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The Canadian Practitioner and Review.

VOL. XXV.

TORONTO, APRIL, 1900.

No. 4.

Original Communications.

A CASE OF HYSTERIA—WITH REMARKS.*

BY J. T. FOTHERINGHAM, M.D.

Miss H., Toronto, seen in consultation February 23rd, 1899.
School girl, aged 18.

Family History.—Father and mother living and well. Eldest child living, aged 23 or 24, imbecile. Two others died in infancy of meningitis, tubercular probably.

Personal History.—Unimportant.

Present Illness.—Two months before had what seemed to be rheumatism, temperature 102° F., with swelling and pain in front of ankle, with pain and stiffness of muscles of leg, then other leg, body, shoulders, and other parts. Did not fully recover her health but gradually developed as follows:

Present Condition.—Well nourished, temperature normal, pulse 80. Is in bed. Digestive system normal throughout. Respiratory system—shallow, somewhat irregular breathing, costal in type, with occasional slight inspiratory stertor, typically hysterical. Circulatory system normal. Genito-urinary system normal.

Nervous System.—1. *Intellect.* Ideation exalted, disordered, *bizarre*, very introspective but not in the neurasthenic sense; very intent on her surroundings, nothing escaping her; not delusional, but very emotional. Volition very unstable and hysterical. No trance or catalepsy.

2. *Motor Functions.*—(a) Reflexes—knee-jerk very exaggerated, but false, almost a clonus, somewhat delayed and evidently

*Read at meeting Toronto Clinical Society, January 3rd, 1900.

volitional and due to cerebrum. Ankle clonus very marked, especially in right leg. All reflexes abnormally active. (b) Spasm—cataleptic stiffness; or rather not the *flexibilitas cerea* of true catalepsy, but mild hysterical rigidity, some days ago, with pain. Now limbs are flaccid, soft, flabby, and the seat of odd sensations. Her legs, she says, feel as if made of mortar. There is now a condition of fine subconscious purposive movements of muscles of arms and hands. Excursions almost rhythmical, co-ordination very good if not perfect. Very marked starting on any little sound in room. Tendency to adoption of peculiar postures in bed, e.g., lying on elbows with face buried in pillows while talking. These movements, she said, kept her awake. They are not ataxic or choreiform. (c) Paresis—hysterical aphonia for past few days, everything said in whispers, with occasional accidental lapses into phonation if forgetful of her part or much excited. Speech hesitating and jerky as if sometimes at a loss for a word, as she often was in her attempts to devise some altogether grotesque subjective symptom or simile by which to describe her condition.

3. *Sensory Symptoms.*—(a) Special senses—very severe photophobia—windows all darkened; but on laying dark scarf over her eyes and distracting her attention, I found her furtively watching me from under the scarf with the full light from the window falling on the eye unnoticed. Had been atropinized for this a month ago under the impression that it was rheumatic iritis. Hearing very acute, abnormally so. (b) Anesthetic areas none. (c) Hyperesthetic areas none, except decided tenderness in ovarian regions. Skin reflexes all very active. (d) Paresthesias—Formication described with much gusto and in great detail. Areas in which a worm $2\frac{1}{2}$ in. long and a $\frac{1}{4}$ in. thick was crawling. The worm would move a short distance under the skin, then begin to scatter and slowly fade away. Less numerous than a few days ago. This also kept her, she said, from sleeping.

About a week afterwards I saw her again. She was much better. Up twice daily and dressed. Very flighty and emotional. Could not walk, especially when we were present. Gait very unsteady, and mainly on tip-toe with tendency to drop forwards on knees. Her attendant found out afterwards that this was suggested by her studies of the gait of an unfortunate victim of chronic chorea who lived in her neighborhood, and of whom she frequently spoke.

Her treatment consisted in: (1) Removal from home to private hospital. (2) Nervine sedatives, especially hyoscine and the valerianates of iron, quinine and zinc. (3) Plenty of good food.

In November last I learned from her medical attendant that

she had been well for some months and at work in a shop, though still somewhat emotional and easily upset.

Points in Case.—(1) Absence of hysterical fit. Fagge quotes Briquet, to the effect that this is usually the case, only one in four ever having the real fit. Not time or place to go into description of fit, but may here lay down old rule that diagnosis of hysteria lies in a thorough knowledge of natural history, cause and symptoms of real organic conditions simulated by particular case of hysteria. True of joint cases, convulsive movements of one kind and another, etc. (2) No serious moral perversion. (3) No delusions. Clouston says in his "Manual on Mental Diseases," that "typical hysteria, pure and simple, always has a mental complication. Intellect or feelings or morals are always affected along with the purely bodily functions." He goes on to speak of the admirable results of asylum treatment of hysterics. He says, too, that so-called hysterical insanity is usually mania or melancholia, with usually marked erotic symptoms or morbid concentration of mind on the female organs in one way or another. (4) Pares-thesia, according to authorities, very rarely seen—here very marked. (5) Ankle clonus—given usually as proof of organic disease as against functional.

THE SUCCESSFUL TREATMENT OF THREE IMPORTANT CASES OF DISEASE OF THE EYES BY THE COMBINED METHOD OF HG AND KI INTERNALLY AND PILOCARPINE HYPODERMICALLY.*

BY G. HERBERT BURNHAM, M.D. TOR., F.R.C.S. EDIN.,

Associate Professor of Ophthalmology and Otology, Toronto University; Oculist and Aurist to the General Hospital, Toronto, etc.

It is my intention particularly to mention three cases—one of cyclo-iritis of both eyes, of long duration, with the other changes in the eyes usually associated with the long continuance of this disease; a second of iritis of both eyes, with typical diffuse scleroderma; and a third of complete paralysis of the left third nerve, from acquired specific disease.

These I bring forward as exemplifications in a most marked degree of the great value of my combined form of treatment, viz., mercury and the iodide of potash given internally and pilocarpine hypodermically.† To these I could add minor cases. At present I have just received under my care a very severe case of rheumatic cyclo-iritis of each eye with vision, good perception of light only; also a case of inflammation of the ciliary region, retina, choroid, vitreous, leading to almost total destruction of the vision of one eye, and less, though marked, affection of the same structures of the other. This has been caused by masturbation, practised a good many years by a young man, twenty-six years of age. I have also another of acquired specific iritis of both eyes; one, the right, made a permanent recovery, but the left has had for one year or more frequent relapses, thus preventing the man from returning to his employment. The pupil is unable to dilate fully, owing to iritic adhesions. He is now for the first time under my care, and I am using my combined treatment for the sole purpose of putting a stop to these relapses, which I am fully persuaded it will.

CHRONIC IRIDO-CYCLITIS.

My first case is an unmarried woman, fifty-eight years of age. The family history seems to be fairly good. In the spring of 1896, the R eye became inflamed for one week. It then

* Read before the Canadian Medical Association, at Toronto, August 31st, 1899.

† See *Arch. of Ophthal.*, xxvii., p. 175.

became quite quiet, but at the end of one month the left eye became inflamed, and has had similar attacks on and off ever since. The R eye had, also during this time suffered, but not nearly so severely.

She consulted a specialist in the spring of 1897. He used my combined form of treatment for seven injections. The eyes were quieter that summer. In the winter, 1897-98, there were, on and off, severe attacks of inflammation. In the summer, 1898, thirty injections of pilocarpine were given. During these injections she had, she said, several attacks of inflammation of the eyes.

With my experience regarding this case, the combined treatment, then tried, failed because it was wrongly given. She continued the use of internal remedies till November, 1898, when she consulted me for the first time. The condition was then as follows:

Left eye: no perception of light, T —, very shallow anterior chamber, and the tissue of the iris infiltrated and covered with a dull whitish exudation, which also involved the pupillary area, so that no details of the tissue of the iris and the pupillary area could be made out—that is, a dull grayish, homogeneous mass covered entirely the iris and pupillary area.

