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# CANADA

## MEDICAL & SURGICAL JOURNAL

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Original Communications.

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### CASE OF EPITHELIOMA OF TONGUE;

*Excision of the entire organ by Galvanic Ecraseur. Followed by deep suppuration and Death.*

UNDER DR. ROSS. REPORTED BY MR. JOHN BRODIE.

(Read before the Medico-Chirurgical Society, Montreal.)

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J. L., æt. 36, single, was admitted into the Montreal General Hospital on the 20th October, 1876, complaining of a sore on his tongue. Is a slim, slight-built man, 5 feet 6½ in. in height; weight 120 lbs. Born in Scotland, came to this city 18 months ago and has been employed as storeman in a wholesale stationer's establishment. Parents are both alive and healthy, also several brothers and sisters. Carefully enquired into, his family history shows no trace of either tubercular or cancerous taint. He has never had syphilis. Is of very regular habits, and has always been healthy. Smokes considerably and generally uses a short clay pipe.

His present trouble began seven months ago as a hard pimple with a double crown on the upper margin of the right side of the tongue about opposite the second molar tooth. This gradually increased without pain until about four months ago, when it began to get painful, with pains occasionally shooting from the pimple towards the angle of the jaw. About this time an ulcer formed on the under surface of the tongue a little further back

than the original induration. Since then the induration has been rapidly extending into the structure of the side of the organ and the ulcer has advanced towards the apex of the tongue. Within the last three weeks the swelling and ulceration have resulted in fastening the tongue down to the floor of the mouth in such a way as to interfere with articulation. There is considerable salivation, and the breath is somewhat foetid.

Heart and lungs examined and found normal. Urine of normal amount and free from albumen and sugar.

On examining the tongue it is found to be unsymmetrical, owing to the presence of a large firm induration occupying the right side and extending from near the base to the apex. It is somewhat nodulated, and terminates abruptly near the root of the tongue. Much the greater portion of it is contained in the right half of the tongue, but about the middle it encroaches upon the left half and then extends almost to the left edge. Beneath the right margin of the tongue, at its junction with the floor of the mouth, is a deep, excavating ulcer, with sharp edges and a sloughing, unhealthy base. The submaxillary gland on the right side is considerably enlarged and slightly tender on pressure. There is also one enlarged cervical gland just behind the angle of the jaw. This gland is as large as a small walnut, quite hard, painful on pressure, and adherent to the deep fascia.

The diagnosis was that of malignant disease with very slight involvement of the neighboring lymphatic glands, and the opinion was held that the case was a suitable one for excision of the tongue. The patient was seen by several members of the attending and consulting staff of the Hospital, and the above view being unanimously supported, the operation was decided upon.

1st Nov.—Operation by Dr. Ross; Drs. Drake and Roddick assisting. The patient having been thoroughly anæsthetized with ether, an incision was made in the median line through the entire thickness of the lower lip, and carried down through the skin and subcutaneous tissues as far as the hyoid bone. The divided vessels were secured with catgut ligatures, cut short.

A small saw was then applied (an incisor tooth having been previously extracted) and the lower jaw was divided at the symphysis. The muscles of the mouth were somewhat dissected away, so that the divided fragments could be widely separated. The tongue was transfixed by a strong loop of cord, and drawn well forward. A thin platinum wire was then made to encircle the entire tongue, being pressed back nearly to the epiglottis behind and well beneath the floor of the ulcer on the side. The small ecraseur to which the wire was attached, was then drawn moderately tight, and the galvanic circuit was closed. The battery used was one of zinc and carbon, in a solution of bichromate of potash and sulphuric acid. Cauterization began immediately and the wire was cautiously drawn through. Ten minutes was occupied in completing the division. There was no hæmorrhage, the whole floor of the mouth having been completely seared. The operator now proceeded to fasten the divided jaw together again and keep it in its place. In this proceeding valuable assistance was rendered by Mr. G. W. Beers, Dentist, who was present for the purpose, and who, by means of a dentist's drill worked with a treadle, rapidly bored two holes through the bone, one on either side—wires were passed through these and twisted tightly together. The teeth were also wired together. This kept everything tightly in its place. The original incision was then closed in the usual manner by harelip pins and catgut sutures.

*Nov. 2nd.*—Feels very comfortable but did not sleep, although he had gr  $\frac{1}{4}$  of morphia hypodermically at night. Swallows well. Pulse 88 ; temperature 100.4°.

*Nov. 3rd.*—Slept well ; feels comfortable and swallows well. External wound closing nicely by first intention. Floor of the mouth covered with a soft, greyish slough, which is commencing to separate in places. Pulse 92 ; temperature 99.4°.

*Nov. 4th.*—Rested well during the early part of the night, but towards 4 a.m., had a severe fit of coughing, followed by some hæmorrhage into the mouth. It was bright blood and pretty rapidly flowing at the time but was controlled readily by ice. Is very comfortable to-day, and is swallowing easily and

freely an abundance of fluid nourishment and drinks. Pulse 92 ; temperature 101°.

*Nov. 6th.*—Last evening he became a little uneasy and a slight swelling was noticed over the situation of the enlarged gland on the right side of the neck already mentioned. This has now considerably increased, so that the whole of the upper part of the right side of the neck is swollen and tender on pressure. At 2 this a.m. there was another slight hæmorrhage, lasting, however, only about 5 minutes, and apparently coming from the centre of the floor of the mouth. Since that time he has found difficulty of swallowing increasing, so that now he cannot swallow at all. The pillars of the fauces and uvula are much swollen, especially upon the right side, where also a greyish, dirty-looking exudation is to be seen. The main slough is separating everywhere, and tending to come away in shreds. Ordered enemata of beef-tea and brandy to be given every 3 hours. Pulse 100 ; temperature 102°.

*Nov. 8th.*—Inability to swallow has continued complete. Is restless but has no pain. The swelling on the side of the neck has increased a good deal. It is hard and brawny and extends completely round to the spine behind. Several incisions were made through the skin and cellular tissue, and a poultice applied. Pulse 130 and getting very weak ; temperature 101.5° Fahr.

*Nov 9th.*—Cannot swallow. Breathing somewhat stridulous. Superficial veins on the right side of the chest are enlarged. The whole remaining slough was removed this morning from the floor of the mouth. Last evening attempts were made to feed him by a catheter passed through the nostril. It was passed down the œsophagus with considerable difficulty, and beef-tea and brandy injected into the stomach. Pulse 140 ; very weak. Evidently sinking.

Died at 1 a.m. on the 10th November.

*Autopsy.*—36 hours after death by Dr. Osler. Neck swollen in anterior and lateral regions. Recent cicatrix in lower lip and chin. *Left lung* extends across the heart, and is attached to the pericardium. Tissues beneath the manubrium sterni infiltrated with pus. *Pericardium* contains a small amount of

clear amber-coloured fluid. *Right Ventricle* contains two large colourless polypi, firm and closely adherent to the walls and extending into the pulmonary artery and the tricuspid orifice. Valves healthy.

*Lungs*.—Left adherent in places, crepitant throughout. Right, strongly coloured in places, crepitant at anterior border and base. Middle lobe and part of upper, firm, and the surface on section bathed with a sero-sanguineous fluid. One small purulent focus at the external part of middle lobe, not a definite collection of pus, but an area of the lung, 1" x  $\frac{3}{4}$ " irregularly infiltrated.

Nothing of importance in any of the other organs.

The tissues of the neck beneath the deep fascia, principally on the right side, and in front were uniformly infiltrated with pus, this fluid having also penetrated the anterior mediastinum, and passed beneath the sternum. There was no definite or circumscribed collection of pus anywhere. The interior of the larynx was healthy. The floor of the mouth was composed of a granulating surface, from which apparently a slough had recently been separated.

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## ON THE USE OF THE ASPIRATOR IN HYDROTHORAX

BY F. D. GILBERT, M.D., M.R.C.S., ENG.

Thinking the following case may prove interesting, if not instructive, I venture to send it for insertion in the *Journal*.

On the 21st September, 1875, I was called in the night to see a lad named John Ross, who had been ill for some ten or eleven weeks, and was represented as in a dying condition. When I arrived I found him propped up in a chair, having been unable to lie down for the previous two or three weeks. Breathing very short and gasping. Œdema of both legs and feet, as also of the general integuments of the abdomen and chest walls, a rapid, weak, thready pulse, almost unable to speak. On physical examination of the chest I found a very weak respiratory murmur on the left side, and none whatever in any part of the right lung. The heart was pushed completely over on the left

side, and very distinct bulging of the intercostal spaces on the right side existed. As there was evidently no time to lose, if the patient's life was to be saved, I deemed it a very suitable case to test a theory I had propounded to myself as to the superior advantages of the aspirator in such cases, in the creation of a vacuum in the pleural cavity, which, I believe, ought to assist in breaking down recent adhesions, and in other respects, aid in the inflation of the compressed lung.

I therefore immediately returned home and procured the instrument and inserted the trochar above the upper edge of the eighth rib, at its most prominent posterior aspect, and drew off pretty rapidly, *i. e.*, in ten or fifteen minutes, nearly eleven pounds of clear serum, instead of evacuating it gradually, as formerly advised by the best authorities.

