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Original Communications.

PHOSPHATURIA.

BY H. ARNOTT, M.D., LONDON.

(Read before the Ont. Med. Association, June, 1887.)

The urine is justly regarded as the most important excretion of the body, from a clinical standpoint. Its constitution varies with every change of diet, habit or health. This very sensitiveness, whilst it gives us the reasonable hope that, at least, every serious disease would be accompanied by a corresponding change in the constitution of this secretion, at the same time warns us that we must be very cautious in our deductions lest we ascribe to disease a change that has been caused by exercise or diet. But if our knowledge were sufficiently thorough we should be able to tell the difference and to read disordered function by the character of this excretion almost as accurately as we do a book. I believe that our knowledge of the urine is only in its infancy and that at no distant day its importance in diagnosis will be much greater than at present. A wide field lies before the diligent student, the cultivation of which will yield him abundant satisfaction. Personally, I am willing to declare that I have received more light in the understanding of obscure cases from even my imperfect knowledge of this subject than from the study of any other single physiological system.

In making a diagnosis we pay attention to the urates, because ready to the eye in cold urine; to the amount of urea, because readily estimated by the urinometer and even by the eye, but the variation in the amount of phosphates is frequently neglected, probably because being largely held in solution they must be precipitated. Phosphoric acid is found in every tissue and fluid of the body in combination with a base and excreted in the urine, the amount varying greatly in certain pathological conditions. It is to the diagnostic importance of this variation that I wish to draw attention. I am aware that Prof. Vogel, after making a thousand observations, has declared that he can draw no inference of any clinical value, so I shall endeavor to avoid the quicksands of doubt and keep to a few points that seem to me to be solid and useful ground in differential diagnosis. Anything that will remove doubt and render diagnosis more certain is of the utmost importance, and I hope that a discussion of this subject will prove interesting and, perhaps, useful. Every one has been puzzled over symptoms that may mean a great deal or nothing at all. In such cases any definite symptom that would set the physician's mind at rest, even as to the reality of some of the symptoms complained of, would be very acceptable. If we discover oxalate of lime crystals in the urine of a patient suffering from a number of subjective symptoms it is satisfactory so far as it forms a basis of certainty from which to reason. We call the trouble oxaluria, for want of a better name, but it does not follow that we regard the crystals in the urine as anything more than the most definite

of a number of uncertain and unsatisfactory symptoms.

Prout, Golding Bird, and others, drew attention to the deposit of phosphates in the urine as a valuable symptom, and even styled the disturbance giving rise to it phosphaturia and expressed their belief in a phosphatic diathesis, but later investigations have dispelled the belief in any such constitutional tendency. I do not think that these acute observers understood the phenomenon to constitute the disease any more than we mean by the term glycosuria, to convey the idea that the passage of sugar in the urine constitutes the disease. They doubtless looked upon it as the most constant and definite of a number of symptoms presented by some constitutional disturbance not thoroughly understood. But they overlooked the important fact that a sample which is muddy from phosphatic sediment may contain very much less of these salts than one that is perfectly clear. Indeed, the probability is that the muddy sample will have a deficiency of phosphates, as we shall see hereafter. Different views have been held on this subject according to the point of view from which it has been studied. Thus, some have studied the phosphates only as they appear as a sediment in the urine, others have separated the earthy and alkaline phosphates but have neglected the total amount, whilst others have, very properly, I think, considered the total amount of phosphate excreted to be the only proper basis for a practical study of the subject. According to this last view, phos phaturia means any deviation from the normal amount excreted, whether increased or diminished. As might be expected, the views put forth by various authors differ as much as their methods of studying it. Some declare it to be merely a symptom of disorder of the stomach or liver, others believe it to be only a question of reaction, etc.

In order to prove that I am not drawing on my imagination, I shall trouble you with a few short quotations from prominent authors. Prout: "nervous irritability the cause of increased excretion of phosphates;" Bence Jones: "merely depressed acidity;" Dickenson: "exaggerated mobility the cause of an excess of phosphates;" Dana: does "not find excess in nervous irritation;" DaCosta: "in spite of the distinct sediment of phosphates it is doubtful if the latter are in excess;" Beale says: "there is not really an excess, but the urine being alkaline, the earthy phosphate is thrown down."

I need not trouble you with any more quotations. I have given enough to show the indifferent manner in which the subject has been studied. In my opinion the important thing is to ascertain the amount of phosphoric acid excreted, but as this would be somewhat troublesome, we adopt the simpler method of estimating the amount of phosphate. The base with which the acid is excreted is largely dependent on the diet, if that be full the tribasic compounds, are common, and the urine is neutral or alkaline, but if the diet be low the reaction becomes acid from preponderance of monobasic compounds and no phosphate is precipitated although there may be more present. Hence precipitation is rather an evidence of deficiency than excess of phosphates. Indeed, it must always mean either an excess of base, or a deficiency of acid.

A similar change may be brought about by the administration of alkalies. A patient whose urine does not present any precipitation of phosphates is given alkalies, and in a short time it becomes muddy and deposits a crust of phosphate on the vessel. Now I am satisfied that increased alkalinity may be the result of true dyspepsia, or even of some peculiar diet, but an increase or deficiency of phosphoric acid to any notable degree and for any length of time, must have an entirely different cause. When dyspepsia occurs under such circumstances it will always be found to be due to some nervous disturbance. This is an important and definite statement, and if I am wrong I would be glad to be shown my error. If it be true, then it must be important to ascertain whether the amount of phosphoric acid is increased or diminished in all such cases. On examining a sample muddy with precipitated phosphates, if I find the amount of phosphoric acid increased I order more rest to the nervous system; if, on the other hand, I find that the amount of phosphoric acid is normal, I request for a time a change or reduction of diet. In the latter case there is an increase of base due probably

to diet; in the former an increase of acid due to nervous exhaustion.

The phosphates appear in the urine in three principal forms: the triple phosphate, earthy phosphate, and crystalline calcium phosphate; each of which, if continued for any length of time, has a certain amount of clinical significance. The triple phosphate is found in cystitis, in states of decomposition of the urine and in some disorders of digestion, and along with other symptoms is valuable in deciding a doubtful diagnosis. The earthy phosphate, when largely deposited, generally indicates a neutral or alkaline condition of urine, which, if pathological and continued for a length of time, is an indication of a grave constitutional disturbance. The crystalline phosphate of lime is, according to my observations, found mostly in chronic diseases of the brain. If a doubtful diagnosis lay between some functional disturbance and an obscure disease of the brain, the discovery of this salt in the urine would decide me in favor of the latter. On more than one occasion I have seen this symptom determine the diagnosis, and correctly so, as the future histories showed. In only one case have I seen it absent where I felt sure there was organic disease of the brain.

But as before stated the most important point is to find out the amount of phosphoric acid excreted, and this is approximately arrived at by precipitating the total amount of phosphates present and estimating the relative amount. This need occupy only a few seconds, and I believe it will soon constitute one of the common tests in every examination of the urine. Dr. Dana, of New York, whose article in the *New York Medical Record* will well repay perusal, uses long tubes about half an inch in diameter and thirty inches in length. The tube is filled three parts with the sample to be examined, and the balance of the tube filled with a mixture composed of magnesia sulph. and ammonium chloride of each one part, liquor ammonia one part, and distilled water eight parts. This causes a precipitation of ammonia-magnesium phosphate, which in about twenty-four hours has settled firmly to the bottom, and the depth of the sediment shows the proportion which it bears to the normal.

With whatever form of test-tube used, a number of experiments with the urine of persons in good health, will soon determine the average depth, and any marked deviation therefrom will indicate the relative amount being excreted. Of course several analyses will be necessary before any conclusion can be arrived at. This may seem rather a crude test, but careful quantitative analyses show that it is sufficiently accurate for all practical purposes.

This simple test is of the utmost importance in many doubtful diagnoses, but unfortunately it has not been uniformly studied from this aspect. Many observers have studied the earthy and alkaline salts separately, whilst others have only taken note of them when precipitated as a sediment. As I intimated before, my observations lead me to the conclusion that whether the acid is excreted in combination with an earthy or alkaline base depends generally on diet or digestion, and is possessed of comparatively little clinical value. But the total amount of phosphate giving an approximation of the amount of phosphoric acid excreted is an event of much greater importance, as observation has shown that whilst the amount of base is regulated chiefly by the diet, that of phosphoric and uric acids varies only with constitutional conditions. Notwithstanding the different methods of studying the subject, there are many useful points on which prominent writers are agreed. For instance, Roberts, Tyson, Wolff, Belfield, and Hoffman and Ultzman agree that the total amount of phosphates are increased in acute disease of the nerve centres and diminished in the chronic stage of the same, with the exception of epilepsy. There is also a pretty general agreement that they are increased during, and for some time after, nervous strain. Dr. Beemer, Assistant Superintendent of the London Asylum for the Insane, who has written an able monograph on brain exhaustion, expresses the same view. I am inclined to believe that when the condition becomes sufficiently serious to justify the term "brain exhaustion," rather than nervous excitement, the phosphates will be found diminished to a marked degree, and reason tottering on her throne.

It is also becoming a recognized fact in the

diagnosis of chronic renal diseases that the phosphates are diminished. Purdy, in his valuable work on Bright's disease, places it as one of the symptoms in his table of differential diagnosis. But, while we have these few points apparently established, there are a great many others on which the authorities totally disagree. Thus, Hoffman and Ultzman find an increase in febrile affections, whilst Wolff says they are diminished, but increased during convalescence. Many authors consider that an increase of phosphates is only an indication of dyspepsia, but Hoffman and Ultzman find them diminished in "severe disorders of digestion." Hoffman and Ultzman find an increase in bone disease; Belfield says you would expect it to be so; but, in fact, they are diminished. And so there seems to be a disagreement with regard to many other diseases which, doubtless, in time, by the accumulation of clinical evidence, will be removed.

In two cases I found the phosphates notably diminished in the late stage of chronic diabetes mellitus. In one of these there was not for several weeks, during which the case was under observation, the slightest trace of phosphate to be found in the urine by the most careful tests. Being anxious to know what became of all the phosphoric acid, I had the fæces of this patient cremated and the ash submitted to a careful analysis by a competent chemist. I expected to find an increase in the fæces when there was none in the urine, but the result of my few experiments would seem to show that such is not the case, and that when not excreted in the urine it must be retained. May not the retention of so much acid in the system be one of the factors in the production of diabetic coma?

An excess or deficiency of phosphates has been most useful to me in the diagnosis of a class of functional nervous disorders where there is no positive symptom. In many such cases where the symptoms related by the patient may be fancied or real, they will often be found useful in deciding the doubt and directing the thoughts to the cause of the trouble.

Many of these cases will be found to be real sufferers from an over-excited condition of the nervous system, due generally to some long-continued drain, and is found among youths as well as adults. There are three principal classes of patients affected in this way.

In the first there is hyperæsthesia and paræsthesia of the nervous system generally. The patient is sleepless, and a peculiar restlessness torments his waking hours; the eyeballs are sensitive to light and tender to the touch; a ring at the door-bell goes through the patient like a painful shock of electricity; the most delicate food causes pain in the stomach; there is frequent scalding micturition, simulating cystitis; and sometimes shooting-pains and numbness of the extremities cause fears of organic nervous disease.

In another class of cases backache and melancholia are the prominent symptoms. In men, the elastic term lumbago often does duty as a diagnosis, whilst in the female the very same symptoms direct our attention to that veritable scape-goat of all obscure symptoms—the uterus.

In some of these cases the pain may be the cry of the lumbar nerves for more healthy blood, but I believe that in the large majority it is caused by the deposit of phosphatic or oxalic crystals in the pelvis or tubules of the kidney. In such cases I have sometimes found casts, doubtless formed by the inflamed condition of the tubules caused by these crystals. A short course of some saline diuretic, with free diaphoresis and restricted diet, generally gives prompt relief. There are many persons who are frequently affected with pain in the back caused in this way. If the cause is understood the treatment will be more satisfactory. It is frequently regarded as rheumatic, but a careful analysis will generally show the very opposite condition of urine to what is found in rheumatism.

A third class of cases complain chiefly of dyspepsia and weakness. There is intense irritability of stomach, the most delicate food causes intense pain of a burning character, and sometimes vomiting is so persistent as to cause fears of organic disease. In such cases anæmia is a prominent feature.

In order to satisfy myself of the truth of these views, I have endeavored to study the natural history of such cases unmodified by

medicine and without any treatment whatever but the removal of what I conceived to be the cause. In this manner, administering only a little colored water as a placebo, I have treated a number of severe cases of dyspepsia, anæmia, melancholia, etc., with the most satisfactory results,—and that, in some cases, after the ordinary medicinal treatment had failed. I do not wish to be understood as applying this treatment to any cases but those that are caused by some disturbance of the nervous system. In such, medicine will often fail without the needed rest.

I am convinced from my, so far, imperfect study of this subject, that the cause of any marked and continued increase in the amount of phosphates excreted is always due to some irritation of the nervous system, whether in the form of injury, disease, or over-excitement. When examining the urine of students passing their examinations, I have invariably found that the anxious, excitable student was distinguished from his cooler companion by a greater excretion of phosphates. But exalted function must always be followed by depression, and an excess of phosphates at one time will bring a diminution at another.

When giving expression to these views I have been asked why we never used to hear of nervous exhaustion. The answer is two-fold. In the first place, disorders that were formerly called "liver complaint," "dyspepsia," etc., are now recognized as merely the symptoms of "exaggerated nervous mobility," and treated accordingly. Again, the nervous strain of this age is immense when compared to that of even a generation ago. More rapid intercommunication, an increased consumption of tea, coffee, alcohol and other stimulants, a greater possibility giving rise to an increased desire for wealth, diminished rest to the nervous system through the improvement and cheapening of artificial light, the more general diffusion of literature and a system of education which exhausts the vital powers of youth before they attain maturity, are only a few of the ways in which the nervous system is more heavily tasked than ever before in the history of the world.

