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THE
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Original Communications.

CASES OF OVARIOTOMY.

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To the Editor of the Canada Lancet.

MY DEAR SIR,

Having commenced the fulfilment of a long made promise, I send you the first four of my ovariotomy cases, and shall supply you with additional cases every month, until the whole are published. Numerous calls upon me have prevented my giving them to the profession in any other form than as they are, transcribed almost verbatim from my case book, omitting only such minute daily or hourly details as would make the reading of them tedious.

Believe me, my dear sir,

Yours very truly,

EDWARD M. HODDER.

Queen Street, Oct. 23rd, 1871.

In the September number of the *Canada Medical Journal*, Dr. Craik has published another case of Ovariectomy, operated upon by himself, and I am happy to find that the medical men throughout the Dominion are beginning to record such cases of interest as must daily fall to their lot.

There are still certain points connected with Ovariectomy, which I think are not fully decided upon by operators, and the first to which I shall allude is, the best time for the performance of the operation; or, as Dr. Craik puts it, "whether would it be better to operate early, while the general health and strength were still unimpaired, or to wait until the disease had begun to toll seriously upon both."

The rule which has been adopted by myself, and which I feel disposed to recommend, is not to operate early, for I have seen numerous cases where timely treatment has kept the tumor in abeyance, and ultimately reduced it to such a chronic condition, that for years the woman has been enabled to enjoy life and attend to her domestic duties, with but little inconvenience. Surely, therefore, the medical attendant would not be justified in subjecting his patient to so formidable and dangerous an operation, until he had exhausted the medical means at his command.

On the other hand, when these means fail, and one or more cysts take on rapid development, and the patient begins to lose flesh and strength, I believe, with Dr. Craik, that the sooner the operation is resorted to, the better will be the chances of the woman's recovery. Yet, the truth of this opinion will hardly be borne out by the cases which I am about to publish; for in some of the operations, early performed, the patients did not do as well as several in whom it was postponed until no other hope was left. This important point can only be settled by a faithful record of all the cases operated upon by men who are not ashamed to publish their unfortunate as well as fortunate operations.

The other point not yet fully settled is, the treatment of the peduncle. Mr. Spencer Wells, the most successful operator, and who has performed more operations than any man living, generally uses the clamp, while others still advocate the ligature, the craseur, or the silver wire.

No universal rule can be applied to these cases, and it would be almost impossible to decide what treatment to adopt, until an

examination of the peduncle and its complications enables the operator to determine.

If the peduncle is very short, the dragging and pain caused by the clamp is very great, and the advantages which it may possess, in some cases, is counterbalanced by the suffering of the patient in others. Although I have used it—and with every respect for the opinions of those gentlemen who still continue to use and recommend it—I cannot look upon it in any other light than the remains of—shall I say it?—a barbarous age.

The immediate closure of the wound in the abdominal walls, must lessen the danger to the patient, and I cannot but think that the safest means of securing the pedicle and closing the wound, will ultimately prevail.

CASE 1.—Mrs. H., æt. 46, the mother of five children, noticed 14 months ago, after a catamenial period, a fullness in the left inguinal region. As it was not accompanied with pain, she thought little of it until after the next period, when her attention was again directed to it from feeling slight pain in the back and hip of the left side.

On examination she discovered a lump the size of a hen's egg,—moveable, hard, and tender on pressure; the pain extending down the thigh. This again subsided, and almost escaped her notice, until the next period, (October, 1859,) when the same symptoms arose, but in an aggravated degree; after which the lump *never disappeared*, although it would increase and diminish as before. Shortly after this she applied to various medical men, some of whom thought it pregnancy, others ovarian, and some a phantom tumor. She was subjected to various kinds of treatment, but irritating ointments appear to have been most in favor. After this period (Oct., 1859) her catamenia became irregular, and the tumor enlarged, but her general health, which had always been good, began to show signs of giving way. She became thinner, and her nights sleepless.

From the cessation of her courses, and from the existence of a tumor, she—with the assistance of her neighbors—persuaded herself that she was pregnant, yet thought it strange that the womb should occupy the left iliac fossa, which it had never done before. Time passed on, little having been done, until she had arrived at nearly the completion of the full term, when finding no movement of any kind take place, that the abdomen was not

large, that the tumor would move from side to side, and that there was more or less pain, she suspected that all was not right, and at once applied for advice.

The opinions of the medical men being anything but unanimous, she determined to come to Toronto and place herself under my care.

Oct. 6th, 1860.

Present condition—She is a woman of average size, dark hair, eyes, and skin, but with a good healthy color in her cheeks, has always enjoyed good health, and is of a very sanguine temperament. Tongue clean, bowels regular, and pulse 72, full, soft, and regular. There is no indication of organic lesion, except the ovary. The tumor occupies the left iliac region, is irregular on its surface, hard and unyielding, reaching as high as the crest of the ilium, and descends into the pelvic cavity, producing by its pressure, at times, difficulty in defecation and frequent desire to empty the bladder; but these symptoms are not so severe and urgent as they were during the first few months, when it occupied the entire cavity. By flexing the thighs on the abdomen the tumor can be raised out of the pelvis, and pushed to the opposite side or up to the ensiform cartilage, without pain, but merely a sense of uneasiness. Its apparent size is 8 or 9 inches long, by five or six wide, and is equally firm in every part. A vaginal examination showed that it was entirely unconnected with the uterus, which organ was perfectly normal in every particular.

Having expressed my opinion, I asked permission to bring Drs. Beaumont and Bovell, who, after a very careful examination, coincided with me in pronouncing the tumor to be one of ovarian origin, very moveable, with few, if any, attachments except the pedicle, and non-malignant.

Under these circumstances we stated that it was as favorable a case for operation as could well be met with; at the same time fully explaining to herself and friends the great risk she ran in submitting to the operation, and the probability of the tumor remaining indolent for many years. Her mind, however, was made up, she was determined, and told us she was prepared to die, and would rather do so a dozen times than continue as she was; and that if we would not remove it she would go to some one who would.

She was accordingly removed from the hotel to the matron's private rooms in the Lying-in Hospital, where I knew she would receive the best of care and nursing from that excellent person, Mrs. Winters.

Every arrangement having been made, her bowels relieved by a dose of oil the previous day, and by an injection the morning of the operation, the temperature of the room raised to about 76°, and kept moist by the vapor of water, the operation was performed in the ordinary manner, on Oct. 11th, 1860, in the presence of, and assisted by, Drs. Beaumont, Bovell, Philbrick, and Aikins, and two students.

The incision extended from half an inch below the umbilicus to a short distance above the pubes, dividing the integuments and cellular tissue down to the fascia, this was divided layer after layer, until the peritoneum was exposed. A little delay occurred here in consequence of the effects of the chloroform passing off, and she became restless, though unconscious.

The abdominal cavity was now carefully opened, and the omentum exposed, and a small quantity of high colored serum escaped. The small intestines, notwithstanding the great care taken by Drs. Beaumont and Aikins, kept slipping out of the wound, and as the attempts to restrain them impeded the operation, I determined to envelope them in a flannel wrung out of warm water, which most effectually answered the purpose.

The tumor was distinctly seen, white, shiny, and very firm; there being no cyst except one about the size of a filbert. It was wedged into the pelvis and removed from it with considerable difficulty, although there were no adhesions of any kind except the pedicle. The pedicle was short and could not be brought to the inferior angle of the wound; but was secured by a double whip cord ligature, and allowed to remain in the abdomen,—the ligatures being brought out at the lower end of the wound. The right ovary was examined and found healthy, and after sponging away a few drops of blood, the intestines were restored to their natural cavity, covered by the omentum, and the edges of the wound brought together by six needles passed through the whole of the abdominal parietes, and kept together by the figure of eight suture; the interspaces between the needles were kept in contact by six silver wire sutures, through the integuments only. Strips of adhesive plaster, a pledget of lint, and a flannel bandage completed the operation.

She did not bear chloroform well; instead of becoming quiet and still, she became very livid about the face and head, and the respiration much disturbed; consequently, muscular action took place throughout the whole period of the operation; but which was, nevertheless, completed in twenty minutes.

The shock to the system was not very severe; vomiting being the most troublesome symptom. Two grains of opium were given after the operation, and one grain of opium and two of camphor every hour or two afterwards. She rescribed the vomiting to the opium, which was therefore discontinued on the 12th, and we found that the stomach was intolerant of medicines, and therefore omitted them altogether. She refused to allow the catheter to be passed, but voided her urine freely and without pain. All went on well,—light food being allowed.

Oct. 16. I removed five of the six needles and one silver suture. A small quantity of healthy pus followed the removal of the two lower needles. There is no pain or tenderness, and she feels well.

Oct. 17. Removed the remaining needle and points of suture. The wound firmly healed, except at the lower angle.

Oct. 20. Bowels moved by injection this morning. She has not an ache or pain of any kind.

Oct. 26. One of the ligatures came away to-day; the second on the 28th, with a small piece of the pedicle attached.

Oct. 30. The wound healed, and she walked two miles without assistance; and on the following day—Nov. 1st—she returned to her home in Canada West.

The tumor measured $16\frac{1}{2}$ inches in circumference in its long axis, and $14\frac{1}{2}$ in its short, and weighed nearly three pounds.

To all appearance it was the ovary itself enormously hypertrophied, stroma appearing more clearly fibrous than in its normal condition. The Graafian vesicles being yet traceable, but having undergone the same changes as the gland. It did not contain any fluid, except that contained in the small cyst at the upper and inner part, and which was clear and transparent.

REMARKS.—In this case there was no necessity for an operation, at the time it was performed, except that the disease was preying upon the patient's mind, and that having decided, she was determined, *coute qui coute*, to have it removed. When I remonstrated with her, she

said, "if you will not do it, I will go to Montreal; if they will not do it there, I will go to New York; if they there refuse, I will go to England; but I will never return home until it is taken away. Under these circumstances, Drs. Beaumont and Bovell agreed with me that we were justified in performing the operation.

In a letter from her husband, dated Nov. 22nd, 1860, he says, "She has not had the slightest inconvenience, pain, or trouble, arising from the operation, but is as active and lively as possible for a woman of her age."

CASE 2.—Mrs. S, æt. 38, dark complexion, spare habit, but general healthy appearance, married 15 years. She became pregnant shortly after marriage, but aborted at the third month. In due time she again conceived and gave birth to a healthy girl, now 13 years of age, since which time she has had three living children; the youngest being five years old. She does not remember having had any severe illness, and her recoveries after confinement were good. About 18 months ago she had sharp pain in the left inguinal region, coming on at a menstrual period, continuing for a few days, then subsiding. Nothing was done for it, as she supposed it to be the result of menstruation. As no further return of pain occurred, she thought nothing more of it till February, 1862, when she discovered for the first time a tumor the size of an orange, low down on the left side, moveable, but not painful. This tumor increased with each menstrual period, and again diminished. She has had no pain since the first attack, 18 months ago, and should not have thought of consulting a medical man had not her size increased so much as to induce her friends to suspect pregnancy. Within the last three months it has increased most rapidly, but she suffers no inconvenience except from its weight.

I saw her for the first time on the 17th of November, 1862, when I found her in good health and spirits,

On examining the abdomen, a tumor was discovered, of an ovoid form, reaching as high as the umbilicus, and extending well over to the right side. It was lobulated, elastic, and fluctuation was distinct in two or three points—very moveable, and not tender or painful to the touch. An internal examination showed the uterus perfectly healthy, but displaced somewhat to the right.

