANADA MEDICAL ASSOCIATION.—The annual meeting of this Society will be held in the City Hall, Toronto, on the 6th and 7th September, under the Presidency of Dr. Fenwick. The local committee have been at work, and the prospects are good for a large and interesting gathering. The usual arrangements for reduced rates will be made with the railways, and certificates

will be issued on application to the General Secretary, Dr. Osler, Montreal, or to the Local Secretaries, Dr. H. Wright, Toronto, Dr. Belleau, Quebec, Dr. C. D. Rigby, Halifax, and Dr. C. Holden, St. John. Gentlemen wishing to read papers are requested to send the titles to the General Secretary at as early a date as possible.

SEMI-CENTENNIAL CELEBRATION OF MCGILL MEDICAL FACULTY.—The Acting Dean has issued the following circular to every graduate whose address is known :—

MEDICAL FACULTY, MCGILL COLLEGE,
MONTREAL, June 27th, 1882.

DEAR SIR,—In October next the Medical Faculty of McGill University will enter upon its Fiftieth Session. We feel that the occasion is one which should not be allowed to pass unnoticed, and arrangements are being made to celebrate the event in an appropriate manner. We trust that you will be able to be present on this occasion. Due notice will be given and a formal invitation sent to you. This preliminary circular is simply for the purpose of announcing the fact, that you may make your arrangements with reference thereto.

Yours truly,
On behalf of the Faculty,
R. P. HOWARD, *Acting Dean.*

CANADIANS AT THE COLLEGE OF SURGEONS, ENGLAND.—The *Lancet* for the 27th ultimo contains the report of the Board and Court of Examiners of the number of candidates who presented themselves during the collegiate year 1881-'82, and the number who have passed and have been rejected from each school. We gather from it that ten Canadians presented themselves for the Primary—of these 7.50 passed : six went up for the Pass, and 4.50 were successful. The fraction indicates that the candidates received their education at more than one school. The percentage of rejections appears to be somewhat less among colonial candidates generally than among the British students, and so it should be, as the former, as a rule, have already taken degrees and followed their studies for four years.

NEW BRUNSWICK MEDICAL SOCIETY.—The annual meeting of this Society was held at St. John, N.B., on the 18th ultimo.

The President, Dr. Steeves, delivered an address upon Insanity containing much that was of interest and founded upon his own observations. Papers were read by Drs. Margrove, Coleman, Gray, Allison and Atherton, and several matters were discussed having in view the advancement of the profession in the Province of New Brunswick. The members inspected the General Public Hospital and the Lunatic Asylum. The meeting was in every way a successful one.

DRAINAGE—CONTAMINATION.—A great outcry has come from the inhabitants of Longue Pointe, a village about five miles below this city. Sickness has been very rife there of late, enteric complaints chiefly prevailing. The water is said to be the main cause of this trouble. It is all obtained from the river, and strangers drinking of it are at once very badly affected. The drain from the Longue Pointe Asylum opens into the river directly at this spot, and it is reputed to be in a very bad sanitary condition. Some repairs are now being done, but the inhabitants would act very wisely if they compelled the authorities to lead their sewage somewhat lower down so as to escape the village.

THE SMALLPOX HOSPITAL.—The Board of Health have decided to remove the Smallpox Hospital from its present site in the Park to some other less conspicuous locality. It is satisfactory to know that it has been without patients for a length of time, although a small staff has been maintained to provide for any possible outbreak of the disease. The great difficulty now seems to be to find any place for it as, naturally, each municipality strenuously objects to harboring such an edifice. The latest idea is to give it a corner in one of the cemeteries. This might have its advantages, but the outlook would hardly be that best calculated to raise the spirits of the survivors.

BELMONT RETREAT.—We have received a circular from Mr. G. Wakeham, the proprietor of the well known Belmont Retreat,—a private establishment for the cure of insane persons and inebriates—stating that he is desirous of either securing a part-

ner or else selling out. This is an opportunity which might be availed of by some young medical man with a little capital, and who has had some experience in this direction.

THE NEW CITY HOSPITAL, HAMILTON.—We had the pleasure of a visit to this fine building a few weeks ago, which is almost ready for the reception of patients. The formal opening will take place shortly, and we will then have an opportunity of giving a detailed description of the building

OLD AUTHORS.—Dr. Oliver Wendell Holmes, in a recent address, alludes to the good things to be got by our going back to some of the older and now neglected authors. He says: "Would you know how to recognize 'male hysteria,' and to treat it, take down your Sydenham. Would you read the experience of a physician who was himself the subject of asthma, and who, notwithstanding that, in the words of Dr. Johnson, "panted on till ninety," you will find it in the venerable treatise of Sir John Floyer. Would you listen to the story of the king's evil cured by the royal touch, as told by the famous chirurgeon who fully believed in it, go to Wiseman. Would you get at first hand the description of the spinal disease which long bore his name, do not be startled if I tell you to go to Pott—to Percival Pott, the great surgeon of the last century."