The patient, who was a small, delicate boy, directly the cavity was exhausted began to cough pretty severely, and I could distinctly hear a slight vesicular murmur returning in the lung. I gave him at once 10 grains of Dover's powder and he was soon able to lie down, and enjoyed several hours' good sleep, the cough abating. In the morning I visited him again and gave him the following mixture every three hours, with seven grains of Dover's powder each night at bed-time, *viz*: cincho-quinine gr. j, acidi hydrochlorici m j, tincture digitalis mvj, aceti scillæ mv, spirit ether. nitrici mxv, syrup ʒi, aquae ʒij. Ordered frequent tepid sponging and frictions over the whole body and extremities, with a light nutritious diet, and plenty of milk. He made an excellent recovery, and there was absolutely none, or at least no appreciable return of effusion, and in about five weeks he was convalescent, but with an inferior respiratory murmur on the right side, and a little falling in of the chest parietes owing, I have no doubt, to old adhesions. About the end of November following, I was visiting a patient in the neighborhood on a cold, rainy day, and saw the boy in the street without coat or hat on playing with other lads. I sent him home at once, telling him if he did not take better care of himself, I should soon have trouble with him again. On the 1st of January 1876, a messenger came in the evening, saying the boy's chest was

filled up again as badly as before. I went at once taking my aspirator with me, and found him about as the messenger had described, as to the distress and difficulty of breathing, though not so exhausted as before; but you may judge my surprise when I found it was the left pleural cavity that was now filled, instead of the right, and that the right lung was all he had to use, the left being completely compressed and all air excluded from it. I at once used the aspirator as before, excepting of course, introducing the trochar on the left side, with the result of evacuating  $8\frac{1}{2}$  lbs. of fluid, and treated the case precisely as I had previously done, with even a better result, as convalescence was procured without any subsequent effusion in about three or four weeks, and in addition I had the satisfaction of finding the right lung had (I presume from the extra hard work it had been compelled to perform), very materially resumed its respiratory power. Now, as I have never met with anything approaching so satisfactory results in similar cases by the old method of slowly evacuating the fluid, I think I am justified in the belief that the sudden withdrawal of the fluid and consequent formation of a large vacuum, had considerable influence in the production of the favorable result. I may perhaps add another peculiarity in this boy's case. In August last I was called to see him again, and found him very ill indeed, with large peritoneal effusion, jaundiced and very emaciated and so weak that I hesitated considerably as to the expediency of tapping him, but finally concluded to give him the benefit of the doubt, and try medicinal treatment first. I therefore gave him calomel gr. viij, and pulv. jalapæ co.  $\mathfrak{z}$ i at once, which procured several large watery discharges, with evident relief to all his symptoms. I then gave him the following prescription: viz. pil. hydrarg. gr. iv., pulv. scillæ gr. iss; pulv. digitalis gr.  $\frac{3}{4}$ , night and morning, with the following mixture three times a day: R. cincho-quinine gr. iss, acidi nitrici miiij, aceti scill mvj, spts ether. nitrici m<sub>xx</sub>, syrupi  $\mathfrak{z}$ i, aquæ  $\mathfrak{z}$ ij, under which treatment the whole effusion became quickly absorbed, and he again made a good recovery, and so far has remained well.

Sherbrooke, Jan. 22nd, 1877.



## Hospital Reports.

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

*Case of Progressive Muscular Atrophy. Treated without result by pure Phosphorus—Under the care of DR. ROSS. Reported by Mr. G. E. ARMSTRONG.*

T. P., æt 54, unmarried, was admitted into the Montreal General Hospital on the 17th October, 1876, suffering from complete loss of power and wasting of the muscles of both arms, and great debility, with wasting of the lower extremities.

When a young man, was tolerably healthy. Has had attacks of ague several times, and has taken a good deal of quinine. Has always been of steady habits, drank but little liquor and smoked very moderately. Never indulged in venereal excesses. About 12 years ago had necrosis of the right femur, and several pieces of bone came away through fistulous openings. At this time he took a good deal of calomel, and also contracted the habit of taking laudanum pretty freely for the relief of his pains.

Four years ago he first felt pain and weakness in his left thumb. This kept on increasing, and shortly extended to the forefinger of the same hand. The loss of power then successively invaded the remaining fingers and passed up the arm, until he completely lost the use of it. Three years ago (or one year after the thumb of the left hand was first involved), he noticed pain in the right shoulder, and afterwards in the same forearm; and this was followed by general wasting and loss of power in the arm. He is certain that in this limb the weakness began in the shoulder and not in the thumb, and that the wasting appeared to him to be general throughout the arm. Sixteen months ago in his right leg, and eight months ago in his left leg, he felt what he describes as rheumatic pains, especially about the knees.

His family history is good, father and mother having both been long-lived. No nervous disorder could be traced in his antecedents.

*Present Condition.*—The muscles of both hands and arms are atrophied to an excessive degree, being most marked and abso-

lute in those of the palms. There is entire absence of the muscles of the thenar regions, thus causing the thumbs to assume the characteristic appearance of the disease. They fall loosely outwards, and he has no power of adapting them to the corresponding forefinger—and the hollowed out concavity of the first metacarpal bone is perfectly traceable throughout. The palms are quite scooped out, and present distinctly the edges of the metacarpal bones and the prominent flexor tendons passing over them—from atrophy of the interossei and lumbricales, nothing being felt between the bones of the hand but the integument back and front. When the arm is lifted up the hand drops from the wrist, the fingers are flexed, and the thumb falls outwards. There is not the least power of flexion or extension in the fingers. The muscles of the forearms, upper arms and shoulders are also excessively wasted. The pectorals and elevators of the scapula are also very much reduced in size and flabby. The spinal muscles are not materially affected. The flexor and extensor muscles of the right thigh are much wasted, and the limb in consequence so much weakened that he is extremely apt to trip and fall in walking. The muscular fibrillar tremor is very frequently seen in many of the affected parts, and is readily induced by a slight pinch or blow. It is sometimes perceptible by himself but gives rise to no pain, but occasionally slight uneasiness.

By the ophthalmoscope no changes are perceptible in the optic discs and retinae. His general health remains good. Appetite very fair and sleeps well.

He was put upon 1-50 gr. of phosphorus in pill (Warner & Co's.) three times a day.

He remained in Hospital several weeks but no improvement was apparent.

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*Case of Fibroid contraction of the Right Lung with displacement of the Heart; Tricuspid Regurgitation, Albuminuria.—Death and Autopsy.—Under the care of Dr. Ross. Reported by MR. C. L. COTTON.*

C. H., æt 37, was admitted into the Montreal General Hospital complaining of cough and swelling of the limbs. She is a

married woman and has had one child, now thirteen years old. Family history good.—No consumption. She dates her present illness from the time of her coming to this country, which was four years ago. She caught a severe cold on board ship, and has never been well since. Has been quite unable to work for the last two years.

There is considerable emaciation and decided pallor combined with a tendency to bluishness of the extremities, the finger ends markedly clubbed. Thighs and legs œdematous, and pit on pressure. Abdomen moderately distended with ascitic fluid. The œdema first showed itself last spring but disappeared, coming on again about a month ago, since when it has been constantly present. Had night sweats some months ago, since which time she has had repeated attacks of blood-spitting, this always, she says, being most profuse during the times corresponding with her menstrual periods. There has now been no hæmoptysis for a month. Has a constant cough, accompanied by much heavy expectoration.

Inspection of the chest shows considerable falling in of the right side, especially beneath the clavicle, and retraction of its entire bulk. Percussion on that side dull throughout, with a tubular quality in the infraclavicular region. Breathing blowing and accompanied by loose moist rales. Left lung somewhat hyper-resonant on both surfaces. Bubbling rales of various sizes almost everywhere heard, especially abundant at the base. Apex-beat of the heart not visible, but distinct pulsation to be seen in the spaces from the 2nd to the 6th on the right side. Heart sounds feeble. A loud systolic murmur is heard over the sternal region and quite distinctly over the whole right anterior aspect of the chest. It is accompanied by a slight, purring thrill. The superficial veins of the neck are very large, prominent and tortuous, and in the jugulars a distinct but not very forcible systolic pulsation is visible.

The urine (31 oz.) contained a heavy deposit of amorphous lithates, and gave a small precipitate of albumen. No casts. Bowels very regular.

Ordered tr. ferri, mur., tr. digitalis aa. mx, three times a day.

*October 12th.*—Has coughed a good deal. Sputa abundant, composed of distinct purulent masses. Temperature normal; pulse 120. Ordered 6 oz., of wine.

*14th.*—This morning had a chill and has since been quite feverish. Pulse 116. No appetite. Œdema rather increased in thighs. Albumen still present.

*18th.*—Not much change but getting gradually weaker. Cheeks and lips nearly purple. Respirations 44; pulse 120. The tr. digitalis increased to m xx.

*21st.*—Passed only 6 oz. urine, containing considerable albumen.

*23rd.*—Very poorly to-day. Has a constant pain across the epigastrium. Passed only 5½ oz., of urine. Œdema much increased. Tongue much coated and always nausea. Ordered potass. bitart. ʒss, pulv. jalap co. gr. xv. at bed time, and to take potass. bitart. gr. xv. infus digitalis ʒij, three times a day.

*24th.*—Very feeble. Pulse weak, thready, and very quick. Lips blue. Is much swollen. Urine 7 oz., highly albuminous.

*26th.*—Is steadily sinking; pulse very small and thready. Hardly able to expectorate at all. The sputa run together. Ordered brandy and soda water.

*27th.*—Died at 10.30 p.m.

*Autopsy.*—By DR. OSLER—Body, that of a medium-sized woman. Emaciation moderate. Skin of upper part of body, especially about the neck, of a livid hue, and scattered over with numerous ecchymotic spots. Lineæ albicantes present in lower abdominal and antero-lateral region of the thighs. Legs and lower and back part of the trunk œdematous. Face not much emaciated. Rigor mortis has almost disappeared.

*Thorax and Abdomen.*—About four ounces of dirty yellowish fluid in the peritoneal cavity. Stomach distended with gas. Position of abdominal viscera normal. On opening the thorax the heart is seen to be drawn over to the right side, the base and great vessels lying beyond the costal cartilages of this side and the organ lay transversely. On removal of the heart, 20 oz. of fluid blood and dark grumous clots escaped into the pericardium.

*Heart.*—Cavities of the right side much dilated and full of blood, walls of right ventricle appeared somewhat thickened. Tricuspid orifice dilated, admitting four fingers nearly to the second joint. Segments of the valves a little thickened at the edges. Musculi papillares look elongated and the apices are fibroid. Pulmonary semi-lunar valves healthy. Left ventricle, cavity and walls look of normal size. Mitral valves a little thickened. Aortic semi-lunar competent, but slightly opaque and atheromatous at their bases.