I have nothing new to suggest regarding treatment. If the theory be true, as I believe, that an excess of phosphate is caused by some irritation of the nervous system, it follows that our principle reliance must be on rest. Whether the complaint take the form of dyspepsia, weakness, anæmia, paræsthesia, insomnia or anything else, this must constitute the foundation of rational treatment. And this principle requires first to be applied to the digestive system. Many of these cases pit slightly on pressure all over the body, due to the deposit in the tubules of phosphatic crystals. A lowering of the diet increases the acidity of the urine, the tubules are cleared out, and, with or without the aid of a saline diuretic, the œdema is removed. In cases due to insolation or injury, counter-irritants are often singularly useful, to the base of the brain or along the spine as may be indicated.

There is no specific for these cases. Nitric acid and strychnia, as recommended by Golding Bird, are useful only so far as they improve nutrition. No amount of acid administered seems to have any appreciable effect in increasing the acidity of the urine, but this is soon effected by reducing the diet. This is an important point, for the more perfect the solution of the phosphates, the less likely they are to cause irritation of the kidney and the consequent œdema. I am fond of prescribing potass. bitartrate, in cases presenting any œdema, for the removal of this is necessary to an improved state of nutrition. Bromide of potass. is sometimes necessary to enable a patient to get sufficient rest; bismuth acts as a nervine tonic through its influence on digestion. Iron and quinine are useful after the nervous agitation has been soothed, and the condition of digestion improved.

I strongly object to the indiscriminate use of a tonic and stimulating line of treatment of such cases. Under such a course the patient gets relief, and is very well satisfied; but he does not know at what a fearful cost to the reserve forces of his system the respite has been purchased. Such treatment represents just so many drafts on his latent vital forces. No additional force has been put into the body—only measures which call out its reserves have been used, and the time soon arrives when such

drafts are dishonoured, the system fails to respond to such demands, and the patient becomes a hopeless nervous wreck. The onward march of rational medicine demands that such a ruinous policy be abandoned for the more enlightened course of husbanding our reserves.

DISCUSSION ON SURGERY.

BY F. W. STRANGE, M.D., TORONTO.

(Read before the Ont. Med. Association, June, 1887).

When I received the honor of an invitation to open the discussion on Surgery at the present meeting of our Association, I was, at the threshold of my attempt, embarrassed with the extent and richness of the wide field from which I had been requested, by our esteemed President, to glean a few ears of surgical grain for mutual discussion. Reflecting on the objects and scope for which we are gathered together, and remembering that our membership is composed, for the most part, of gentlemen busied in the arduous and noble lives of general practitioners, I considered that it would not be amiss to abandon the customary plan of submitting for discussion a thesis on a subject which, while of important interest to all surgeons, falls more especially within the province of an hospital surgeon, and to substitute therefor some topic with which we are all familiar, and with which we all have more or less constantly to deal.

I have, therefore, ventured to introduce a group of subjects which have certain kinship, and to ask the gentlemen around me to contribute their views and experience on the treatment of

I. Whitlow; excluding from this term paronychia and superficial abscess of the fingers.

II. Phlegmonous erysipelas.

III. Carbuncle.

And first as to Whitlow. We are all acquainted with it, but woe to the surgeon who allows his familiarity to lead to contempt. I think I am safely within the mark when I say that I honestly believe I have seen as many permanently damaged and deformed fingers, resulting from whitlows neglected or badly treated, as I have from direct injuries from accidents. A man enters my surgery with the end of one of his fingers hard, red, swollen, and exquisitely painful. The slightest pressure will intensely aggravate the pain. He tells me has run a splinter of wood, or possibly a rusty tin tack, into the part, or has injured the finger by a crush or bruise. Occasionally no exciting cause has been noticed. I summon my pathological knowledge to my aid, and I see that there is an intense inflammatory process going on in the pulp of the finger, commencing in the dense cellulo-fibrous tissue in which the ungual phalanx is imbedded, and causing more or less irritation and inflammation of the lymphatics of the arm. But if the case be a more extended and severe one, I shall probably find that the inflammation extends to the sheaths of the tendons, that the whole finger participates in the process, that the back of the hand has become puffy, red, and swollen, presenting the ordinary characters of erysipelas, and that the palm of the hand has swollen and become white owing to the thickness of the cuticle and its close connection with the fascia. Having satisfied my mind as to the pathology of the case, the next thing to consider is what shall I do for my patient, how shall I treat him? Many are the vaunted abortive remedies. Plunging the finger into very hot lye, human or otherwise, is a favorite panacea to the lay mind; so also is an abominable plaster of soap and sugar, which to my mind only adds to the mischief by increasing the tension of the part. I have known them tried often, with no success. Painting the part with nitrate of silver or tincture of iodine has been extolled, but in my hands has utterly failed. In fact, in my experience, all the highly extolled abortive remedies have indeed proved abortive remedies and nothing else. Some practitioners are content with ordering hot poultice after hot poultice, as the only topical remedy, with a view to bringing the whitlow to a head. I regard this expectant measure as one fraught with the greatest danger to the vitality of the part. By its means, no doubt, suppuration is hastened; but, alas! instead of coming to the surface—to a head as it is called—the pus has a much greater tendency to burrow along the sheaths of the tendons, and produce

that lamentable condition of things of which I have before spoken. My own practice is, the moment I see a case of whitlow, and am sure of the diagnosis, to plunge a scalpel through all the tissues well down to the phalanx, and make as free an incision as the parts will permit. I never wait for evidence of suppuration. I am content to relieve tension, obtain local depletion, and make a way of escape for pus in advance of suppuration. This having been done, I soak the incision for a few minutes in water as hot as can be tolerated, in order to encourage bleeding. Now is the time to apply the hot poultices without stint and without fear. I then order a brisk purgative or two, rectify any general condition that may be noted, by means of appropriate medicines, and dismiss my patient with fair assurance of speedy restoration to health and work.

The arm has swollen and becomes a deep scarlet in color, with pungent burning pain. The swelling is first œdematous, then tense and brawny with the skin stretched to its utmost capacity. In fact the arm is laboring under the second subject for our consideration, viz., phlegmonous erysipelas. What follows? Resolution occasionally though rarely occurs; but usually, hidden by the change of size and color, pathological changes of a deadly character quickly ensue. Suppuration and necrosis attack the deeper structures involved in the process, both soft and bony, and the sufferer's limb, nay his life also, is in imminent peril. There must be no dallying now with the expectant treatment. The patient's safety lies in the surgeon's scalpel. Numerous parallel longitudinal incisions from two to three inches long, avoiding the positions of the arteries, and sufficiently deep to reach the bottom of the inflammatory process, which, in the limbs, is usually limited by the deep fascia, should be made. This practice was originally introduced by Mr Hutchinson, and modified by Mr. South so that the parallel incisions should alternate with each other. Here, again, the knife should be beforehand with the process of destruction. The relief of tension, the free escape of exuded serum, and the local blood-letting are so many ministering angels to the suffering parts. Should hemorrhage ensue too freely from any of the incisions, it is easily controlled by a plegget of lint stuffed into the incision, and pressure for a few moments by the fingers, or a pad and bandage. The incisions should then be covered with a piece of antiseptic gauze or lint, and hot fomentations or poultices, containing a watery extract of opium to soothe and tranquilize the injured nerves, should be constantly applied.

Such, in my judgment, is the only local treatment on which much reliance can be placed. It is true, as I mentioned a moment ago, that occasionally under very favorable conditions, and by the aid of appropriate internal remedies which I shall have occasion to refer to shortly, aided by hot external appliances, especially a strong lead and opium lotion, resolution may occasionally take place. But how is the surgeon to foresee this happy result? I know of no rule by which he can govern his action. Extended experience, and profound judgment may enable him to do so, but I fear he is just as likely to err as to hit the mark. My strong conviction is that early incisions through the entire depth of the morbid process, both arrest the progress of the disease and, to a great extent, limit the area of suppuration and necrosis, and preserve intact, structures which, if not so treated, would inevitably become greatly damaged, or even die. On the other hand, supposing the case to be one of the fortunate ones in which resolution would have supervened, and the surgeon has made his incisions. What damage has the patient sustained thereby? Simply little or none. Resolution will be, if anything, hastened. There will be slight suppuration from the surface of the incisions, but they will rapidly heal, leaving only a few white lines in the skin to mark the site of the battle-field on which disease and the surgeon have measured swords.

In considering the general treatment of such a case, we must not lose sight of the type of patient who is generally the victim of the disease. It is most common, I believe, in those who have been intemperate in eating and drinking. Next to these, I should place those whose health has been impaired by hard work and privation. In both cases, it is well to cleanse the portal system, and unlock the bowels. In

the intemperate class, much benefit will accrue from a good, prompt emetic, followed by saline aperients. In the over-worked class, I should omit the emetic, and administer warm stomachic aperients. Following this, as soon as the tongue begins to clear, I order tincture of iron, 15 to 20 drops every four hours. I do not possess the faith that iron is useful in cutting short erysipelatous inflammation, such has not been my individual experience, but I place it in the highest rank as the best drug we possess to restore the health of such individuals to its proper balance, and to hasten permanent convalescence. Quinine, mineral acids, and strychnia may also be necessary. This disease is one of those in which I say unhesitatingly, that the administration of alcohol is frequently absolutely necessary. It has bridged over many a bad case for me, and is, in my opinion, one of the most useful drugs we have in combating the disease. Opium also in many cases is of great service as a stimulant.

I now pass on to the consideration of the treatment of carbuncle. Here again we have a spreading inflammatory condition attacking the subcutaneous cellular tissue, which rapidly runs into slough and suppuration. The slough is characteristic of the disease. The cellular tissue involved, breaks down into greyish or ash-colored sloughs. The skin covering the part affected becomes slightly elevated, assumes a purple or brownish red tint, becomes undermined, and gives way at several points, forming openings through which the ash-grey sloughs appear, and from which an unhealthy, purulent discharge, scantily issues. The extent of the disease varies from one to several inches across. The local treatment of carbuncle is one in which great diversity of opinion exists. Sir James Paget, Mr. Le Gros Clark, and others emphatically urge the expectant or do-nothing plan. Destruction of the diseased part by nitrate of silver or caustic potash has its advocates, while others regard the time-honored crucial incision as the best method. In view of such diversity of opinion, it may appear somewhat arrogant and presumptuous on my part to speak decidedly in favor of either plan, but every surgeon should have the courage of his own convictions, and I have no hesitation in giving my allegiance to the crucial incision. The incisions should be made sufficiently free to reach healthy tissues, both at the base and the sides of the sloughs, and this is the point to which the surgeon should direct his chief attention. If the incisions are carried short of this, the spreading of the disease will probably continue, and the operation prove in a great measure futile. If healthy tissue be reached by the point of the knife throughout the entire length of the incisions, the spreading of the disease will be immediately checked, the sloughs will be rapidly thrown off, and a healthy granulating surface appear. Profuse, primary or secondary hemorrhages may occur, but as the disease in most cases is situated at the back of the neck and trunk, it is not difficult to apply sufficient pressure to control it. I have made incisions of this character, over five inches in length, and have seen no bad effects therefrom; but on the contrary have been gratified at the beneficial result. So strongly am I convinced of the desirability of the crucial incision, that were I the victim of carbuncle, I should urge my professional attendant to resort to it.

Mr. Timothy Holmes, who is in favor of the crucial incisions, records the case of a "man admitted into St. George's Hospital, in whom a carbuncle had been treated on the expectant plan, and the result was an immense ulcer occupying the whole of the nape. Soon after his admission another carbuncle formed, and was rapidly extending. A crucial incision soon stopped its course, and he recovered with hardly any mark from the second carbuncle, forming a striking contrast to the tremendous ravages of the first."

After the incisions have been made, hot poultices should be applied to hasten the separation of the slough, after which stimulating ointments, such as the ung. resinæ or ung. terebinthinæ will increase the vitality of the part, and hasten the growth of granulations. I have never had occasion to substitute any of the caustics for the knife, and consequently have no remarks to offer on the plan of treatment by these agents, but I can imagine the objections to their use on account of prolonged pain, and constitutional irritation.

As the disease is one of advancing years, and almost invariably occurs in persons whose con-

stitutions are broken down by concurrent diseases of the viscera or blood, our general treatment resolves itself into one of support and nourishment, and of all our drugs, opium in small, continued stimulant doses, is paramount. Half a grain of pure opium every six hours, increasing the quantity if necessary, acts like a charm. It subdues the pain, equalizes and strengthens the heart's action, soothes the nervous irritability, and produces refreshing sleep. Stimulants also, especially good, sound red wines, porter, and ale are of great service. Co-existing diseases must of course be treated on their own merits.

I have as briefly and concisely as possible gone over the ground of the treatment of these three affections, merely introducing such of the pathology of each as is necessary to keep the bent and scope of our discussion directed to the best methods of restoring the damage done by those pathological changes. I have purposely avoided all speculative inquiry into the remote causes of these diseases, and have endeavored to open the discussion as practically as I could. The surgical point which I have endeavored to make, is this, that in all three affections, the early and free use of the knife does actually limit the extension of the disease, and is greatly conservative to the integrity of the part attacked, and that in all cases in which deep structures are threatened with destructive inflammation, the employment of the knife should if possible precede the destructive process. If empiricism is understood to mean that which is founded on experience, I must confess myself an empiric, and in that character I beg to express the hope that the gentlemen around us to-day, more especially those who live in the country districts, and who are compelled by force of circumstances to be more self-reliant and self-dependent than those who dwell in the cities, will sustain this discussion, and favor us with their practical experiences on these questions. By doing so, they will aid in the advancement of our Association, and assist their professional brethren in their difficult labor of subduing pain, and easing the burdens of their disease-stricken fellow-creatures.

About fifty students are now in attendance at the Hospital Summer Session.

PELVIC HEMATOCELE.

BY DR. POWELL, OTTAWA.

(Read before the Ontario Medical Association, June, 1887.)

I would ask your attention a few moments to a case I propose to relate that recently came under my observation, causing me much anxiety for my patient's welfare, and much satisfaction and surprise in its happy and unlooked-for termination. I have termed the case one of pelvic hematocele, as I believe that term, in its wider signification, covers all those cases of blood effusion into the pelvic cavity, which are bound down either by adhesions or by the regular tissues of this region, and are thereby converted into the so-called blood tumors, and this whether the effusion be intraperitoneal, retro- anti- or peri-uterine, which I believe is the most common variety, and due to several causes, or extra-peritoneal into the cellular tissue of the pelvis, which is less frequent. I would probably be more correct, and in greater accord with modern nomenclature, were I to term my case a pelvic hematoma, and no doubt this would indicate to the large majority of my hearers the pathological condition present.