—We have received a copy of the second annual report of the astronomer in charge of the Horological and Thermometric Bureaus in the Observatory of Yale College, by Leonardo Waldo. It contains a number of interesting statements concerning their work with reference to the correction of physicians' clinical thermometers. During the year, 3811 thermometers have been examined and returned to the owners with certificates. It is found that considerable improvement is being made in the manufacture of clinical instruments in the United States. Experiments have been made with a view of discovering some ready test by which one could estimate, with any particular instrument, the time required for obtaining the maximum reading; but this has not yet been obtained. The variations in

time are mostly due to the varying thickness of the glass forming the bulb, and the shape in which the latter is moulded.

Obituary.

PROF. BALFOUR, OF CAMBRIDGE.—By an unfortunate accident in the Alps this distinguished investigator has lost his life, and the University, which had so recently established for him a Chair of Morphology, mourns over an unusually brilliant son. Though a very young man Mr. Balfour had done exceptionally good work, and his two volumes of Comparative Embryology will secure him a lasting reputation. He was one of a band of earnest workers which Professor Michael Foster has gathered about him at Cambridge, and in a touching notice in the *British Medical Journal* Dr. Foster places on record a fine estimate of his life and work.

DR. ALEXANDER GREENLEES, of Toronto, died on the 10th. He graduated at Toronto University in 1870. Entering upon practice in Toronto he soon acquired a large *clientele.* For several years he lectured upon Practical Chemistry in the Toronto School of Medicine.

Personal.

Dr. Robert Wight, of St. Johns, Que., died on the 28th ult., aged 69.

Hugh Gale, M.D. (McGill, '82), has begun practice at Bad Axe, Michigan.

Alexander Shaw, M.D. (McGill, '82), has begun practice at Bancroft, Michigan.

Robt. C. Blair, M.D. (McGill, 1865), has moved from Chicoutimi to Three Rivers.

Dr. John Chiene has been appointed to the Chair of Surgery in the University of Edinburgh, in the place of the late Prof. Spence.

Napoléon Chevalier, M.D. (McGill, 1873), late of Iberville, Que., is at Lewiston, Me.

V. G. B. Chagnon, M.D. (McGill, 1861), late of St. Pie, Que., is at Fall River, Mass.

Dr. O. C. Edwards, who left this city for Qu'Appelle a short time ago, gives a glowing account of the district.

B. W. Burland, M.D. (McGill, '82), has begun practice at Mineville, N.Y.

John G. Kittson, M.D. (McGill, '69), formerly Surgeon to the N.W. Mounted Police, has begun practice at St. Paul, Minn.

Walter J. McInnes, M.D. (McGill, 1865), whose address in the last college commencement is given as East Saginaw, Mich., is practicing at Vittoria, Ont.

R. J. B. Howard, B.A., M.D. (McGill, '82), passed the M.R.C.S., Eng., on the 31st ult. Reuben Levi, M.D. (McGill, '76), passed the Primary of the same College. H. W. Thornton, B.H., M.D. (McGill, '82), and R. J. B. Howard, passed the L.R.C.P., Lond., on the 27th ult.

A medical friend writes from Winnipeg that "the city is in a beastly healthy state at present, and any number of medicos here." Another, an assistant surgeon on one of the sections of the C.P.R., gives an accout of pretty rough life looking after the men in the different camps.

Dr. Silver, for many years intimately associated with the editorial department of the *Medical Times and Gazette*, died on the 16th ult., aged 41. He is best known as the editor of Hooper's *Vade Mecum*, and as the author of a small work on "Practice of Medicine. He was a physician to Charing Cross Hospital, and a very popular teacher in the school.

The Registrar of the Medical Faculty sends the following corrections :—In the recently issued announcement the name of John R. Church should appear in the list of those who passed the Primary. In the list of Prize-men and Medallists the names

of J. M. Lefebvre, of Brockville, Sutherland Gold Medallist, 1878, and W. L. Gray, of Pembroke, Sutherland Gold Medallist, 1879, were accidentally omitted.

Medical Items.

British Medical Association.—The fifteenth annual meeting was held at Worcester on the 8th, 9th, 10th and 11th inst.

Four Years' Course in the United States.—At the recent commencement at Harvard University—28th June last—nine men graduated after a four years' course, whereas seventy-seven graduated at only three years. This is the first time that the longer course has ever been followed in any American college.