Right V = less than $\frac{2}{300}$, T +, halos at times, pupil contracted and margins held by fine exudation. A dull, white patch of exudation showed in the pupil and reached down behind the iris, apparently unattached to the pupillary margin; at the upper margin the same condition, but the exudation smaller in size.

My combined form of treatment was begun at the end of the first week in November, 1898. Fifteen hypodermic injections of pilocarpine were given.

December 16th, 1898.—R V = $\frac{2}{300}$ and $\frac{2}{100}$; she says the sight is clearer and the halos are less marked; Tn. full.

February 2nd, 1899.—Returned for another series of injections. R V = $\frac{2}{100}$. The injections were begun but discontinued in a few days as a very severe attack of follicular tonsillitis set in. R eye at once became painful and a little injected, T +, and the two patches of dull, whitish exudation before mentioned came out from behind the iris, and passing through the pupil lay in the anterior chamber well down in front of the iris, but still attached at one end behind the iris. This attack, the only one experienced since the beginning of my treatment, lasted but a few hours. With its cessation the lymph patches again went back into their former position and the eye became quiet. This short-lived attack has been the only one up to the present time, that is, August, 1899, and seems in some way to have been connected with the tonsillitis.

May 27th.—R eye V = $\frac{2}{70}$ less one letter, Tn.

L Tn. full, no p. l.

Now the iris tissue can, for the first time, be seen in some places. Where previously a uniform grayish membrane only could be made out, now the tissue of the iris can be distinctly seen.

She returned August 7th, 1899, for another series of injections.

R eye V = $\frac{2}{70}$, Tn.; eye quiet since her last visit.

L Tn., no p. l. The clearing-up process still progresses most satisfactorily.

This left eye will, of course, never regain perception of light, but the unmistakable evidence of improvement in this lost, degenerated eye again puts beyond dispute the radical and far-reaching effect of this treatment. With respect to this case I was more sceptical regarding the results to be got from my treatment than any other I had yet met with. However, the treatment is having a most beneficial effect, and pursuing exactly the same course for the next two, three, or four years, I expect to be able to chronicle another decided success.

My second, a man, a Jew, William D., aged forty-eight years, is a most typical case of advanced diffuse *scleroderma with iritis in each eye*. This iritis was marked by fine posterior synechias and a thin covering of lymph on the anterior capsule of the lens. The sight was very poor.

He was put under my combined form of treatment the latter part of December, 1898. At present the iritis is very much improved, and the vision decidedly better. As to the scleroderma, in that there has been a steady, uninterrupted change for the better, till now it has reached a stage of improvement which forms a most striking contrast to the pitiable and apparently hopeless condition he was in when I began. This patient is shown in the skin clinic organized in connection with this meeting and held in St. Michael's Hospital, so that you all can see him. I may mention that I have been informed that previously this patient had been an inmate of some of the most prominent hospitals in the United States. I would like the treatment to be tried in lupus and kindred affections.

My third case is of a different type. The specific disease was contracted four years ago and was under treatment for some time.

For about nine months before consulting me the iodide of potash was given. At the end of this time there came this total paralysis of the left third nerve. The patient went to bed apparently in the usual good health. In the morning on arising the eye felt queer, and by nightfall the paralysis, from what I learn, was complete.

At the end of one week I was consulted. After a delay of two weeks I began my combined treatment. I gave fourteen hypodermic injections. At the end of the twelfth, that is, at the end of thirteen days, there was an increase in the movement upwards of the eyelid and a slight movement inwards of the eyeball. One week later, the injections being now stopped, the eyelid could be raised a full two-thirds of the normal amount and the eyeball could be brought to the median line and held there. Three weeks after the first, the second series of injections, seven in number, were given. Diplopia is at six feet. At any great distance the vision is single. Three weeks later there remained only a very slight drooping of the eyelid, and the patient could walk comfortably with both eyes open, up to this time being unable to do so on account of the confusion of images. Two weeks later diplopia is not now made out till the object is at the distance of ten inches. The progress after the use of my combined treatment I consider most rapid, viz., in eight weeks from the beginning of this treatment no diplopia till the distance of ten inches from the eyes was reached. I have no notes since that date, that is, six weeks ago, as the patient has not put in an appearance.

As to the method of administration, my previous articles have, I think, fully dealt with that. I shall only say, tuck well in the bed-clothes along the whole spine from the occiput downwards; and in cool or cold weather put a hot bottle to the feet. Two symptoms of a proper effect are very free perspiration and the free flow of saliva, viz., six fluid ounces to one pint. As to the length of time to continue these recurring series, I name no special limit, but do always advise to go on as long as there is any improvement. In my minor and easily managed cases a few months will suffice, whereas in my severe ones I have continued them for three or four years.

There is one peculiarity in this treatment—that is, that no relapses occur, even in cases in which under the forms of treatment previously used they have recurred frequently and severely. The nerve centres, especially what we term the absorptive system, are most profoundly and directly acted upon in this treatment. Especially marked is this stimulated condition of the nerve centres during the first few hours after the injection. Hence the great necessity of exercising the care I am ever insisting upon.

Having thus been able to produce the effect upon the diseased tissues which I have drawn attention to, it follows that to keep up the desired action we must go on using the remedies, and hence the consistency of advocating their methodical administration, and in severe cases their long-continued use.

In cases of old iritis where there is much damage to the vision through the effusion and organization of lymph, I never do an iridectomy. Instead I cause its absorption by my method with far better vision than by any other procedure, operative or otherwise. In my earliest papers I said that any other organ or part of the body ought to be as easily influenced by this treatment as the eye. This case of iritis with diffuse scleroderma most satisfactorily emphasizes and bears out this contention of mine. It ought to encourage the members of the profession to give my treatment a fair and impartial trial.

In the eye minute changes for the better can very quickly be seen, whereas if the eye were much less easy of observation, a much longer time for the recognition of an improvement would be needed. This must not be forgotten when my treatment is applied to other organs not so easily observed as the eye. Hence patience must then be exercised, as an improvement may sometimes have been going on for quite a length of time before the observer has the changed condition drawn to his attention. This combined form of treatment applies equally to *syphilitic* and *non-syphilitic* affections.

After the many years of close observation regarding this treatment, I now feel that I can, and have a right to, speak emphatically as to its assured, and I might almost say unique, position.

THE REPAIR OF OLD LACERATIONS OF THE PELVIC FLOOR.*

BY M. L. HARRIS, M.D.

So much has been written on the subject of the perineum and pelvic floor of the female, that it would seem almost impossible to present anything new in this connection. My anatomic studies and investigations, together with my clinical experience, have convinced me that much that has been written has been based on imperfect knowledge of the anatomy and mechanics of the parts. Nor is this surprising when it is seen how lamentably defective the text-books on anatomy are in the description of this region.

The pelvic outlet of the male is often well described, while that of the female, even in some of our most recent anatomies, is almost entirely neglected. As the female perineum requires the attention of the surgeon many times as often as that of the male, this must be considered a serious omission.

* Read at the Meeting of the Chicago Gynecological Society.

The old idea of the central perineal body forming the main support of the pelvic contents has long since been abandoned by most writers, and proper attention and study have been directed to the muscular layer with its fasciæ, which forms the true support at the inferior strait.

It still appears difficult, however, for some to properly appreciate this supporting layer, and the value of active muscular action in its maintenance. The layer as a whole may be recognized, but the fasciæ are looked on as playing the chief role in the support. For instance, in one of our most recent and excellent text-books on gynecology, we find this statement:* "It is equally untrue that the muscles, especially the levator ani, furnish a continuous support, *i.e.*, it is unphysiological for muscles to be in a constant state of action. Such tendency would soon destroy their power. The recto-vesical fascia is in itself sufficient when intact to afford the required support." There is much contained in this statement, and as I disagree with it almost *in toto* the various points will be considered in order.