*Lungs.*—Right, universally adherent, and removed with difficulty; organ firm, solid, and to the touch gives no indication of crepitation. On section no trace of the lobes remains. A large cavity occupies almost the entire apex, situated chiefly in the antero-lateral region, the posterior wall being composed of irregular fibroid masses, through which two or three large bronchi open directly into the cavity. The upper and antero-lateral walls are made up of a layer of fibrous tissue  $\frac{1}{4}$ — $\frac{1}{2}$ " in thickness, the outer part white: the inner portion darkly pigmented. Two irregular prolongations from this cavity extend downwards and forwards towards the anterior margin of the lung, and another narrow one extends for two inches along the posterior part of the organ, immediately beneath the pleura, which is here thin. The lining membrane of these cavities is dark red in colour, and traversed by numerous bands, the remnants of bronchi and blood-vessels. The base of the organ is firmly united to the diaphragm, and the portion which is received into the angle between this membrane and the ribs is, for the extent of  $1\frac{1}{2}$ " transformed into a mass of white fibroid tissue, devoid of any trace of lung substance. Between the upper margin of this fibroid area and the cavity of the apex—a distance of 3"—the lung presents a marbled appearance, is dense, firm, and with the exception of one small spot close to the root, airless, a few small dilated bronchi are evident below, while immediately beneath the pleura are one or two small cavities filled with a bloody and purulent matter. The anterior border of the organ is in the same condition, and on section numerous small cavities (some of which are dilated bronchi) with bloody contents are seen. The organ is

not excessively pigmented. The main bronchus and its branches of the 2nd and 3rd degree are moderately dilated. Bronchial glands firm, not enlarged, moderately pigmented.

Left lung adherent at the apex only. On section a large irregular cavity with thick dense walls occupied the upper and anterior part of the apex, the lining membrane of which is hæmorrhagic, and the contents, pus with blood. The remainder of the organ is extensively emphysematous, especially at the anterior border, but presented no other degenerative signs.

*Spleen.*—Of average size, tolerably firm, capsule opaque. Organ on section of a dark-purplish red colour. Malpighian corpuscles indistinct, vessels full.

*Kidneys.*—Capsules thick and detached with difficulty, leaving the surface slightly granular. Substance firm, cortex a little diminished and pale. Vessels at the bases of the pyramids full. One or two cysts noticed.

*Stomach.*—Veins full, and dependent parts of the organ dark in colour. Mucous membrane of the organ dark and easily torn.

*Intestines.*—Veins full, but nothing abnormal noticed.

*Uterus, Ovaries and Bladder* look natural.

*Brain*—Long clot in superior sinus of dura mater. Veins of pia mater full in posterior parts. Nothing abnormal noticed about the supervisceral parts. Organ reserved for dissection.

## Reviews and Notices of Books.

*A practical Treatise on the Diseases, Injuries, and Malformations of the Urinary Bladder, the Prostate Gland and the Urethra.*—By SAMUEL D. GROSS, M.D., LL.D., D.C.L., Oxon., Professor of Surgery in the Jefferson Medical College of Philadelphia. Third edition revised and edited by Samuel W. Gross, A.M., M.D., Surgeon to the Philadelphia Hospital; illustrated by 170 engravings. 8vo. pp. 574. Philadelphia: Henry C. Lea, 1876.

This may be looked upon as an entirely new work, although it is published by the author as a third edition. Upwards of twenty

years have elapsed since the second edition of Gross on the Urinary Organs, issued from the press, so that the book has long been out of print. This did not proceed from the indifferent character of the work itself, nor from any lack of interest on the part of the author in this class of diseases, but apparently from his having gone into another groove, possibly in more extended duties as Professor of Surgery in the Jefferson Medical College. Furthermore, the erudite author of this treatise has given to the profession his system of surgery, pathological, diagnostic, therapeutic and operative, which is reaching its fifth edition, and has also been extended to two large volumes. This might be considered sufficient for any one man to accomplish if 'tis well done, an opinion which on a former occasion we, with others, have fully expressed. As will be observed, this edition has been revised and edited by Dr. S. W. Gross, the son of the author, and to his pen we are indebted for chapters on tumours of the urinary bladder and prostate gland.

The arrangement of the subjects under discussion in this edition is the same as that met with in the original work, with the exception that the introduction in the former editions, which dealt with the anatomy of the perineum, urinary bladder, prostate gland, and urethra, has in this been omitted.

The work is divided into three parts. In Part I is discussed "Diseases and Injuries of the Bladder." After treating of inflammation, both acute and chronic, and its results we have a chapter on functional derangements and incontinence of urine. This occupies the first four chapters. We then have chapters on "retention of urine," tumours and tubercle, varix and hæmorrhage from the bladder.

Calculous affections in the male and female, with their treatment are then discussed in the next three chapters. Wounds of the bladder, malpositions, malformations and the results of arrest of development are next in order, although these subjects in the former editions were described in the first and second chapters of Part I.

There is also omitted in this edition chapters on worms in the bladder, foetal remains, hair and other foreign substances which

have been in some very exceptional cases passed with the urine. In the discussion on calculous disorders and the relative frequency of stone in different countries, the author notices its infrequency in Canada and the New England States. This is a matter of such notoriety that many surgeons of eminence in this part of the country have never seen a case of stone in the bladder.

Stone, in this city, has been much more frequent of late years than formerly, from what cause we are unable to determine. We were always impressed with the belief that stone in the French Canadian colonist was an exceedingly rare event, almost as much so as in the negro of the South. Up to the year 1867 we had seen but two cases of calculous affections, and they were both in children of English parentage, and both cases of urethral impacted calculi. This was during the first twenty years of our professional career. In examining the records of the Montreal General Hospital for the past ten years, ending 30th April, 1876, we find that there have been admitted into the house 55 cases of stone in the bladder, of these, 34 underwent the operation of lithotomy, with a result of three deaths, giving a percentage of 8.82. The remaining 21 cases were treated by the crushing operation, and all recovered. The large majority of these cases was in children. The author remarks "Certain facts seem to warrant the inference that this affection is hereditary," on this point we have met with four cases which would almost lead to that conclusion, and they are of sufficient interest to mention here. In 1867 we cut a child of  $2\frac{1}{2}$  years of age, and removed a small calculus from the bladder. The father of the child was a soldier, and had been operated on by the crushing operation some years before in England. The second case was that of a merchant from the neighboring States, on whom we performed the operation of lithotomy. As he expressed it, he said it was a disease in the family. His father, two uncles and a brother had suffered from gravel, all had passed small calculi from time to time. They all lived in the States, but they were not all residing in the same State. In the third instance, not perhaps so remarkable as the foregoing, all were living under the same hygienic conditions, occurred in a French Canadian family



in this city. The grandfather had been operated upon when a young man, by the late Dr. Robert Nelson, formerly of Montreal. The father of the child suffered from gravel, and passed from time to time masses of uric acid calculi, some as large as a pea, some of which we have in our collection. The child we cut and removed a small solitary stone from the bladder, shaped somewhat like a French bean. In the fourth instance of apparent hereditary predisposition, the family lived in Vermont. The father was a strong large-framed man, tolerably robust in appearance who had suffered from symptoms of stone for several years. Two, if not three, moderate sized calculi were found in his bladder. In this case we were informed that several members of the family had suffered from stone, and quite recently, we received a small pill-box from the son of the above patient which contained several small calculi, and which he declared he had passed with his urine. One, indeed, is of considerable size, and must have given considerable pain in passing through the urethra.

Part II is devoted to diseases and injuries of the prostate gland, we have a chapter on inflammation of the prostate and its results, one on prostaticorrhœa, an affection first described by the author, and which is often confounded with gleet, seminal losses and cystorrhœa. It is due to a condition of chronic inflammation of the prostate gland, the discharge itself being thin and glairy. We then have chapters on hypertrophy, atrophy, tumours, prostatic calculi, hæmorrhage of the prostate, wounds and malformations of the prostate gland.

In part III is described diseases and injuries of the urethra. In the chapter on stricture of the urethra the author remarks "upon the testimony of personal experience, that there is a class of strictures, the result of ordinary cause, which while they admit of the passage of urine, slowly and imperfectly it may be, do not permit the introduction of any instrument however small, into the bladder." This we believe is correct, rare, perhaps, though it is entirely denied by some surgeons. In the treatment of stricture, the author advises preliminary means to be adopted with a view of allaying excessive sensations, such as the methodical introduction of a conical steel bougie, or stimulating injections,

and he believes great benefit is to be derived in cases where the lining membrane is studded with granulations by the topical application of nitrate of silver, the application to be made by Lallemand's *porte-caustique*, or a modification of that instrument suggested by himself,

He is convinced that the least irritating instrument for dilating a stricture is a nickel-plated steel bougie with a short curve, a heavy handle, and terminating in a somewhat conical point, the introduction to be practised every second or third day. The instrument should be passed into the bladder and at once removed, after the bladder becomes more tolerant of its pressure it should be retained five minutes. In speaking of forcible dilatation the author remarks that it "may be said to be absolutely free from danger unless there is advanced renal disease." Of internal urethrotomy in suitable cases he speaks most favorably, and is "convinced of its superiority as to enduring results, over all other plans." There is figured a new urethrotome by the editor, which is favorably noticed. The remaining chapters in this section are on false passages, infiltration of urine, urinary abscess and urethral fistula, these all come under the consideration of the results of stricture of the urethra. The author then proceeds to discuss prolapse of mucous membrane of the urethra, tumours, foreign bodies, laceration and malformations of the urethra, and closes with a chapter on lesions of the *veru montanum*. The work as a whole is a valuable contribution to the surgery of this region. It will be found of great use from its practical teaching, expressing as it does the observations and convictions of a surgeon of large experience.

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*The Electric Bath; its Medical Uses, Effects and Appliances*  
By GEORGE M. SCHWEIG, M.D., Member of the New York County Medical Society, and of the Medical Journal Association of the City of New York; one of the Physicians of the New York Lying-in Asylum, &c. 8vo. pp. 131.  
New York: G. P. Putnam & Sons, 1877.

In any branch of therapeutics whose development is so recent as that of electro-therapeutics, a book of original contribution

to our knowledge is welcome. The little book before us by Dr. Schweig, introduces to us a new method of using electricity, which originates with him, and merits some consideration. The method he calls Electro-balneology. It consists in the application of electricity through the medium of water, pure or medicated, in a bath.

The apparatus which the author uses consists of a bath made of some non-conducting material, if wood, thoroughly painted in the inside for an obvious reason, a plate of carbon fitted into the head and foot, each connected by insulated copper wire, with binding screw, to which also the poles of the battery are attached. He also has a surface board, a movable board into which is fitted a carbon plate, to which can be connected either pole of the battery, for the purpose of localizing the action of the current. The continuous galvanic and the faradic or induced currents may be applied according to indications which he points out. Either a descending or ascending current may be applied according as the positive or negative pole is connected with the carbon plate at the head of the bath. As to the temperature of the water, the comfort of the patient may be consulted, ranging, from 85° to 105° Fahrenheit.