—The *London Gazette* of the 19th June announces that the Queen has been pleased to appoint T. Grainger Stewart, Esq., M.D., Professor of the Practice of Physic in the University of Edinburgh, to be one of Her Majesty's Physicians in Ordinary for Scotland, in the room of Sir Robert Christison, Bart., deceased.

—The new antiseptic, boro-glyceride, has been successfully used by Mr. Richard Barwell as an antiseptic in surgery. He places a few folds of lint soaked in the solution upon the wound. It is unirritating, and healing takes place in a perfect manner. The dressing is exceedingly simple.

—Carelessness at judicial autopsies is notoriously frequent in the United States (and perhaps here also). Insufficient remuneration is sometimes given as the cause. In a recent case, where the witness could not testify upon an important point and was asked the reason, he replied that "the authorities were only willing to pay for a dollar *post-mortem*, and he had given them only a dollar one."

A Mistaken Diagnosis.—A case of sickness occurred twelve miles from Fort Worth, Texas. A country physician in attendance was asked if the case was not one of smallpox. He,

in reply, stated no; that the case was one of extraordinary interest, and without parallel in his whole reading or personal experience. Further, that he would wager that, should Dr. A., B. or C. be called from Fort Worth they would corroborate his diagnosis, which was that the man had "erysipelas from the toes to the knees, measles from the knees to the waist, and seven years' itch from the waist to the top of the head." An intelligent physician being called in readily diagnosed confluent smallpox.

—Dr. Payne, in the *North Carolina Medical Journal*, strongly condemns kissing, from its liability to propagate disease, and cites the case of a young man in the secondary stage of syphilis conveying the disease by kissing to a child sixteen months old, the child in turn giving it to the mother.

—Dr. O. W. Holmes says he has known a practitioner—perhaps more than one—who was as much under the dormant influence of the last article he has read in his favorite medical journal as a milliner is under the sway of the last fashion plate. The difference between green and seasoned knowledge is very great, and such practitioners never hold long enough to any of their knowledge to have it get seasoned.—*Atlanta Medical Register.*

One Cow's Milk.—A child fed on one cow's milk recently died of tuberculosis, and the cow died a few months later of tubercular disease. If the milk of several healthy cows had been mixed with this one cow's milk, the results might have been different. See to the condition of the cow before selecting its milk for your babe.

Treatment of Tympanitis.—In Dr. Nicolas Culpepper's Astrological Judgment of Diseases (London, 1671), the following case is recorded: "I care not greatly if I relate the cure done in such a case by one of the wisest Physitians that ever the Sun shon upon in England, Dr. Butler of Cambridge. A gentleman was possessed with Wind in his belly; a great inflammation there was there. The Doctor comes to him, and perceiving the

original of it was wind, for he was a man of penetrating judgement, calling for a Rolling-pin; The man was never subject to covetousness, and as little to pride; Down turns he the Cloaths from the Bed; up he gets, Boots and all, not regarding the Holland-sheets; and falls to rolling the man's Belly with a Rolling-pin; the Patient's Fundament sounds an alarm, and certifies all the company that ease was a coming."

LACTOPEPTINE.—In the treatment of cholera infantum and other intestinal troubles so frequently met with among children and teething infants at this time of year, Lactopeptine will yield very satisfactory results; relief and recovery often follow rapidly after its use. We have no hesitation in recommending the preparation as one of great value.

MALTINE IN PHTHISIS. BY WM. PORTER, A.M., M.D.—"After full trial of the different oils, and extracts of malt preparations, in both hospital and private practice, I find maltine most applicable to the greatest number of patients, and superior to any remedy of its class. Theoretically we would expect this preparation, which has become practically officinal, to be of great value in chronic conditions of waste and malnutrition, especially as exemplified in phthisis. Being rich in *diastase*, *albuminoids*, and *phosphates*, according to careful analysis, it aids in digesting farinacious food, while in itself it is a brain, nerve and muscle producer. In practice, this hypothesis is sustained. A female patient at St. Luke's Hospital, aged 35, with phthisis, signs of deposit in left upper lobe, losing flesh for six months, poor appetite and night sweats, began taking Maltine March 13th, 1880. She now weighs 121 lbs., eats well, no night sweats, and the evidence of local diseases are much less marked. Another case of phthisis: A gentleman from Alabama, with all the physical signs of phthisis, rapidly losing health and strength. His was the remarkable gain of 10 lbs., *from six weeks use of* Maltine. These instances are sufficient for illustration, and are *duplicated many times in the experience of physicians everywhere.*"—*Quarterly Epitome of Practical Medicine and Surgery.*