The tumor was clearly ovarian and cystic. She was determined on having it removed, and I had some difficulty in inducing her to wait until after the next catamenial period—now almost due—for a consultation. Dr. Small and myself met on the 26th of November, three days after the catamenia had ceased (Dr. Beaumont and Bovell were unable to attend), and after a very careful examination, both external and internal, we stated our opinion to her, explaining the great risk of the operation, and the possible continuance of the disease for many years without material change; but she fairly scorned the idea of postponing the operation. Her mind, as well as that of her husband, having been firmly made up from the commencement. Accordingly she was advised to go to the private ward of the Lying-in-Hospital, where she would have kind care and skilful nursing. Having made all her arrangements, she went to the hospital on Sunday, Nov. 30, 1862, having taken, before going in the morning, Decoct. Aloes, Co. ζ ij, with Soda Bicarb, ζ j, which acted two or three times.

Dec. 2nd, 1862. The operation was performed in the presence of, and assisted by Drs. Beaumont, Bovell, Small, Aiking, Woodfull, R.A., Wm. Covernton, and my son, Dr. Frederick Hodder; the ordinary precautions as to temperature, etc., having been taken. The incision extended from a little below the navel to near the pubes. The oozing was allowed to stop, and the peritoneal cavity was opened to the extent of two inches. The tumor was then examined and found to be ovarian, cystic, and free from adhesions. The opening was then enlarged to the size of the external wound, and with a little management the tumor was made to slide out edgewise through the wound. The intestines were kept from protruding by flannels wrung out of warm water, held by an assistant, while Dr. Beaumont supported the tumor. The peduncle was large, and sufficiently long to bring it to the lower end of the wound,—the veins were of enormous size. A double whip-cord ligature was passed through the middle of the pedicle near the tumor, avoiding any large vessel, and securely tied. The tumor was then separated and removed. There was no bleeding, not ζ ij of blood altogether being lost. The intestines were replaced, covered by the omentum, and the edges of the wound brought together and secured by five needles passed through all the tissues, the lowest needle transfixing also

the pedicle of the tumor. Between each needle a point of suture through the integument only was passed; a piece of lint, strips of adhesive plaster, and a flannel bandage, completed the dressings, and the patient was returned to bed. Opium, grs:ij. were given, and at 8 p. m. she had slept for five hours; pulso 84, soft, skin cool, and feeling comfortable in every way except from thirst.

Dec. 6. Everything went on well, she had not a bad symptom. The dressings were removed to-day, and the wound was found united throughout.

Dec. 7. Wound dressed, four of the five needles were removed; no suppuration or discharge of any kind. She complains only of hunger. To have chicken broth, and rice and milk.

Dec. 10. Going on well, the fifth needle was removed on the 8th; wound healed except where the ligatures came out, and there is slight suppuration.

Dec. 13. She has had colic pains through the night, but without tenderness or any unpleasant symptoms. To have *Ol. ricini* ʒiv. immediately, and an injection if the oil does not operate. The catamenia came on to-day in their ordinary manner, but a few days before their usual time.

Dec. 19. After the action of the bowels she felt quite well. The first ligature came away to-day, and the second on the morning of the 21st, after which the wound immediately closed; and she returned home on the 24th, quite well, and determined to eat her Christmas dinner with her family.

The solid part of the tumor weighed 5 lbs., 2 oz., and was purely cystic. None of the cysts were large, and they did not communicate. Some contained a thick, tenacious, creamy substance; some a clear albuminous fluid, while one or two were very dark. The tumor lay across the abdomen, the lowest and smallest lobe occupying the pelvis.

REMARKS—Nothing could have been more satisfactory from the beginning to the end than this case, and it fairly represents ovariectomy under its most favorable circumstances. The patient was of good constitution and otherwise healthy; her strength had not been seriously reduced by the disease, the tumor was non-adherent, and what I always value in these cases, she was hopeful and determined.

CASE 3.—Mrs. C, æt. 32, fair skin and-complexion, and delicate constitution, the mother of three children—the youngest four years of age—was attacked about three years ago with severe pain in the region of the left ovary, continuing for some time, and was then treated for inflammation of the bowels. She recovered slowly from this attack, but has never since felt as well or as strong as before. Some months afterwards she discovered a tumor or swelling where she had felt the pain, and from the first appearance of the tumor, she has been liable to attacks of a similar kind at intervals of a few months. The pain was supposed to be inflammation of the bowels by the medical man in charge, and she was treated accordingly, but, after a severe attack about twelve months ago, the tumor enlarged rapidly, and fluctuation became apparent.

Feb. 10th, 1862. I saw her for the first time to-day, and although her general health appears fair, she is very much depressed in spirits, and doubtful and desponding as to the result of the operation, and gave me the idea that she had been talked into submitting to the operation, rather than wishing to have it done of her own free will and desire. She was, however, resigned, and urged its performance for the sake of her husband and children. The tumor now reaches the ensiform cartilage, and nearly fills both sides of the abdomen alike, fluctuation being distinct in every part. A careful external and internal examination convinced me that it was a multilocular ovarian tumor, slightly, if at all, adherent, and that the uterus was not in any way involved. In consultation with Drs. Beaumont and Borrell, and at the earnest request of her friends, the operation was decided upon, and Feb. 17th was the day fixed. Accordingly, everything being ready, the ordinary precautions as to temperature, &c., and the patient well under the influence of chloroform, I commenced and completed the operation in the usual manner. There were no adhesions, the pedicle was large and secured by the double whipcord ligature, and brought to the lower angle of the wound, where it was transfixed by the long needle. The wound was closed and dressed exactly as in the last case, and my patient was removed to her bed. Pulv. opii. grs. ij. were given immediately, and gr. j. was to be given every hour until sleep or drowsiness came on.

17th, 8 p.m. Complains much of pain in the abdomen, although

she has had six grains of opium. Pulse 116, small, weak, countenance dejected, speaks but little. Catheter passed and about 6 oz. of urine taken away.

18th. Much the same, slight tympanitis, pain not increased, slept but little. Pulse 120 to 130, weak, skin moist. To have broth and milk alternately.

18th, 7 p.m. No material change, all the symptoms nearly the same. The grain of opium has been continued at intervals of four or six hours.

19th, 9 a.m. Abdomen much more distended and more tender on pressure, pulse very weak, could not be counted correctly, skin moist, somewhat clammy, countenance sunken. Ordered brandy and egg, ammon carb. ex. mist. camph., &c., &c. 8 p.m. Worse in every respect.

20th, 9 a.m. Moribund. She died at 2 p.m., exactly three days after the operation. No post mortem was allowed, as the friends were anxious to remove the body immediately.

The tumor was multilocular cystic, but towards its base, near the peduncle, there was a mass of greyish semi-gelatinous matter, very suspicious of colloid in its appearance. Dr. Bovell very kindly examined it for me, and in his note, with a sketch of the microscopic appearance, he says. "Dear Hodder, I have no doubt that the tumor is colloid, there is a great preponderance of long slender fibre cells, and endogenous-cells."

REMARKS.—This poor woman never rallied completely, from the moment of the operation to the hour of her death. As I have before stated, I believe that she had become resigned, and determined to meet death, to gratify the wishes of her husband and friends, although convinced of the result to herself. The operation was not more severe than favorable cases usually are, there was no hæmorrhage, there was nothing in fact to account for the depression which followed the operation, except the condition of her mind. The question might be asked—Had the suspicious character of the tumor anything to do with the want of stamina which existed in her constitution? and if so, is there any possible way of diagnosing the exact character of the disease before its removal? I have sought in vain for a single diagnostic symptom, by which we might even suspect, in the early stage of its existence, the presence of malignant disease, complicating cystic disease of the ovary, but, although we may not be able to detect

the disease, I am convinced that its presence would so affect the constitution, as to render it less able to bear up against the shock of so formidable an operation.

CASE 4.—Mrs. H., *æt.* 46, the mother of seven children, of dark and somewhat sallow complexion, spare habit, but of uniform good health, discovered a tumor in the lower part of the abdomen, and on the left side, about the beginning of January, 1863. It was the size of an egg, moveable, not painful, shifting from side to side according to her position, and not causing her any inconvenience or pain. She remembers that, for six months before this date, she felt a weight at the lower part of the abdomen when she was ironing or long standing, but, as it caused no other uneasiness, it was disregarded.

In the first week of July, 1863, she applied to me. The tumor was then the size of a child's head of a-year old, quite moveable, easily turned from side to side, lobulated, with indistinct fluctuation above, but hard and firm below, and attached to the left side. The uterus was half-an-inch larger than its normal size, but otherwise healthy, and menstruation was quite regular. As the warm weather had set in, I advised her to wait until September, at the same time ordering an aperient pill to be taken when required, and the bromide of potassium three times a-day.

Sept. 15th, '63. The tumor has now acquired the size of the uterus at full term, and fluctuation is very distinct, she has neither pain, tenderness or inconvenience, except from its weight. Her general health is perfect, and she states that she has never been ill in her life. Having met with a patient upon whom I had operated some time ago, she had made up her mind to have it removed, and is desirous that it should be done as speedily as possible. In consultation with Drs. Beaumont and Small, the case was considered a favorable one for operation, and the 1st day of October was the day named for its performance.

Oct. 1st, '63. All preliminary arrangements having been made, the operation was performed at 1 p.m., in the presence of and assisted by Drs. Beaumont, Bovell, Small, Richardson, Staff Surgeon Webb, Dr. Woodfall, R.A., Dr. C. B. Hall, and my son, Dr. F. Hodder, 45th Regt.

The abdomen was unusually tense, and it had increased in size within the last ten days. An incision three inches in length

was made mid way between the umbilicus and pubes, through the abdominal wall down to the peritonaeum, this covering was carefully cut through, when the sac of a large cyst was brought into view. There were many adhesions, but of recent date, and easily broken through. A large sized curved trocar was passed into the sac, when a quantity of thick, dark colored fluid, flowed away. When the sac was nearly empty, the opening was tied to prevent the escape of any of its contents into the abdominal cavity, and the extent and firmness of the adhesions more carefully examined. I then found the sac at its upper, anterior, posterior, and right side, almost universally adherent. Fortunately, however, most of them were recent and easily separated by the hand, but a few bands were stronger and partially organized and bound the tumor down to the adjacent parts, and required more careful manipulation. The ivory handle of a scalpel slightly serrated was the instrument I used, and seemed to answer very well, for after long and careful attempts the whole of the adhesions were broken down, and the tumor turned out of the abdominal cavity. I should here state, however, that finding the external wound too small it was extended down to the pubes. The peduncle was long and was secured in the usual manner by the double whip cord, the tumor was then removed.

The other ovary was examined, the abdominal cavity well sponged, a few small clots removed together with some serum which it contained, and the wound closed by passing three long needles through the whole of the coverings, the lowest needle transfixing the pedicle, several points of suture between the needles, together with lint, plaster and bandage, completed the operation, and the patient was placed in bed.