Take the point that "the recto-vesical fascia is in itself sufficient when intact to afford the required support." This, in my opinion, is an error. Fasciæ in themselves never furnish the kind of support here meant. There is not an instance in the human body where a fascia, aponeurosis, ligament or similar structure, unaided by muscular action, sustains for any great length of time any weight or tension. It is an invariable rule when weight or tension is permanently thrown on fasciæ or ligaments, through the loss of muscular power, that these structures yield and lengthen. If the muscles of one side of the back become weakened or paralyzed, scoliosis quickly results, notwithstanding the powerful ligaments binding the vertebræ together. When paralyzes of certain muscles of the leg occur, the ligaments of the arch of the foot and the plantar fascia invariably yield and the arch of the foot is lost. So it is in every instance throughout the body, and so it would inevitably be were the fasciæ mentioned left alone to furnish the support at the pelvic diaphragm.

The second point with which I disagree is that "it is unphysiological for muscles to be in a constant state of action" as "such tension would destroy their power." The direct opposite of this is true. Every normal muscle is in a constant state of activity. This does not mean that every muscle is constantly exerting its full contractile power, but that every muscle is constantly exerting a certain amount of contractile power which varies somewhat in different muscles. Cut any normal muscle and its ends instantly retract. This is called

* Dudley, 1898, p. 438.

muscular tone, but call it what you will it can only be interpreted as the constant exertion of a certain amount of energy due to the continuous activity, in a manner, of the contractile elements composing the muscle. As already stated, the degree of activity varies in different muscles. No one will deny that the sphincter ani practically acts continuously, and that it exerts a greater degree of tension than does the sphincter oris. The length of time which increased or so-called voluntary muscular action may be sustained varies greatly in different muscles, according to habit. For instance, one may sit for hours, reading, totally unconscious of the constant action of the muscles of the body holding him erect, of the muscles of the arm holding the book, and of the eye producing accommodation. Yet some other and less powerful muscular action, to which he was accustomed, would produce fatigue in a very few moments.

The third point in the above statement, namely: "It is equally untrue that the muscles, especially the levator ani, furnish a continuous support," it is evident I likewise dissent from, and in answering the first two, have, at the same time, answered it. My position then is, that the so-called pelvic diaphragm or floor depends for its support absolutely on the practically continuous activity of the intact muscles which enter into its formation, and that the fasciæ are merely adjuncts to the muscles and in themselves entirely inadequate to furnish the support required.

The muscles entering into the formation of the pelvic floor, as has already been remarked, are very imperfectly described in most text-books of anatomy. They may be divided into two layers, an inner and an outer. We will concern ourselves for a few moments with the inner only. This is the layer which enters into the formation of the diaphragma pelvis proprium and is composed of four paired muscles. It is not always easy in the human subject to draw sharp lines of demarcation between some of these muscles at all points, and some knowledge of comparative anatomy is necessary to a clear understanding of them.

Comparative anatomy teaches us that these muscles are the representatives of well-developed, clearly defined muscles which, in the lower animals, are concerned in the movements of the caudal appendage, and which, owing to the loss of the caudal appendage, and the assumption of the erect posture through evolution, have somewhat readjusted their character and attachments to conform to their new function of closing the pelvic outlet and supporting the pelvic contents. These four muscles are called the ischioceccegeus, iliococcegeus, pubococcegeus, and puborectalis.

Briefly, the ischiococcygeus arises from the spine of the ischium and is inserted into the lateral border of the lower part of the sacrum and the upper part of the coccyx. The iliococcygeus arises from the iliac portion of the obturator fascia, and is inserted into the lateral border of the lower part of the coccyx and a median raphe. These two muscles will interest us but little, and will not be further considered.

The pubococcygeus arises from the lower border of the symphysis ossis pubis, from the posterior surface of the body of the os pubis, and from the obturator fascia as far back as the iliopectineal eminence. From this somewhat extensive origin the fibres pass mesodorsad, passing by the urethra, vagina and rectum, lying cephalad of the lower portion of the iliococcygeus, and are inserted with those of its fellow from the opposite side by means of a tendinous expansion into the ventral surface of the coccyx and lower part of the sacrum, the more ventral fibres interlacing directly with those of its fellow as a girdle posterior to the rectum.

The puborectalis lies beneath or caudad of the ventral portion of the pubococcygeus, from which it is separated ventrally by an intermuscular fascia. It arises from the outer lower portion of the symphysis ossis pubis or the beginning of the descending ramus and the cephalic surface of the urogenital fascia. Its fibres usually form a well-defined muscular loop which passes dorsad, encircling the rectum at the perineal flexure, when it becomes continuous with its fellow. In passing by the rectum some of its fibres enter the wall of the rectum, gradually become tendinous and pass caudad as far as the cutaneous surface. A few fibres also pass anterior to the bowel, between it and the vagina, some of them eventually becoming continuous with the transverse perinei muscle of the opposite side.

The pubococcygeus and the puborectalis together form what is usually termed the levator ani muscle, and are the most important muscles of the pelvic floor. They produce the characteristic perineal flexure of the rectum and vagina, and form the chief support of the pelvic viscera. They must undergo the greatest elongation during dilatation of the pelvic outlet for the passage of a child, and, therefore, are most liable to suffer rupture or laceration, as will be shown later. The more ventrally placed fibres pass almost directly ventrodorsad, while on frontal section the muscular plane slopes from the periphery toward the centre and cephalocaudad. In the space between the opposite muscles ventrally pass the vagina and urethra, and it is extremely important to clearly understand the relations of these muscles to the lateral walls of the vagina. The normal virgin vagina is not a simple straight tube. In passing from

without inward the general direction of the vagina, for a distance of 1.5 to 2 cm. within the hymen, is dorsocephalad. At this point a distinct change in direction takes place and the vagina passes almost directly dorsad. The point of angulation lies opposite, and corresponds to, the perineal flexure of the rectum, and is produced by the pubococcygeus and the puborectalis muscles encircling these organs at this point and drawing them forward, or in a ventral direction. With the finger introduced into the vagina one is able to easily recognize the point of angulation, and to distinctly feel the edge of the puborectalis muscle through the lateral wall of the vagina as it passes in its course toward the symphysis.

An incision through the lateral wall of the vagina 1 to 2 cm. to the inner side of the hymen or its remains will expose the median edge of this muscle. It may easily be dissected up almost from its origin from the symphysis ossis pubis to the rectum, and in passing by the vagina its fibres do not enter or form an attachment directly into the vaginal wall. The muscle varies from 3 to 6 mm. in thickness, and extends, in connection with the pubococcygeus, latterly to the wall of the pelvis the plane in the transverse direction being oblique to the wall of the vagina.

That portion of the vagina lying internal to the point of angulation or perineal flexure, and which composes by far the major portion of the canal, lies in its ventrodorsal plane almost parallel with the muscular plane and rests on it, the rectum alone intervening.

Contraction of the muscles of this layer tends to increase the perineal flexure of the rectum and vagina by drawing the parts in a ventrocephalic direction, and the opening through the muscular floor is thereby maintained ventrad of the line of gravity. The weight of the pelvic organs is thus brought to bear on the muscular layer of the pelvic floor. That mass of tissue ordinarily called the perineal body lying between the rectum and vagina, and extending from the muscular floor of the pelvis to the cutaneous surface, has little or nothing to do with sustaining the pelvic organs.

We will now proceed to a consideration of those lesions of the pelvic outlet resulting from extreme dilatation. It is sufficient to say that they are produced by the passage of the child during labor, without attempting to explain the mechanism. We may divide these lesions or lacerations into three classes: (1) Those involving the muscles of the pelvic floor. (2) Those involving the tissues between the lower end of the rectum and vaginal opening, external to the muscular layer. (3) A combination of these two.