The advantages which the author claims for Electro-balneology, and by which he establishes for it an "individuality as an Electro-method," are that to the benefits of the electricity are super-added those of the warm bath, and that "the bath is the only method by means of which general electrization can be realized." It accomplishes all that is effected by the general faradization, more perfectly than the latter does. By means of the bath, "the current at one and the same time impinges directly on every peripheral nerve end, (excepting those of the head and face), and traverses every part of the body, obtaining both as to reflex and direct effects, as a whole, that which the method known as general faradization seeks to obtain by the cumulation of fractional portions." After a description of the apparatus and the mode of administration, the author devotes a chapter to the physiological effects of the special electrical method, another to its therapeutical effects and uses, and fills the rest

of the book with special applications accompanied by clinical records.

*A priori*, we should think that Electro-balneology would be most useful in those conditions of the system which require a general nervous tonic, and those local affections which depend on such conditions, and from the record of Dr. Schweig's experience we conclude that it is specially applicable in such cases. The results appear to have been most satisfactory in what he calls neurasthenia, or general nervous exhaustion, impotency, habitual constipation, &c. The application of the galvanic bath, which Dr. Schweig has not been the first to make use of, is for the extraction of metallic poisons from the system, as lead, mercury, &c. There is a case of extreme plumbism reported in *The Lancet*, vol. ii. 1876, page 531, which was treated most successfully by this method in St. Mary's Hospital, London. Actual traces of lead were found in the water of the bath after its use. Dr. Schweig recommends the addition of iodide of potassium to the water for lead poisoning. The substances with which the baths are medicated are various. With a view to their absorption, iron, iodine, and extract of malt have been used; others for some special action on the skin, as counter-irritation, and others for the elimination from the system of metallic substances.

Whatever limits future trial may assign to the therapeutical uses of electro-balneology, its originality renders it interesting, and the favorable results of Dr. Schweig's short experience, extending over only two years, compel us to recognize it as a valuable method of electro-therapeutics.

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*A Manual of Percussion and Auscultation; or the Physical Diagnosis of Diseases of the Lungs and Heart, and of Thoracic Aneurism.*—By AUSTIN FLINT, M.D., Professor of the Principles and Practice of Medicine, and of Clinical Medicine in the Bellevue Hospital Medical College. Philadelphia: Henry C. Lea. 1876. pp. 255.

Whatever has been done by Prof. Flint has been done well. It is so with this little manual of Percussion and Auscultation. Of

course there are already to be had a number of works with similar title, and the subject itself does not permit of a great deal of originality. At the same time much of the usefulness of a manual of this kind will depend upon the manner in which the subject-matter is arranged and selected, and the extent to which the fundamental principles of the art are made to prominently appear throughout so as to impress themselves firmly in the mind of the reader. In the matter of sounds (both percussional and auscultatory) a vast amount of refinement and hair-splitting has been indulged in by various authors, which has served no purpose but to exhibit their own expertness in their detection, and to lead to the greatest possible confusion of ideas on the part of those who attempt to follow them. This error has been most carefully avoided by Dr. Flint. He tries in every case to simplify and reduce to a common basis, rather than to amplify and subdivide. For this the beginning student especially who may use his manual, cannot be too thankful, for by its very simplicity it is easily understood and remembered. Another point in favor of the plan of this work, is that, in many cases the mechanism of a certain sound will be found to be open to explanation in perhaps several different ways. Here it serves but little good to argue upon these points, and hence they are frequently entirely discarded. Of course, when the mechanism of the sound can be clearly explained this is done, the knowledge of it being then valuable owing to the constancy of the connection existing between the sound and its cause.

It is an excellent manual for teaching this important branch of the medical art, and we commend it to the notice of students for daily use in connection with their Hospital practice, and to practitioners for frequent reference.

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## Extracts from British and Foreign Journals.

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

**Trephining in Osteo-myelitis.**—M. Ollier, in a recent communication to the Academy of Sciences of Paris, holds that trephining is applicable to all forms of osteo-myelitis which have, as a predominant character, intense and persistent pain. The operation is also applicable, under certain conditions, to acute osteo-myelitis with severe general symptoms. Intense and persistent pain, is not, M. Ollier states, peculiar to a single variety of osteo-myelitis. The most diverse lesions of the bone-marrow may have a neuralgic character, the pain being the result of compression of the inflamed and swollen medullary tissue by the surrounding bone. In different cases of painful osteo-myelitis the bone-marrow, when exposed by trephining, presents the most diverse appearances. In some instances there will be found a fungous mass bathed in serous fluid and enclosed in an osseous capsule. In other cases the medulla will be firm and gelatinous, and be traversed by trabecule of newly-formed bone; or, again, the surgeon may strike on a regular cavity with smooth walls, and filled by pus. When the osteo-myelitis is of slight extent, and the disease is circumscribed by an osseous wall, immediate and decided relief may usually be obtained by trephining. In the plastic form of osteo-myelitis, accompanied by more or less eburnation of the peripheral layers, relief is less speedy and less certain, except a considerable portion of bone be removed. When the foci of disease are disseminated, the causes of the compression of the bone-marrow will, probably in part, be left without the track of the trephine. In this diffuse form, however, the operation may arrest for a time the intolerable pain, and enable the patient to live in ease for several months, and even for years. Painful osteo-myelitis is generally met with near an end of the shaft of a long limb-bone (tibia, radius, femur).

The name of *epiphysial osteitis* cannot be properly applied to painful osteo-myelitis near one end of a long bone. An epiphysis is rarely the primary seat of the affection, and when it is,

the neighbouring articulation is also involved. The seat of election of painful osteo-myelitis is the spongy part of the diaphysis, near the cartilage of conjunction.

Notwithstanding its brilliant results, trephining, M. Ollier states, should not be performed till after the non-operative resources of treatment have been exhausted. In some cases the pain may be relieved by simple separation of periosteum, and without perforation of bone. Trephining should be reserved for those cases in which the inflammatory character of the lesion cannot be doubted. The operation may, when other plans of treatment have failed, be applied in any form of inflammation, if the severity of the symptoms demand intervention. In the acute form the grave and often fatal symptoms of suppurative osteo-myelitis may be prevented, and in the subacute or chronic forms, the predominant phenomenon of which is intense and obstinate pain, relief may be afforded by relaxing the pressure of the peripheral osseous tissue on the swollen marrow. The trephine, in its course to the medullary spaces, will traverse in some cases thickened and more or less eburnated bone, and in other cases bone that has become soft and atrophied. The condition of thickening is met with generally in old cases in which prolonged plastic transformations have taken place around the primary seat of disease; the condition of softening in cases of recent subacute inflammation. In the former class of cases spontaneous cure is almost quite impossible by reason of the resistance of the osseous walls. In the latter class pus will gradually find a way to the surface of the bone through gradual "medullisation" of the wall of the shaft. This process of natural cure, however, may be carried over a long period, and may keep up for many months' suffering that might at any time have been instantaneously relieved by surgical intervention.

In eight out of nineteen cases of painful osteo-myelitis treated by trephining M. Ollier found pus. In ten cases were found the different morbid conditions of the marrow that have been mentioned. In three out of these ten cases there was a distinct and regular cavity. In the remaining seven cases the disease was not well circumscribed. In the last case — one of acute-

osteo-myelitis of the femur—M. Ollier gave exit to a large collection of fluid blood. The result of the operation, in most of these cases, was very simple. The type and character of the pain were at once changed, and the nocturnal attacks of deep-seated and lancinating anguish were replaced by a feeling of uneasiness in the wound, which gradually ceased. This change took place most rapidly in those cases in which a circumscribed cavity had been found in the bone.

Of the nineteen cases of trephining alluded to by M. Ollier two were fatal through pyæmia. In one of these cases osteo-myelitis persisted after the operation; in the other case the patient died on the sixty-third day from the date of operation after convalescence, as it was thought, had been well established, and the wound had been almost completely closed.—*Gazette Médicale de Paris*, No. 36, 1876.—*Brit. & For. Medico-Chirurgical Review*, Jan. 1877.

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**Hypodermic Alimentation.**—(By DR. G. F. DUFFEY).—In a case of chronic gastric ulcer, accompanied by high temperature, almost imperceptible pulse, and the delirium of inanition, and in which even milk was constantly vomited and rectal injections were no longer retained, a trial was given to hypodermic injection of a teaspoonful of milk, alternating with beef extract, every two hours. These injections were continued for four days, and at the end of this time there was a marked abatement of the unfavourable symptoms. A little milk was given by the mouth, but as it again caused pain, cod-liver oil was given hypodermically, every two hours, for three days, after which the patient had sufficiently recovered to take food in the usual way. The patient then received sixty-eight hypodermic injections in one day in different parts of the body, receiving in one day as much as four ounces of cod-liver oil. Two small abscesses formed, both from the milk. The oil caused no pain, but the precaution was taken to raise it almost to the temperature of the body. In another case olive oil was used, and the patient, a lunatic, was supported by hypodermic injections for twenty days without any



other aliment whatever; he made a good recovery (Richmond and Louisville Med. Jour.) Hypodermic injections of liquefied fats, saccharine solutions, and yolk of egg have also been used. Stricker and Oser have even tried injections of peptone. Krueger has found this method eminently successful in the treatment of an insane patient who refused to eat, and in whose case the oesophageal sound was fraught with danger. Nutrient hypodermic injections were decided upon. The syringe, which could contain 15 centigrammes of fluid, was connected by means of India-rubber tubing, to an ordinary Pravaz's syringe. The passage of the fluid could be readily seen in the glass-receiver of the syringe; the India-rubber tube diminished the shock and rendered any movement on the part of the lunatic less dangerous. At first one syringeful, afterwards two (30 centigrammes) were injected each day. The duration of the operation varied from half an hour to an hour. The longer the time devoted to it, the less was the pain caused. Once only was it followed by an abscess, the contents of an egg having been injected. These hypodermic injections were had recourse to from the 7th to the 25th February, with the exception of the 13th, 16th, 18th and 23rd, during which days he consented to eat, and also were used from the 27th to the 30th of March. The unpleasant odour caused by prolonged fasting disappeared after the first injection (Rev. des Sci. Med., 15 Jan.) The subcutaneous injection of sheep's blood in the insane was the subject of a paper recently read before the Société de Médecin Pratique, by Dr. Voisin (London Med. Record, April 15.) This method of treatment is not directed against the mental state, but it is intended to keep up nutrition in sufferers from melancholia considered as incurable. In one case fifty grammes of blood ( $1\frac{1}{2}$  oz.) were injected into the subcutaneous cellular tissue of the arm every eighth day.