I have made a tolerably careful search through the literature at my command, but have not met with a case similar to the one I propose to relate, though cases of the same nature are referred to by Dr. West, M. Virsin and Beruntz, and also one by Cogeaux, and I regret not having access to the latter's cases, because in Dr. Playfair's work on the "Science and Practice of Midwifery," an aggravated case of Cogeaux's is there referred to, though the details are not given. The best description of the condition as it applies to my case, that I have read, I may mention is in the work just referred to—Playfair's "Science and Practice of Midwifery." On March 2nd, this year, I was hastily summoned to Mrs. P——, said to be in labor. On my arrival I found that she had been taken in labor at full term at noon, that it had progressed very rapidly with strong expulsive pains, and that the child, a well-developed female, had been ushered into the world quite unexpectedly by a strong expulsive

effort before the mother was in proper position on the bed, she not anticipating the birth so rapidly. It was born, therefore, before I entered the house. The mother was a strong, healthy woman, an artizan's wife, aged 25, and she had enjoyed excellent health throughout gestation. I recognized her as having attended her in her first labor in September 1884, when, on reference to my note-book, I find she was delivered of a healthy female child at full term, the labor being in all respects normal, and she made at that time a rapid and complete convalescence. She informed me that since September 1884 she has had two miscarriages. I may say that on this present occasion my friend Dr. McDougall had been engaged to attend, and it was in his absence that I was summoned so hastily. I satisfied myself that there was no hemorrhage, and moderate pressure on the fundus, which was well contracted, soon expelled the placenta. The third stage was quite normal, as was also the placenta itself, and no hemorrhage followed; indeed, she lost less blood than usual on such occcasions. I left her after careful bandaging, and she expressed herself as quite comfortable and in no pain. This was at 2.30 p.m. I sent a message to Dr. McDougall to see his patient on his return home. Within an hour a message reached me that Mrs. P—— was in great pain. I sent her a morphia powder to soothe her if pain continued. At 5 p.m. I was sent for hurriedly, the message stating that she was still suffering severely. On my arrival I found that Dr. McDougall had been there, and had given her a morphia powder, and that she had also taken my half grain, but had experienced no relief. I was struck by her appearance, which was that of acute suffering and of fear. She was blanched, her features were pinched, and she complained of an agonizing pain, not in the lower abdominal region as I had supposed, but in the lowest segment of the rectum, and as she expressed it, she wanted to pass something and could not, though she was straining quite vigorously. I at once instituted an examination, and to my horror, on passing my finger into the vagina at once encountered a firm, elastic, tense tumor filling the pelvis almost completely. The vagina was flattened towards the pubes, and I could not reach the os uteri. On rectal examination the same tumor was felt through its walls, the rectum being also flattened, not directly backwards, but rather towards the right side of the pelvis, and the sensation to the finger was the same as per vaginam, viz.: firm, tense and elastic. The hand placed on the abdomen, the fundus was felt pushed high above the pubes, and to gain slight comfort the bandage had been unpinned by the nurse half-way up. The bowels had been well cleared the morning of the labor by castor oil, and she had passed water freely before the onset of labor, and during the pains as well. I felt I had to deal with a pelvic hematocele, and its situation, to my mind, forbade the intraperitoneal variety. I was not alarmed as to the hemorrhage itself, because I knew that in all likelihood it would be controlled by the pressure exerted through the pelvic viscera and cellular tissue, and, besides, her appearance rather suggested a condition of fear and nervous shock than the blanching due to excessive loss of blood. Her lips were not completely anæmic, and her pulse was fairly good. The flattening of the vagina was such that I feared, perhaps, the lochia would be obstructed. Pain, then, was the chief symptom I had to deal with, and, as I say, it was referred entirely to the lower rectal region and about the coccyx. Dr. McD. not being expected home for 6 or 7 hours, I administered a full hypodermic dose of morphia and atropia into the coccygeal region, which soon gave complete relief, the pain not returning till about 5 or 6 a.m. the day following. About 9 a.m., 3rd March, Dr. McD. and I visited her. The symptoms had not changed. The intense pain had returned in the rectum with the desire to evacuate something; her appearance, however, had greatly improved since the preceding day. The lochia had been normal in quantity and quality. She had not passed water, so we catheterized her and again gave a hypodermic in the coccygeal region. The local pelvic condition was unaltered, but as far as I could judge the hemorrhage had not increased, as the facts all bore about the same relative position as the afternoon before, and the tumor gave the same sensation to the touch. Dr. McD. agreed with the diagnosis, and the woman being fairly comfortable when the pain

was in abeyance, and the lochia being properly established we determined to let well alone, giving a very guarded prognosis. That evening she was seen also by Dr. H. P. Wright, who agreed with the diagnosis and course we proposed to pursue. Another hypodermic was then given.

On the morning of the 5th, at the usual visit, there was a subsidence of the symptoms, the woman expressed herself as feeling comfortable, was in no pain and had lost all sense of distress. She said that very early in the morning she felt as if something had given way, to her great relief, and on examination it was found that nature had done what art feared to interfere with, and that the cellular tissue about the ischio-rectal fossa had given way to the blood, had forced its way down beneath the perineal fascia and had extravasated between the layers of cellular tissue and fascia under the skin of the inside of the left thigh and over the buttock to the outside of the hip, and no doubt also between the layers of gluteal muscles, as the left buttock felt firm and resisting in the region of the large ecchymosis. On vaginal examination there could still be felt a soft boggy swelling, quite unlike the former firm, elastic, tense one, and it was no doubt the melancholy or rather happy remains of the pelvic hematoma. No untoward symptoms occurred to mar the convalescence which was rapid and in all respects normal, and the patient was out of bed in a fortnight. The remains of the tumor were gradually and rapidly absorbed, and on the 2nd of May I had the privilege of examining her and found no trace whatever of her former tumor. She was strong and well and her appearance did not belie her, and she was preparing to leave town for the Eastern Townships to earn a holiday. Now, in considering this case, to me a most interesting one, I believe it is almost unique, though the condition, as I remarked before, is referred to casually by several authors. It is so by Meadows in his work on Midwifery, yet writing in the *Lancet* of Nov. 15th, 1873, he says he never yet met with a case of pelvic hematocele or thrombus where the blood was effused in the cellular tissue of the pelvis outside the peritoneum; and again he says, "In a certain number of cases, but they are in my experience very rare, the hemorrhage occurs in connection with pregnancy, or rather with delivery, either at term or more commonly prematurely, especially during the earlier months." This must, of course, refer to the usual intraperitoneal variety when taken in connection with his former statement. I mentioned before some authors who refer to somewhat similar cases, but I have not access to the details. While speaking of the causes, Thomas says that they are predisposing, because it is rare to meet with the disease in a woman who has previously been in perfect health. In the case under discussion no bad condition of the health was observable, though pregnancy was here the predisposing cause. Speaking of the exciting causes, Thomas coincides with the other authors who have dealt with this subject, and the only one that would seem to cover our present case is given by him as "violent efforts." The most recent article is that by Lawson Tait, and he may be quoted freely as probably the highest authority on this subject, and certainly the one whose writings are the most lucid and the most free from confusion and mystery. The article I refer to is the Ingleby Lecture of last September, given in full in the *Lancet* of October 30th, 1886. Speaking of extra-peritoneal hematocele, he says there are only two causes known to him—one very common, viz., a sudden arrest of a metrostaxis, and this may be that observed after abdominal operations or ordinary menstruation; and the other very rare, viz., rupture of a tubal pregnancy about the 12th week. In these cases the hematocele takes place into the broad ligament. As to the cause of the hemorrhage in the case we are considering, of course it is obscure, and fortunately a *post-mortem* examination did not step in in this case to throw light on the question, but it was in all probability due to rupture of one of the veins of the plexus about the cervix and upper part of the vagina. It is easy to understand that during pregnancy these veins are apt to become gorged and even varicose, just in the same way as occurs in the labia and thigh and even the leg, and in this present case I incline to the opinion that the cause of the ruptured vein was the almost precipitate labor, for such it was at

its termination, and the violent expulsive effort of the woman just as the head reached the perineum caused the vein to tear. It certainly did not take place prior to delivery, because such a tumor would have prevented anything like a rapid ending to a labor, and besides when I delivered the placenta I would most certainly have been struck with such an abnormal condition even if the patient had not complained of pain or of anything unusual in her sensations, and no such hematocele could occur without attracting her attention as to something unusual having happened. As a matter of fact, no word of complaint came from her up to the time I left the house, which was about half an hour after the delivery.

REST IN THE TREATMENT OF WOUNDS.

BY DR. MURRAY, OF THORNDALE.

(Read before the Ont. Med. Association, June, 1887.)

On the 18th of Feb., 1885, I was called upon to treat a lacerated wound of right thigh of J. Mc——, aged —, who had been gored by a bull; the upper wound extended nearly into the bone; and the adductors being torn through, the sheath of the femoral vessels was exposed. The horn of the bull being short and blunt, allowed the artery to slip off the end, but tearing the sheath of the vessels six inches below, the horn had passed through under the artery without tearing through. The tissue between these two wounds sloughed away, leaving the femoral artery exposed in the upper part of its course. What I feared was, that there would be hemorrhage from the injured artery at a point where it had been injured, but during the critical time we watched it night and day, the nurse having instruction to compress the artery until I arrived. A question just here comes in, in case of hemorrhage above the profunda, would there have been any other alternative than amputation, the one upon which I had determined? The wound was dressed antiseptically, a perforated drainage tube placed through the wound, the ends being covered with antiseptic compresses, the discharge was not very great. We cannot lay down any fixed period when the first dressing should be removed. When through a crush or a bruise we are uncertain whether there will be sloughing, absolute quiet of the part is essential. To use a legal phrase, the surgeon should show cause why he should interfere before he does so, for it is not to be denied that even with the gentlest and most skilled manipulation there must of necessity be some interference with the reparative process, some slight tearing away of the new reparative material, some taking away of support where support is essential, or removal of local pressure when such is needed. The point upon which I desire to lay stress is the absolute rest of the injured part; complete immobility of the part should be guaranteed by the judicious application of splints, pads and bandages; this fact, like the ten commandments, needs continual enforcing, the tendency is to do something. Our position should be one of "masterly inactivity." The prisoner is given the benefit of the doubt; where the life of the part hangs in the balance, treat it as though we believed it would live, and how can we better do so than by making the conditions as favorable as possible for the spark of life that remains. Public speakers often forget some of their best thoughts when on the platform, and I am reminded by my experience in this case that the surgeon is apt to do the same; on dressing this wound the first time I did not place myself in the most comfortable position. He should therefore place his patient in the most comfortable position he can and then place himself comfortably, for no surgeon can do his work well if he is in a constrained position. The wound must be kept clean under all circumstances and free from every septic risk, the wounds of the class we are considering particularly. A wound must be kept quiet if repair is to go on steadily, and this quiet is as necessary for the lacerated as the incised wound or the fractured bone.

CHOLERA INFANTUM.—Dr. Her (Ottœssa) extols the hydrochlorate of cocaine in cholera infantum. He has used it successfully in cases where the limbs were cold, the eyes sunken, face cyanotic, and the pulse very rapid. He gives a centigramme every hour or every two hours as indicated.—*Lyon Médical.*

Selections.

☞ *We are indebted to* DR. NEVITT *for the translations from the Italian and to* DR. ZIMMERMAN *for the French.*

TREATMENT OF SCABIES; CLINIC.

BY PROFESSOR KAPOSI.

The treatment of scabies, so simple as it is, so clear the indications, so effectual the remedies at our disposal, is however not so simple after all. Before we had any suspicion of the existence of the itch insect and the people with a practiced eye recognized the disease, a remedy was known for it, and sulphur was used to cure the itch as far back as there is record in history, and is still a sovereign remedy against it. Since scabies has been recognized as a disease which is produced by certain epizoon, the acarus scabiei, much consideration has been given, both in relation to the remedies for its cure and also the methods for their use. Besides sulphur are used solutions of certain metallic salts as sulphate of copper, then also petroleum, balsam of Peru, styrax, soaps, pix liquida, and other preparations of tar, also a great variety of the æthereal oils as juniper, rosemary, cloves, etc. In earlier times it was the custom—and sometimes is the custom among the people now—that the patients before being anointed were placed in a bath and rubbed with soap, then some sulphur or mercurial application was made after which, being wrapped up in blankets and a diaphoretic drink administered, they were allowed to sweat. This method which was much practiced in England was called the "*English* cure."