Lacerations of the first class may be compound, by involving

the mucosa and wall of the vagina, or they may be entirely submucous. Each of the varieties may vary greatly in degree. This is a practical division of all lacerations, and such elaborate classifications as are found in some text-books—as, for instance, in Byford's twenty-three distinct varieties of laceration are described—are confusing and without importance. Lacerations of the second class are usually of little importance, except from a cosmetic or perhaps hygienic point of view, and they will not be further separately considered here. Our remarks will be limited to old lacerations of the muscular plane.

Schatz* was one of the first to call attention to lacerations of these muscles and the ill effects which followed the loss of muscular support. Since then many others have written about lacerations of these muscles with their fasciæ, but most of their statements have been founded on opinion unsupported by anatomic demonstration, hence are not always strictly in accord with the facts. As the caudal end of the spine in the human subject is much less movable than in the lower animals, we find the muscles which were active in moving this appendage in animals gradually becoming more fibrous or fascial in character in man as we approach the spine. As the extent of motion of the pelvic outlet or degree of laceration produced by the passage of the child at birth increases markedly as we proceed ventrally, we would expect to find lacerations more common and of greater degree in this portion of the pelvic floor; and such is true.

The puborectalis and ventral portion of the pubococcygeus are the muscles which must undergo the greatest elongation. In all cases of relaxation of the pelvic floor in which I have resected these muscles I have found lacerations of greater or less degree. Lacerations may take place in any portion of the length of the muscles, but are more common in that portion of the muscle which passes across the lateral wall of the vagina. It may be that the parietal bosses or the blades of the forceps are instrumental in determining, to some extent, the location of the laceration. The location of the laceration in the muscle does not necessarily correspond to the location of the tear in vaginal wall, and the muscle may be extensively torn without the vaginal wall giving way at all. In fact, many, if not a large majority, of the muscle lacerations are entirely subvaginal.

The lacerations may be multiple or single. Numerous slight lacerations may take place, as shown in the specimens under the microscope. Here the separation from any individual tear is slight, but taken altogether produces considerable lengthening of the muscle. We may have a single, complete, transverse tear of the muscle, with wide separation of the ends.

* *Archives f. Gyn.*, 22.

This is a complete laceration of the left puborectalis with the ends separated at least 1 cm. The laceration may take place opposite the dorsolateral junction of the vagina, and then corresponds to what some writers term detachment of the levator ani from the rectum. It is not a detachment of the muscle from the rectum, but a laceration of the puborectalis, just as it is about to curve posterior to the bowel. Lacerations may be lateral or bilateral. The effect of lacerations of these muscles is to produce a lengthening of the muscles with a loss of their mean effective contractile power. As a result the ventrocentral portion of the pelvic floor moves in a caudodorsal direction. The vagina loses its perineal flexure or angularity above mentioned. The major portion of the vaginal canal, instead of lying in a nearly transverse plane, slopes ventro-caudad. The posterior vaginal wall recedes from the pubic arch, and the ostium vagina is enlarged and lax. The finger no longer feels the firm edge of the puborectalis as it crosses the lateral vaginal wall. The perineal furrow has lost much of its depth, and the anus, instead of being cut by a transverse line extending between the tuber ischii, lies posterior to this line. It is not the object of this paper to discuss the remote effects on the pelvic viscera of this change of position and loss of tone in the pelvic floor.

The lacerations of the muscles may be associated with lacerations of the true or cutaneous perineum, or this part may be intact. The correction of the condition resulting from these lacerations of the muscles must be sought in shortening the muscles torn; in a removal of the cicatricial tissue intervening between the separated torn ends, with a restoration of the continuity of the muscles.

The Emmet operation and all denudation methods of the vaginal orifice, which are the operations in almost universal use to-day, fail to restore, in any degree, the real pelvic floor. They are suitable in lacerations of the so-called perineal body, but not when the muscles are torn. The method which I wish to present involves a resection of a portion of the puborectalis muscle so as to shorten up the pelvic floor. It is performed as follows: When laceration of the perineum is present, the denudation of this part is made in the usual manner. If this body be intact the denudation is omitted. An incision is then carried up each lateral wall of the vagina from 3 to 5 cm., a little posterior to the centre. The vaginal wall is raised in a flap each way from the incision. The edge of the muscle can now usually be felt, and an incision parallel therewith is made through the perivaginal connective tissue, exposing the muscle, which may easily be dissected out with the handle of a scalpel, blunt dissector, or the finger, ventrally as far as the symphysis

and dorsally until it curves around posterior to rectum. Should the muscles have been so ruptured and its ends so retracted that its edge cannot be distinctly felt, the incision is made along the line which the muscles should occupy, and careful dissection made for separated ends. The ends of the muscle will be found connected by cicatricial tissue. I have not yet failed to find the remains of the muscle even when badly torn, and the ends widely separated.

The muscle may vary considerably in thickness, and, when very thin and ribbon-like, it may be torn by a careless dissection. When multiple small lacerations are present, the muscle will not be entirely separated at any point, but will be lengthened, loose and relaxed. In width or distance laterally, the muscle may be dissected from 3 to 5 cm. When it has been well freed, forceps should be placed on either side of the portion to be resected, so that the ends when cut shall not retract out of reach. The portion resected should correspond to the point of laceration if found, or when no distinct separation is found, to about the centre of the muscle. The extent of the piece resected will depend on the amount of separation or the degree of lengthening and relaxation. It should be sufficient so that when the ends are drawn together the floor of the pelvis will be restored to its normal position and degree of tension. The ends of the muscle are then sutured together with an interrupted or continuous catgut suture which, of course, remains buried. The opposite side is treated in a similar manner, when the incisions in the lateral walls of the vagina are closed by a catgut suture. This latter suturing should be thoroughly done so that no openings will remain through which fluids or infection may reach the deeper parts. When the perineum has been torn, this is closed in the usual way. I generally close the deep portion with a buried catgut suture, and then use silkworm gut for the cutaneous surface. The hemorrhage, in dissecting and dividing the muscle, is sometimes free but never great. It is very essential that all hemorrhage be completely controlled before closing the wounds, so that a hematoma may not develop in the deep parts and compromise the results of the operation. The subsequent care is that usual after a perineorrhaphy.

This operation restores the pelvic floor to its normal position. The vaginal opening is carried ventrad, the angularity or perineal flexure of the vagina returns, the posterior wall of the vagina loses its sagging and becomes more nearly horizontal again, and a good support is re-established. The clinical results have been very good. The muscles retain their active contractile power, and their elevating and sphincteric action at the vaginal opening is again restored and well maintained.

Clinical Note.

ANTISTREPTOCOCCUS SERUM IN MEASLES.

BY M. EDGAR GILLIE.

Thinking that my experience might prove helpful to some others, I submit a report of the following case: Myrtle Lee, aged 6, contracted measles somewhere about March 6th, during the epidemic which prostrated several hundred of the children in our city. No physician was called until March 14th, when I was asked to see her. I learned that the rash had appeared on Saturday the 10th. Upon examination I found the rash well developed. Temperature, 103°; pulse, 120; respiration, 35 per minute. Her respiration was mostly nasal, and quite labored. She had a short hacking cough. Examination of chest revealed nothing of importance. Her eyelids were sealed together firmly. Tongue was brown, dry and leathery, and teeth covered with brownish sordes. The bowels had moved during the previous night, and she had urinated several times in her napkin. The mother stated that she would not swallow any form of nourishment, not even water, during the last twelve hours, and that there had been constant delirium during that time. I left a simple fever mixture, to be used every two hours, and ordered cold sponge bath every four hours. Next morning, the 15th, her condition was still more serious. Pulse, 160; temperature, 104°F.; respirations, 55 to minute; cough not quite so persistent. She had been unconscious with delirium and carphologia during the whole night: also had evacuated bowels and bladder involuntarily. The mother was urged to persist with the cold sponging, and we managed to get some whiskey (1 to 8 of water) swallowed. Rectal nourishment was suggested, but the mother did not approve. By night her condition was marked by two changes (1) greater prostration; (2) a fall of temperature to 100°F. I now decided that she would die under ordinary circumstances, and suggested serum injection. At eight o'clock (p.m.) 10 c.c. antistreptococcus serum, P. D. & Co., were injected into buttock (after well washing with alcohol solution). Other treatment continued as usual. At my next visit in the morning, March 16th, the child was decidedly improved. She would answer questions; open her eyes—considerable photophobia still being present, however. Tongue was nearly cleaned off. She drank water greedily; bowels had acted twice during the night; urination about normal. Her temperature, 103°F.; pulse, 120;

respirations, 35 per minute. At four o'clock (p.m.) another injection of 5 c.c. made into opposite buttock. Improvement now continued rapidly, although temperature kept up to 103°F. until Sunday morning, forty-eight hours after last dose of serum, when it fell to normal. Cold sponging was used freely during the period of high temperature. No examination of urine was possible, as we were unable to obtain a specimen. The following points seem worthy of note in this case:

1. No form of nourishment was given other than whiskey, until she sufficiently recovered to ask for it herself.

2. The rise of temperature from 100°F. to 103°F. under the serum treatment, indicating reaction to the antistreptococcus. No local trouble at site of injections whatever.

3. The rash was very general and profuse, and was marked by large brownish blotches, which faded very slowly.

HAMILTON, ONT., March 20th, 1900.

Selected Article.

NOTES, CHIEFLY CLINICAL, ON BRIGHT'S DISEASE AND ITS TREATMENT.*

BY G. A. GILBERT, M.D., DANBURY, CONN.

In past years, the strongest clinical evidence to the diagnostician of the existence of Bright's disease in any given case has been the presence of albumin in the urine, usually determined by heat or the nitric acid test. But, inasmuch as all simple proteids are precipitated from solution by an excess of nitric acid, and as all but traces of nitrogenous waste matter are eliminated through the kidneys, it might be well to use the more general term "proteids," in the place of the historical albumin. Chemically considered, albumin is a complex ureide containing one-fifth of its nitrogen in the form of urea. The presence of urea in the urine excites no apprehension, but on the contrary is considered normal, the adult human being eliminating about 30 grams daily as an expression of nitrogenous waste. In case of incomplete combustion, however, or faulty elimination of effete material, we have uric acid as a product; which, occurring as it does in the form of insoluble urates, is mostly retained in the circulating medium, serving as a source of irritation to both kidneys and liver, thus initiating the protean symptoms hitherto classed under the generic term "uric acid diathesis;" while, in the more advanced stages of mal-elimination, as in Bright's disease, much of the urea itself is retained in the circulation, giving rise to the well-known symptom "uremia." In an article on this subject published in the *New York Medical Record*, August 26th, 1899, Walter Sands Mills, M.D., defines Bright's disease as "a disease characterized by degeneration of the kidneys, whereby the excretory function is so impaired that urea is not sufficiently eliminated by the blood." In other words, he considers, as does Semmola, that the changes in the kidneys are the result and not the cause of the disease. In the Goulstonian lectures delivered before the Royal College of Physicians, in March, 1898 (*Cf. London Lancet*, March and April, 1898), John Rose Bradford, M.D., devoted some attention to the subject of uremia, and, in summing up, says: "It is probably due to some abnormal product of disordered metabolism." Commenting on this statement, Dr. Mills continues: "The following facts comprise the

* Reprinted from the *Massachusetts Medical Journal*, September, 1899.

sum total of our knowledge of the pathology of uremia," to wit: "1. Before an outbreak of uremia, there is a diminution in the amount of urea excreted by the kidneys. 2. There is an increase in the percentage of urea in the blood."

It is becoming more evident from day to day, as the question receives scientific consideration, that the presence in the blood of uric acid and urea, and in the urine of uric acid and albumin, indicates abnormal conditions that differ only in degree. There exist the same evidences of faulty metabolism; and, in both cases, owing to its having been forced to attempt the work of other organs, the kidney is found to be incapable of performing its excretory function in a proper manner. In one case, this important organ indicates simply the incipient stage of inflammation, *i.e.*, high arterial tension and evidences of proliferation of connective tissue cells; in the other, the stage has become more advanced, *i.e.*, the inflammatory process has already begun and its products infiltrated into the interstitial tissue of the organ itself. It is evident, therefore, that the treatment should be directed toward relieving that organ of all impossible efforts; to accomplish which the insoluble urates should be rendered soluble, while the entire alimentary tract should be urged to perform its duty, and perform it unusually well, the liver being stimulated to action and the bowels kept open and free from all extraneous and poisonous matter. Furthermore, albuminous foods, especially meats, should be largely interdicted, and a milk or vegetable diet substituted in most cases.

The medicinal treatment of Bright's disease has usually proved unsatisfactory from the fact that too little attention has been paid to its real cause. It is probably owing largely to their extreme fondness for red meats and high living that the English-speaking people are so prone to this dread disease, while strict vegetarians, like the Chinese, are comparatively free from its ravages. (The variable climate is, of course, another factor.) It is obvious that by restricting the diet principally to the carbo-hydrates there will be less manufacture of uric acid, and necessarily less retention of its salts and urea in the circulation. In case, however, of the actual retention or presence in the blood of either of these toxins, it behooves us, as careful physicians, not only to recommend a fixed diet, but to prescribe a remedy which will readily form soluble urates, thus relieving the terrible strain upon the kidneys, and at the same time, a remedy hydragogue in action in order to stimulate the flow of bile and institute a free movement of the bowels. For this purpose the laxative salt of lithia, thialion, has been found efficacious, having been used in several instances with unusually favorable results.

At a meeting of the Danbury Medical Society, October 12th, 1898, during the discussion which followed the reading of a paper by George E. Lemmer, M.D., entitled "Uric Acid in the Blood: What Does it Lead to and How Can we Eliminate it?"* William C. Wile, M.D., presented a letter on this same subject written by Hamilton Kibbee, M.D., a distinguished physician of Oblong, Illinois, wherein the latter said:

"I believe we are all wrong about the treatment of interstitial nephritis. I don't believe the albumin tests are of much value. The thing to keep the finger on is the test for urea, Doremus test the best. The excretion of urea is the barometer that indicates improvement or contrary. I think that excess of urea [in the circulation?] is the cause of the nephritis, and that the local trouble in the kidney is due to excessive uric acid in the blood. . . . Let us get rid of the urica; there can be no question but this is the first and most urgent requirement, while the second thing would be to stop the excessive accumulation of uric acid. That thialion will get rid of these toxins I have demonstrated."

Continuing his letter Dr. Kibbee says:

"Fully expecting to be disappointed in the results, I ordered four ounces of thialion for use in my son's case. He is a young man twenty-three years of age, who was taken with albuminuria about seven months ago, while at work in Chicago. For several weeks he was under the treatment of Dr. Purdy, the distinguished specialist and author of note on diseases of the kidney. By the advice of Dr. Purdy, I finally brought him home, where he has remained, improving in general health greatly by proper diet and rest. I have battled with this case with all a father's anxiety, and have grasped at everything which offered hope, but nothing has ever relieved the uremic symptoms like thialion. Its action has given me the greatest encouragement. His most troublesome symptoms were flushing of the face, congestion of the eyes, pulsation of the temporal arteries and beating of the heart against the chest wall. There was great restlessness and sleeplessness, throwing himself over the bed and moaning. The urine was sometimes (usually) profuse, specific gravity 1010, and it contained always about one-fourth of one per cent. albumin. Urea, by Doremus test, was less than 500 grains in twenty-four hours. If he exercised it brought on pulsation with increased arterial tension and dizziness. I began the thialion about fifteen days ago and within three days I could see improvement. His flushed face has disappeared and his eyes are now normal. For the first few days he had pulsations, but they lasted only about half an hour, and for the past three days he has had no

* Published in the *New England Medical Monthly*, November, 1898.

pulsations whatever, and he says he feels better than he has for a year. I cannot tell you how thankful and hopeful these results have made me, I tremble lest the benefit should only be apparent and not real.