*The Transfusion of Milk.*—In connection with the above-mentioned subject of hypodermic alimentation, may be noted a case in which a patient, who was apparently moribund four days after the operation of double ovariectomy, was revived by the transfusion of eight and a half ounces of fresh cow's milk into

the median basilic vein. The woman made a good recovery. (American Jour. of the Medical Sciences, January, 1876.) The operator, Professor T. Galliard Thomas, says he is averse to the transfusion of blood, and was induced to employ milk, from the success which attended its use in the hands of Dr. Hodder, when injected into the veins of apparently moribund cholera patients in the Canadian epidemic of 1850. Dr. T. W. Howe, of New York, has also injected six ounces of warm goat's milk into the cephalic vein of a patient suffering from tubercular disease, and who appeared to be dying from starvation, in consequence of inability to retain nutritious material by either stomach or rectum. This patient felt better after the operation, but only survived it four days. There were no clots in the veins of the arm or in the lung. Donn e has shown that milk may be injected into the veins of dogs and rabbits without any injury to them.—*Dublin Journal of Medical Science*, June 1876. p. 584.—*Braithwaite's Retrospect*, July to Dec. 1876.

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**Stricture of the Œsophagus; Gastro-tomy; Recovery.**—(Under the care of M. Verneuil, of the Hôpital de la Pitié, Paris.)—The operation of gastro-tomy was performed for the first time by Sédillot in 1849. Since then this operation has been practised a large number of times in England, America and Germany, but before the present case it had never been followed by recovery. It is true, that in the great number of cases which have hitherto been recorded, the operation was undertaken where the stricture was due to some morbid growth of the œsophagus. The account of the case is briefly as follows:

R. M.—. seventeen years of age, of somewhat slender build and childish appearance, inadvertently swallowed on the 4th February, 1876, a solution of potash, which caused a very severe burning sensation in the throat. Strong fever came on, and deglutition was excessively painful, and almost impossible during a few days. After two weeks the œsophagitis subsided, but the youth continued to experience great difficulty in swallowing solid

food. On the 31st of March he was admitted into the Pitié, into the service of M. Dumontpallier. Under the care of this gentleman dilatation of the œsophagus was attempted during two months by means of various instruments, and finally on the 24th May, seeing that the general condition of the patient was gradually growing worse, he was passed into the wards of M. Verneuil. At this time swallowing was almost impossible, and he threw up what he took after a short interval. He had lost a great amount of flesh, and was almost exhausted. The skin was cold and cyanosed towards the extremities, and the pulse was very weak. Hunger and thirst were persistent and very trying. Upon exploration the stricture was found to lie seven centimetres down, but it was found impossible to make way into the stomach. Nutrient enemata were given in order to gain time, but finding that the general condition was getting less and less satisfactory, M. Verneuil decided upon operative interference. A last attempt to pass the stricture, under chloroform was made, and was crowned with success. This caused temporary relief, and allowed the patient to take some nourishment. On the 10th of July, however, the stricture became, seemingly without any reason, suddenly and completely impassable. The axillary temperature at this moment was  $35^{\circ}$  C. ( $95^{\circ}$  F.)

The patient having implored M. Verneuil to do something in order to relieve him, it was decided to make an opening in the stomach on the 25th July. Having taken all necessary antiseptic measures, an incision five centimetres in length, at the left limit of the epigastrium, parallel to and two centimetres from the cartilage of the eighth rib, was made. The several tissues were successively incised, and lastly, the periœneum having been opened, the stomach was laid bare. This organ was then drawn to the orifice of the wound by means of a pair of forceps, and firmly sutured to its edges, without an opening having been made. This method is superior to that in which the stomach is incised before being fixed to the edges of the wound, as in the former there is no danger of any blood falling into the peritoneal cavity. A buttonhole opening was then made in the wall of the stomach. A soft red caoutchouc sound was next placed in the

stomach in order to keep the opening patent and to allow the free introduction of food. A plug was placed in the extremity of the sound, in order to prevent any air penetrating into the cavity of the stomach. Antiseptic dressings were then applied to the wound. Evening temperature, 35.6° C. Slight pain. Pulse normal. At midnight 140 grammes\* of milk were injected, but they produced vomiting, and a portion of it was thrown out by the tube, in a semi-coagulated state.

July 27th.—Complains of some difficulty of breathing. Nothing wrong on auscultation. Complains always of pain. Pulse feeble; temperature low. Injection of bouillon and Bordeaux wine every four hours. Slight jaundice. Wound healthy.

28th.—Jaundice more pronounced to-day. No fever. Stomach painless. Bears the injections well.

29th.—Pulse and temp. higher; breathing freer; no cough.

30th.—General condition the same. Slight blush round the wound; no erysipelas.

August 1st.—From this date the patient continued to recover rapidly. He gained flesh, his cheeks filled out, and he became cheerful. The injections do not inconvenience him in the least.

15th wound completely healed.

The following table gives an idea of the rapid manner in which the economy repaired its forces:

July 26th.	Patient weighed	33	kilogrammes.	†
Aug. 18th	“	“	34	“
21st	“	“	34.4	“
25th	“	“	35.5	“
31st	“	“	36	“
Sept. 8th	“	“	37.5	“
14th	“	“	39	“
Oct. 4th	“	“	40	“
20th	“	“	42	“

The nutrient injections into the stomach only determine a sensation of cold or heat. The absence of saliva among the ingested articles does not seem to interfere with the functions of digestion, as every kind of food seems to be assimilated with an equal

\* One gramme is equal to 15.4 grains.

† One kilogramme is equal to 2 lb 3 oz. 120 grains (nearly).

degree of facility. Eminent physiologists are now utilizing this subject for the purpose of making researches on digestion. At a later period we hope to publish the result of their researches, and the ultimate issue of the operation, which up to the present moment, may be considered a complete success.—*The Lancet*.

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**Paracentesis Thoracis.**—Eri reviews 75 cases of Thoracentesis in serous and purulent exudations, which occurred at the medical clinic of Basel, from 1874-76.

The puncture was made usually in the hinder part of the thorax, in the scapular line, or between this and the vertebral column, and in the lowest intercostal space possible, commonly the twelfth. The resistance frequently met with in this operation may be caused—independently of the formation of coagula and prolapse of the lung—by the thickened pleura or adhesions preventing the expansion of the lung, which in forcible aspiration may even be torn, and cause a slight hæmorrhage. When this is the case the patient experiences a sensation as if something had cracked in his chest. An instance of this with recovery is given. If the lung be not capable of expansion, continued aspiration draws the mediastinum to the affected side, and the diaphragm up. By very forcible aspiration the chest wall may sink in, rupture of the pleura not occurring unless there are extensive changes in the lung substance, cavities near the periphery, &c. Hence in the aspiration of old exudations it is advisable if phthisical changes are discovered, if the exudation becomes mixed with blood, or if much pain is complained of to discontinue the operation when the resistance becomes increased. In large and old effusions the author advises that not more than 1500 cc. of fluid should be drawn off at once.

After the subsidence of the fever, *i e.*, at or about the end of the third week, is thought the most favorable time for the operation; still, even if the fever continue after this, it is not contraindicated.

In 75 operations, 52 were performed during the continuance of the fever, in 32 of these the character and height of the fever

remained unchanged; in one case it rose, in the remainder it disappeared either completely or partially.

In two cases the exudation became purulent after the operation, in one after the first, in the other after the third puncture; both were, however complicated with tubercular phthisis. Pneumothorax followed the removal of the exudation in one instance, and in the same individual accompanied each operation, disappearing every time very quickly.

The lung was repeatedly perforated in the operation without any ill effects following. Once the wound led to an hæmoptysis, by which directly after the operation three tablespoonsful of bright red blood were brought up. In this case the layer of effusion was so thin that the needle passed through into the lung.

In another case a pneumonic lung, which was falsely supposed to be an effusion, was punctured. The error arose from the fact that a croupous coagulum completely blocked the main bronchus causing thereby an entire absence of breath sounds and vocal fremitus. In a third instance a tumour was mistaken for exudation and punctured.

With regard to the evacuation of empyema by aspiration—the method employed in the Basel clinic,—the author recommends that not more than 500 cc. of pus should be removed in one sitting. The lung in these cases, on account of the thickening of the pleura, is not capable of complete expansion, and if the evacuation be made forcibly the chest wall and diaphragm are drawn to the affected side. Of six patients treated in this way five recovered, of whom three required but one puncture, the other two from four to six operations.—(Stuttgart 1876. 8vo. Rft. in Centblt. f. Med. Wissen, Dec. 23rd.)

### **Therapeutics of Nervous Disorders.—**

(Dr. Berger of Breslau.)—

(1). *Phosphorus*. — Berger has employed phosphorus in twenty-two cases of neuralgia, and was unable to secure the brilliant results the English authors promise. Certainly five of the most recent cases were cured by this drug, but with the rest this remedy had no effect, although most of them were subse-

quently cured or improved by the administration of other remedies. In six remaining uncured cases the subsequent employment of phosphorus had no effect whatever. So it appears that the famed anti-neuralgic action of this remedy is very problematical, and Berger says he cannot recommend its employment. Berger also used phosphorus with little effect in that peculiar disorder for which there is no anatomical explanation, but which he calls *neurasthenia cerebri*, and by which he understands that there exists a condition of pathological lessening of the psychical functions, and in which there is total unfitness for any form of intellectual activity, without any palpable lesion taking place in the brain or other organs. These patients are generally young men belonging to the educated classes, and more especially those predisposed to neurotic affections. They may have suffered for years under what was supposed to be hypochondria. This affection generally comes on without cause. The treatment Berger found most useful was complete rest of brain and change of air.

(2.) *Zincum Phosphoratum*.—Berger tried this in 15 cases of different nervous disorders (neuralgia, chorea, singultus hystericus, &c.) in doses of 5–8 mgrm., in form of pill three times a day. In one case only of hemicrania was it of any use, in all the other cases it signally failed. If continued long he found it caused disorder of the stomach.

(3.) *Camphora Monobromata*.—This was tried in 36 cases of different nervous disorders, the results were as follows:

(a). As a hypnotic in doses of 1.0–to 1.5 grm. this remedy is powerless.

(b). Of five cases of chorea, two improved under it soon after its employment. The other three it did not benefit in the least.