Sulphuric ether was used instead of chloroform, but she bore it so badly that the latter half of the operation was performed without its aid. Three ozs. of brandy were given during the operation, and two grains of opium upon her being removed to bed, although she expressed herself as feeling comfortable, with a moist tongue, pulse 98, soft, and no acute pain, but general soreness. On measuring the fluid and weighing the sac with the small cysts, the tumor was found to contain $33\frac{1}{2}$ pints of fluid and $3\frac{1}{2}$ lbs. of solid contents. In the evening she was comfortable, reaction fairly established, pulse 112, soft and even, tongue moist, and she had dosed several times. Continued 1 gr. opium as occasion required.

Oct. 2nd. Has passed a quiet comfortable night, pulse 120 full but soft. No pain. 8 p.m., doing well, no pain or swelling of the abdomen, respiration easy and tranquil. She bears pressure well and is cheerful, but the pulse is 132. Continue pill as required.

Oct. 3rd. Doing well in every respect, pulse down to 112. To have light nourishment.

Oct. 4th. Slept all night, countenance cheerful and better than before the operation; pulse 104. Chicken broth and other light food ordered.

Oct. 5th. Not an unfavourable symptom. Slept well all night. Continue nourishment. The wound was dressed, the needles removed, union was complete. Opium from time to time has, in this case, acted like a charm; it has kept her quiet, calm and composed, and enabled her to sleep away the time. Its future use is, however, discontinued.

Oct. 12th. The bowels not having acted since the operation, an injection of soap and water was ordered, and acted comfortably.

Oct. 17th. The bowels act regularly without medicine or injections. The first ligature came away. Sat up for the first time. Strength good.

Nov. 2nd. The remaining ligature appears as firm as ever. As she feels quite strong and well, she is desirous of returning to her family, and upon her promising to use every precaution to guard against accidents, she was allowed to do so.

Nov. 14th. The last ligature came away to-day. She is quite well.

Oct. 23rd, 1871. I saw her a few days ago, when she told me she had never enjoyed such health as since the operation.

REMARKS—I was somewhat surprised to find the adhesions so numerous, particularly as she most positively stated that she had not felt pain of a severe nature at any time. The recent adhesions occupied the most prominent part of the tumor, and readily yielded to the pressure of the hand, while others were of long standing and broken through with difficulty. I saw this patient in the first week of July, when the tumor was as easily moved from side to side, or elevated towards the diaphragm, as any tumor I ever met with, yet in less than three months, without any inflammatory attack, blow, or other injury, the greater portion of the whole mass was more or less adherent. It is worthy of remark, that large ovarian tumors are frequently found adherent to the under surface of the liver, to the stomach, a great portion of the large intestines, the omentum, the lumbar portion of the peritoneum, and the whole of the anterior walls, but rarely to the small intestines.

(To be continued.)

SCROTO-PLASTIC OPERATION.

BY J. FULTON, M.D., M.R.C.S., Eng. &c., PROFESSOR OF PHYSIOLOGY,
TRINITY COLLEGE, TORONTO.

In the summer of 1869, while practicing in Fingal, Ont., I was called one day in a great hurry to see a patient who was severely injured by a threshing machine. Upon my arrival at the patient's house, a distance of about 5 miles, I ascertained that he had not only received most serious injuries, but injuries of a peculiar and delicate nature. He had been standing astride the tumbling rod at its connection near the cylinder of the machine while oiling some part of the gearing, and that inadvertently his pantaloons and shirt became entangled in the bolts, and drew him down to the rod. Realizing his dangerous position he placed his hands on the rod and with a powerful bound freed himself from his entanglement, at the same time stripping himself of every article of clothing. At first he was scarcely aware of having received any injury; but the hemorrhage attracted his attention, and on examination it was discovered that the scrotum was entirely removed, and the integument of the penis torn from the root and reflected forward over the glans. This was replaced by the bystanders, and he was taken up and conveyed home. The hemorrhage was not great, and very little constitutional shock was occasioned by the injury. Upon examination I found the whole of the perineal region stripped of integument, the scrotum entirely removed, and with it the left testicle, the cord of which was torn from its connection within the body. The right testicle and cord were laid bare, but otherwise uninjured. No serious damage was done to the urethra, and I was able to pass the catheter into the bladder, and remove a small quantity of urine. The remaining testicle being entirely free from any organic lesion, I felt it my duty not only to try and save it, but also to provide it with a suitable covering. True, it might have healed over, forming for itself a kind of integument, but this I felt would be a tedious process and would not form a very good covering when done, and therefore I decided at once to utilize a portion of the integument from the upper and inner surface of the corresponding (right) thigh.

The patient was put under the influence of chloroform and

ether, and, assisted by Dr. McLachlin, of Fingal, I proceeded to fashion a new scrotum for the *forlorn* testicle. I commenced the incision at the upper and inner part of the thigh, at the anterior part of the perineal region, and carried it downwards to the extent of six or seven inches, then outwards and upwards towards Poupert's ligament, an inch and a-half external, to the situation of the cord. I then dissected up this portion of integument, which was oval in shape, from six to seven inches long, and from four to five inches wide, taking care not to wound the *saphena vein*. The flap so formed was next brought over the anterior surface of the testicle, made to surround it, and the edges stitched posteriorly throughout the whole length. A small quantity of adipose tissue was dissected up with the integument, and did good service in preventing any sloughing of the flap. The newly-formed scrotum was connected, as will be seen, by a neck an inch and a-half in width, which was sufficient to insure the vitality of the flap, and was sufficiently large to embrace the testicle comfortably. A small portion of integument was also removed from the left thigh, and brought across the perineal region, in order to facilitate the formation of integument in that part.

This might be considered almost a case of transplantation, although that subject had not as yet been discussed, much less put into practice. The wound in the thigh was partly brought together with adhesive plaster, and the patient put quietly to bed, and opium ordered to be given to allay the pain and procure rest. The stitches were removed on the third day, when adhesion was found to be tolerably complete. The patient made an excellent and rapid recovery. In three weeks' time he was able to move about the house, and in five weeks was able to attend to ordinary business.

I have been induced to report the above case on account of its rarity, and also because the operation I have thus described has never been performed in Canada, so far as I am aware. I have styled it a scroto-plastic operation. The principle upon which the treatment is based is not new; but its application in a case of this kind has not yet been recorded, so far as I have seen, and therefore I felt constrained to place this case on record.

ON RETAINING THE COMMON FLEXIBLE CATHETER
WITHIN THE BLADDER.

By A. MACKINNON, M.D., Sarnia, Ont.

Most surgeons, doubtless, have been perplexed and annoyed by attempts at retaining the common flexible catheter within the bladder in cases requiring it. To obviate the difficulty, Mr. Holt, an English surgeon, has added wings to the common catheter which prevent its slipping out. To these wings, Sir Henry Thompson takes strong objections, on the ground that they cause irritation both in the introducing and withdrawal, and thus mercilessly demolishes Mr. Holt's supposed brilliant invention. Sir Henry, however, has a plan of his own. He gets the instrument-maker to introduce into the common catheter a thin German-silver tube about four or five inches long, so that the last six inches of the catheter remain as flexible as ever; also about two inches of the anterior part. It is fastened to the penis by silk cord tied below the glans.

Some years ago I had a troublesome patient six or seven miles in the country. His bladder was paralyzed, consequent upon spinal disease. On one occasion, having introduced a fresh catheter and leaving him as comfortable as circumstances permitted, I returned home, but not to remain long, for a messenger was soon after me, saying that the catheter had slipped out, and that none of the attendants could re-introduce it. On my way back I meditated how to prevent the recurrence of the annoyance the mishap had occasioned, and had the good fortune to hit upon the following expedient, namely, to shorten the stilet five or six inches, which I accordingly did with perfect success. After introducing the catheter, I withdrew the stilet, cut off five or six inches, wound thread tightly around the upper end, (pyramidal shaped) so as to close the extremity completely to prevent the dribbling away of urine, and finally tied the catheter to the penis with tapes.

There is probably not a single Holt winged catheter in the Dominion, nor is it likely there is any of Sir Henry Thompson's, but every surgeon has a common flexible one, and can make it answer any purpose by proceeding as above indicated. Had I known the anxieties and perplexities of Mr. Holt and Sir Henry,

I should have relieved them of their troubles years ago, by informing them of my method of "Retaining a Common Vulcanized India-rubber Catheter within the Bladder."

REMOVAL OF TUMOR OF THE NECK.

BY CHAS. D. DOIG, M.D., L.R.C.P., EDLI., DENBIGH, ONT.

The extensive vascular apparatus that exists in the neck, more especially in the anterior part, for the carriage and distribution of blood, renders operations in this locality somewhat formidable, owing to the rapid and profuse hemorrhage which is apt to take place.

G. M.—, eleven years of age, native of Canada, Ontario, consulted me some time ago regarding an enlargement of the neck. The tumor, which was of considerable size, was situated on the anterior part of the neck, in front of the trachea, and in the vicinity of the isthmus of the thyroid gland. It projected very considerably, and was not only a source of annoyance, but also occasioned considerable difficulty in breathing. It was somewhat spherical in shape, solid to the touch, and with force could be almost isolated from the surrounding parts. The tumor commenced to make its appearance about six years ago, and has kept constantly increasing.

On the 17th of July, 1871, having produced complete insensibility to pain by means of chloroform, I proceeded to the operation. I made a sufficient incision in the middle line of the neck,* over the tumor, seized it with forceps, and with a few strokes of the knife, completely removed it from its attachment. Three small bloodvessels were divided by the knife,—these bled freely: one of them only required the ligature. I brought the edges of the wound together and applied two stitches to keep them in apposition. The peculiar feature of this case was, that no more than a large teacupfull of blood was lost in the operation. On section the tumor presented the appearance of a gland in structure. It was spherical in shape, and measured more than an inch in diameter. It had an outer capsule not easily separated, and seemed to consist of several smaller lobes.

In a science where ascertained facts are much preferable to

conjecture, however plausible, it is pardonable to enquire, what was the origin of this tumor? Whatever answer may be given regarding its true nature, it would appear that a portion of the thyroid gland became accidentally isolated and assumed a separate existence, and increased in size, deriving its support from the general circulation through the arterial twig which I ligatured.

SEQUELÆ OF TYPHOID FEVER.

BY A. ARMSRONG, M.D., ARNPRIOR.

I was called some time ago to see a man named Edward Gorby, who was suffering from typhoid fever. The fever ran its usual course, and presented no special features worthy of notice. The patient was a very delicate young man, and was much reduced by the attack. After the fever ran its course and, when he was just beginning to recover, his left leg began to swell, and became very painful. The pain extended along the back part of the leg, and also in the groin. At first when the pain set in, in the groin and hip, I thought my patient was attacked with morbus coxæ. However, as the case advanced, I saw that phlebitis was the true nature of the disease. I treated him with tonics and generous diet, as he was very emaciated and weak. I also gave diuretics, such as Pot. nit., Pot. acet., Sp. aeth. nit. Ordered the limb to be bandaged, and poultices of bran and vinegar with hops to be applied and changed often enough to keep up heat and moisture. The limb began to improve, and, in a short time, recovered itself; but no sooner had this taken place than the opposite limb was similarly attacked. This limb was treated on the same principles, and both limbs are now nearly normal. On my last visit I ordered the feet to be bandaged, and tinct. iodine applied once or twice daily.