'The boy was morose, despondent and hopeless; now he is his natural self again.'

The above letter was written on the 9th of September, 1898; and one month and three days from that date the doctor writes again:

"My son has continued to improve up to Friday of last week, when he started to spend the winter with his brother, Kent V. Kibbee, M.D., Professor of Chemistry in the Medical Department of Fort Worth University, Fort Worth, Texas. For two weeks previous to his departure he had no flush, headache or other symptoms connected with his kidney trouble and his urine in every respect was perfectly normal, even to excretion of urea. Though he suffered from a painful jaw, as the result of the extraction of an ulcerated tooth, he had no nervous symptoms, and insisted upon making the trip. He left here on Thursday and St. Louis on Friday morning, reaching Fort Worth on Saturday night. I had a letter from his brother, who visited us in October last, and he informs me that the boy got to Fort Worth in good order, and that he is greatly surprised at the improvement in his condition since he saw him last in October."

In commenting on this letter, Dr. Wile made the following remarks:

"Dr. Kibbee's words convey to us information which ought to prove valuable; certainly the results are remarkable. The trouble is that we have been growing more and more a gouty people, due to the fact, largely, that meat being cheap with us, we eat it in excess. The profession has long been looking for a reliable remedy to combat the multitude of ills directly traceable to an accumulation of uric acid in the blood, one which when ingested will convert the insoluble phosphates, oxalates and urates into a soluble compound which can be readily eliminated. This subject confronts the general practitioner daily as he goes his rounds. He has grasped at everything from pure waters down to dangerous drugs with but little avail, and I believe in thialion he has an invaluable agent for good."

The following case, reported by E. M. Smith, M.D., of Newtown, Conn., appeared in the *Journal of Science and Medicine*, May, 1899:

"Mrs. B., American, aged 47, now passing menopause, is recovering from acute nephritis—urine scanty, high in specific gravity, exceedingly acid, liver torpid and inactive, bowels

sluggish, torpid and inactive; a marked degree of mental hebetude.

"This patient gave me considerable anxiety, inasmuch as I had given her almost all the diuretics with indifferent results—a little better now, not so well a little later.

"I finally put her on thialion in teaspoonful doses thoroughly dissolved in a cupful of hot water each morning, insisting upon the dose being taken as soon after waking as possible, and to be drunk as hot as she could. It was but a few days before improvement began all along the line. There was a general amendment—urine increased in quantity, and nearly approached the neutral line, bowels acted in the most satisfactory manner. In this case the liver played an important part. This was stimulated until the stools became like that of the child. Mind cleared up, becoming very natural. She is now on the way to complete recovery, though I still insist that she take thialion three or four times in succession every two weeks. In this case the different symptoms, added to the mental condition, made it doubtful whether she could ever recover, but I feel confident that this most happy result will take place."

A plan of treatment similar to the above was observed in the following case of "Chronic Interstitial Nephritis Accompanied with Melancholia," as reported by William B. Mann, M.D., of Evanston, Illinois, in the *New England Medical Monthly*, October, 1898:

"Mr. J., aged 49, had for several years been a sufferer from asthma, headache, loss of appetite, constipation, fetid breath, copious discharges of offensive mucus from both nose and mouth, heavy dragging pains over the kidneys, puffiness of the feet and face, especially under the eyes, and insomnia. There were also frequent attacks of extreme melancholia, which were so depressing that the patient would have weeping spells, followed in a day or two by delusions of persecutions from an imaginary foe. He seemed at times on the verge of insanity. The pain in the region of the kidneys he described as constant and severe.

"An examination of the urine revealed the fact that the quantity voided was below normal and contained a small quantity of albumin, hyaline casts, an excess of uric acid and the urates. He was badly emaciated and had a history of three years' illness. A more careful examination of the urine revealed the following: Quantity diminished to twenty ounces; specific gravity diminished; solids diminished; albumin present in considerable amount; urea diminished 50 per cent.; pus corpuscles and epithelium present; tube casts in small amount. Taking the case altogether it was one of the worst I was ever called upon to attend.

"After ten days' treatment with thialion, the urine became almost normal, both in quantity ($3\frac{1}{2}$ pints), and also chemically. I commenced a systematic course of diet, carefully avoiding that which would increase the irritability of the kidneys, at the same time building him up to the fullest extent. I gave him a teaspoonful of thialion three times daily, dissolved in a glass of hot water and the result was immediate and clearly apparent to physician and friends. It is unnecessary for me to state that his bowels, liver and stomach were thoroughly cleared out by this medicine. The acid eructations which had been so persistent rapidly passed away. After ten days' treatment the patient said: 'You have done me more good in this short time than I have received heretofore in all my treatment by a number of physicians, some of whom stand very high in the profession.'

"One of the remarkable features of this case was the fact that nothing else was used but thialion; that all the depressing symptoms passed away, and, of course, the crying spells with them. Since this time the improvement has been steady, and though the case from start to finish has been an unpromising one, still I am satisfied a cure is certain."

A case somewhat like the above, and one that is of sufficient importance to be cited in this connection, has been treated by the writer recently in a similar manner, and with equally gratifying results, to wit:

"Mrs. W., widow, American, aged 60, appeared for treatment in August, 1898, bringing a sample of her urine and giving the following history:

"Since her menopause, ten years ago, she had been gradually failing in general health. She first noticed attacks of vertigo, flushing of the face, irregular heart action and headaches. Her appetite became poor and she was obliged to refrain from eating meat, which had always been her main article of food, but which now, for some reason, 'did not agree with her,' causing 'hot flashes,' etc. Her ankles became swollen, and latterly she has complained of dropsy of the abdomen and some dyspnea. She has spent sleepless nights and admits that she has become extremely nervous and feels at times like committing suicide. Her hearing and eyesight were both rapidly failing, and at times she saw 'dark specks' floating in the air. Her strength was gone and she was unable to do her housework. During the past two years she had consulted four local physicians and a New York specialist.

"Physical examination revealed some tenderness on pressure over the region of the kidneys. There was extreme pallor of the skin and prominent dark rings under the eyes. When talking the patient frequently wandered from the subject,

seeming to be unable to concentrate her attention, though she was evidently an intelligent woman. The urine was scanty, rather high colored, and contained considerable albumin and some casts. Calcium oxalate crystals and the urates were also present in abundance, and there were the usual indications of a torpid liver. Obstinate constipation was admitted on questioning. The most striking features, however, to a general observer, in this case, would undoubtedly be the anemia, weakness, and rambling conversation.

The patient was at once put upon thialion and a milk diet, the former being prescribed in half-teaspoonful doses in a teacupful of hot water three times daily until four ounces were taken and the urine had become markedly alkaline. The medicine was then omitted for two or three days, when it was again prescribed and taken in the same manner as before. At the end of the first month the urine had increased greatly in quantity and indicated a loss of at least 50 per cent. of the albumin. The patient reported improvement in every respect, and expressed her gratitude in glowing terms for the speedy relief she had obtained. She soon afterward removed to New York, and the case was lost sight of until a few days ago, when her son, by request, visited the office and made the following statement:

"My mother, when she went away, had with her two bottles of the medicine, which she took according to your directions until it was all gone. She then felt so much better that she considered it unnecessary to take any more. She is now able to do her sewing and housework herself, and talks as lucidly and clearly as she ever did. Her urine was recently examined and only a trace of albumin was found. She is not nervous, sleeps well at night, eats well of everything but meats, and looks as well in the face as she did before she was taken sick. She says she believes that the disease has been permanently checked, that she is likely to live for many years yet, and finally die of something else."

Society Reports.

TORONTO CLINICAL SOCIETY.

STATED MEETING, MARCH 7TH, 1900.

The President in the chair.