(c). Little satisfaction was got by employing it in neuralgia, (12 cases), or hysteria.

(d). Good results followed its employment in nervous heart palpitation, and in irritative conditions of the genital organs.

(e). In five cases of delirium tremens treated by it, no effect was produced in quieting the patient until chloral hydrate was added, but it produced decrease of temperature. The monobromate was given in gradually increasing doses of 0.5 grm. to 1.0

grmm. every half hour. In one case of delirium tremens, in which it alone was used to the quantity of 16 grmm., the delirium lasted six days. This remedy must be more used in this disorder before any conclusions are come to.

( ). Its efficacy in epilepsy is very questionable.

The ordinary dose of this remedy is 1—0.6 grmm., three or four times a day, and it may be given in gelatin capsules. It is seldom given in pill. To know how far this remedy can be pushed, notice the temperature; if it descends below normal, then stop the further employment of the remedy. It sometimes gives rise to stomach trouble, and Berger says its employment has not fulfilled the promises of the French physicians, except in those disorders under class (d).

(4). Bourneville has lately conducted a series of observations in Charcot's clinique, in which he found that the application of ice had a good effect in hysterical and true epilepsy; ice was applied over the region of the ovaries, and by this treatment many of these cases were cured or much benefitted. The application of ice over the region of the heart he found useful in hysterical palpitation. Ice had no effect in true epilepsy applied over the spine, but much diminished 'Petit Mal.' Ice was found useful in many cerebro-spinal affections, applied over the spine, but was most useful in cases of hysterical epilepsy, applied over the region of the ovaries.—*Schmidt's Jahrbücher*, Bd. 172, No. 8, 1876.

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### **On a case of Intracranial Sarcoma.—**

Clinical lecture by J. W. Hulke, F.R.C.S., Surgeon to Middlesex Hospital:—

GENTLEMEN,—There died in Forbes ward, on October 28, a patient who for nearly nine months had been under observation, first at the Royal London Ophthalmic Hospital, and latterly here. I have often called your attention to him at my visits to the wards. The tumour, removed by Dr. Coupland from his body after death, is before you, and I propose to day to review his case.

On February 19 last, when he first came under my notice, I wrote this memorandum:—"W. J., aged thirty-nine, a worn-



looking, pale boot clicker, complains of confusion of sight, hindering him from working. The confusion is an incomplete diplopia; the double images partially cover one another, except at the outskirts of the visual field. Marked palsy of the musculus rectus externus, and slighter palsy of the muscoli recti superior and inferior. Slight proptosis. Myosis. Blunted tactile sensitiveness of the left side of face, corresponding to the distribution of all three divisions of the fifth nerve (most marked in the parts supplied by the first and second divisions), with formication and a sensation of numbness. Loss of tactile sensibility and also of taste in left side of tongue from tip almost to root. Wasting of left temporal and masseter muscles, which are contracted, and act less forcibly than the right muscles, and, as he expresses it, with a feeling of stiffness.

“A sore on penis seven years ago, with knots in both groins which did not suppurate; and some time later (within one year) ulcerated throat, and rash on trunk and arms. June, 1875, toothache, for which four teeth were pulled out without relief. At Christmas confused sight.”

The diplopia, the patient's chief distress, plainly arose from derangement of the concerted movements of the two eyes, for, as you know, single vision with two eyes requires that they shall both be so moved together and directed towards the object that the image of this shall fall upon identical or corresponding parts of the two retinae. This derangement of their consensual movements obviously proceeded from palsy of the muscoli recti, which, in turn, meant impairment of the third and sixth nerves. The association of myosis (contracted pupil) with palsy of the upper and lower rectus muscles, supplied by the third nerve, seemed at first puzzling, for, as you will remember, this same nerve supplies the sphincter pupillae, the dilator deriving its supply from the sympathetic. You would therefore expect that dilatation (not contraction) of the pupil would accompany palsy of those external ocular muscles to which the third nerve is distributed; and this is the rule. The apparent anomaly here had its explanation in the implication of the fifth nerve, for section of this nerve at the

Gasserian ganglion produces contraction of the pupil which is even greater than that which follows section of the sympathetic alone. The myosis, together with the concurrent implication of the whole of the fifth, and also of the third and sixth nerves, fixed the situation of the disease in the neighborhood of the cavernous sinus. As to its nature, his syphilitic antecedents made it not unlikely that it was a gumma of the dura mater or bone pressing on the nerves. He was therefore ordered iodide of potassium three times a day, in doses of eight grains, which were later increased to fifteen grains. In spite of this, the proptosis and the paralysis increased, and the hollowness of the temple was replaced by an unnatural fullness. The malar region, too, became fuller. At the end of April his tongue, when protruded, deviated very positively to the left, indicating that the hypoglossal nerve had become involved in the disorder. He then began to suffer extremely from excessive pain in the temple, and his strength became so reduced that he could no longer struggle on with work, and was glad at the middle of May to become an in-patient. By this time the fulness of the left temple was very conspicuous, and the protrusion of the eyeball considerable. It was now evident that this latter was due to the invasion of the back of the orbit by a tumour, and that it was not simply a consequence of the want of tonicity in the palsied muscles. Taste was now lost in the left half of the root of the tongue, indicating implication of the glosso-pharyngeal nerve. The hearing of the left ear was not so acute as that of the right, but as no previous comparison had ever been made, the precise value of this as a sign of extension of the disease to the portio mollis of the seventh pair could not be fixed. The left facial muscles were not all palsied, but rather in a state of slight tonic spasm. The course of the malady had plainly shown that we had not to deal with a simple syphilitic gumma, and made it probable that it was a periosteal sarcoma beginning inside the skull and extending into the orbit, and through the outer wall of this or through the sphenc-maxillary fissure into the zygomatic and temporal fossæ. The sight of the eye had become much impaired, with congestive swelling of

optic nerve disc; and, at the middle of June, ophthalmia with dullness of the cornea supervened. Thinking the latter might be due to the exposure of the insensible eyeball, and the intrusion of foreign bodies, dust, etc., of the presence of which the man had no warning, the eyelids were brought together with a strap and covered by a light compress; this gave some relief, but it could not be efficiently applied owing to the protrusion of the eyeball between the eyelids, which steadily increased, till by August it was so far advanced that a needle might have been pushed behind it, between it and the orbital margin. The lower eyelid was now everted, and a large roll of swollen conjunctiva filled the angle between it and the eyeball. The pain in the left temple had grown so severe that the patient required several times a day a hypodermic injection of morphia. On October 3, upon my return from my autumn vacation, I found all his symptoms increased, and he had, added to his other troubles, difficulty in swallowing. Whatever he took stuck, he said, in his gullet, beyond which it would not go, but returned by the nares, and occasionally got into his larynx, threatening to choke him. The vagus was involved. From this time life was supported by enemata, but the rectum at length became irritable, and no longer retained them. Finally his breathing became embarrassed, and he sank on the 28th of the month, his mind being clear to the last.

At the post-mortem examination this sarcomatous tumour was found. Originating apparently at the tip of the petrosal bone, it had involved and destroyed the Gasserian ganglion and the third, fourth and sixth nerves. It had entered the orbit through the sphenoidal fissure, filling the apex of this cavity, displacing the eyeball forwards, and wasting and thrusting up the roof, so as to project into the anterior fossa of the skull as a considerable hummock, which had wasted and flattened out the inferior frontal convolution. From the orbit it had spread into the zygomatic fossa, but it had not ascended, as we had thought during life, into the temporal fossa. The temporal muscle had a very curious appearance—it was swollen, of a pale buff color, and, when cut across, the section was translucent and of a jelly-

like consistence. The rough characters were strikingly like those of myxoma; yet a closer examination did not confirm this, but showed merely an extremely wasted muscle thoroughly soaked with serum, thoroughly œdematous—a condition which depended doubtless on the obstruction of the deep temporal and of veins in the zygomatic fossa. The cavernous sinus was destroyed. From the tip of the petrosal bone, where the tumour formed a considerable knob, it had extended downwards and backwards, and involved the eighth nerve and the hypoglossal as they enter the foramina by which they respectively leave the skull. Dr. Coupland tells me that the finer structure of the tumour places it amongst the sarcomata.

Here, then, there was a considerable tumour projecting into the anterior and middle fossæ of the skull, wasting the corresponding portions of the cerebral hemispheres, revealed only by the palsies of the several nerves which it successively destroyed. No hemiplegia, no fits, no disorder of mind marked its existence; not even aphasia was present, although the inferior frontal convolution, particularly its posterior part, was wasted by it. Such absence of brain-symptoms is by no means infrequent. It is a negative evidence which counts for nothing when, in considering in any given case of external tumour attached to the skull, the question of an operation, where the propriety of interfering or of abstaining depends on the integrity or penetration of its walls. We have in our museum a myxoma of the size of a small orange, which grew from the orbit into the right middle fossa of the skull, and thoroughly wasted the temporo-sphenoidal lobe, without any cerebral symptoms denoting its presence until a few hours before death, when a persistent epileptic condition supervened. This is by no means exceptional. I have seen more than one other of the same kind, and I have no doubt that many have been recorded.

Here the question of direct interference never arose, because it was evident, when I first saw him, that the disease, which in its progress had caused the proptosis, had begun behind the orbit, and therefore inside the skull.

The ophthalmia and the ulceration of the gums bear on the still vexed question of the trophic influence of the fifth nerve,

apparently proved by the well-known experiments of Majendie, and refuted by the exceedingly ingenious experiments of Snellen. I have so often seen the ophthalmia quickly disappear, and corneal ulcers heal, where the eyeball has from disease of the fifth been absolutely insensible to touch, when some small foreign body has been taken away, and the eyelids closed with a strap of isinglass-plaster covered with a compress to prevent fresh intrusions and to protect against exposure to cold, etc., that, without absolutely denying the fifth any influence over the nutrition of the tissues, I am forced to think that this influence is less than was long believed. With respect to the mouth, although the ulcerated parts could not have been reached by the teeth, they might have been scalded by too hot liquids, of the excessive heat of which his insensible gums would not have informed him. Very considerable injuries may sometimes arise in this way. Last summer I saw a boy whose hand, after a very severe compound fracture of the arm, was perfectly anæsthetic. Whilst toasting a slice of bread, he had, without knowing what was going on, roasted deeply his fingers.