I am inclined to think that the attack of phlebitis was caused by the absorption of the poison from the abdominal viscera, as the pain and swelling first appeared in the groin in both limbs. I saw a child that was similarly attacked a few days ago. The skin was very clear, and the very dark color of the veins on the abdomen and limbs was so apparent for some days, that the mother became very much alarmed, imagining that mortification had set in. The child is, however, I am happy to say, rapidly recovering, and the discoloration gradually disappearing.

OVER-GROWN CHILD.

While on a professional call last night, after leaving the room occupied by my patient, I was attracted to a cradle by the immense size of a child's face. After looking over the child, I remarked that it was the largest I had ever seen. On my visit to-day I was determined to take some measurement of it, and forward to you.

The child, Thos. White, son of John and Elizabeth White, of the Township of Pakenham, born on the 13th of February, 1871, is to-day 7 months and 22 days old, and weighs 40 pounds; is fair complexioned, and has blue eyes. The child is apparently healthy. His hair is coarse and strong, and he looks manly and intelligent. His bones are largely developed, and his flesh is pretty solid and firm. He was very small when born; is not a great eater, yet nurses well. I took the following measurements.—head measures 17½ inches in circumference, above the ears; 22 inches around the chin and occiput; height, 2 feet, 4 inches, circumference of chest, 2 feet; circumference of body (abdomen), 2 feet, 4 inches; arms, 13½ inches long, including hand and fingers; circumference of upper arm 9½ inches, forearm 8½ inches, middle finger 2 inches long; length of leg 13 inches, length of foot 5 inches, circumference of thigh 16 inches, calf 10½ inches.

About 2 months after the birth of the child, the mother brought him into my surgery, to consult me concerning his then state of health. She informed me that he had not slept well for several nights, was very restless, and required constant attention. He appeared to suffer pains which I supposed to be *growing pains*, as old ladies term them. He also appeared to suffer from asthma. I prescribed some simple remedy, which had the effect of not only relieving the asthmatic breathing, but caused him to rest well. I may also state that the mother is a sufferer from asthma, and had a severe attack, complicated with bronchitis, during her pregnancy with this child.

A. A.

CORRESPONDENCE.

To HENRY STRANGE, Esq., M.D., Registrar of the College of Physicians and Surgeons of Ontario, Hamilton.

108 BAY STREET, TORONTO, 3rd October, 1871.

DEAR SIR,—The action of the majority of the Council of the College of Physicians and Surgeons of Ontario, on the last evening of the meeting in Toronto in June, has led to the very general belief in our section of the profession, that our continuing to act in concert with the members of the "General" School will not lead to beneficial results; and that it will be better for our body and for the Eclectic School also, that the connexion should cease. I am instructed to take immediate measures to apply to the Parliament of Ontario for the repeal of the "Medical Act," and to ask either for the re-establishing of the Homœopathic and Eclectic Medical Boards, or for the entire removal of all restrictions upon the practice of Medicine, putting it on the same footing as in the adjacent State of New York.

I need not say that, after the pains I have taken to bring about harmonious action between the different Schools of Medicine in Canada, that it is with the deepest regret that I look forward to the approaching disruption of the "COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO," where, until the last day of our last meeting, we had all worked together with perfect good feeling and cordiality for the raising of the standard of medical education in all the different Schools. I cannot, however, resist the appeal made to me to take action in this matter, admitting as I do the justice of the complaint made both by the Homœopathic and Eclectic Schools, that their students are compelled to pay exactly double for their education than the students of the "General" School do. Two years' attendance upon lectures in any Medical Institution gives a right to all subsequent sessions free; when three sessions are exacted from students at the same College, it adds only the board to the expense; but when Homœopathic and Eclectic students, having as yet no College in Canada of their special Schools of Medicine, go to the United States for their education, they are compelled, no matter how complete that education may have been, or how well qualified they might be to pass any ordeal however searching, they

are, I say, compelled by the Council to pay in full for another medical education in Ontario, before they are admitted to examination. This is no mere imaginary or fanciful grievance, it has begun to tell very seriously upon the number of students applying to enter with practitioners of our School, and several young men have distinctly stated that they cannot afford to become Homœopaths, when they can enter the Old-School for *half the money*. This may be a matter of exultation to those who have looked upon the Medical Act as the means of extirpating Homœopathy from Canada, but it is scarcely a creditable mode of proceeding, when arguments have failed, to have recourse to fining students to coerce them into the "General" School.

The proposal, which I made at the last meeting of the Council, and which met with the unanimous consent of both the Homœopathic and Eclectic Members, was to the effect that students whose course of study had begun subsequent to 1870, as far as concerned Graduates of our Schools from the United States, should be in the same position as those whose studies had begun prior to that year—this was the substance of the motion that I made; although there were only four colleges of each School in the States to which we asked that this privilege should extend; and it was further guarded by the stipulation that the matriculation examination should be passed before the beginning of the professional education. When a motion so moderate and equitable was voted down by the whole of the Members present belonging to the "General" School, we may well give up all hope of ever receiving fair play at their hands.

It is some satisfaction to me to find that the *London Lancet*, opposed as it is to us in every thing else, adopts our views as to places of study. In the No. of that journal of the 12th of August of this year, the Editor, who has erroneously stated that the Homœopaths wished to diminish the stringency of the examinations, ends by saying, 'On the other hand, so long as Homœopathic students are ready to pass the regular examinations, all oppressive regulations as to curriculum and places of study, should be swept away. It is unnecessary to inquire where men studied, if they are prepared to pass a fair and scientific examination.' Now, I can confidently appeal to you, who have acted not only as Secretary to the Council at its annual meetings, but who have likewise as Secretary to the

Board of Examiners been present at all our examinations to say, if the Homœopathic or Eclectic Members have ever in the slightest degree tried to diminish the stringency of the examinations or to facilitate the entry of incompetent men into the profession.

As the present Council will not likely meet again before the period for which the Members were elected expires, and, as in all probability, they will have no successors, I have thought it right to state to you as fully as an ordinary letter will admit of, the causes that have led us to take the position we are about to take. I think it due, in courtesy to those gentlemen, with whom I have always felt pleasure in associating, that I should, through you, give them notice of the application we intend to make to Parliament, to repeal the "Medical Act" under which we have worked together.

I am, Dear Sir,

Yours very faithfully,

D. CAMPBELL, M.D.

Homœopathic Member of Council of College of
Physicians and Surgeons of Ontario.

A WRONG DIAGNOSIS.

(To the Editor of the Lancet.)

SIR,

A case of unprecedented assault on the person of a man, resident with the party who committed the deed, was tried at the late assizes for the County of Peel. The victim lived eight days. The medical attendant from the first examination pronounced the lower jaw broken at the symphysis and at the angle of the ascending ramus, a rib broken on left side below the apex of the heart, also one rib on the right side, but not creating any uneasiness. Three other medical men were summoned by the defendant, but could not discover any or either of the fractures, until a *post mortem* examination revealed the truth. Then the fractures were discovered in the jaw. The broken rib on left side was found to have produced active inflammation and adhesion of lung to the pleura costalis, ending in gangrene, and the upper part of the chest and neck which was beaten showed contused marks of extensive dimensions. Now, SIR, is it probable—it

might be possible—that three medical men could not find the fractures in the jaw, a part so easily examined, particularly when the fracture at the symphysis was moveable? I cannot account for it in any other way than that they were determined to upset the evidence of the medical attendant; but the *post mortem* they so eagerly wished for, upset all they so positively swore to.

A passing notice of this case may be of service. Medical men cannot be too cautious in giving evidence in court, as there are lawyers well versed in jurisprudence, who would leave them with blushed faces. I think the *trio* will be more careful in future, and hope this case may be a warning to them.

I am, sir, yours, &c.,

THOS. HENRY, M.D.

Sandhill, Oct. 1871.

HOW TO CURE DISEASE.

Dr. C. B. Hall, of Toronto, writes on "Consumption" in the *Canada Lancet*, and thinks that treatment must be chemical. He expects the good derived from cod-liver oil will be equalled by any fat properly given, and he says we must use an alkali with it.

This is his favourite formula.—

R—Butyrii,	oz. ij. drs. vj.
Vitell ovi,	No. j.
Pepsine,	drs. ij.
Soda bi-carb,	drs. iv.
„ phosphat.,	drs. iv.
Theriacæ (molasses),	oz. iij.
Aq. flora aurant,	oz. j.
Syr. tolu,	oz. iv.
Aq. destill,	ad. oj.—M.

In other diseases Dr. Hall professes to have arrived at certainty. Thus he tells us to alkalinize the blood and pneumonia is arrested, so that liq. potassa is specific. And diabetes he finds as easy to control.

In this disease the whole process is chemical, the nature and abnormal change is chemical, the prevention and cure alike act by chemical laws. Starch is given for food. Sugar is found in

the excrements. In the cure, sugar is converted into the most important and useful agent in the animal economy. In each and every process chemical tests unquestionably confirm, "or at least so prove it, that the probation bears no hinge nor loop to hang a doubt on."

Happy Dr Hall to see through and remove disease after this fashion. Oh! for such faith!—*Medical Press and Circular.*

(To the Editor of the Canada Lancet.)

SIR,

I would not call your attention to the flippant remarks of the September 13th number of the *Medical Press and Circular* on my paper on Consumption published in the *Canada Lancet* a short time ago, if this were not the particular season when medical students are mostly undecided as to the relative importance of different schools in granting degrees in their profession, and to show, from this circumstance, how much are our own country schools in advance of their forefathers. For the former would have given "happy Dr. Hall" credit for a medical practice taught by the first men of Europe for twenty years or more, nor would they have applied the term "faith" as illustrative of that which has been the subject of perfect demonstration. The chemical theory of consumption attempted to be ridiculed is taken from Professor J. Hughes Bennett's work on Tuberculosis, published in 1853; the use of chemical agents in the treatment of disease generally, and particularly of pneumonia, from Liebig of a little earlier date; the application of fats, as used in the prescription referred to, from the discovery of M. Pelouze, who states that animal oils at an elevated temperature are resolved into their respective acids, and can in this state be brought into the general circulation. My reasons for giving the preference to butter over other fats is fully shown in the October number of your journal. For the further chemical changes in the animal economy, such as starch into sugar, and of its being checked in diabetes, as well as the change of lithic acid by this same chemical process into hippuric acid, I appeal to the distinguished names at the close of my paper, viz., Lohman, Jones, Garrod, Ure, and others. One most important mistake as to the use of fats I wish to correct. "He expects the good derived from cod-liver oil will be equalled by any fat properly given." This is

not my meaning as I would have it understood. What I do mean to say is, the reason *no good* of any consequence has been derived from cod-liver oil, or any other fat, is owing to its not having been *properly given*, but in such unprepared form as to allow of its combining with the alkalies of the system, and conversion into soap.

C. B. HALL, M.D.

Adelaide Street, Oct. 1871.