A rational treatment of scabies must proceed from a definite standpoint. The question must be decided, what remedy, which method, and under what circumstances it should be used. Scabies is an eczema produced by a particular cause, a cause which continues to exist, viz., the acarus scabiei. The first indication therefore is to remove the cause. If the eczema be cured by itself, the insect will continue to irritate the skin and the patient will still have the disease. A remedy must therefore be used which will destroy the insect and its eggs. Such a remedy acting chemically can produce eczema by itself, therefore it is important to use that remedy which will most quickly destroy the insect and its eggs and at the same time cause the least possible irritation of the skin and even relieve the eczema. It is further of importance to secure a medicine whose action in destroying the insects and their eggs is evident to the eye. Certain remedies cause eczema papulosum, which is itchy; the patient scratches himself, and you don't know whether he scratches because of the eczema or because the acarus is not yet completely destroyed. With the balsamic remedies, such as balsam of Peru, styrax, petroleum, etc., one cannot know, owing to the condition of the epidermis, whether the medicine has entered the furrow of the insect and killed it. By the use of tar, this enters the furrow, which immediately becomes black as if injected with ink, and as the acarus cannot survive tar, one knows that it is destroyed. If now the patient continues to be itchy, and one finds that in every part of the body the tar has entered the tracks of the insect, one at once discontinues its use and employs the most soothing remedies to relieve the irritation of the skin. Here, in the clinic, the treatment of scabies averages with men from three to five days, and with women five to seven days, because an eczema about the nipple, which is common in women with scabies, is very obstinate, and often requires three months to cure. The treatment of scabies is only completed when the eczema produced by it is also cured, hence we do not consider here the patient cured when our application has been made, but only when the skin is restored to its normal condition. In the milder form one application of an efficient remedy suffices, but when the disease has lasted months, and the accompanying eczema has become intense, then several applications are necessary to complete the cure. Of the numerous remedies which have been employed against scabies, one of the best is the modified Wilkinson's ointment:

℞	Flor. sulphur.....	œ
	Rusci ana.....	20 parts.
	Sapon. virid.....	40 "
	Pulv. creta alb.....	5 "
	Adipis.....	40 "

The ointment is a brownish black, and every furrow is injected by it, the epidermal layer shrivels up, and the eczema is to some extent improved. This is an excellent remedy; after many experiments with other remedies we have always returned to this one. We have used the balsams for years, but they have not supplanted Wilkinson's ointment. A great objection to the latter, however, is that it is black and smells strongly. Many patients will not submit to be anointed with it on this account. A few years ago I discovered a remedy which had not this disadvantage, and that is naphthol. Prof. E. Ludwig has investigated to learn what was the particular constituent in tar which diminished the itching, caused shrivelling of the epidermis in the eczema and reduced the hyperæmia, etc. With this view, we have tried many substances and after different experiments have found naphthol a very efficient remedy. Naphthol is an ash gray, violet-tinted substance which has a smooth crystalline feel, insoluble in water but easily soluble in alcohol and oils, forming a clear solution. Too frequently applied it produces an erythema toxicum. Napthol is therefore a poisonous substance, it is very quickly absorbed and is removed from the system by the kidneys. Therefore care must be exercised in the method of its use. Lesser employed a scabies ointment with 25 per cent. of naphthol and observed unpleasant symptoms as a result. I have advised only a ten per cent. solution. It has been used in immense doses—which I have condemned—and in some few cases a fatal termination has resulted. In our experiments with naphthol we observed, in the case of a boy on whom a 5 per cent. solution had been used, an acute attack of eclampsia supervene and Bright's disease develop. However, after 8 to 14 days the symptoms subsided, and then he bore the naphthol very well. Since then we have seen no disagreeable result from the use of naphthol so long as we kept within the above-mentioned limits. In prurigo we use a 5 per cent. solution of naphthol for weeks, but for scabies, after the application of a 5-10 per cent. ointment, the acari are destroyed. Now, however, when we have established the physiological fact that the naphthol suffices to destroy the acari, it is advisable also, in order to alleviate the accompanying eczema, as quickly as possible, to use green soap in addition. We have accordingly produced an itch ointment, the ung. naphtholi co.

℞. Naphtholi.....15 parts
Saponis virid.....50 "
Adipis.....100 "
Pulv. cretæ alb.....10 "

The patient is anointed with this salve without any bath previously, whereby the skin might be irritated. This ointment is applied only once, whilst the Wilkinson ointment requires always two applications. The naphthol ointment further is colorless and odorless, and as a comparatively small quantity is used the linen is not ruined but acquires in course of time only a violet hue, and does not become filthy as with tar. Further, with the naphthol ointment the skin feels soft and supple. After the application the patient should lie quietly in bed for a few hours between woollen covers. Such has been our treatment since April, 1883, and since that time we have had no reason to depart from it. Now and then we use the Wilkinson salve because it has, perhaps, a better effect on the eczema. Other remedies which may be used with good results in scabies are balsam of Peru and petroleum. The latter, however, is a dangerous remedy owing to its combustibility, and we are not justified in placing in the hands of people in the lower ranks of life—and it is among such people that scabies most frequently occurs—a remedy which requires so much care; the poor people are not in a position always to watch their children who might easily cause it to inflame. If one uses petroleum, one should always mix it with something which lessens the danger of combustibility, such as balsam of Peru. Petroleum has also another disadvantage, in that it smells disagreeably, and also irritates the skin in eczema. Therefore, since we have so many anti-scabietic remedies, I am against the use of petroleum. Balsam of Peru is a very good remedy if the symptoms are very slight; styrax also answers the purpose, but it is sticky and filthy and smells abominably; besides, on account of its tough consistence, one cannot use it alone; mixed, however, with other remedies it does very well. For instance:

℞ Styrac. liquid.....10 parts.
Petrolei venal.....20 "
Bals. Peru .....5 "
Spir. sapon. kalin... 20 "
Flor. sulphur .....10 "

To be well shaken before using. The celebrated Alibert remedy is chiefly a simple sulphur ointment.

℞ Lact. sulphur..... 20 parts.
Ung. emollient.....100 "
Sapon. medicin..... 5 "
Ol. neroli..... gtt. x.

The Bourgonignon ointment is very expensive and smells strongly, besides all æthereal oils irritate the skin. For all that is necessary, however, sulphur will suffice, and it may be made into an ointment with lard or butter or soap. You will observe therefore that for itch remedies we labor under no difficulty.—*Wiener Medizin Zeitung.* G. R. McD.

LAWSON TAIT AT HOME.

. . . The next morning, at nine o'clock, found me again at Mr. Tait's house, as the operations were to be performed in his private hospital, which constitutes a part of his house. I was shown into a room where a number of physicians had congregated. As we were all strangers to each other, silence reigned supreme until we were informed by one of the nurses that everything was ready. We filed up a flight of stairs and entered one of the rooms, where we found Mr. Tait standing by the side of the anæsthetized patient in his shirt sleeves and a rubber apron. The temperature of the room was comfortable. A female assistant administered the anæsthetic, and a young physician stood opposite Mr. Tait ready to render assistance, but it soon became evident that his presence was more ornamental than useful, as the operator appeared to require no assistance. The few instruments that I saw were kept in clean pans. The often described bag containing the sponges was hanging from a nail upon the wall, and was taken down and a few sponges thrown into a basin of warm water. The patient's abdomen had not been shaved, and was now sponged off lightly and covered with a rubber cloth with a slit in the centre. The first patient was a lady, about fifty years of age, suffering from an abdominal tumor which extended a little above the umbilicus. The abdominal incision was made quickly, and was about two and a half inches in length. The omentum was found adherent to parietal peritoneum, and the adhesions were separated by tearing. As soon as the cyst was exposed it was tapped with the blunt fenestrated trocar devised by the operator. This instrument does not cut the tissues when it is pushed through the cyst wall, and consequently extravasation along the side of the tube does not take place, a source of trouble and danger attending the use of all trocars with a cutting edge. The pedicle of the cyst was twisted and appeared like an umbilical cord. The pedicle was transfixed with a long needle slightly curved at the end, and threaded with medium-sized Chinese silk, which, after the needle was withdrawn, was tied into a Staffordshire knot. The operator showed his unlimited confidence in this method of tying by dropping the pedicle at once in every instance, without examining the cut surface or separately ligating any of the visible vessels.

The immense experience Mr. Tait has had in this manner of securing the pedicle certainly entitles him to speak with authority, and after seeing him tie five pedicles I am convinced of the advantages of the Staffordshire knot over the ordinary methods of tying, and should recommend its general adoption. During the whole operation I observed that the abdominal wound was kept practically closed, either with the cyst, the pedicle, a sponge, or the fingers of the operator. This I observed not only in this case but in all of the three cases, and to this circumstance, undoubtedly, a great share of the wonderful success of Mr. Tait must be ascribed. The operations are done, as it were, subcutaneously, thus reducing the danger from infection to a minimum, provided the hands of the operator, the instruments, and the sponges are aseptic, and that this is the case in Mr. Tait's practice I became convinced, and his results only corroborate this statement. Mr. Tait may not be an antiseptic surgeon, but he is certainly, in principles and practice, an ideal aseptic sur-

geon, whether he is willing or unwilling to acknowledge such a designation. The abdominal wound was closed with four deep sutures. A small gauze compress and a thick layer of cheap cotton, with a wide flannel bandage, constituted the dressing. Time of operation and dressing, twelve minutes.

As soon as the operation was completed, the visitors were requested to retire to the same room, where I spent half an hour in meditation, trying to unravel in my own mind the mysteries which had led this wonderful man to such unparalleled success, when I was aroused from my dreaming condition to reality by another message that everything was ready. The little crowd of seekers for knowledge were led into another room, where we could hardly find time to arrange ourselves around the table when Mr. Tait was already in the abdomen with his bulky index finger, searching for the ovaries. In this case the incision was a mere button-hole. We were informed that the removal of both ovaries and tubes would be done for the purpose of preventing pregnancy in the future, as the patient had suffered greatly during and after delivery on account of a contracted pelvis, including the formation of a vesico-vaginal fistula, which, however, had been cured by operation. Both ovaries and tubes were removed. It was also stated that the patient was suffering from prolapse of the uterus, and this opportunity was utilized and the uterus was stitched to the inner surface of the abdominal wound after both tubes and ovaries had been removed. The whole operation, including the dressing, occupied only seven minutes. I forgot to mention before that the dressing is first fastened upon the abdomen with numerous strips of adhesive plaster which overlay each other, and embrace about two-thirds of the circumference of the body, over which another cotton compress is applied, and retained with a broad flannel roller.

To me the indications which had led to the removal of the ovaries and tubes in this case afforded abundant food for serious thought. There can be no question in my own mind, and in the mind of anyone who has the well being and happiness of his fellow-beings at heart, that it was not desirable that this woman should again be exposed to the dangers of another pregnancy, but as a practical American it occurred to me that it would have been wiser to resort to the less hazardous procedure of unsexing her husband, which would have certainly secured the same immunity at a minimum risk to life, and morally would have been more justifiable. This poor creature had suffered untold agonies, and why submit her to such a serious operation to procure sterility, when the same object could have been reached without any danger to life by unsexing the other party?

The third operation was set for twelve o'clock. I was told the evening before that this patient was probably suffering from a pelvic abscess, and I was exceedingly anxious to see the operation devised by Mr. Tait for the radical cure of this often intractable affection. The abdomen was again opened by an incision only sufficiently large to introduce two fingers. A brief digital exploration resulted in the announcement that the swelling in the pelvis was not an abscess, but a small fibroma of the uterus. As it was claimed that this tumor must be the cause of the recurring attacks of pelvic inflammation, it was decided to again remove the uterine appendages. One of the ovaries was adherent, and required more than the usual length of time for its removal. Duration of operation and dressing, nine minutes. The explanation of the cause of the pelvic inflammation was new to me, as I had always entertained the idea that submucous and interstitial myo fibromata of the uterus, even when of large size, seldom gave rise to inflammation of the adjacent or contiguous tissues, but for the sake of the patient I hope that the interpretation of the case was correct, and that the operation will be the means of preventing future attacks, as the patient, who has lost one of her most important organs, is certainly entitled to an equivalent of happiness in another direction.

From what I gleaned from my observations in the practice of Mr. Tait, I have come to the following conclusions: 1. He is a skilful and dexterous operator; 2. He depends on a diagnosis by digital exploration in the majority of cases; 3. He removes the ovaries and tubes in cases for indications which few gynecologists would be willing to accept as justifiable for such

a serious procedure. His wonderful success may be attributed to: 1. Aseptic surgery; 2. Small incisions; 3. No unnecessary exposure of peritoneal cavity; 4. Perfect familiarity with pelvic and abdominal surgery as far as the mechanical performance of operations is concerned; 5. Rapid operating; 6. Careful personal supervision in the after-treatment. There can be no question that much of his success also depends on the fact that he performs his operations almost without assistance, and in this respect all laparotomists should lose no time in imitating his example. With all his faults, Mr. Lawson Tait has done much towards the advancement of gynecology, and we may learn from him many a valuable lesson which will add to our success in practice.—DR. SENN, in the *Journal of the American Medical Association.*

CUTANEOUS PUNCH.—For eradicating powder-marks, by entirely taking away the portion of integument involved in the colored scar.

They are small cutaneous trephines, or punches, with a sharp cutting edge; the diameter of the cutting edge varying from one millimetre upwards—each larger trephine having a diameter one-half a millimetre greater than the next one below it. These little instruments, by being

placed upon the skin and sharply rotated, will cut out a circular piece of integument of the size corresponding to their own lumen, and the depth of the portion to be excised can be varied according to pressure.

After the colored spot has been surrounded by the circular incision made by the punch, and shows slightly above the surface, it is seized by a pair of fine toothed forceps, slightly pulled upon, and snipped away with a pair of small scissors curved on the flat. The little bloody pits in the skin are allowed to fill with coagulated blood, and left without any dressing, as the bleeding promptly ceases.

I have also used the instrument to take away from the face of young ladies, and fastidious young gentlemen, small moles and other disfigurements. I have found it possible, in some instances, by carefully circumscribing the pigmented area, to cut away the colored deposit through the continuity of the true skin, without destroying the entire thickness of the felted sub-papillary layer beneath, in this way removing the discoloration with a mininium of the resulting scar. I think that these uses, and a number of other similar ones which readily suggest themselves, are sufficient to commend this little instrument for general adoption among dermatologists.—*E. L. Keyes, M.D., in Journal Cutaneous and Genito-Urinary Diseases.*

A NEW ARTIFICIAL LEECH.—I have for some years been in the habit of using the leech in the treatment of many diseases, and have had considerable trouble in obtaining any which were sufficiently active. For nearly a year I have endeavored to overcome the difficulty by using artificial leeches. I have made some leech tubes, shown in the accompanying illustration, which, after an experience with them of several months, have given satisfaction in every detail. This leech consists of a glass tube with a bulb of a capacity of one fluid ounce. The mouth of the tube is made broad enough to prevent constriction of the tissues, and is covered with a rubber band, when necessary, in order to protect the inflamed tissues from injury by the hard surface of the glass. Two sizes are made; one with a short neck, for use on external surfaces, and the other with a long neck, to be applied to the uterus, tonsils, or other surfaces in the interior of cavities. The distal end is constructed so as to fit the screw on the end of the aspirator tube. The advantages of this instrument are that it can be attached to any form of aspirator, and that the blood will soil only the leech tube, which can be readily cleaned. The opening in the tissues can

be made by one or two incisions with a sharp-pointed lance, or with one of the circular scarifying instruments.—*Henry F. Flood, M.D., in Medical Record.*

THE COMPARATIVE ACTION OF ANTIPYRIN AND ANTIFEBRIN. — Although antifebrin has just come into use as compared with its fellow, antipyrin, little doubt exists that it is preferable to the latter. Aside from the results obtained by comparative tests at the bedside, more particularly by Eisenhart, as reported in *Münchener Med. Wochenschrift*, 1886, No. 47, and by Cahn and Hepp in *Berlin Med. Wochenschrift*,, 1887, Nos. 1 and 2, the general profession has not reported as many untoward effects from its use as from antipyrin, while its cheapness, small dosage, and reliability have already given it a place of high esteem among clinicians. Both Eisenhart and the French observers reach the conclusion that five grains of antifebrin are equal to twenty of antipyrin, and although this is somewhat below the estimate made by the profession in America, it so nearly approaches the results obtained here that the matter may be considered as settled. It will be remembered that the chief objection to antipyrin was that it was capable of causing profound collapse, as well as other minor, but scarcely less alarming, symptoms, and it should not be forgotten that antifebrin may produce the same result, if given in large doses in susceptible cases.