Fellows Present: Drs. Aikins, Peters, King, Primrose, Small, Trow, Lehman, Oldright, Thistle, Fotheringham, Rudolf, Silverthorn, Pepler, Fenton, McCollum, Dwyer, Boyd, Hamilton and Elliott.

Visitors: Dr. Clarence Starr; and Dr. Spence, of the Toronto General Hospital.

Nominations: Dr. C. B. Shuttleworth and Dr. A. Y. Scott, by Drs. Fenton and Pepler.

Nominations for officers for 1900-1901 will be held in April.

Cases Illustrating Operative Procedure in Tuberculous Disease of Knee.

Dr. A. Primrose presented two patients, one a young man of nineteen years and the other a boy of eight, showing different forms, the first one complete excision and the second a case of erosion. The first patient came under his care in July, 1894. Three years prior thereto great swelling occurred in the knee-joint, and patient was treated at that time by rest and the application of a Thomas' splint. Became apparently well under this treatment until February, 1894, when the trouble again appeared. Under somewhat similar treatment he became gradually worse, and at the time he came under Dr. Primrose's care there was very advanced disease of the knee-joint. At that time the knee was flexed at an angle of 100 degrees, with little or no pain unless on manipulation, when there was a slight amount of pain; there was also marked atrophy in the muscles of the thigh and leg—very pronounced symptoms of extensive tuberculosis of the knee-joint. He was treated by rest and the Thomas' splint: improved for a time, but during the next two months improvement did not continue and abscesses formed. He again came under the surgeon's care in February, 1899, and at that time he had sinuses in connection with the knee-joint. One sinus existed in the popliteal space and one to the outer side of the joint, both discharging pus; and there was a great deal of thickening about the synovial sac of the joint. The operation was an extensive one. In the first place the surgeon concluded that the best thing to do was, where one found the joint stiff, to attempt, with a

certain degree of force, to break down the ankylosis; because ankylosis, which occurs during the course of the disease of the knee, is usually not firm and readily yields. This was done above and below the joint. The surgeon here exhibited the specimen of bone removed, which consisted of the lower end of femur and upper end of tibia, each about an inch in length, and the posterior part of the patella. When broken down it fractured obliquely, exhibiting a carious cavity showing tuberculous material. The operation was commenced with an U-shaped incision, the large flap being turned up, the joint exposed and the mass of diseased bone removed. Excavations were scooped out in both tibia and femur until healthy bone was reached. Then the operation was concluded by dissecting away all the tuberculous tissue about the joint. There was considerable bleeding after the operation and the general condition of the patient was anything but satisfactory. The anterior wound healed up well. In order to secure union and osseous ankylosis, wiring was performed on one side alone, because of the lowness of the patient under the anesthetic. There is just the amount of flexion one would wish to have in these cases. There is firm ankylosis so that he can put the foot firmly upon the ground. In December last he had a sinus in the popliteal space and the surgeon determined to enlarge it. A small cavity in the bone was found, which was curetted. The anatomical relations were fairly confused of course, the external popliteal nerve being somewhere near. The sinus was stretched forcibly and the nerve was implicated, and an extreme neuritis was set up, with great pain on touching the sinus; and complete paralysis of parts supplied by this nerve. Subsequently this returned. He had reaction for faradic electricity. Whilst at first it took 25 milliamperes to cause any contraction, the muscles now react to less than 12; and from Dr. Dickson's experience that gradually decreases in the strength of the stimulus. This necessarily gives an extremely favorable prognosis, and in all probability he will recover in time most of the functions of the external popliteal nerve. When he stands up you can see how firmly he can come down upon the foot; he has firm, bony ankylosis, and the case illustrates how much can be accomplished in tuberculous trouble in the knee-joint. He will have a good useful limb. Sensation has returned, but he cannot extend the toes.

The second case exhibited was that of a boy about eight years of age, and was one of those cases where there is tuberculosis of the synovial membrane, and apparently confined to the membrane; no disease in the joint itself. This had become progressively worse, and he had been under treatment for considerable time—rest, extension, etc., but did not improve. In

May, 1898, the surgeon performed the operation of erasion, as described by Mr. Cheyne, viz., an H incision—two vertical, an outer and an inner incision, and a cross incision. The patella was sawn across and two flaps turned up and down, thus exposing the whole of the joint without any difficulty. The synovial membrane was pulpy and very much thickened, to the extent that it was impossible to make a clean dissection of the anterior part of it. The specimen was shown to the Fellows. The lateral ligaments were examined and tuberculous disease found there, and the greater part of the crucial ligaments were also destroyed. The joint was thoroughly cleaned out, as regards the tuberculous disease. Then the wound was stitched up and plaster-of-Paris splints put on. The first dressing was done six weeks after, the splints removed and the stitches taken out: the wound had healed by first intention. It was kept in plaster for considerable time, and now the boy is going about having a good use of the joint. Dr. Primrose had expected ankylosis, but the boy has a good degree of movement. He can walk wonderfully well, which is an interesting feature in the case. The limb on the affected side is half an inch longer than that on the sound side. This, the surgeon thought, to be due to irritation at the line of epiphysis, causing increased growth not going on to disease or destruction. This is an extremely interesting point in this case. Speaking again on the first case, Dr. Primrose stated there never were any reactions to galvanic electricity. It reacted to faradic electricity readily.

DISCUSSION.

Dr. Bingham thought that Dr. Primrose ought to be congratulated on both results. In the first case he would have been tempted to perform an amputation at once. The fact of having secured such an excellent result by incision should be encouragement in these cases. He had come across more than once lengthening in these cases, and thought the version given by Dr. Primrose the correct one.

Dr. Clarence Starr stated he had followed the case from the beginning, speaking of the latter one, and his angle of extension is now 165 degrees. It is a question whether that is not increasing until it goes on and gets in the neighborhood of a right angle. He should be watched carefully to see if that occurs, and if so he should be put on an apparatus to get the angle extended again. Excision in a child of that age is not to be desired if it can be avoided. He has seen all the way to eleven inches of shortening in these cases, and in a case like that it would have been better to have performed an amputation. He thought the final result in this case excellent.

Dr. Fotheringham spoke regarding the lengthening of the leg in the second case, and said it could be proved from other cases that the lengthening occurred in those in which the disease occurs in the synovial membrane. If it occurred in the bone in the neighborhood of the epiphysial line you would inevitably have shortening.

Dr. W. H. B. Aikins asked whether the patient in the first case would not have been better off with the leg off. Is it better to have a stiff leg than a good artificial one?

Dr. Rudolf asked in regard to the electrical reactions in the first case: Did the galvanic current cause no contractions?

Dr. Primrose: It will react to galvanic, but did not cease to react to faradic electricity. If the nerves are paralyzed it reacts to galvanic, whilst if the nerves are present it will react both to faradic and galvanic.

Dr. Primrose, in reply: With regard to Dr. Aikins' question he would prefer to have a limb which was attached permanently than one which would be constantly wearing out and giving trouble through misfit and such like things. A firm, stiff, stable limb—firm ankylosis—he considered better than an artificial one.

Serious Wound of Skull and Acromion.

Dr. William Oldright presented a boy of twelve years who had been attacked in September last with a knife, the blade of which was about thirteen inches in length, having a handle five inches in length. He had a triangular piece of bone cut in the vertex about $1\frac{1}{2} \times 1\frac{3}{4} \times 1\frac{3}{4}$ inches and a number of other cuts, nine in all, mostly in the occipital region. There was also a large wound through the acromion process. The strength of the shoulder-joint is not impaired in any way.

Appendiceal Abscess.

Dr. Oldright also exhibited this specimen, removed after eleven successive attacks of pain and colic.

Symposium on Hysteria.

Dr. J. T. Fotheringham read notes of a case. (See page 171.)