THE ORIGIN OF FIBRIN.—Dr. L. S. Stille in the *Medical Times*, gives a clear discussion of the origin of fibrin. This is an old problem, and every contribution to its solution is welcome. Dr. Stille says, "that fibrin can be demonstrated to be formed from albumen by the following facts. the chyle contains more albumen and less fibrin than blood, hence a part of the albumen must have been converted into fibrin. The chyle immediately after being absorbed by the lacteals from the intestines contains more albumen and less fibrin than that which has passed through the mesenteric glands. The arterial blood contains more fibrin and less albumen than the blood in the veins, and this can only result from a transformation of the latter material into the former." But a part only of the albumen is so transformed. Why not all? To answer this he adduces the evidence for believing that the fibrin is formed from the albumen by the white blood corpuscles. Lastly, he states that recent investigations show that a "substance exists in blood serum which is apparently as essential to coagulation as white blood corpuscles. This is called paraglobulin. If taken from freshly drawn blood, no coagulation occurs in that liquid until it is replaced. If added to hydrocele fluid, which at best forms only a small coagulum, instantaneous fibrillation is the result. From these facts, we must say that white corpuscles make fibrin. They are organized and act upon an unorganized substance, to produce a third body. The origin of paraglobulin is still open to research. To sum up, "Fibrin does not exist as such in the blood, but is a product of the white corpuscles upon a material named paraglobulin existing in the serum."

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TORONTO, NOVEMBER 1, 1871.

PROSECUTION FOR ALLEGED MALPRACTICE.

ANDERSON ET UX. VERSUS N. O. WALKER, M.D., PORT DOVER.

This was an action brought against Dr. Walker of Port Dover, to recover damages in a case of inversion of the uterus. The trial took place at Simcoe, and we are indebted to Dr. Clark of Princeton for the following report of the case.

Dr. Walker had been called to attend a Mrs. Anderson of Port Dover, on 6th October, 1870. The case had progressed rapidly, and, to all appearance, satisfactorily, with the exception of severe flooding a short time after the birth of the child. Dr. Walker attended Mrs. Anderson until the 14th of the same month, when he was dismissed, and Dr. Stewart, of the same place, called in. Dr. Stewart refused to prescribe for her without consultation, and suggested that Dr. Covernton of Simcoe should be sent for. He arrived shortly afterwards, and his account of the case has been already published in the June number of the *Lancet*. Dr. Walker, in his evidence gave substantially the following history of the case.—

I was summoned to attend Anderson's wife on the night of the 6th October, 1870. I found the patient in strong labour pains, presentation natural, and the head in the vagina. After a few strong, long, expulsive pains, the child was born. I had only to support the perinæum. After bringing about full

respiration in the child, I separated it from the mother. Perhaps two or three minutes elapsed from birth until separation. I applied the bandage loosely around the hips of the patient, and in fifteen or twenty minutes proceeded to remove the placenta; found it lying in the vagina. I removed it with little difficulty, and when expelled, some well-formed clots followed. While the right hand was in the vagina, I had the left over the pubes, or uterine tumour, which was moderately firm. I called one of the nurses to keep up pressure on the uterus, while I cleared the bed of placenta, &c. After washing my hands, I relieved the nurse, and tightened the bandage over the body. The uterine tumour was now firmer, and more distinctly felt. After making the patient dry and comfortable in bed, I retired into an adjoining room, and visited the patient occasionally. All seemed to be progressing well. The patient asked me to give her something for after-pains. I explained to her that I wanted her to have four or five good pains before I gave her any, as I feared hemorrhage. I feared hemorrhage, as the patient appeared a delicate, anæmic person, and one in whom the fibrin might be deficient, and I had not given ergot, as labour came off so quickly after my arrival, that I could not prepare it in infusion, the form in which I usually administer it. I retired again for some fifteen or twenty minutes longer, nearly three-quarters of an hour or an hour having elapsed since labour. I visited her again, preparatory to prescribing some powders for after-pains, which were now more severe, and preparatory to going home. I found the patient leaning on the shoulder of the nurse, and when I felt her pulse, found her sinking, I raised the covers and found copious hemorrhage. I at once lowered the head of the patient, called for some brandy, and administered a large dose of brandy with opium and acetate of lead. I had the window raised, and all covers removed, except a thin cotton sheet. I then proceeded to make a vaginal examination, putting my hand on the outside of the bandage, I felt the uterus firm, and as I was about introducing my hand I saw that hemorrhage had ceased. I did not examine then for fear of disturbing any clots that might have formed, and to which I attributed the cessation of hemorrhage. I directed my attention to the patient, administering brandy freely and prepared ergot, sent for my galvanic battery, fearing return of hemorrhage, when the patient rallied. She rallied

slowly, and there was no return of hemorrhage, nor any cause to justify me in making a vaginal examination. I remained with her all night, not leaving her more than five minutes, while I went to the office for some drugs. In the morning I left her in charge of the nurse, and diminished the amount of brandy prescribed. I returned frequently during the day, and found the patient as well as could be expected. I used the catheter in the evening, withdrew the Lead and gave Dover's powder and Tannin. The patient complained next morning that the brandy and powders made her thirst intolerable, and I next day (second day after confinement) prescribed liquor ammonia acetatis with excess of ammonia, and withdrew the brandy. I used the catheter twice daily, and gave powders only night and morning. Added next day, digitalis to the mixture. The patient progressed fairly, and wished me to allow her to get up to stool, as she thought she could void her urine if allowed to do so. I refused permission, telling her the danger. On the night of the 12th I ordered her a dose of oil. I called next morning about nine o'clock, and found the patient in bed; distressed expression of face, pulse quick and irritable, she complained of stricture of the throat, in short, hysterical symptoms. I found the oil had operated strongly, and while at stool a large clot passed from the vagina, and the patient said she thought "every thing would pass from her." Found she had used the stool out of bed, and had set up upon a chair, and changed her clothes. I was much embarrassed, but added tinct. moscha, and spiritus eth. nitrici to mixture, and cheered the patient, hoping a good sleep would restore her (she had not rested during the night previous). I called again in the evening of the 13th, and found no improvement, I added a full dose of morphine, and called next morning, the 14th, and found symptoms worse, intending to ask for a consultation in case the patient was no better at the next visit. * * *

Mrs. Anderson (the patient) gave her evidence in a very candid manner, and corroborated Dr. Walker's statements, with the exception of a denial of the number of times the medicines were administered, and denying that any examination was made over the abdomen, or per vaginam, after the night of the birth of the child. She asserted to a feeling of incessant pain and bearing-down, as if something was about to come away from her.

She spoke about "a clutching" of the bowels by the Doctor when she was flowing; and when she exclaimed, "Oh! Doctor, I shall die," Dr. Walker replied, "Yes, you will, if the flooding does not stop; you are flowing to death." She spoke of a "jerk of the cord," but denied forcible traction being used. She said that the Doctor did *not* forbid her to leave the bed to go to stool, and that these feelings of an absence of "something" in the abdomen were from the time of labour.

Dr. Stewart, who was called by the plaintiff, stated it was his belief that complete inversion of the uterus took place *at, or shortly after* labour. He believed an examination should have been made soon after the time of labour.

Dr. Hodder, Toronto, deposed to having attended about 7,000 cases of labour, and never had a case of inverted uterus. It was so rare in practice that its occurrence would never enter into a practitioner's mind, unless more than ordinary symptoms supervened, which would point out that such a change *might* have taken place, as indicated. If he found, as stated by Dr. Walker, by pressure on the abdomen, a contracted uterus above the pelvis, after the expulsion of the placenta, he would not dream of their being an inverted uterus afterwards; even from the assertions of Mrs. Anderson at the time, for her exclamations were such as are often used by women in the pangs of natural labour. If there was swelling of the bowels after a few days, he would likely have made an outward examination, fearing puerperal peritonitis. He did not think it would have been wisdom for Dr. Walker to have made a vaginal examination, immediately after *the flowing, on a mere supposition of an inversion of the uterus*, if he felt the uterus *in situ*, for it might have resulted in a removal of clots and a return of hemorrhage, and would have been bad practice. Taking the evidence of Mrs. Anderson as true, he heard nothing to show neglect or unskillfulness in the treatment. He believed that the inversion took place when the patient was at stool on the 13th October.

Dr. Workman, Toronto, corroborated to a great extent what Dr. Hodder had said. He said that the evidence of the nurses was of no account in such cases, as they were not competent to judge. He explained to the Court what an inversion was, and how it might take place some time after labour, when relaxation of a partial kind took place, and after the uterus had emptied its

contents. At that time contraction of a section of it, say the fundus, might take place by pressure on it, by the abdominal walls, in straining at stool, or by the want of tonicity in the organ itself. A flaccid state of that organ might cause inversion, or be the occasion of it, by a subsiding of the uterus, in the first place, by its own weight towards the *os uteri*. Inversion might take place at any time after labour; but so rare was the occurrence, that it would require *something more* than usual symptoms to excite suspicion of such an event having taken place. He could not infer from the statements of the witnesses of the plaintiff, that Dr. Walker had done, or neglected to do, otherwise than that which was according to good practice.

A good deal of extraneous matter was introduced in the examination, but the above is the substance of the evidence. The two nurses of Mrs. Anderson (mother and mother-in-law) were examined, but their evidence had little bearing on the cardinal points at issue. Dr. D. Clark, of Princeton, was subpoenaed by defendant, but his evidence was not thought necessary after the clear and decided testimony of Drs. Workman and Hodder. Mrs. D. Walker (sister of the plaintiff) substantiated what Dr. Walker had said in regard to "cautioning" Mrs. Anderson not to use the stool on the 13th of October. She said that Mrs. Anderson told her so.

It will be seen by the evidence that the chief question was as to the *probable* time when inversion took place. Did it take place at or within a few hours after labour? Was it, if so, at that time, *partial* or complete? If not, did it take place on the 13th? In no case can a valid charge be made, unless it was complete at first, and no correct diagnosis arrived at while the inversion was recent. As the case is likely to come up again before a jury, we pass no judgment upon it at present. A question arose during the trial as to the weight to be attached to medical testimony, based upon the statements of witnesses and not known facts, to the medical witnesses. Judge Wilson said that in cases of that kind, it was looked upon as if these Drs. had been in council with the parties whom they defend, and had (as it were) given medical advice in the case. He (the defendant) had done as they would have done, had they been present in consultation. That was the position in which such witnesses stood.

The damages claimed were \$2000, and the jury gave \$275. A new trial has been applied for by Dr. Walker.

MORE-QUACKERY.

We regret very much, for several reasons, to be again called upon in our capacity as Journalist to refer to another gross and flagrant case of quackery. In this instance the person charged holds a seat in the Council of the Colloge of Physicians and Surgeons of Ontario. The advertisement which has been brought under our notice appears in the *Whitby Gazette*, and we give below a few extracts from 18 or 20 of a similar kind. Such practices as these are not only dishonest in themselves, but incompetent with the spirit in which a liberal profession should be practiced, and we feel that the Council will be wanting in its duty if it fails to remonstrate or protest against such conduct on the part of any of its members.

We having nothing to say against Dr. Carson, who is an able representative of the Eclectic school, as a man; but we think he has formed an incorrect estimate of what is due to himself as a physician, and a member of the Council. What will be thought abroad of such plans for prosecuting a profession as the following exemplifies:

Dr. Carson,—Dear Sir:—Please send me another Bottle of your *Cough Drops*. I do really think they are the best in the world.

Myrtle, Ont., March 2nd, 1871.

R. HURLBUT.

I have used and prescribed Dr. G. A. Carson's *Cough Drops*, and in all instances I have found it to be a most excellent Medicine, not only in reference to myself, but also in all cases where I ordered it.

Whitby, April 25th, 1871.