Many observers have noted the appearance of an exanthematous rash under its use, and Heinzelmann, in the *Münchener Wed. Wochenschrift*, 1887, No. 3, reports cases in which deafness and mydriasis occurred. These instances of untoward effects produced by antifebrin are fortunately sufficiently scattered to permit us to use the drug with great freedom. Indeed, the only manner in which the two drugs act identically, other than as antipyretics, appears to be the profuse sweat which they produce about the time of their absorption into the circulation.

Sudden cardiac failure has been produced by both drugs, and in a simple case of pneumonia, in which antifebrin was administered, which has come to our knowledge, the patient, apparently convalescing, while sitting up in bed talking to a friend, suddenly dropped back dead on the pillow. It is but just, however, to state that the patient had been a sufferer for many years from disease of the mitral valve, and as no post-mortem was allowed, the exact cause of death cannot be stated; although the attending physician, a man of good judgment, ascribed it to the drug, with sufficient reason in his own mind to prevent his using it but carefully a second time.

The experience of the profession in this city has certainly engendered the belief that in a very large proportion of cases the newer antipyretic may be used with advantage in place of antipyrin, and unless some as yet undetected evil influence exerted by it is discovered, it will, without doubt, remain one of our chief aids in the reduction of abnormally high temperatures.—*Med. News.*

GAVAGE OF THE NEWBORN.—Gavage was first employed by Tarnier in the case of infants born prematurely; and it is recommended, also, for those who, though born at term, suffer from coryza, or who have just been operated upon for harelip, the former not being able to nurse, while in the latter the movements made in sucking interfere with primary union. In the *Archives de Tocologie* for March 30th, we find a description of the method of gavage advised by Bar. Human milk is, of course, preferable, and next that of the ass. But instead of these cow's milk may be used, prepared according to the following method advised by Tarnier. One part of sugar is added to twenty parts of water, and this is added to cow's milk in the proportion of three to one. The mixture is kept in boiling water for half an hour; then the sterilized liquid is decanted, and placed in a suitable vessel of glass or of porcelain.

The simplest form of apparatus, advised by Bar, for administering this food to the infant is composed of a glass funnel to which a sound (No. 14), or a rubber-tube of the same diameter, but twice as long, is attached. The funnel and tube being filled, pressure is made upon the tube just below its attachment to the funnel,

in order to prevent the escape through the lower end. The infant is placed in the lap of a nurse, the head moderately extended, and the physician, holding the apparatus in his left hand, takes the free end of the tube in his right hand, and, after moistening it, passes it into the back part of the throat, and thence by gentle pressure into the œsophagus; when about six inches of the tube have passed the lips the end is in the stomach, and the compression of the tube is stopped, and the liquid passes simply by gravitation into the stomach. The tube should be removed immediately after the funnel is emptied, in order to prevent regurgitation; the quantity of nourishment used should be, if the infant is very small, only two or three drachms, and in that case the gavage should be repeated every hour. Fermentation of the nutritious mixture should be prevented by the proper preparation of the latter, by washing out the apparatus with a one per cent. solution of boric acid, and by keeping the apparatus in the intervals between its employment in a similar solution. The results of this treatment have been so satisfactory in Paris—many infants having been saved by it that would otherwise have perished—that it is worthy of a more extensive trial.—*Med. News.*

THE CHEST MOVEMENTS OF THE INDIAN FEMALE.—It has long been believed that a fundamental difference exists between the chest movements of females and of males during respiration; that the former breathe principally with the upper part of the thorax, and the latter principally with the diaphragm—this difference being known under the names of costal and diaphragmatic or abdominal types of respiration. No one had, however, investigated this question in relation to the chests of persons whose bodies had not yet been dominated by tight dress and other constricting influences incidental to more modern life until very recently, when Dr. Mays, of this city, made a number of observations on the chest movements of the Indian girls at the Lincoln Institution, the results of which, with specimen tracings, are published in the *Therapeutic Gazette* for May 15, 1887. From these experiments it appears that the Indian female, unlike our civilized female, has a marked abdominal or diaphragmatic respiration, with but slight, if any, costal motion; showing that the abdominal respiration is common to man and woman in their primitive condition, and that the costal respiration of the civilized female is an acquired feature.

The question of the type of respiration, as Dr. Mays points out, has a most important practical value, especially in its bearing on the etiology of pulmonary consumption. This disease, in most instances, is undoubtedly engendered by a want of proper expansion of the lung apices. Is this inexpansibility in the upper portion of the chests of these Indian girls a mere coincidence, or is there a casual relation between it and pulmonary consumption? Such a relation becomes quite evident when we take into consideration the fact of the alarming extent to which this disease prevails among those very Indian tribes from whom these children are chiefly obtained.

Dr. Mays propounds the interesting question, whether the influence of the abdominal constriction, which is practiced by our civilized female, is detrimental to the respiratory organs, or whether it has a tendency to produce compensatory activity in the upper portion of the chest, and in conclusion asks whether there is any logical relation between the assumption that it develops the lung apices, and the fact that proportionally a less number of females than males die of pulmonary consumption.—*Med. and Surg. Reporter.*

DIET FOR THE NEUROTIC.—Dr. Dana, of New York, recommends the following in the *Journal of Reconstructives* for April, 1887:

In persons of a sensitive and irritable nervous system, those who are classed popularly as "nervous," neurasthenic, or hysterical, the same rules as to a nitrogenous diet, plus as much fat as can be digested, apply. There is a class of nervous persons who, of themselves, find that they cannot take anything sweet without producing headaches, rheumatic pains, and dyspeptic symptoms. These persons should live on meats, fish, with plenty of butter, oysters, cream and milk with soda water, the yolk of

egg with sherry. Beef-tea with the white of an egg, or some peptonoids, forms a very nutritious dish. It has been the canon of medicine for many years that animal food must be the soul of the neurotic's diet.

Most nervous persons find, in addition, that green vegetables, like spinach, agree very well with them. Stale bread can be taken twice a day freely, plenty of butter being used upon it. The dietetic breads from which the starch ha been removed are sometimes useful, but are, as a rule, unpalatable, and soon cause disgust.

When a rigid diet is to be laid down, there is no better list for nervous invalids than the following: beef, and its preparations; mutton and lamb; fowl; fish, boiled or broiled; oysters; milk; butter; egg, raw or soft-boiled; graham bread and gluten bread; spinach; stewed fruits, slightly alkalinized.

Nervous patients, especially hysterical patients, should not use alcohol at all. Tea and coffee can be taken in very moderate amounts. The various mineral waters may be used with impunity, but none of them have much effect in relieving nervousness, or curing the nervous temperament.—*Med. News.*

Coffee to Disguise the Odor of Iodoform.—Valuable as coffee, when freshly ground, has proved in disguising the odor of iodoform, it has the following disadvantages: 1. It is only for a limited period that its effects last; and, 2. It is very difficult to grind the coffee so fine as to prevent the grains irritating a sore part; and especially is this felt if the iodoform be used in the form of an ointment. I have found that by macerating the coffee in hot lard or vaseline, all the deodorising powers are absorbed by and retained in the vehicle employed, and a perfectly smooth, inodorous, and unirritating ointment can be prepared.—Richd. Neale, M.D., London, in *Brit. Med. Journ.*

Salol in Sciatica.—Dr. V. Aschenbach, of Corfu, reports in the *Fortschrith der Med.* that suffering from sciatica, for which all known remedies have been tried in vain, he at last resolved to try an unknown one—to himself at least unknown as a remedy for sciatica. In the evening he took a dose of half a gramme of salol, and at night one gramme, after which he fell asleep, and remained perfectly free from his pains.—*Technics.*

Therapeutical Notes.

For Warts.—

Bichloride of mercury..	1 gramme.
Collodion.....	30 grammes.

Apply carefully to the warts once a day.—*Journal de Med. de Paris.*

Pomade for Pigmentation of Pregnancy—(Monin.)—

℞ Oxide of zinc....	20 centigrammes.
White precipitate.	10 "
Cocoa butter.....	10 grammes.
Castor oil.....	10 grammes.
Essence of roses..	10 drops.

Apply to the face night and morning.

Counting the Ribs.—(Duroziez).—Physicians are frequently mistaken in counting the ribs. One must never start at the clavicle. We must start from the supra-sternal notch, obliquely and below which is the first intercostal space. Or again by palpation of the sternum the first projection is the junction of the first and second piece, at which we find the articulation of the second rib. One is sometimes astonished at the space between the clavicle and third rib. One forgets the breadth of the first rib.—*Lyon Medical.*

Treatment of Diarrhœa by Iodoform and Charcoal—(Pichinni).—In eight cases of diarrhœa, in which examination of the fæces showed signs of fermentation, the author successfully used the following:—

℞. Iodoform.....	0 gr. 60 centigrammes.
Ether.....	100 grammes.
Vegetable charcoal, finely powdered	100 "
Glycerine.....	180 "

Dissolve the iodoform in the ether, and mix thoroughly with the charcoal. Allow the ether to evaporate, and mix with the glycerine. To be taken during the 24 hours in tablespoonful doses suspended in water.—*Revista Clinica et Terapeutica Journal de Med. de Paris.*

FORMULÆ FOR NEW MEDICINES HYPODERMICALLY. (*From Bourneville and Bricous' Manual.*)—

1. ℞ Acid chrysophanic..0 grs. 0,005 to 0.01.
Distilled water ....1 gramme.
Used successfully in eczema, lichen, prurigo, psoriasis, and urticaria.

2. Osmic acid.....0.10 centigrammes.
Distilled water ....10 grammes.
Used in interstitial injection of tumors, in obstinate neuralgias (Bilbroth, Neuber), in doses of 50 centigrammes to 1 gramme of solution injected near the affected nerve.

3. Agaracine..... 0 gr. 05 centigram.
Absolute alcohol ...4 gr. 50 "
Glycerine.....5 gr. 50 "
A syringeful at a time for night-sweats of phthisis.

4. Chlorhydrate of antipyrine.....1 gramme.
Water (warm).....1 gramme.
A powerful antipyretic.

5. Pure cotoin.....1 gramme.
Acetic ether .....4 grammes.
Inject a Pravaz syringeful every 15 or 20 minutes, or every hour as antidiarrhœic, except in intestinal ulceration, cirrhosis and alcoholics. Recommended in cholera, night-sweats, sialorrhœa.

6. Chlorhydrate of kairine .....0.10 centigrammes.
Distilled water ....1 gramme.
Powerful antithermic, but rather dangerous.

7. 1 part solution (alcoholic) trinitrine..30 drops.
Distilled cherry laurel water.....8.40 gram. to 10 gram.
To be injected into the muscles of the back or thigh. For angina pectoris and all affections in which symptoms of cerebral anæmia predominate.

8. Paraldehyde .....5 grammes.
Cherry laurel water. 5 grammes.
Distilled water ....15 grammes.
To be warmed before injecting. Hypnotic and sedative in mania and melancholia.

9. Chlorhydrate of pereirine .....1 to 2 grammes.
Distilled water ....20 grammes.
One to four decigrammes in intermittent fever.

10. Sulphate of thalline. 1 gramme.
Distilled water ....5 grammes.
Use warm, 10 centigrammes of this solution, suffice to lower the temperature 2.10° to 3.10° during six to nine hours.

—*Journal de Med. de Paris.*

THE
Canadian Practitioner.
(FORMERLY JOURNAL OF MEDICAL SCIENCE.)

TORONTO, JULY, 1887.

MEETING OF THE ONTARIO MEDICAL COUNCIL.

The recent meeting of, what is facetiously called by the lay press, the "Doctors' Parliament," was not exciting in any way; but there was a good quantity of routine work done which was laborious in its nature and important in the interests of the public and profession generally.

As will be seen by our report the work of the Committee on Education was the most important, as in fact it generally is. There were more than the usual number of petitions from rejected candidates, some of which were decidedly "cheeky" in character. Some asked to have their papers re-examined, having apparently a confident feeling that the excellent answers must in whole or in part have been mislaid or stolen. The Committee, very good-naturedly acceded to their requests, but were unable in all cases to put a higher value on their papers than the Examiners, and in some cases they expressed the opinion that the Examiners had been too lenient.

It is a question whether rejected candidates have any right to cast doubt on the efficiency or impartiality of an Examining Board by

making such demands, and it is thought by some that if the Council have confidence in their examiners (as we hope they have) they show bad taste in acceding to these demands unless under very exceptional circumstances. We some years ago expressed the opinion that the Council should exercise great care in the selection of examiners, and that having done so they should be loyal to them and their decisions, especially when such decisions have resulted from combined written and oral examinations.

Others of the rejected asked for a supplementary examination; and we hope that the time will soon come when there will be at least two examinations in the year and we would like to see three. Many petitions were presented from students with reference to the matriculation examinations, and we find that certain slight irregularities have crept in, such as adding together parts of different examinations and giving the candidates credit for the success thus obtained. Although, as far as we know, no injustice was done in such cases, we are glad to know that the Council desires no repetition of such mathematical complications.

In addition to such requests there were various petitions from graduates in this and other countries asking for certain privileges peculiar to each case. The Committee appeared to consider all cases very carefully, and their decisions were exceedingly judicious.