The first diagnosis—syphilitic gumma—which I always looked upon as provisional, was disproved by the progress of the case. The error was justified by his history, and it was without influence on the result. Of all forms of primary tumours of the skull, sarcoma is by far the most frequent. I have seen a very considerable number originate in and about the orbit. Mostly starting from the periosteum, they invade the bones, and extend rapidly from one to another, the sutures offering no effective barrier. Their tendency to grow again after extirpation is very strong, and unless they begin in a situation which is freely accessible, and where their thorough destruction can be effected (often with the assistance of the actual cautery and escharotics after excision), the prognosis is highly unfavorable.—*Medical Times and Gazette.*

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**On "Cellulo-vascular" Polypi of the Urinary Meatus.**—The following is an abstract of some clinical remarks made by M. Gosselin, of the *Hopital de la Charité*, on two cases of urethral polypoid growths in the female :

In each case there was at the external urinary meatus a small red granular prominence resembling an overgrown granulation, or one of the small vascular tumors that are sometimes developed on the neck or within the cavity of the uterus,—tumours that have been called vascular polypi, but incorrectly, since they differ from ordinary polypi of the womb in being less voluminous, and in not containing uterine fibres and muscular tissue. To these growths of the meatus, M. Gosselin applies the name of “polypi” in conformity with general custom, but he takes care to point out they cannot be strictly regarded as such, since they are attached to the mucous membrane of the urethra by a broad base, and do not present a well-marked narrow pedicle. A similar exception in nomenclature is generally made with regard to the so-called naso-pharyngeal fibrous polypi, which have a too extensive attachment to allow of their being classed as true polypoid growths. Nélaton, indeed, proposed for them the denomination of fibromata of the base of the cranium. The tumors removed in M. Gosselin’s two cases were found to be made up of embryonic cells without any admixture of fusiform fibres. The growths were more vascular, but in every other respect were constituted like ordinary mucous polypi. These tumors of the meatus do not involve the whole contour of the urethra, or spread to the vagina as cancerous growths do. But it very often happens that they rapidly recur after excision. This recurrence is probably due to the fact that the base of the tumour is large and extended for some distance along the urethra, and that a portion of this base may be left after operation. It is in respect only to this recurrence that these polypoid growths of the female urinary meatus are analogous to cancerous formations. The removed growth takes place only in the urethral mucous membranes; the glands do not become engorged, and there is never any cachexia. This tumour of the meatus is a vascular mucous polypus, and is essentially benign in its nature. In one of the cases referred to by M. Gosselin, the subject of which was fifty-five years of age, the tumor of the meatus was quite indolent. The patient suffered

neither in walking nor during micturition, and there was no absolute indication for the removal of the small vascular growth. In the second case the tumor, though resembling that in the first-named case in size, nature and composition, gave rise to acute suffering. The woman had intense pain when she walked, when the tumor was touched, and both during and for some time after micturition. Of this difference between the tumors in the two cases, M. Gosselin can give no explanation beyond the assumption that it was due to idiosyncrasy or individual variety. An analogous difference in character is presented in cases of erythema of the vulva. In some patients the eruption is absolutely indolent, in others it is associated with intolerable pruritus, and very intense pains about the vulva.—*Gazette des Hopitaux*, No. 112, 1876.—*Brit. & For. Med. Chir. Review*.

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**The Inoculation of Cancer.** — Noiviusky records the following experience in this matter. He employed bits of medullary cancer from the nose of a dog and inoculated in 27 cases on inflamed, in 15 on normal skin. The former were without effect, of the latter two were successful. One of these cases was as follows: In a fresh wound on the back a small bit of cancer was imbedded and the wound closed by stitches. It healed by primary union. After 14 days, in the cicatrix a small tubercle the size of a pea was evident, which grew with tolerable rapidity, so that by April 1st, three months after the inoculation, it had the size of a walnut. On the 4th May the dog was killed. The tumour was soft, on section white, and on microscopical examination, in structure similar to the medullary tumour which the inoculation was made. In the subclavian region a lymphatic gland was enlarged, and had the same appearance histologically.

In the second instance the inoculation was made in a three month's pup with a bit of the cancer from the above case. In a month and a half the dog died of the distemper. In the scar, where the inoculation had been made, was a small cancerous mass the size of a pea, which presented the characteristic structure of a medullary growth.—*Centralblatt f. d. Med. Wissen.* 4th. Nov. '76.

### **Tincture and Oil of Decayed Maize.—**

*Employment of the Tincture and Oil of Decayed Maize as a cure for Impetigo, Chloasma and Pityriasis.* By DR. G. ROSSI. *Riv. Clin. de Bologna, Aprile, 1876.*

CASE I.—Mrs. P. G., mother of a large family, suffered in May 1875, from severe itching of the head caused by *pityriasis capitis furfuracea*. She took a teaspoonful of the tincture of decayed maize (Indian Corn) internally every morning, and rubbed the head daily with the rancid oil of maize mixed with a little fat. The itching soon disappeared, and in twenty days the pityriasis was cured. The administration of the tincture at first caused slight nausea and eructations which, however soon disappeared.

CASE II.—A child aged seven, suffered in October, 1875, from *impetigo capitis*. The head was covered with thick, yellow crusts of dried matter, in which parasites developed and increased. A teaspoonful of the tincture of decayed maize was given every morning, and the oil was daily painted on the head. At first the patient complained of nausea, general uneasiness, and a feeling of heat all over the body. These symptoms disappeared in a few days. In a month the cure was complete.

CASE III.—Two sisters Rosa and Maria P., had patches of *chloasma* of different sizes on their breasts and front of the arms. There was no itching or uneasiness; under the above treatment, cure was effected in 35 days.

The mother also suffered from the same affection and was cured by the direct application of the rancid oil. Patients never object to the oil as they do to the internal administration of the tincture. The tincture is very disagreeable to the taste, and frequently produces nausea.—(Quoted in Schmidt's *Jahrbücher*, Bd. 172. No. 10, 1876.)

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**On the use of Salicine in Rheumatic Fever.**—The following conclusions have been arrived at in connection with the administration of Salicin in cases of Rheumatic Fever under the care of Dr. Ringer:—

*Pain.*—Dr. Maclagan says that "the relief of pain is always



one of the earliest effects produced." The present cases fully bear out this conclusion ; and even when the pain was persistent, and migrated from joint to joint (as in Cases 5 and 6), it was not severe, and there was usually no subsequent swelling. Dr. Maclagan's sixth and seventh conclusions are : that " in acute cases, relief of pain and fall of temperature generally occur simultaneously," and that " in subacute cases the pain is sometimes decidedly relieved before the temperature begins to fall." The present cases do not support these two propositions. In three acute cases (Cases 1, 4, 7) the joint-pain ceased at least twenty-four hours before the temperature began to fall, and at least four days before it became normal. In three others (Cases 2, 5, 6) the temperature became normal before cessation of pain, and in two of them the pain "persisted." In cases 3 and 8 the pain subsided and temperature became normal simultaneously. Perhaps the beneficial action of the drug on the pain ceases when the temperature becomes normal.

*Cardiac Complications.*—The present cases support Dr. Maclagan's statements. In only three did a murmur develop while taking salicin : this was in each case a distinct apex systolic, and it disappeared before the drug was discontinued. In one case a murmur developed after the discontinuance of the drug. In the other four cases no murmur existed, though the soft, low first sounds in two of them suggested the anticipation of murmurs.

*Sweating.*—Profuse in three cases ; produced miliaria in one of them ; was alkaline in a third. In all the rest the skin was simply moist.

The *urine* never gave any large deposit of lithates ; was usually only moderately acid, and on one occasion was alkaline. Salicin was detected in the urine in one case six hours after administration, and gave the purple reaction as late as the fourth day after the discontinuance of the drug—in this respect differing notably from quinine.—*Medical Times and Gazette.*

CANADA

# Medical and Surgical Journal.

MONTREAL, FEBRUARY, 1877.

## COLONIAL SURGEONS AND THE MERCHANT MARINE.

By the action of the Board of Trade of Great Britain, ship owners have been notified that from and after the 1st January, 1877, all surgeons in charge of emigrant ships, sailing from any British port, must hold a British qualification, or a diploma from some British University or College. In the case of Canada this appears to be an exceedingly hard matter, as it places the institutions of our country at a disadvantage. We do not desire to call in question this action of the Board of Trade, but think that hasty legislation will end in trouble and may lead to difficulty. We in Canada are governed by laws of local origin, and which the Board of Trade of the mother country has no power to alter. It is in every way desirable that persons in charge of emigrant ships should be duly qualified and hold legal status. But it must be borne in mind that no British graduate, as such, holds any status in Canada, he cannot practice his profession in this country on the strength of his holding any British degree, nor can he enter any Court of Law, or be recognized as a duly qualified medical practitioner in Canada, unless he complies with the law of this colony and is duly registered in the books of the Provincial Medical Board.