W. H. EVANS, M.B. (111)

G. A. Carson, M.D., ? Whitby.

Dear Sir:—Your invaluable *Hair Tonic* has given me the greatest satisfaction. As a hair dresser, it is the best I have ever used, besides its excellence as a Hair Dressing, it proves a superior cleaner and invigorator to the scalp and hair,

I am, yours, &c., &c.,

L. WARNER, Wesleyan Minister

Dr. Carson, M.D., Whitby, Ont.,

Dear Sir:—I have given your *Worm Specific* a fair trial in my family, and have to bear testimony to its great worth as an immediate destroyer of this great family pest.

MRS. JOS. WILKINS.(1)

G. A. Carson, M.D., Whitby, Ont.,

Dear Sir:—It affords me sincere pleasure in giving this testimony of my unqualified approbation in reference to your *Stomach Bitters*. No preparation of the present day, professing similar qualities, can, in my opinion, compare with it. It is gentle though effectual in its operation.

Very respectfully, WALTER ROSS, M.P.

Prince Edward.

G. A. Carson, M.D.,

Dear Sir.—It gives me sincere pleasure in testifying to the excellent qualities of your *Cough Drops*, also *Stomach and Constipation Bitters*. I have used them personally, as also in my family, and I have found nothing to equal them, and I can confidently say they perform all they are recommended for.

Very sincerely yours,

J. H. GREENWOOD, Solicitor, &c.

COLLEGE OF PHYSICIANS AND SURGEONS, Ont.—Thirty-three candidates presented themselves for the matriculation examination, in October, of whom the following twenty eight succeeded in passing.—

Thos. S. Barclay,	Geo. E. Bornberry,
F. G. B. Clarke,	F. R. Berry,
Alex. Douglas,	Henry Edmunds,
Jas. A. Fisher,	E. Freel,
W. J. Grasey,	Geo. Gordon,
John Kirkpatrick,	Jos. Livingston,
Albert Luton,	James McWilliam,
Hugh McDonald,	W. C. Morton,
Duncan McLeod,	W. H. Moorhouse,
R. J. McKinnon,	J. M. Nelles,
James Phelan,	James W. Renwick,
Walter Scott,	Albert Sanderson,
Levi Secord,	G. P. Sylvester,
Jas. W. Thompson,	J. D. Wilson.

ARTHUR WICKSON, M. A., L.L. D., Examiner.

The death of Samuel Solly, F.R.C.S., Eng., late surgeon St. Thomas' Hospital, is announced. He had been in ill health for some time past, and was reported to have had a stroke of paralysis.

MEDICAL MEN v. INSURANCE COMPANIES.

Our attention has lately been drawn to the subject of the payment of medical men for the filling of a certain form as the medical attendant of the party who applies for life insurance. Some maintain that the company should in all cases pay for this service; some are willing to take the fee from the applicant, others refuse to do so, and a few fill up the form gratuitously. Now as the filling up of this form is in some particular cases of great value to the company, and as it requires a good deal of time and care on the part of the medical attendant, such as keeping a record of the date of the patient's illness, its nature, &c., it is a service that should be properly remunerated, and that too by the company undoubtedly. The ordinary fee for such service varies from \$2.50 to \$5.00, depending upon the amount insured. But you say some companies refuse to pay the medical attendant for this service, and in that case the applicant must pay, or the service must be done gratuitously.

There is one view in which it seems unreasonable that the applicant should pay for this service, viz. a case in which the medical attendant's report condemns him. He therefore pays a fee of \$4 or \$5 for good service rendered the company, but very damaging so far as he is personally concerned. We have been informed that this subject was under discussion twenty-five years ago in the *London Lancet*, and it was then decided that the companies should in all cases pay the fee, which was to be one guinea. We earnestly hope that the present discussion may be as satisfactorily arranged. To this end it is absolutely necessary that there should be unanimity of action among medical men themselves, and then the companies would be forced into paying the fee.

REPEAL OF THE MEDICAL ACT.

We publish elsewhere a letter from Dr. Campbell, Homœopathic member of the Council of the College of Physicians and Surgeons, addressed to the Registrar in which he complains of the action of the Council at its last meeting, and gives notice of his intention to apply to the legislature for the repeal of the act

now uniting his body and the Eclectics with the general profession. The whole ground of complaint appears to be the refusal on the part of the Council to pass a resolution exempting students of the Eclectic and Homeopathic persuasion from attendance on more than one session in a Canadian school.

We have already given expression to our views on the principle contained in the resolution referred to, in the July number, and we have seen no reason to change them since. It would be wisdom on the part of the Council, to call the executive together and decide as to what action should be taken in reference to this matter. The act has done a great deal of good, and when properly amended by the insertion of penal clauses, it will be still more acceptable to the profession, and we trust that wise counsel and unity of action may prevail to prevent the repeal of an act which has done so much to elevate the standard of the medical profession in Ontario.

ICE IN THE RECTUM IN RETENTION OF URINE.—Dr. Casenave has for the last twenty years used ice in retention of urine, and has never failed in giving relief. He introduces into the rectum a piece of ice of the form of an elongated oval and about the size of a chestnut, which he pushes up beyond the sphincters, and renews every two hours. Almost always in an hour and a half urethral spasm ceases, a certain quantity of urine is passed, and the bladder is emptied without effort by the patient. If in rare and exceptional cases this does not take place, he, besides this, places ice from the anus to the end of the penis, until the urine flows, which it infallibly does. Where prostatic hypertrophy causes the difficulty, the good effects of *the ice are longer coming on.*—*The Doctor.*

TREATMENT OF PRURITUS VULVÆ.—Mr. MacGrath states that he has found the application of the undermentioned lotion (by means of a soft sponge after ablution, morning and evening) attended with the most satisfactory and speedy results.—Biborate of soda, two drachms, hydrochlorate of morphia, one scruple, hydrocyanic acid, one drachm, glycerine, one ounce, distilled rose-water, eight ounces.

APPARATUS FOR THE CLINICAL EXAMINATION OF URINE.

BY REUBEN A. VANCE, M.D.,

Physician-in-Chief to the New York Institute for the Paralyzed and Epileptic, etc.

It is now several years since that, as an *interne* at Bellovo Hospital, it became my duty to make a large number of urinary examinations daily. For my own convenience, I had an instrument-maker construct me a sort of clinical pocket-case, containing the following articles:

An axillary Thermometer (*a*), Specific Gravity apparatus (*b*); Nitric Acid bottle (*c*), Two small Test Tubes of different sizes, with wire to hold them (*d*), pair of Forceps (*e*); Platinum foil (*f*); two Pipettes (1 and 2) and Litmus paper, red and blue.



—the whole being neatly enclosed in a leather-covered case, 4 inches long, 2 inches wide, and 1 inch thick, making when closed, a very conveniently sized case for the pocket. * * *

These few instruments enable the physician to determine quickly, and with a great deal of accuracy:

1. The reaction of the urine—whether acid, alkaline, or neutral.
2. The relative quantity of urea.
3. The relative quantity of solid ingredients.
4. The relative quantity of inorganic ingredients.
5. The relative quantity of organic ingredients.
6. The specific gravity of the urine.
7. The presence or absence of albumen.

No detailed description of these various appliances need be gone into here. The appearance of litmus-paper is familiar to every medical student; and the same may be said of the urinometer, the instrument employed for determining the specific gravity of the urine.

The two pipettes, as will be seen by the accompanying illustration, should be of different lengths, so that they need never be confounded the one with the other. The smaller one is to be used with nitric acid alone; the larger one is to carry urine, and should be used for no other purpose. It is a well-known fact, that when a pipette is inserted a given length into any fluid, and the bulb of the finger placed over the other opening, it can be removed from the liquid, and carried any distance, without spilling any of its contents, so long as the upper opening remains closed. Advantage can be taken of this fact in the present instance, and the pipettes are placed in this case for the purpose of actually measuring, and carefully carrying, small quantities of urine and acid. It will be noticed that each pipette is marked by a horizontal line, which, in the smaller one, is much nearer its lower extremity than in the larger one. The reason for this will be explained presently.

The platinum foil is simply a section of a thin sheet of platinum, and is used when it is necessary to evaporate the urine. It is also useful in testing the quantity of urea in the specimen under examination, and in incinerating the dried residue when we desire to separate the inorganic from the organic constituents. The forceps are intended to hold the platinum when in use. * *

The first thing to be done is to determine the reaction of the specimen to be examined. For this purpose we employ the urine-glass, in which we subsequently place the urinometer when testing the specific gravity. Two pieces of litmus paper—one red and the other blue—are placed in the bottom of the glass, and a quantity of urine is poured upon them. The normal urine being acid, in the majority of cases both pieces will assume the same color—red. But in certain cases the urine is alkaline when voided, and in certain others it becomes alkaline from decomposition, and then the reverse will obtain—both pieces will turn blue. Great care should be exercised in keeping the urine-glass clean, and free from acids especially, otherwise the results may be vitiated.

To determine the amount of urea in the specimen, place a single drop of urine (which is to be taken from the bottle with the large pipette) on the platinum foil, which with the aid of the forceps is to be held in the left hand, and, with the small pipette, add an equal quantity of nitric acid. In normal urine no immediate effect will be produced, but should there be an excess of urea, crystals of the nitrate of urea will at once make their appearance. In proportion to the excess of urea, this process of crystallization will be rapid and extensive. It will occasionally happen that the liquid on the foil will appear to solidify at once, so quick and complete will be the process. Should nothing of this kind take place, the amount of urea in the specimen is either normal or deficient. To test this latter point clean the foil, by bringing it to a red heat over a candle or gas flame, and, with the large pipette, place upon it double the quantity of urine used in the former experiment, evaporate slowly to half its original bulk, and then add to it an equal quantity of nitric acid. Normal urine submitted to this test will at once crystallize: should no change of this nature ensue, the amount of urea is palpably deficient. * * * * *

After cleaning the foil carefully by raising it to a red heat, as in the former case, we can proceed to test the quantity of solid ingredients present. This is to be done by carefully evaporating a given quantity of urine, and comparing the residue with that obtained from the same amount of healthy urine. The platinum foil is to be used for this purpose, and it is well to accustom ourselves to using the same amount of liquid upon all occasions. The large pipette has a mark near its lower pointed extremity which is intended as a guide for dipping out the urine for this test—the pipette should be filled exactly to that point. In evaporating the urine, care must be taken not to raise the boiling mass to a very high temperature, and in practice it will be found convenient *not* to evaporate all the liquid, but to form an estimate from the pasty mass which is left upon the foil some time before the last of the water disappears. The quantity of this material furnishes the observer with the data from which to form an idea of the amount of solid ingredients in the given specimen. As in testing the amount of urea, continual practice is essential to enable a physician to judge with a great degree of accuracy.

The residuo, which gives us our idea of the amount of solid ingredients, can be used in determining the quantities of organic and inorganic constituents, and their relative proportions in a given case. The pasty mass on the foil is to be slowly raised to, and for some time kept at, a red heat—the organic matter is thus dissipated. With the handle of the forceps we can gather together the inorganic ingredients which have remained on the platina, and the difference between their present size and their bulk before incineration will indicate the amount of organic matter driven off by the heat, while the residuo will denote the quantity of inorganic materials in the specimen under examination.