Of course, one of the most important of the functions of this Committee is the selection of a Board of Examiners. It happens, fortunately, that there is less "log-rolling" during recent years than existed at one time; but we have a vague suspicion that it has not all disappeared yet. It may sometime be in order to discuss the merits of certain examiners and the reasons for their appointment. We regret that the rule is still observed which prevents teachers from examining on the subjects which they are best suited for. We hope the time will soon come when the lectures in the various medical schools may include a certain number that are considered sufficiently honest, and broad in their views and knowledge of their subjects, to make them suitable examiners in their own departments. We are glad to know apart from these considerations, that the Board of Examiners recently appointed will, as a rule, command the confidence of the profession, though it is by no means perfect, nor does it come as near perfection as it might.

There is still a slight feeling of antagonism between the "schoolmen" and the territorial representatives; but there was perhaps less evidence of it at this meeting than at former ones. Upon the whole the representatives of the general profession have shown the stronger desire to raise the standard of medical education in all respects. Some have gone so far as to advise a preliminary course in arts before entering the study of medicine. While we generally sympathize with the outside profession rather than the schools, we think this is going too far. The present regulations, which come in force next year, respecting matriculation are excellent, and assure a higher standard than has heretofore been demanded by any university in Canada, either in Arts or Medicine. We can desire nothing better than this, but it would be well for the Council to extend slightly the scope of its curriculum, especially in the departments of science, and demand more practical and less didactic teaching in both primary and final subjects.

We are pleased to know that the Council is becoming stronger from year to year, and commands the confidence of the profession and the public to a greater extent at the present time than it ever has in the past. It is important that it should be so, as it gives us the strongest possible guarantee for a judicious and high standard of medical education in the Province of Ontario for all time to come. With a number of competing Universities and Medical Colleges our greatest safety lies in a Central Examining Board, in which we can place reliance. Our system is in this respect the best in the world. The majority of intelligent physicians in Great Britain and the United States would gladly adopt a similar system from their respective countries or States, but the strong opposition of various degree-conferring Universities and Corporations present a strong barrier to such a happy consummation. Considering all the circumstances we think the profession of Ontario owe the Council a loyal support.

THE ONTARIO MEDICAL LIBRARY ASSOCIATION.

A scheme is now on foot for establishing, in the city of Toronto, a medical reference library. Many practitioners in the city, and throughout the province, have long felt the necesity for such an institution. It is almost impossible to write an article or paper on any medical subject, which will be of lasting value, unless the writer has access to a large reference library. Authors of papers are frequently compelled to go to Philadelphia or New York to consult medical works which cannot be procured here. This, of course, incurs great loss of time as well as expense. It is the intention of the committee, which has the temporary management, to give the library as much a provincial character as possible. One of the plans which is now under consideration is the following: The name of the institution is to be the Ontario Medical Library Association. It shall be composed of stockholders who shall also be members, and resident and non-resident members. The stock, in shares of five dollars each, will be issued to the amount of $10,000. The stockholders in Toronto, as well as the resident members, shall pay an annual fee of three dollars; the stockholders outside of the city, as well as the non-resident members, shall pay a fee of one dollar per year. The library shall be the property of the stockholders, and each stockholder shall have, in addition to his vote as a member, votes in proportion to the number of shares which he has purchased. In this way it is hoped that we will secure sufficient capital to commence the library, and the annual fees will form an income to be used in its sustentation. Large donations of books will doubtless be made by older practitioners, and the library will obtain the more recent works from authors and publishers in many cases without cost.

As previously stated, this is an outline of one of the schemes proposed, and if any of our readers have suggestions to offer, we shall be glad to publish any communications on the subject. It is the wish of the present committee to commence in the best way to insure the future success of the project.

THE ONTARIO MEDICAL ASSOCIATION.

The recent meeting of the above Association —a full report of which will be found on another page—was in many points the most successful which has yet been held. The attendance was much larger, and a greater feeling of unanimity prevailed than on any former occasion. The Association is much indebted to the gentlemen from New York, Philadelphia and Detroit for their attendance and for the papers read by them. Dr. Gerster's paper excited a very interesting discussion, which, if not quite in order, was of great benefit to those who heard it. Dr. Fox's paper was listened to with close attention, as also were those of Drs. Packard, Porter and Satterthwaite. The members of the profession resident in Toronto did not take such an active part in the discussion as they would have done if the meeting had been held elsewhere. They had their practices to attend to as well as to look after the entertainment of their brethren from other places. This frequently rendered it impossible for them to listen to a paper throughout, and they could not therefore offer any opinion upon it. Although we are indebted to the medical gentlemen from the United States for their valuable papers, it has occurred to some that their presence has rather a depressing than stimulating effect upon the discussions. This should not be the case, but there is always the feeling of diffidence on the part of practitioners of limited experience in discussing medical points with those who have enjoyed such superior advantages. One of the main objects of the Association should be the development of home talent, and the fostering of a home literature. Anything which impedes the progress of the Association in this respect should be carefully guarded against. We would therefore suggest that in future the number of papers to be read by those outside of the Association be limited to two or three. The meeting, however, was a grand one, and was especially pleasing to those who had watched the progress of the Association from the time of its commencement six years ago.

THE ILLNESS OF THE CROWN PRINCE OF GERMANY.—Dr. Morell Mackenzie, of London, has telegraphed the *New York Medical Record*, stating that the tumor on the throat of the Crown Prince is of a dense warty character (pachyderma verrucosa). Prof. Virchow has not been able to find any evidence of malignancy in the removed portion.

The *Record* says: "A growth presenting such characteristics possesses no elements of malignancy, and depending as it may upon various constitutionals as well as local causes is, as a rule, perfectly amenable to treatment."

TORONTO GENERAL HOSPITAL.—Patients in the Hospital on April 1st, 226. The number admitted during the month was 198, and the number of births 19, making a total of 443. The average daily number of patients was 229. The largest number of patients ever admitted in the month of May is 444, made up as follows:—Patients in the hospital on May 1st, 227, admitted during the month 204, number of births 13.

Where are the ethics of the profession? Have they left the city for a summer vacation? We find posters on door steps and telegraph poles announcing the amazing fact that Dr. —— has removed, and another, Dr. —— tacks his cards in small shops, with a foot-note attachment "16 years' experience, references if desired." O shade of the great Hahnemann!

THE TREATMENT OF PHTHISIS BY GASEOUS ENEMATA.—At the recent meeting of the American Association of Physicians, this subject was thoroughly discussed. The general conclusion arrived at was that Bergeon's method has proved of service in some cases, but that it is by no means a specific.

The following Canadians received the L.R.C.P. London:—W. R. Watson, M.D., and William A. Young, M.D.; and J. McLurg, M.D., A. F. McVety, M.D. and W. T. Parry were admitted to the membership of the Royal College of Surgeons.

Meetings of Medical Societies.

THE MEDICAL COUNCIL.

The Medical Council of the College of Physicians and Surgeons, Ontario, met in the School of Pharmacy on June 14th. The President, Dr. H. H. Wright, occupied the chair.

The election of officers for the ensuing year resulted as follows:—President, Dr. Henderson, Strathroy; Vice-President, Dr. Burns, Toronto; Registrar, Dr. R. A. Pyne (re-elected); Treasurer, Dr. W. T. Aikins (re-elected); Solicitor, B. B. Osler, Esq. (re-elected).

On motion by Drs. Geikie and Edwards a congratulatory message was cabled to Her Majesty Queen Victoria, to which a response was received next day.

It was resolved that the minutes of the Council be printed, and a copy sent to every member of the college who has paid his annual assessment, and that the minutes appear in full in the announcement.

A motion introduced by Drs. Orr and Henry providing that the territorial representation be increased from 12 to 18, was lost, and the matter was on motion laid over to the next meeting of the Council.

The Executive Committee were directed to appoint a Public Prosecutor for the Province.

The following motion in reference to the registration of British graduates was passed:—Resolved that a special committee consisting of Drs. Fowler, Geikie, Logan, Wright, Bergin and Williams be appointed to consider upon what terms British graduates may be allowed to become registered and to practice in Ontario, and that they report at the next meeting of the council; and that in the meantime they be not allowed to register except in the ordinary way—by examination.

A motion providing for the admission of British graduates to registration in Ontario upon the same terms on which Ontario graduates are registered in Great Britain, was lost.

For the purpose of carrying out the provisions of the amendment to the Ontario Medical Act, passed at the last session of the Provincial Legislature, a committee to be known as the Committee on Discipline was appointed.

The members of this committee are Dr. Logan, Ottawa; Dr. Bray, Chatham; Dr. Day, Trenton (chairman); Dr. Russell, Binbrook; Dr. Wright, Toronto.

REPORTS OF COMMITTEES.

The Committee on Legislation expressed satisfaction with the amendments passed by the Legislature in their last session, and recommended that the thanks of the Council are due and are hereby tendered to J. M. Gibson, Esq., M.P.P. for Hamilton, for his arduous work in behalf of the bill.

The report of the Building Committee was received and adopted. Mr. E. J. Lennox is the architect of the new college building in course of erection on the corner of Bay and Richmond streets. The old college building was sold to the highest bidder for $100, the buyer to bear expense of removal. The construction of the new building in accordance with the plans approved of by the Council was tendered for, and the lowest tender was accepted. This provides for the completion of the building for $60,385.60. It is expected the new building will be completed by Nov. 1st of this year. For the information of the Council the committee have made an estimate of the prospective revenue from the building when completed—if all occupied, $8,000 per annum rental will be derived, computing the rental at a low rate. Besides this the Council will have ample room for the purposes of its own examinations, etc. The estimated cost of running the building including caretakers, water-power, lavatory, gas, coal, taxes, interest on mortgage and insurance is, say $4,600, leaving an annual surplus of $3,400.

The report of the Finance Committee declared the assets of the College, consisting of site of building, new building (so far as completed), assessment dues and cash in bank, to be $53,450.63, and the liabilities, consisting of mortgage, accounts just passed, and extra expense of the session, to be $18,487.45, leaving a balance to the credit of the College of $36,963.18.

This committee also reported that in accordance with instructions from the Council they "met with the committee of the Ontario Medical Association, to consider the establishment of a medical library in the city of Toronto, and would recommend the Council to set apart a room in the new college building to be properly equipped with shelving for a library, provided our registrar have charge of the same; and that a room be placed at the disposal of the Ontario Medical Library Association at a nominal rental."

The report as read was received and adopted.

The report of the Committee on Education dealt with appeals from defeated candidates, in which the decisions of the examiners were in all cases sustained; with petitions for supplementary examinations, which were in no case allowed; with petitions for permits, in regard to which the Committee advised "that the Registrar be requested to inform all such applicants that the Council can in no case grant permits, and that if they practice they do so at their own risk, and not with the sanction of the Council;" and with other communications of divers kinds. In fact, this Committee dispensed justice without fear or favour, and in a manner indicating that they felt themselves fully masters of the situation.

A communication was read from Henry A. Pitman, Registrar of the College of Physicians, London, Eng., asking for a copy of any rules and regulations having reference to registration in the Province of Ontario of medical qualifications obtained in England. The Committee advised that the Registrar say in reply that all graduates in medicine in Canadian universities being required to present themselves for examination before the examiners appointed by the Medical Council of Ontario, British Registered Practitioners are placed in exactly the same position.

The Committee also considered the matriculation examination, and advised "that the second class non-professional examination for teachers' certificates be adopted, including Latin, Physics and Botany, and that the subjects be distinctly specified in the Annual Announcement, and that the said matriculation come into effect July 1st, 1888."

Dr. Geo. Duffield has been elected to the chair of medicine in the Detroit Medical College.

THE ONTARIO MEDICAL ASSOCIATION.

The seventh annual meeting of this Association was held in the theatre of the Normal School buildings on the 8th and 9th of June, under the presidency of Dr. James H. Richardson. The Association met at ten o'clock when Dr. J. T. Duncan submitted the report of the Committee on Arrangements. On motion of Dr. Bruce Smith, seconded by Dr. Rosebrugh, of Hamilton, a congratulatory telegram was sent to the American Medical Association then holding its thirty-eighth annual convention in Chicago. On motion of the Secretary, seconded by Dr. Thorburn, a jubilee telegram was sent to Her Majesty the Queen, and the members indulged in the singing of the National Anthem.

Dr. J. E. Graham brought up the subject of the establishment of a

MEDICAL REFERENCE LIBRARY

in the city, and spoke briefly on the advantages of such, and the unfavorable contrast which in this respect Toronto makes with American centres of medical science. On motion of Dr. McPhedran a committee was appointed to meet with one from the Toronto Medical Society and discuss plans for the furtherance of this object.

Dr. Henderson, of Kingston, then discussed the question of forming a Medical Defence Fund, and a committee was appointed to consider the matter and report at a later session.

Dr. Ferguson then moved that the following gentlemen be a temporary committee on physiology :—Drs. A. H. Wright, W. H. B. Aikins, Sheard, J. E. White and J. Ferguson, Toronto ; MacCallum, London ; and J. H. Duncan, Chatham.

AFTERNOON SESSION.

The Association met at two o'clock with the President in the chair. The following gentlemen, guests of the Association, were introduced and welcomed to the platform :—Drs. Porter, Gerster, Fox and Satterthwaite, of New York ; Drs. Manton and Duffield, of Detroit ; Dr. J. H. Packard, of Philadelphia ; Drs. James Stewart and Cameron, of Montreal, and Drs. Cronyn and Hubbell, of Buffalo.

The President then delivered his

ANNUAL ADDRESS.