An emigrant ship leaves Liverpool for Quebec in charge of a British graduate duly registered in Great Britain. If it is a steamship, three or four of the last days of the

voyage is performed in Canadian waters, from the time the vessel enters the Gulf of St. Lawrence up to the time of her arrival in the port of Quebec or Montreal, as the case may be, the surgeon, if he is not registered in Canada, is acting as such surgeon to his vessel in contravention to the law of this land. He is liable to fine and imprisonment, which fine is recoverable from the ship-owner. Such is the law as it stands in respect to our country. The General Council of Medical Education and Registration of Great Britain has refused to recognise Canadian qualifications, and the Canadian Colleges of Physicians and Surgeons of the Provinces of Quebec and Ontario refuse to recognize British qualifications and to admit the holders of these qualifications to registration in this country. Here, then, is a stop put to all amicable relations in these particulars. Let it be understood that in the Province of Ontario no degree or qualification of any description is recognized, except as an evidence of the holder having passed through a regular curriculum of study. In Ontario there is but one door of entrance to the profession. Before a candidate can obtain an examination before the examiners appointed by the Medical Council of Ontario he has to give evidence of having passed a preliminary examination on subjects which are the same as those demanded by the British Act, and of having studied his profession uninterruptedly for four years from the time of passing his preliminary examination, during which period he is required to attend three sessions of medical lectures at some University, College or incorporated school recognized by the Council, a session to consist of six months' lectures on each subject, of having attended the practice of an hospital for a period of eighteen months, and of having spent a period of six months in the office of a regularly qualified practitioner in compounding medicine. The examinations may be optional on the part of the student at the end of each year, after the first year he may pass on the following subjects: Anatomy, including the bones, ligaments, muscles and viscera of chest and abdomen; physiology of locomotion, respiration, circulation and digestion; chemistry inorganic, and botany. In the second year's examinations the subjects are: Anatomy other than those in the

1st year ; physiology other than those of 1st year ; chemistry and sanitary science. At the end of the third year the subjects are : Anatomy, surgical and demonstrative ; pathology, medical and surgical ; jurisprudence ; operative surgery and operative midwifery. In the 4th year : Toxicology ; materia medica ; theory and practice of medicine ; midwifery and diseases of women and children ; surgery ; and clinical examinations on all the practical branches. All persons desirous of practising in Ontario are obliged to pass an examination equivalent to that indicated above after having given evidence of regular and uninterrupted study for four years. Graduates from British Universities and Colleges are admitted to examination, but the Council have the option of admitting a British graduate to registration without examination ; this, however, has never yet been done. Registration gives the required status, and without it the person so unregistered is disqualified, and holds no legal status as a medical practitioner. In the Province of Quebec we are under a somewhat different regime. The profession in this Province is incorporated under the name and style of the College of Physicians and Surgeons of the Province of Quebec. The College meets every third year, and elects from its members 40 governors—these are the representatives of the profession, and in their hands is left the destiny of the medical ship of state for the ensuing term of three years. The Board of Governors is not an examining body ; they appoint examiners to examine candidates for admission as students of medicine, and the subjects exacted are the same as those demanded by the Council of Medical Education and Registration of Great Britain. After having passed his preliminary examination the student of medicine has to pursue his medical studies for a period of four consecutive years, during which time he has to attend three sessions of six months' courses of lectures on the various branches of medical science at some University, College or Incorporated School of Medicine recognized by the Board of Governors. And he has to attend the practice of an hospital of over sixty beds, for a period of eighteen months. The qualification conferred by

the teaching body, its diploma or certificate, entitles the holder to registration without further test by examination, and to secure an efficient system of teaching and examination, the Board of Governors are required to appoint two or more assessors who shall visit and attend the examinations at the schools. We copy the clause in the Act, which runs as follows:

“It shall appoint assessors not of its own body, but from among the registered members of the College, to visit and attend the medical examinations of the various Universities, Colleges and Incorporated Schools of the Province, and to report to the Provincial Medical Board upon the character of such examinations. The assessors must not be chosen from the Professors of any of the said Universities, Colleges or Incorporated Schools, and should such report be at any time unfavorable to any University, College or Incorporated School, the Provincial Medical Board shall in such case, and under such circumstances, have the power to refuse the registration of the degree or diploma of the institution so reported upon until such method of examination shall have been amended.” The above is clause 4, section 12 of the Act, and is sufficiently explicit.

To enter on the study of medicine in this Province the student is obliged to give evidence, by examination, of proficiency in preliminary education. This examination is equivalent to that exacted in England, and is accepted by the General Council of Medical Education and Registration of Great Britain. He has then to pursue his medical studies uninterruptedly for four years at a recognized University, College or Incorporated School of Medicine, and what is meant by recognition is indicated in the clause above quoted. The College of Physicians and Surgeons of the Province of Quebec has hitherto acknowledged and accepted British degrees for what they set forth. If any man presents his papers and they are deficient in any particular, he is expected to satisfy the Board of Examiners on this point, or if he fails or refuses to do so, registration is withheld. In Canada we are general practitioners, and the distinctions recognized in the mother country are unknown here, so that a man to register in this Province must possess the double

qualification. We say that hitherto the Provincial Medical Board of this Province has recognized all British degrees and diplomas. But by the recent Act the power is delegated to the Board to admit or refuse, at its option, registration to the holders of medical degrees or diplomas from any British or Colonial University or College. The action of the Board of Trade of Great Britain appears to have been forced upon that body from the great laxity which for years has prevailed in supplying the merchant marine with surgeons. This has been a grievance which demanded attention. In the London *Lancet* of March 4th, 1876, page 367, we find the following item: "Some ten days ago was posted in the letter cage of the Marischal College, Aberdeen, the following notice:—'*Seal Fishing*.—Wanted, immediately, a surgeon for the S.S. "*Mazinthien*," sailing from Peterhead on Thursday or Friday next (24th or 25th). A junior student not objected to. Must be a good shot.' \* \* We commend this interesting notice to the attention of the Marine Department of the Board of Trade." The subject of ship surgeons to emigrant vessels, and the laxity displayed, we might characterize it by a much stronger term, in supplying vessels putting to sea with unqualified persons, had become such a grievance that it was brought up on the floor of the British House of Commons and a return demanded of the names, ages and qualifications of ship surgeons leaving British ports. The return which was made left the Board of Trade no alternative but to enunciate the determination not to permit emigrant vessels to clear for sea without a duly qualified medical practitioner being in charge. So far we consider that the action of the Board of Trade was in every particular just and reasonable. But while we agree with the necessity and commend the action of the Board of Trade, we must respectfully submit that Colonial surgeons holding qualifications equivalent in every respect to those conferred by British Colleges, should not be excluded from serving on board of vessels which are identified with the progress and enterprise and wealth of the Colony; vessels that are performing the passenger traffic of the Colony, that are subsidized by the

Government of the Colony, that carry the mails of the Colony, and that are in every way Colonial vessels, except in being registered as British ships. If, as Colonists, we attempted to supply the marine service with men who were professionally unqualified, but who possessed the only, but unmistakable capacity of being good marksmen, then, indeed, might the Board of Trade, in all justice and in the cause of humanity, object. Such, however, cannot be advanced, and in conclusion we can merely state that we have entered thus fully into the method of making doctors in the two most important Provinces of this Dominion with a view of laying the whole matter before those who may be interested. And as an evidence of the kind of men who enter the merchant marine, we subjoin a letter addressed to G. W. Campbell, A.M., M.D., Dean of the Medical Faculty of McGill University, from Sir Hugh Allan, the largest ship owner in this country, and head of the firm of Allan Brothers, Liverpool, whose line of steamships have for over twenty years traded to our ports; a line of steamships that are second to none on the Ocean. This Colony is largely indebted for its present condition of prosperity to the industry and enterprise of the Messrs. Allan. They were the pioneers of the steamship service to which Canada owes much of its present wealth.

### ALLAN LINE OF ROYAL MAIL STEAMSHIPS.

SIR HUGH ALLAN, }  
ANDREW ALLAN. }

H. & A. ALLAN, Agents.

MONTREAL, 19th January, 1877.

DEAR DR. CAMPBELL,—Our Agents in England have received notice from the Board of Trade in London, that from henceforth our steamships will not be allowed to clear at the Custom House in England, unless the Surgeons on board are provided with Diplomas from some College in England, Ireland or Scotland.

I am totally ignorant of the reason why this regulation is proposed, or of any good to be attained by it.

We have for the last twenty years carried Canadian Surgeons on board of our steamers, as well as English ones, and the result of our experience is, that the Canadian Surgeons are quite equal both in professional acquirements, and gentlemanly bearing, to those we receive from the Colleges in England.

I therefore am not disposed to submit to this requirement, inasmuch as I think it is a great injustice to the institutions of

this country, as well as to the young men who study therein, and in point of fact it is a slight upon the Dominion itself.

I have written to the Government urging them to take action in this matter without delay, and I write this letter to you with the view that you should bring it before the authorities of the University of McGill College, or in any other way that you think most likely to attain the object I have in view, and that is a full and perfect recognition of our own medical men as being equal to any others.

Yours, very truly,

(Signed,) HUGH ALLAN.

DR. G. W. CAMPBELL,  
Dean of the Faculty of Medicine, }  
McGill University.

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#### FOREIGN MEDICAL PRACTITIONERS IN FRANCE.

Some discussion has arisen in English and other journals in respect to a Bill which was introduced before the Chamber of Deputies, France, by M. Marvais, and which provides that a foreigner can only be authorized to practice medicine or surgery on the territory of the Republic after having passed the test examinations prescribed by French law. And that no one in the practice of the medical profession in France can adopt the title of Doctor, unless he has obtained that title before a French Faculty. The law of France bearing on foreign medical practitioners has hitherto given the power to the Minister of Public Instruction to admit the practitioner on the strength of his foreign diploma to exercise his calling in any one department of France, without requiring him to submit to examination, or the applicant can submit to examination for the diploma of *Officier de Santé* without further study, which is equivalent to a surgeon's diploma, and by which he can practice his profession in a particular locality, but which does not give him legal authority to practice in every portion of the French Republic. It has been stated that the bill, as introduced by M. Marvais, would prevent, absolutely, all foreign physicians or surgeons visiting French territory in such capacity, and that physicians and surgeons of eminence would be unable to visit patients sent by them to



French watering places, or health resorts. From all we can learn from the published reports in the *London Times* it appears such an idea never was contemplated by the Bill in question. France, like other countries, has been, perhaps, overrun by spurious medical practitioners, and it appears to us that the Bill in question is a salutary measure, one which was in all likelihood urgently demanded. There can be no hardship to a doctor, who has any claim to that name, if he is desirous of residing in France, and exercising his calling, to be expected to give evidence by a practical test, of his knowledge of his profession. A French student of Medicine must pass through a regular course of study at the hospitals, and submit to several rigorous examinations, before he receives the authority from the state to practice as a physician or surgeon. Every state is expected to look after the welfare of its own subjects, and on the one hand should, in this connection, protect the interests of the children of the soil, and on the other rest satisfied that the lives of its subjects shall not be imperilled by the incompetency of foreigners, who for their own pecuniary advantage, elect to reside in its territory and practice as physicians or surgeons.

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### CODDING.

This is a slang phrase in common use amongst school-boys, on the other side of the border, which is, we believe, of celtic origin, it is meant to signify misrepresenting, humbugging, joking—the precise derivative of this term we are unable to supply. Some very remarkable statements were made recently by an antivaccination lecturer in respect to the published statistics on vaccinal syphilis by Dr. Ballard of London, Eng., which have been repudiated by that gentlemen in a letter which he addressed to the Mayor Dr. Hingston. From the remarkable similarity of the lecturer's name in sound if not in orthographical construction, we suggest that possibly there may be some connection between the two, and therefore the antivaccination lecturer, might, we think, in future be styled with perfect correctness, Codder.