The urine which was poured in the urino-glass for the purpose of testing the reaction can now be used for determining the specific gravity. The urinometer is to be placed exactly in the centre of the glass, care being taken to avoid contact between the graduated tube and the walls of the glass. As soon as all motion ceases, the figures at the surface of the urine will indicate the specific gravity of the specimen. The specific gravity of normal urine varies from 1,016 to 1,020, 1,018 being a fair average. There is an old rule, called the rule of Trapp, which, while it is far from being altogether accurate, yet possesses a certain amount of truth, and is well to be known. It states that, to determine the amount of solid ingredients in a given specimen, find the specific gravity and then double the two last figures used in expressing that sum. For instance, the specific gravity being 1,018, the amount of solid ingredients is $18 \times 2 = 36$.

In testing for abnormal ingredients, our attention is drawn most prominently and forcibly to the solution of the question of the existence of albumen in the urine. No other substance possesses such interest or is of so much pathological importance. The commonly used tests (heat and nitric acid) are sufficiently delicate, but it is to be feared that, in their general application, their value is more or less impaired by inattention on the part of the examiner to one or more very important rules.

In the first place, the reaction should be accurately noted before applying either test. The reason of this is sufficiently obvious, when we remember that albumen is not coagulated by heat when the urine is alkaline, and that even in normal urine—much more so in a strongly acid specimen—we are liable to be deceived by an abundant deposit of amorphous urates upon the addition of nitric acid.

The reaction having been determined to be acid, the smallest test-tube can be filled one-half full of the urine under examination, and the upper part subjected to the action of heat. The wire-handle will now be found of great service in holding the tube over the candle or gas flame. This test is especially satisfactory in cases where the specimen is more or less opalescent from a deposit of the urates. Heat alone will speedily clear up the solution, and the upper transparent portion will contrast strongly with the cloudy lower layer. The albumen, should any be present will not coagulate until this change has taken place, and will then declare itself as a beautiful white circle at the upper part of the test-tube, which will persist after the addition of nitric acid. The turbidity commonly produced when neutral or alkaline urine is submitted to the action of heat (due to a precipitation of the earthy phosphates) is readily distinguished from that of coagulated albumen by the fact that the former disappears instantly upon the addition of nitric acid.

The test of universal applicability is that of nitric acid. The reaction of the urine does not interfere with its operation—it is equally efficacious in acid or alkaline solutions. But one caution is necessary, and that is, that in highly concentrated urine a deposit of amorphous urates will occasionally follow its addition, and produce a turbidity which might be mistaken for albumen. "The two conditions are however, easily distinguished by observing the level at which the cloudiness begins, and the direction in which it spreads. Albumen begins to coagulate immediately above the stratum of acid, and the turbidity spreads upwards, but the urates appear first at or near the surface of the urine, and the opacity spreads downwards. Heat also readily resolves the doubt, for the urates speedily disappear when the urine is warmed, but turbidity from albumen is not affected by heat." — *Roberts.*

The following simple plan is one I can recommend most thoroughly, and I doubt if those who adopt it will often find themselves disappointed with its facility or accuracy. It is to take the largest of the two test-tubes in this case, fill it two-thirds full of urine, and add the acid by means of the small pipette. The quantity of nitric acid should not exceed five drops, and can be readily estimated by filling the pipette to the horizontal line, near its lower extremity. Then, holding the test-tube in the left hand, carry the point of the pipette to the bottom of the urine and remove the finger from its upper end. The consequence will be that the nitric acid will at once form an even thin layer at the

bottom of the test-tube, and the pipette can be removed without disturbing the contents in the slightest degree. Should there be albumen in the specimen, it will coagulate at the top of the acid, and will be at once plainly apparent. Three distinct layers can then be distinguished. First, the nitric acid, next, the coagulated albumen; and, above that, the urine presenting its ordinary appearance. If both albumen and urates are present—the latter being very common in acid urine—four very distinct layers are formed. At the bottom will be nitric acid; over it, the coagulated albumen, next, a layer of urine, in which the acid is still so concentrated that it retains the urates in solution, while it is too dilute to coagulate the albumen [Heller]; and above that again, the cloudy urates.—*Medical World.*

SUCCESSFUL TREATMENT OF UTERINE CATARRH BY INTERNAL APPLICATION OF CARBOLIC ACID.

CLINICAL REMARKS BY DR. W. PLAYFAIR, AT
KING'S COLLEGE HOSPITAL.

In a large proportion of old-standing cases of uterine catarrh it is hopeless to expect a permanent cure by any means which do not act directly on the seat of the disease, which is the lining membrane of the cavity of the uterus and cervical canal beyond the external os, accompanied, of course, with secondary morbid states of the body of the uterus and cervix, such as hypertrophy, congestion, &c. Rest, applications to the exterior of the cervix, and general treatment will unquestionably cause a temporary improvement, but on a recurrence to the old habits of life all the old symptoms return. There are serious objections to intra-uterine injections, unless the os is first dilated with laminaria tents, as they are apt to bring on severe uterine colics. By means of fine probes of whalebone or flexible metal, round which a thin film of fine cotton wool is wrapped, alterative applications can readily be made to the interior of the uterus, without pain or danger. In the very numerous cases in which this plan of treatment has been carried out, in no single instance has anything but the greatest benefit accrued. It is no doubt advisable to select the cases judiciously, and where there is much uterine tenderness, intra uterine treatment should be postponed until this has been

diminished by rest, leeching, &c.; but with proper precautions the treatment is perfectly safe. A concentrated solution of carbolic acid, eighty parts to twenty of water is used: and it acts so well that for a long time nothing else has been employed. After the first application the discharge is sometimes increased, but after the second or third it is generally greatly diminished, and a single application is often sufficient to cure superficial erosions of the cervix. As a rule, there is no difficulty in passing the probes, as in true uterine catarrh the os is invariably patulous. As the case improves, the patulous state of the os diminishes, and this is found to be one of the most certain signs of improvement.

The following cases are selected, not because they present any peculiar features, but because each of them had been assiduously treated for lengthened periods by the ordinary methods employed, and without permanent relief, while they were rapidly cured as soon as the true seat of the disease was attacked:—

Mrs. P—, aged thirty-three, was the mother of four children, the youngest of whom was six years of age. Ever since the birth of her last child she had suffered from uterine diseases, the prominent symptoms being constant bearing-down pain which entirely incapacitated her for work, and a very profuse leucorrhœal discharge of a transparent gelatinous character. The latter was steadily increasing, and she became now thin and cachectic. The menstrual flow was irregular, scanty, and very painful. The uterus was large and tender on pressure; the cervix greatly hypertrophied, and covered with a villous erosion, which bled on being touched. The leucorrhœal discharge was seen to issue freely from the os uteri. During six months the patient had attended the out-patient department of a metropolitan hospital, and during two months she had been treated generally, with occasional application of tincture of iodine to the cervix. Her general health improved somewhat, but the uterine symptoms did not become much better, while the discharge continued unabated. She was then treated by the intra-uterine application of carbolic acid once a week, along with the application of iodized cotton and glycerine to the cervix. After the third application the discharge was much diminished, and the erosion of the cervix almost healed. In four months the patient was perfectly well, the uterus being of normal size, and the uterine leucorrhœa

having entirely disappeared. She has since remained perfectly well in every respect.

M—, aged twenty-six, domestic servant, had suffered from uterine disease for four years, with constant pain, and the discharge so profuse that it ran freely from her, and incapacitated her for work. She had, on two occasions, been an in-door patient in a metropolitan hospital for several months, gaining only temporary relief. On examination, the uterus was seen to be large and heavy, the cervix greatly eroded, and the os patulous, admitting the sound with ease. A glairy discharge was pouring out abundantly. After the fifth intra-uterine application of carbolic acid, the discharge, which had continued unabated for four years, almost entirely ceased. There remained neither pain nor bearing down. The patient was able to walk a good distance, and carry weights without inconvenience, for the first time since the onset of her illness. She had gained in flesh and general health.

Mrs. K—, aged twenty-six, the mother of four children, had suffered greatly for three years from uterine disease, and had undergone a variety of treatment, including repeated leeching of the uterus, and the application of potassa fusa to the cervix, without any permanent relief. She was entirely unable to walk, in consequence of bearing-down pain and profuse leucorrhœal discharge. The menstrual flow was irregular and scanty. On examination, the uterus and cervix, were both greatly hypertrophied. The latter was softened, and covered with granular erosion, which bled on being touched. Much glairy discharge being exuded from the os. The uterus was anteverted, and the cervix exposed with difficulty. A band of adhesion was felt in the direction of the right broad ligament—probably the remains of an old attack of parametritis. There was, however, no swelling or tenderness on pressure in that situation.

The carbolic-acid treatment was then commenced, and from the very patulous condition of the os the probes could be passed with great ease. An immediate improvement commenced. In two months the uterus and cervix were much diminished in size, the discharge lessened, and the patient was able to walk about with ease, and to attend to her duties. In six months she was perfectly well, and the probes could no longer be passed through the os, which had resumed its natural dimensions.—*The Lancet.*

LIGATURE OF THE EXTERNAL ILIAC.

BY HENRY SMITH, F.R.C.S.

The patient was only thirty-two years old, and had a large aneurism, which involved the right common femoral artery, and extended above Poupart's ligament. It was intended to perform the operation on February 11th, but a day or two prior to that date the woman suddenly disappeared, and did not return until after another week. During that short interval the aneurism had increased very much, and had come to extend nearly two inches above Poupart's ligament. The patient complained of intense pain in the tumour and the upper part of the thigh.

Mr. Smith made a very free incision above, and internal to, Poupart's ligament, carrying it high up so as to permit the ligature of the upper part of the artery. The tendons of the oblique and the subjacent muscular tissue were freely incised, and, the handle of the knife being lightly applied, the peritoneum was exposed, and with the forefinger of the left hand was gently turned upwards and inwards toward the median line, so as to bring the artery into full view. Its sheath was opened, and the needle was passed around it well above the aneurism. No director was employed, and no vessel of any importance was wounded; in fact, the operation was one of the simplest character.

In alluding to this case, Mr. Henry Smith said that whereas the operation which Sir William Ferguson had just performed (ligature of the subclavian) was one rare of occurrence and of a very formidable description, his own case was an example of aneurism which was not unfrequent, and required an operation which, though of great magnitude, was not usually of a formidable description. In illustration, he pointed out that, in his own comparatively limited experience, he had tied the external iliac artery on six different occasions, whereas Sir W. Ferguson had performed ligature of the subclavian twice only. After minutely describing the operation, Mr. Henry Smith took occasion to warn the pupils against imagining that the operation was always as easily performed as in the present instance. It might be attended with considerable difficulty, in consequence of the presence of a

large quantity of fat or enlarged matter. He had witnessed two instances in which the difficulties were of a formidable character, and it was impossible always to predict what they might be. Great stress had been laid by some authorities upon the necessity of dividing the transversalis fascia freely upon a director, but his experience of this operation had not led him to acknowledge the importance of this precaution. He would, however, caution them to handle the peritoneum very gently while turning it on one side; for if hasty or rough manipulation were employed in that important part of the operation, the artery would be pushed up along with the membrane, and the surgeon, although seeking it in the right place, would actually not be able to find it. This accident had occurred to him whilst operating on the dead body, and once in the theatre of King's College Hospital whilst seeking for the vessel in the living subject.

The patient progressed most satisfactorily; the ligature came away on the thirteenth day, and the wound rapidly closed.
—*Lancet*.