After thanking the Association for the honour they had conferred upon him in allowing him to preside over their deliberations, he offered a hearty welcome on behalf of the Ontario Medical Association to the distinguished visitors who were present. He then proceeded to say that the science of medicine was cosmopolitan, that in all parts of the world were to be found earnest and diligent workers who were pouring in their contributions to all departments of medical and surgical knowledge, and it would be invidious to record pre-eminence to any nation or people whilst we rank them all as brethren, and accord to all the honour which is their due no matter what their nationality. It is only natural that we should be in more complete sympathy with those who share our glorious inheritance and who are one with us in a common language, a common literature, common liberty and common aspirations. He then proceeded to discuss those points which he chose for more particular consideration. 1. Has any marked advance been made since he (the speaker) entered the profession of medicine as regards the general nature and treatment of disease ? 2. Have we any reason to hope that any great advance will be made in the future ? 3. In what lines we may expect to advance. In pursuance of these enquiries he wishes to be understood as not comparing past or present opinions on this or that special disease or particular method of treatment, but he would refer rather to the nature of disease and the general principles of treatment. These changes may be comprised under the heads of inflammatory and zymotic diseases. Forty years ago inflammation was the *bête noir* of the physician. The most incongruous diseases were classed under this head, and the most ingenious and artificial distinctions were made to retain them there. Some inflammations were sthenic, others asthenic; some arose from plethora, others from weakness. Then there were special varieties, strumous, rheumatic, erysipelatous, specific and intermittent inflammations, and so on. The treatment was most formidable—bleeding, blistering and purging and depressants of various kinds. As late as 1853 blood-letting was advised to be practised most

freely even to a prodigal extent—even scarlet fever and erysipelatous patients were subjected to copious bleeding. It was a tremendous forestalling of the modern delusion, "Similia similibus curantur." We were for many years kept in error by the deductions from pathological anatomy. The diseased tissues were minutely examined and described as if in them existed the cause of disease. True etiology was ignored in the supremacy which pathological anatomy maintained. In pneumonia, for instance, the diseased tissues were examined regardless of whether the disease was the result of deranged circulation or innervation, of malarial or septic poisoning. So also puerperal fevers. We now recognize the truth that instead of inflammation being a disease it is but a local manifestation of a general depraved condition, and that to combat it rationally we must ascertain the cause of it, and that as its results are great decrease of the vital energies, these must be supported by every effort rather than further weakened.

The other great advance that has been made in modern times is with reference to the nature of contagium. Until quite lately our ideas with regard to the causes of disease were most vague. Malarial diseases, for instance, were supposed to be the result of emanations from decomposing animal and vegetable substances without our having any knowledge of the active principles of these emanations. We observed that they obeyed the laws governing material substances in that they could be conducted or carried about, but further we knew nothing. The discussions as to the nature of contagium ranged between the theories of common causes, germinal matter, catalysis, bioplasm and fermentation. The last named theory seems to have led directly to the germ theory as at present held. He would refer more especially to two diseases in regard to which great improvements had taken place within the last quarter of a century, viz., splenic fever and hydrophobia. Dr. Budd, of Bristol, seemed to have had the high distinction of being the first British physician to forsee the importance of the agency of minute organisms in the propagation of disease. Dr. Budd seemed to have been led to this conclusion by the fact of the invariable reproduction of every specific disease. Splenic fever was a terrible scourge in Europe, how malignant might be gathered from one paragraph from Trousseau :—"The period of its incubation is very short. An ox which has been at work may return to its stall apparently healthy. He eats as usual; then he lies down on his side and breathes heavily, while the eyes are still clear. Suddenly his head drops, his body grows cold, at the end of an hour the eye becomes glazed, the animal struggles to get up and falls dead; the struggle only lasting one hour and a half." Devaine, as early as 1850, discovered the presence of minute rods in the blood of animals which died of splenic fever, but it was not until 1863, after Pasteur's researches into the part played by microbes in fermentations, that he suspected their real agency in the production of disease. Pasteur's experiments were well known; his last experiment was made at the invitation of the president of the Society of Agriculture, and was watched by Pasteur's colleagues, who feared he had been too rash. "A flock of sheep was divided into two groups, the members of one group being all vaccinated with attenuated virus while those of the other group were left unvaccinated. A number of cows were also subjected to a precisely similar treatment. Fourteen days afterwards all the sheep vaccinated and unvaccinated were inoculated with a very violent virus, and three days subsequently more than 200 persons assembled to witness the result. Twenty-one of the twenty-five unvaccinated sheep were already dead and the remaining four were dying, The twenty-five vaccinated sheep were in full health. A similar result occurred amongst the cattle. The breeders of cattle at once overwhelmed Pasteur with applications for vaccine, and by the end of 1883 nearly 500,000 animals had been protected." Pasteur's crowning triumph was achieved over that dread disease hydrophobia, which had hitherto baffled medical skill. Instead of cavil and doubt, we ought to lay hold with gratitude and confidence on the grand fact which had been established conclusively by direct experiment, viz., that some of the most deadly diseases which afflict human and brute creatures, are the result of the introduction of micro-organisms into the animal system; that they have been isolated and re-produced generation

after generation by the most guarded, precise, and definite methods of the laboratory, and that they can be so modified in their strength as to be safely introduced into healthy animals and so protect them from the deadly effects produced by the unmodified poison. In view of the facts of the discoveries of recent years, they might surely "thank God and take courage" for the future. The difficulties before them were great. The life history of each class of these minute beings was so different, and the conditions under which they must be investigated were difficult, but there was no royal road to knowledge, and perseverance and research were certainly necessary. Yet they were on the road, and it only needed courage, faith, and constant advance, to open up newer, larger, and brighter vistas of truth. (Cheers.)

Dr. Fenwick, of Kingston, was the first to read a paper, the title of which was "Laceration of the Cervix Uteri." He paid a warm tribute to the careful labor and researches of Sims, Emmet, Thomas, and Bennett; pointed out how frequently the lacerations were overlooked. and laid down the following propositions:— 1. A certain degree of laceration of the cervix is the rule in all first labors. 2. A certain number of these are entirely recovered from, or else they exist without producing any symptoms. 3. A certain proportion form important factors of disease. It is the last class alone which require Emmet's operation and in which relief of the symptoms may be expected. The procedure which he had adopted in all his operations for the laceration was described.

Dr. Groves, of Fergus, then read a paper on "Prostatotomy," and Dr. John Ferguson followed with an elaborate study on "Arsenical Neuritis."

Dr. Arnott then read an able paper on "Phosphaturia." (See page 197.)

Dr. G. H. Fox, Professor of Dermatology in the College of Physicians and Surgeons of New York, read a much appreciated paper on "The surgical treatment of some diseases of the skin," and illustrated his subject by the scarification of lupus, the extraction of superfluous hairs by electrolysis and the surgical treatment of pustular acne.

In the discussion which followed, Dr. Graham referred to the difficulty of permanently removing superfluous hairs by electrolysis. Two qualifications are necessary for a successful operator—first, that he should have a good eye and a delicate sense of touch; and, secondly, that he should have experience. The needle should be introduced into the hair follicle and passed along until the point reaches the hair bulb, when the electrical current will loosen the hair so that it can be readily removed. If the needle is passed outside of the follicle so that the hair bulb is not touched, the hair will probably grow again. Many dermatologists have become discouraged at their want of success in this operation. In skilful hands such as those of Dr. Fox it has no doubt been a great success. With regard to the management of acne, the speaker did not think the local treatment had in most cases more than a temporary effect, and that the disease could only be permanently benefitted by constitutional means.

Drs. Oldright and Holmes also took part in the discussion.

Dr. Murray, of Thorndale, then read a paper on "Laceration of the Femoral Artery." (See page 208.)

EVENING SESSION.

Dr. Taylor, of Goderich, gave a paper on 'Extra-Uterine Pregnancy."

Dr. James Ross gave the histories of two similar cases; in the last case abdominal section was performed in St. John's Hospital.

Dr. Gerster, of New York, was very cordially received, and held the complete attention of the members during the reading of an interesting and erudite contribution on "The antiseptic principle as applied to the treatment of the primary induration and the initial sore of syphilis." (This paper will appear in the next issue of the *Practitioner*.)

Dr. Canniff did not agree with Dr. Gerster in saying that suppuration is always caused by microbial action. He insisted that the presence of a foreign body will sometimes give rise to such intense inflammation that pus will be formed, even where air is entirely excluded. To show that we cannot always account for the cause of suppuration, he instanced two cases of compound fracture under his care; one was submitted simply to the water dressing, and

healed rapidly without suppuration; the other was dressed with antiseptic precautions, but suppurated profusely.

Dr. Macfarlane, in speaking on this subject, cited two cases in support of the microbial origin of suppuration. One was a man suffering from double psoas abscess, in whom an opening was made in the lumbar region of one side with antiseptic precautions. The opening drained both abscesses, and by keeping the hips elevated, and dressing with rigid antiseptic care, the wound healed almost completely in six weeks. The other case was an excision of the wrist joint. All the bones of the carpus were found carious, and were removed. The good result which followed he attributed to the success in keeping the wound aseptic.

Dr. Teskey considered that suppuration might be caused by either microbes or a foreign body. Suppuration meant death of tissue, and this occurred whenever the parts were deprived of nourishment. Hence in any inflammation, whether caused by a foreign body or by microbes, whenever so much inflammatory matter was thrown out, that the cells occupying the centre of the mass were too far from the circulating medium to derive nourishment therefrom, they died, or, in other words, broke down into pus. In support of this view cases were cited, in which an extreme degree of irritation had caused suppuration in localities to which microbes could not possibly have access.

Dr. Porter, of New York, strongly insisted upon the distinction between the lesions of syphilis and those of tubercle, and cited experimental and microscopical evidence in support of his assertion.

Dr. Gerster, in reply, explained that he did not say in his paper that the lesions of syphilis and tubercle were *identical*, but that they were *similar* in many respects, and he still held to this view. He cited a case in which a blacksmith had been stabbed in the hand with a clasp-knife. The wound healed by first intention. Many months afterwards the patient again presented himself, showing a hard, angular foreign body near the elbow. This was cut down upon, and proved to be the blade of the clasp-knife with which he had been stabbed months before. In the interval he had worked steadily at his trade, without any apparent inconvenience. The fact that a man could use his arm as actively as a blacksmith required to do, with a knife-blade four inches long imbedded in the muscles thereof, was surely strong evidence that irritation alone cannot induce suppuration. In reply to Dr. Teskey, he held that the death of cells deprived of nourishment in absence of microbes did not constitute suppuration, but a condition called by Weigert, *coagulation necrosis*. The tissue so affected is capable of reabsorption, and does not necessarily result in an abscess.

Dr. Holmes, of Chatham, read a paper on "Puerperal Fevers," and Dr. J. H. Packard, of Philadelphia, on "Our View of the Surgeons of the Last Century;" these papers will also shortly be published in this Journal.

SECOND DAY.

The President, Dr. Richardson, in the chair. A discussion took place on the question, "Is the continued employment of large doses of the fluid extract of ergot likely to be injurious when employed in cases of fibroid tumors of the uterus when operation is inadmissible?" The opinions expressed by the members who took part in the discussion were to the effect that no ill effects followed even a continued use of the drug.

Dr. Lett read a paper upon the "Relationship between Insanity and Masturbation," in which he took the ground that masturbation *of itself* was seldom or never a cause of insanity, but only a factor or single link in a long chain of combining causes, which led up to and finally culminated in an attack of pronounced mental alienation. He held that with an adequate predisposition it became an *exciting cause* of insanity, and gave to the malady special characteristics, which are described by writers under the head of "Masturbaturial Insanity." Whilst it was admitted that in this sense it was an *exciting cause* of insanity, the Doctor contended that it was more frequently a symptom of that disease, and instanced several forms of mental unsoundness where it was clearly the outcome of disease or irritation in the nerve centres. The paper then took up the subject as to what is known with regard to a local centre in the

encaphelon for the sexual appetites, and pointed out that according to the experiments of Eckhard, irritation of the upper part of the cord, medulla oblongata, the pons, and as high up as the crura cerebri, caused vascular turgescense of the generative organs and priapism. This, however, was attributed not to these parts being the seat of the sexual appetite, but the effects produced by Eckhart in irritating the parts named was the result of altered nervous action from the centre to the periphery upon the vascular supply. The nearest approach that has been made to a centre for the sexual appetite is that of Ferrier, who concludes from experimental research that its *probable* seat is localizable in the cerebral cortex, connecting the occipital lobes with the lower and inner part of the tempero-sphenoidal lobe.

The presence of masturbation combined with insanity was held to hamper the treatment of that disease, retard recovery, and in many instances preclude the possibility of a cure.

Dr. Burns thought much benefit might result as a preventative measure, from pretty generally adopting the plan in early ages of circumcision. He spoke strongly on the subject, and advocated the practice. Dr. Oldright was not prepared to endorse the remarks of Dr. Burns, and go in for wholesale circumcision; that whilst in many cases benefit results from the operation, he was of opinion the prepuce was there for the special purpose of preventing the glans from being subjected to the irritation of foreign substances coming in contact therewith, such as the clothing. He also thought the sensitiveness of the glans would be impaired, which might or might not be an advantage.

Others entered into the discussion, taking up several forms of treatment, not forgetting religious influences. The President (Dr. Richardson), warmly sustained the paper, especially on the ground that masturbation was frequently a symptom, and not the cause of insanity. He instanced several cases under his own observation supporting this view, and asked the question, "How is it that in injuries to the spinal cord indications of sexual appetite are so frequently seen?"

Dr. Lett, in reply, stated that with exception to Dr. Richardson all the speakers had taken up the subject of treatment which was foreign to the subject of the paper. In answer to Dr. Richardson, he stated that injuries to the spinal cord would be likely to produce similar results to those observed by Eckhart when he irritated the upper portion of the cord, the medulla or the pons.

Dr. Strange then read a paper opening the discussion on surgery and dealing with "points in the minor surgery of the general practitioner." (See page 202.)

Dr. Strange spoke strongly in support of the sometimes absolute necessity for alcoholic stimulants in such cases, asserting that nothing else could take their place, and that surgeons should not be hampered in their work by the objections of well-meaning but ignorant persons who took an opposite view. He was strongly supported in this opinion by Dr. Richardson, who gave an amusing account of his own experience with carbuncle and descriptions of the striking results he had known to be derived from the free use of alcoholic stimulants. In reply to a question, Dr. Strange stated that it is not his usual custom to give chloroform before lancing a felon. Several other doctors gave their views on the treatment of whitlows and carbuncle.

Dr. Geister agreed in every point with Dr. Strange as to his advocacy of the thorough use of the knife, though he would not be thought to advocate that mode of treatment in every case. There were cases, as where the patient is very anæmic, where such treatment would be highly prejudicial. In such he would use caustic, which though a slower and perhaps more painful cure, is just as certain as the knife. He thought highly of the antiseptic dressing after cutting. The patient had nothing to do with it, and consequently there was no fear of the unpleasant results from the application of such a piece of nastiness as a poultice often becomes in the hands of ignorant and uncleanly persons.

Hon. G. W. Ross, Minister of Education, having come in, was invited to the platform by President Richardson, and spoke briefly, welcoming them in the name of the Ontario Government, expressing the hope that they found themselves in every way comfortable, and

praising the way in which the profession interested itself in all that pertains to the public health. He took his seat after a closing remark or two on the proposed establishment of a medical faculty in connection with University College, and the desirability of keeping up a high standard of professional efficiency.

Dr. J. E. Graham (Toronto), read some pathological notes of a fatal case of "Herpes Zoster," which had come under his notice, including a report by Mr. McCallum, of the School of Practical Science, a full report of which will be furnished at another time.

Dr. Manton, Detroit, being unable to remain his paper on "Tumors of the Vulva," was read by title.

AFTERNOON SESSION.

The following cablegram addressed to the secretary was read:—"The Queen thanks the members of the Ontario Medical Association for their kind congratulations.—PONSONBY."

A telegram was also read from the American Medical Association, acknowledging the friendly greeting of the Ontario Medical Association and conveying to them their sympathy and good-fellowship.

Dr. W. H. Porter, of New York, read a paper on "The Etiology and Pathology of Increased Body Heat, in Relation to Disease, and the use of Anti-pyretics."

Drs. Temple, Turver, Hunt, Cronyn and Covernton took part in the discussion.

Dr. Satterthwaite, New York, was then called upon to read his paper on "The So-called Uric Acid Diathesis."

A hearty ovation was tendered the venerable Dr. Joseph Workman, the Association's first President, when he entered the room and took a seat on the platform beside the President.

Dr. W. T. Aikins presented to the Society a lady patient, aged 73, having a large tumor adherent to the face and neck, situated beneath the *platysma myoides*. It commenced to grow 35 years ago, forming a small tumor behind the lobe of the ear. Of late it has increased rapidly in size. The tumor is cylindrical in shape, non cystic; the surrface presents a lobulated appearance; there is no enlargement of the lymphatic glands; the weight of the tumor, which measures in the long diameter nine inches and in the transverse six, is about five pounds.

A paper by Dr. Ryerson, Toronto, on "Thalmic Epilepsy," was on the motion of that gentleman held as read, owing to want of time during that sitting.

Dr. Adam Wright, Toronto, read a paper on "Removal of the Uterine Appendages," reporting certain cases of operation in the Toronto General Hospital which furnished illustrations of three aspects of the question: 1. Operation for the relief of nervous diseases. He thought, as a general rule, all such operations were unjustifiable; but in certain exceptional cases when life or reason was endangered such interference, after careful deliberation, might be considered advisable. 2. Operation for bleeding fibroids of uterus. He thought it the best treatment while dangerous hemorrhages occurred which could not be controlled by medicinal agents. In the vast majority of cases it stopped the hemorrhages and frequently reduced the size of tumors. 3. Operation for disease of appendages; hydro-salpinx, pyo-salpinx, or hemato-salpinx. He advised the operation when a persistent attempt to relieve the symptoms according to the methods advised by Emmet failed to produce a beneficial effect.

Dr. Temple, Toronto, thought the reader of the paper had not attached sufficient importance to the difficulties of diagnosis of such diseased conditions. In some of his cases he had to depend to a large extent on the subjective symptoms; and, after operations, found undoubted evidence of diseased tubes. He thought it likely that Mr. Tait was correct in his opinion, that when disease existed in either tube, both should be removed.

Dr. Rosebrugh, Hamilton, reported a case in that city when the second tube was lately removed about a year after the first had been removed in Toronto by Dr. McFarlane. He was inclined to agree with Tait in his views of such cases as mentioned by Dr. Temple. He gave a description of Mr. Tait's methods of operating as observed by himself during his visit to Birmingham last year.

Dr. Oakley asked the results as far as nervous symptoms were concerned.

Dr. Wright, in reply, said he had had very little experience, as he had seen no operation

for purely nervous symptoms, but when such symptoms existed with local diseases the results as far as they were concerned, had not been very satisfactory.

Dr. Powell, Ottawa, before reading his paper on "Pelvic Hæmatocele" (see page 205,) said he had an apology to offer the Association as the framer of a resolution which had been adopted some time ago in the local society at the Capital, setting forth that the Ontario Medical Association would ultimately crush out its more useful parent, the Canada Medical Association, to the detriment of local organizations. This, Dr. Powell was happy to say, had not been the case, and instead of crippling its parent the child had brought it strength. He extended a hearty welcome to the Association to hold a meeting in Ottawa.

Dr. Palmer, Toronto, explained O'Dwyer's method for intubation of the larynx, and exhibited the instruments.

EVENING SESSION.

Dr. McDonagh, of Toronto, read a paper on "Tuberculosis of the Larynx." The point of greatest importance urged by the writer was the necessity of examining the larynx in all cases of suspected phthisis, arguing that many cases of phthisis could be diagnosed by the laryngoscope before the signs in the lungs were sufficiently marked to allow of a diagnosis being made by the ordinary physical examination. The history of a case in practice was read to illustrate this point. It was also argued that tuberculosis may occur primarily in the larynx, and if recognized at this stage by the laryngoscope, the disease might be arrested before the lungs became affected. The importance of using the microscope for the detection of tubercle bacilli, was referred to and strongly urged.

Dr. Palmer introduced the subject, "Intubation of the Larynx," and spoke of the result which has followed his use of the intubation process, and of the confidence he had thereby been led to repose in it, to the disadvantage of tracheotomy. Professor Packard, of Philadelphia, on the other hand could not see how it was possible for the tubes in this process not to become choked with desiccated mucus. He entered a strong plea for tracheotomy, acknowledged the difficulty and danger which often beset that operation, but urged that the only thing for the physician to think of was how most efficiently to relieve his patient. He should always, if he thought the operation necessary, advise the friends of the patient to have tracheotomy performed. If they refused, then his responsibility was over. His opinion was that tracheotomy in general could not entail more suffering than the patient was already undergoing, and if the operation were properly performed, the chances were largely in favor of great relief being given. It was also his opinion that it is very possible to quite overdo the necessity of keeping the atmosphere of the room where the patient is moist and warm. Dr. McFarlane stated that his experience with tracheotomy had been so painful that he had abandoned it. Since coming to this conclusion he had had two cases, in which, according to past analogies, the probabilities were all in favor of the patients dying, but he had done nothing but adhere to the ordinary treatment, and both recovered.

Dr. Shaw presented the report of the Committee on Public Health. The report favoured the placarding of houses where infectious diseases existed, and the exclusion of children from schools for at least twenty-eight days after infection from diphtheria, and forty-nine days after scarlet fever.

The report of the Standing Committee on Ethics, sent in by Chairman A. McLean, of Sarnia, was tabled on motion of Dr. William Oldright, the latter stating the report had not been submitted to the other members of the committee. In its place, Dr. J. E. Graham of this city, presented the report of the special committee on the same subject. The committee advised the adoption of the code of ethics of the American Medical Association. They also advised the embodiment of the following article in the above-mentioned code, and recommended its proper enforcement by the Association:

It is derogatory to the dignity of the profession to resort to public advertisements, or private cards or handbills, inviting the attention of individuals affected with particular diseases; publicly offering advice and medicine to the poor gratis, or promising radical cures;

or to publish cases and operations in the daily prints, or suffer such publications to be made; to invite laymen to be present at operations, to boast of cures and remedies; to adduce certificates of skill and success, or to perform any other similar acts. These are the ordinary practices of empirics, and are highly reprehensible in a regular physician.

The Committee also drew the attention of the Association to article 4, sec. 1, of the American Medical Association's code, as follows:

A regular medical education furnishes the only presumptive evidence of professional abilities and requirements, and ought to be the only acknowledged right of an individual to the exercise and honors of his profession. Nevertheless, as in consultations the good of the patient is the sole object in view, and this is often dependent on personal confidence, no intelligent regular practitioner who has a license to practice from some medical board of known and acknowledged respectability, recognized by the American Medical Association, and who is in good moral and professional standing in the place in which he resides, should be fastidiously excluded from fellowship, or his aid refused in consultation, when it is requested by the patient. But no one can be considered as a regular practitioner, or a fit associate in consultation, whose practice is based on an exclusive dogma to the rejection of the accumulated experience of the profession and of the aids actually furnished by anatomy, physiology, pathology, and organic chemistry.

As another matter which comes under this head, the committee would mention the injustice of the present system of club practice. In this province benefit societies are increasing in number every year, and the fees given for medical attendance are in most cases quite inadequate. Your committee think it might be well for the Association to give an opinion upon this subject.

Considerable discussion followed the reading of this report, which was adopted.

On the motion for the adoption of this report, Dr. Ross condemned club doctoring as commonly carried on. Dr. Oldright pointed out that a specialist might be excused for advertising his specialty for the purpose of notifying the public that he did not wish for general practice. Dr. Burnham argued that his experience showed that it was not even necessary for a specialist to advertise his specialty on the door-plate to escape demands for general practice. The report was adopted.

The treasurer's report was a favorable one, showing $109 to the credit of the Association.

Dr. Henderson introduced the report of the committee appointed to consider the question of a medical defence union as follows:—

The committee appointed to report on the motion of Dr. Henderson, regarding the formation of a medical defence union, beg to report that in their opinion it is desirable to appoint a committee whose duty it would be to consider appeals from members of this Association who may consider themselves persecuted by unfounded and malicious accusations. If requested, this committee will give professional advice to any member of this Association who may be defendant in a case of surgical malpractice, the Advisory Committee to consist of Dr. Moore, Brockville; Drs. Sullivan and Henderson, Kingston; Dr. Day, Trenton; Dr. Malloch, Hamilton; Drs. Thorburn, Richardson and White, Toronto; Dr. Eccles, London; Dr. Harrison, Selkirk; Dr. Taylor, Goderich; Dr. Thorburn chairman of the board. The report was adopted.

The Nominating Committee brought in the following nominations of officers for the ensuing year:

President, Dr. J. W. Rosebrugh, Hamilton; First Vice President, Dr. H. M. McKay, Woodstock; Second Vice-President, Dr. Moore, Woodstock; Third Vice-President, Dr. Adam Wright, Toronto; Fourth Vice-President, Dr. Taylor, Goderich; General Secretary, Dr. J. E. White, Toronto; Treasurer, Dr. N. A. Powell, Toronto; Corresponding Secretaries, Dr. Fenwick, Kingston, Dr. McPhatter, Guelph, Dr. R. W. Powell, Ottawa, Dr. Shaw, Hamilton.

The nominations were adopted without amendment.

Dr. Richardson, the retiring president, then led his successor, Dr. Rosebrugh, to the dais, and that gentleman thanked the Association for the honour conferred on him.

The Association will again meet in Toronto next year.

NOTES.

We trust the guests of the Associaation at future meetings may have more attention paid

them by the reception committee, and not have to stand before the door of the room of meeting until the financial sentinel on guard is satisfied of their identity. It was positively disgraceful that some eminent visitors were forced to stand about the door till some friendly doctor vouched for them.

Is it not too bad that the various committees do not allow themselves to take more united action? If they did, the ubiquitous general secretary would no doubt be greatly relieved, and would not be obliged to superintend all the details.

The President led the singing of the National Anthem. Did you ever hear a choir of doctors? You should have been present.

The lupus, kidney-shaped knife recommended by Dr. Fox, can be procured at Hernstein's, N. Y.

Obituaries.

DR. GEORGE H. SHAVER.

Dr. Geo. H. Shaver completed his student's course in the Toronto School of Medicine in March last, and passed his final examinations in Victoria University and the Ontario Medical Council, with great credit, in April. He went to New York in May, to take one of the post-graduate courses in that city. He left in bright, happy, and apparently good health. In a few days we received word that he was no more, his death having been caused by diphtheria.

DR. BART. B. PATULLO.

Dr. Bart. B. Patullo was well known in Brampton, where he spent most of his life, and in Toronto, where he lived as a student, in the Toronto School of Medicine. As he was genial, generous, and affable in the highest degree, he always made friends wherever he was. He was a son of Dr. Patullo, formerly of Brampton, and now of Toronto. After he graduated in Victoria University, in 1885, he went to Great Britain, and took the degree of L. K. and Q. C., in Dublin. After his return he commenced practice in Tilsonburg, with bright prospects. Suddenly he was seized with pneumonia, and died after an illness of ten days.

Personal.

Dr. Barton has located on Louisa Street.

Dr. Avison has located on Carlton Street.

Dr. J. Galloway will practice in Beaverton.

Dr. Cotton, late of Mount Forest, is now practicing on College Avenue.

Dr. Grant, of Ottawa, has been made a companion of St. Michael and St. George.

Dr. J. H. Hamilton has entered into partnership with Dr. Miller, of Woodhill.

Dr. Graily Hewitt has been elected a Vice-President of the Gynæcological Section at the forthcoming International Medical Congress.

T. J. Alloway has been appointed assistant surgeon of the Montreal General Hospital, *vice* Dr. Girdwood, appointed consulting surgeon.

Dr. James Stewart has been appointed assistant physician to the Montreal General Hospital, *vice*, Dr. J. C. Cameron, appointed consulting physician.

TRINITY MEDICAL COLLEGE.—Dr. Grasett has been appointed to the chair of surgery rendered vacant by the death of Dr. Fulton. Dr. Covernton, sr., takes medical jurisprudence, and Dr. Covernton, jr., sanitary science.

Owing to ill-health, Dr. Wallace, Medical Superintendent, of the Insane Asylum of Hamilton, has been forced to resign. Dr. Russell, of Binbrook, member of the Ontario Medical Council, has been appointed in his stead at a salary of $1,800 and residence.

Dr. Albert Robin, who has just been elected a member by a large vote, is now the youngest member of the French Academy of Medicine. He is only thirty-eight years old, and is already one of the most brilliant of the savans of France. Dr. Robin has made a specialty of typhoid fever, and out of twelve hundred patients he has never lost one.

A daily paper is responsible for the truth of the report of Dr. Robin's magnificent percentage. Either typhoid fever is peculiarly mild, or the report—well, there is one alternative.