ON EXTRACTION OF CATARACT.

BY DR. N. J. MARTINACHE, LATE MASTER OF CLINIC OF SICHEL
AND WECKER, PARIS.

It is not my intention to give a complete description of the operation for cataract, but simply to call the attention of physicians to a particular *modus operandi* for the extraction of the crystalline lens in the capsule. Every physician knows perfectly that the methods of operating for cataract are very numerous—too numerous, indeed, but little by little, all these methods have almost entirely disappeared, and the only one now performed on adults is the extraction. This is certainly great progress, and it is not my design to commence any discussion as to the comparative merits of the ordinary method and Graefe's linear extraction.

It is enough to mention the name of Von Hasner, who is absolutely in favor of the ordinary extraction, to prove its merits. But putting the merits aside, let us speak of the inconveniences. By these two methods we leave certainly in the eye some crystal-

line elements, impossible to be removed; and these, acting as extraneous bodies, are a permanent cause of irritation. A simple comparison, drawn from common practice, will plainly illustrate this fact. I mean the delivery of the placenta after accouchement. Every one understands the importance of it, and foresees the danger of a placenta remaining in the uterus. So it is with the operation for cataract. When crystalline elements are left in the eye, the eye is in danger, more or less, according to the quantity of the retained elements, and, cautious as he may be, the surgeon is bound to leave some cortical masses, when the extraction is performed by opening the capsule.

In my opinion, the true operation for cataract is the extraction of the lens with the capsule. By doing so, no irritating spur is left in the eye, and no danger is to be feared after the operation; the healing process is more rapid, and the power of the sight is greater than in any other method.

Some weeks ago, I saw a patient who had been blind for ten years. In the right eye the sight was annihilated, and in the left eye there was a very peculiar form of cataract. Looking at this left eye, it was impossible to see any opacity of the lens in the pupil, but by looking through the pupil with a plain optical microscope, a black spot was to be seen. This spot was a cataract, situated in the posterior cortical masses of the lens; it was round, and about three lines in diameter. The perception of light was good, and the patient having been for ten years in the same condition, I proposed the operation, and it was agreed to. Owing to the fact that the anterior part of the lens was *transparent*, it was a very difficult one to perform. As it was impossible to see the opacity in the pupil, it was to be feared that, after lacerating the capsule, the surgeon would be at a loss and unable to finish the operation, as I had observed in a former case. So I decided to remove the lens with the capsule.

The patient having been placed under the influence of chloroform, I made a large incision, upward and in the sclerotic, as in Græfe's operation. Then, without any iridectomy, I proceeded to the removal of the lens, by exerting pressure with the india-rubber scoop on the inferior part of the eye-ball. When the lens was engaged between the edges of the wound, I depressed the iris downward and backward with another scoop, and

removed the lens with capsule. About the fifth part of the vitreous humor escaped. I reduced the iris, and put the bandage on. Two days after, the iris was protruding; I made the excision, and in five days the cicatrix was complete. The patient never had any pain during the healing process, and four weeks after the operation the sharpness of the sight was number one.

In conclusion, I will venture this remark: It is to be hoped, and I feel confident of it, that in the future, and before a long time, the only operation performed will be the extraction in the capsule, without any iridectomy—*Pacific Medical and Surgical Journal*.

THERAPEUTIC ACTIONS AND USES OF TURPENTINE.

Dr. Warburton Begbie read a paper on this subject before the Medico-Chirurgical Society of Edinburgh. He gave a brief sketch of the ancient history of the drug from the time of Hippocrates, with a notice of the various forms in which the oleo-resins of the conifers are used or have been used in therapeutics. Oil of turpentine was described as being irritant and stimulant, quickening the circulation and augmenting the temperature of the body. In larger doses it produces a sort of intoxication, in drachm doses it is hypnotic. Externally it is a valuable rubefacient, and is absorbed by the skin so as very soon to be recognized in the breath, and by its characteristic violaceous odour in the urine. The production of this violaceous odour in its perfection seems to be a test of the integrity of the urinary organs, as it is less marked in disease of the kidneys. The therapeutic actions and use of turpentine are various. 1. As a cathartic it is uncertain, but along with castor oil it is useful in cases of obstinate obstruction and tympanitis. 2. As an anthelmintic it is chiefly used as a cure for tapeworm, also, in the form of enema it destroys ascarides and lumbrici. 3. Though turpentine sometimes causes hæmaturia, it cures certain passive hæmorrhages. It is useful in purpura, probably acting through the nervous system; and it is also useful in hæmoptysis, hæmaturia, and uterine hæmorrhages. 4. As a stimulant, it is especially valuable in adynamic fevers; as in the stupor of typhus, in certain kinds of delirium, and in the latter stages of enteric

fever with a dry tongue. 5. In certain nervous diseases, such as epilepsy and chorea, it is said to be very useful, but in epilepsy it is supplanted by bromide of potassium, and in chorea by arsenic. In certain forms of sciatica and crural or brachial neuralgia in the aged, twenty-minim doses thrice daily have a very good effect. In the nervous headaches of delicate females, and the headache which is induced by *saigüe*, it is a better stimulant even than strong tea, and without the effect which tea so often has of banishing sleep. 6. In all chronic discharges from mucous membranes, such as chronic and fetid bronchitis, it is very useful, and even is advantageous in gangrene of the lung in checking the fetor. Under this head some interesting cases were given of gangrene of lung depending on the presence of foreign bodies. —*British Medical Journal*.

A SIMPLE DRESSING FOR FRACTURE OF THE CLAVICLE. Dr. L. A. Sayre, of New York, has finally reduced the treatment of this fracture to *two strips of adhesive plaster, without any axillary pad*, and as such he now gives it to the profession as the simplest and most efficacious plan yet devised.

His method of keeping the inner portion of the clavicle from riding over the outer portion is *by putting the clavicular portion of the pectoralis major muscle on the stretch*, and compelling it to *pull* the clavicle in place, and thus overcome the tendency of the clavicular portion of the sterno-clavido-mastoid to elevate it, which it will always do unless this precaution is taken. After drawing the arm backward and retaining it there by a strip of adhesive plaster, pass another piece of plaster from the *well shoulder* across the back, and by pressing the elbow well forward and inward, the first plaster around the middle of the arm is made to act as a *fulcrum*, and the shoulder is necessarily carried *upward, outward, and backward*, and the plaster, being carried over the elbow and fore-arm (which is flexed across the chest) to the opposite shoulder, the place of starting, and then secured by pins or stitches, permanently retains the parts in position.

Dr. Sayre formerly commenced the first plaster on the inner side of the biceps, but he found that that muscle would roll around and the plaster would lose its hold, requiring to be renewed occasionally, and if it completely encircled the arm for the purpose of a stronger attachment, it would arrest the circulation, and thus prove dangerous. He uses strong and good adhesive plaster (Maw's moleskin is the best) cut into two strips three to four inches wide (narrower for children.) By this plan of treatment the patient is only detained from his daily avocation a sufficient length of time to properly adjust the strips of adhesive plaster.

In one instance a prominent lawyer of New York City slipped

upon the ice and fractured his clavicle on the way down town. He was brought to his office. Dr Sayre dressed him in the manner described at 9 A. M., and before eleven he was pleading his case in the open court. A blacksmith was brought to his office with a fracture of the left clavicle. He dressed it, and in less than an hour the patient was again working at the forge with his other arm, and continued his labor without any interruption. In both cases the union was perfect and without any deformity. In closing, Dr. Sayre could multiply these cases by many similar ones, and he therefore feels quite confident that if any surgeon will follow the plan suggested he will have equally good results. —*American Practitioner.*

BOOK NOTICES.

A Practical Treatise on Fractures and Dislocations. By Frank Hastings Hamilton, A.M., M.D., LL.D., Professor of the Practice of Surgery with Operations, in Bellevue Hospital Medical College, etc. Fourth Edition, Revised and Improved. Illustrated with three hundred and twenty-two wood-cuts. Svo. pp. xxiv., 789. Philadelphia: Henry C. Lea, 1871. Toronto. Willing & Williamson.

This is the most complete work on this subject in the English language; and in fulness of detail, accurate description and systematic arrangement, it has no equal. Many important additions and improvements have been made to the present edition. A large number of original wood-cuts have been introduced. All obsolete forms of apparatus have been excluded, and the modern and improved forms introduced. We regard this work as one of the most valuable books in our library, and we do not see how any surgeon can afford to be without it.

ON SOME DISORDERS OF THE NERVOUS SYSTEM IN CHILDHOOD. Being the Lumleian Lectures delivered at the Royal College of Physicians in London, in March, 1871. By Charles West, M.D., Fellow and Senior Censor of the College, Physician to the Hospital for Sick Children. Philadelphia: Henry C. Lea. 1871. Pp. 131. Toronto: Willing & Williamson.

There are three lectures in this series: 1. Neuralgia and Epilepsy; 2. Chorea and Paralysis; 3. Disorder and Loss of Power of Speech, etc. This author is already well and favorably known to the medical world as a writer on diseases of women. His reputation will not suffer in any degree from these lectures. They contain a great deal of good, sound, practical information on this subject.

HANDY-BOOK OF THE TREATMENT OF WOMEN'S AND CHILDREN'S DISEASES ACCORDING TO THE VIENNA MEDICAL SCHOOL. With Prescriptions. By Dr. Emil Dilaberger. Translated from the second German edition, by Patrick Nicol, M. B. Philadelphia. Lindsay and Blakiston. 1871. Toronto. Copp, Clark & Co., \$1.75.

This little manual contains about 250 pages, and is divided into two parts, the first treats of diseases of women and the second of diseases of children. It contains a large amount of valuable and practical information within small compass. An appendix is added, containing notes on practice, intended to show the difference between Austrian and British practice. The book is well worthy a careful perusal.

WRIGHT ON HEADACHES. A new Edition. Their Causes and Their Cure. By Henry G. Wright, M.D., Member of the Royal College of Physicians, &c., &c. From the Fourth London Edition. Philadelphia. Lindsay & Blakiston Toronto: Copp, Clark & Co. Price \$1.25.

This is a very comprehensive little work. The writer treats of headaches in childhood and youth, adult life and old age, and gives the varieties and treatment of each. It appears to have been well and favorably received by the profession, as is seen from the fact that this is the *fourth* edition. It is well worth the small amount of its cost.

PEREIRA'S PHYSICIAN'S PRESCRIPTION BOOK. A New American from the Fifteenth London Edition. Containing Lists of Terms, Phrases, Contractions and Abbreviations used in Prescriptions, with Explanatory Notes, the Grammatical Construction of Prescriptions, Rules for the Pronunciation of Pharmaceutical Terms, a Prosodial Vocabulary of the Names of Drugs, &c. By Jonathan Pereira, M.D., F.R.S., &c. Philadelphia. Lindsay & Blakiston. Toronto. Copp, Clark & Co. Price, in cloth, \$1.25, Price in leather, with tucks and pocket, \$1.50.

We have also received a copy of Lindsay & Blakiston *Physicians' Visiting List*, for 1872. A very convenient article and one which we prize very highly. Every Physician should have it.

THOMAS HAWKES TANNER, M.D., F.R.C.S., died July 7th, aged 47 years. Since 1854 he has been suffering from renal disease, the result of an attack of scarlatina. He is well-known as the author of several very successful medical works.