Dr. W. H. Pepler read notes of a case of what he considered to be hystero-catalepsy in a child five years old. There was nothing especially interesting in the family history, except that the father appeared to be decidedly neurotic. The child was a full-term child; walked at ten months; talked at nine months. An attack of measles noticed at two years of age; no complications, no sequelæ. Never suffered from indigestion nor constipation to any extent. About a year ago the child

was taken suddenly with an attack of stiffening of the limbs, both arms and legs, and blueness in the face. She is far advanced for her age, intellectually. More like a child of fifteen years. Present attack came on about 6.30 p.m. one day immediately after being refused some article at the tea-table. She fell forwards with her head on the table. On the doctor's arrival she gave the appearance of a healthy child apparently asleep—eyes closed, muscles all relaxed, eye-balls turned up in the natural position of sleep, pupils slightly dilated, but equal, responding slightly to light. The pulse was regular at 80; respiration at 17. The mouth was opened quite easily; tongue clean. There was no urine passed during this condition. On raising the arm it would be kept in that position from 20 to 30 seconds. Then it gradually fell. An enema was given and the child ordered to be kept quiet. Two hours afterwards it awoke.

Dr. W. B. Thistle said he had been impressed with the presence of ankle clonus in the case of Dr. Fotheringham, as many authorities seem to think that that is not consistent with the diagnosis. He recited the history of several cases and dwelt on the difficulty of diagnosis in these cases.

Dr. Rudolf confined his remarks to prognosis, and stated it was necessary to be careful in diagnosis to eliminate the presence of organic disease. He recited several cases illustrating this, which also had a bearing on the prognosis. As regards death intervening the prognosis was nearly always favorable. Recovery was not so good.

Dr. Dwyer emphasized the importance of eliminating organic disease being present, and gave several apt illustrations proving the necessity of employing great care in excluding the organic factor. He was inclined to think also that the reports of a rise of temperature were not substantiated with solid and accurate facts.

Drs. Primrose and Oldright contributed to the discussion by referring to cases seen by them.

Dr. Fotheringham, referring to the question of age: Hysteria coming on after puberty is not recovered from to the same extent as that occurring before that age. The medicinal treatment was not of much use; the suggestive treatment was the best. Hypnotism, especially in children, was of no service. He closed the discussion with an allusion to the diagnosis.

GEORGE ELLIOTT,
Recording Secretary.

PATHOLOGICAL SOCIETY.

FEBRUARY 24TH, 1900.

Dr. J. J. Mackenzie in the chair.

Present: Drs. Anderson, Peters, Goldie, Parsons, Amyot, Silverthorn, Bruce, Rudolf, Primrose.

Visitors: Dr. Scott, Mr. Walker, Mr. Marlow, Dr. King Smi h.

Dr. Amyot:

Sarcomatosis of Peritoneum.

Briefly mentioned the conditions found were: Hypospadias—hematoma of left testicle. Large cyst of head of epididymis of right side, and large retro-peritoneal mass. Kidneys normal. Ureters normal, not dilated. Lymph glands were examined and show no extension of the growth. The peritoneal growths are spindle-celled sarcoma. In mesentery there are numerous nodules. Same form of sarcoma in all sections examined. The liver itself was free from growth, but the peritoneum over liver (right lobe) shows nodules. Thorax free from metastasis.

Dr. Amyot thought left testicle was primary seat. There are other cystic enlargements along the left cord.

Microscopic preparations of the growths were shown.

Dr. Anderson, discussing Dr. Amyot's specimen, thought the primary focus was in the large tumor masses behind the peritoneum, with secondary infection of the testicle and cord, rupture of the cystic sarcomatous masses and implantation throughout the peritoneal cavity.

Drs. Mackenzie, Parsons and Bruce also discussed the case.

Imperforate Anus in a Pup.

The animal lived four days. The anal pit and rectum well seen. The tail is wanting, which is interesting. Normally the anal opening is first on the back, then it is folded under, the caudal end then grows out and folds downward.

Dr. Mackenzie discussed the case.

SPECIMENS—DR. AMYOT AND DR. D. K. SMITH.

1. *Tuberculosis of Cow.*—Specimen of omentum showing large tubercular nodules or masses, many being from one-half to an inch in diameter, and some were supported by a cord-like pedicle. Sections showed a large amount of fibrous tissue; giant and epitheloid cells were present.

2. *Tuberculosis of Pleural Membrane.*—Many were distinctly separated from one another, while in areas large numbers ran together forming large tubercular patches.

3. *Lung*.—Specimen showed markedly the large amount of interlobular fibrous tissue peculiar to lung of ox.

4. *Pericarditis of Ox*.—Section through right side of heart. The pericardium was greatly thickened, about three-eighths of an inch in some places. The cause of the pericarditis was a foreign body; a piece of nail or wire was swallowed, lodged in stomach, then ulcerated its way through stomach wall and diaphragm into the pericardium.

5. *Glanders*.—Specimen showing a large ulcer in the septum nasi of a horse. The ulcer presented well-defined edges.

6. *Measley Pork*.—Specimen of muscles from pig; the cysts are numerous and present a white, glistening appearance.

7. *Gangrene of Cow's Foot*.—Specimen showed beautifully line of demarcation; the separation is at one of the joints. This form of gangrene is due to animal eating ergotised grasses.

DR. ANDERSON AND DR. WALKER.

1. *Tumor of Penis of Bull*.—Pedunculated tumor so large as to interfere with copulation ($3\frac{1}{2} \times 2 \times 1$ in.). No recurrence after removal. Microscopically it shows the structure of a spindle-celled sarcoma. The interstitial tissue is large in amount, so the degree of malignancy is not great.

2. *Diverticulum from Trachea of a Drake* forming a rounded hollow prominence at the point of bifurcation, communicating with both trachea and bronchus.

3. *Osteosarcoma* involving the os innominatum of a sow, with extension into the surrounding soft tissues. The sow died during parturition, from the pelvic obstruction. The specimen was from Dr. J. Macdonald, of Acton.

4. *Ureters of Calf* opening into urethra in front of the sphincter of the bladder. The calf had incontinence of urine with continual dribbling.

5. *Bifurcated Rib* in a pig.

6. *Large double meningocele* in a calf, presented by J. J. Walker. The largest tumor, 30 inches in circumference, protrudes through the upper part of the right frontal bone; the smaller one, 15 inches in diameter, protrudes through the lower part of the left frontal in front of the position of the horn. Both communicated through the openings in the skull with the cranial cavity. The sacs were lined with dura mater and contained a thin, clear, serous fluid. Cerebrum and cerebellum were both poorly developed. Calf died during parturition.

7. *Actinomyces* in a cow, involving jaw, invading the oral and nasal cavities and appearing as a large oval tumor in the skin of the lower jaw. Specimen was obtained by Dr. Sheard from a slaughter house in Toronto. Microscopically the tumor shows the granulation tissue characteristic of the disease, and

the ray fungus (*actinomyces*) is demonstrable. The actinomyces or ray fungus is found originally on plants, especially barley and corn. Infection is produced by small wounds in the mucous membrane produced by particles of the grain, or through carious teeth. The parts usually first affected are the gums, tongue, or jaw, though the pharynx, lungs, skin or internal organs may be involved. Actinomycosis has been observed in cattle, pigs, horses, sheep and man. Cases are usually sporadic, but may be enzootic. The disease is not contagious, inoculation experiments having been unsuccessful. The disease is widely distributed, $2\frac{1}{2}$ to $5\frac{1}{2}$ per cent. of cattle slaughtered in Russia being infected, while in Canada 2 per cent. are said to have the disease. Meat from cattle suffering with actinomyces is only rejected in cases of general infection.

HAROLD PARSONS,
Secretary.

ONTARIO MEDICAL ASSOCIATION.—The meeting will be held in the Normal School Buildings, Gould Street, on June 6th and 7th. The discussion in Surgery will be opened by Dr. Luke Teskey with a paper on "Appendicitis: Its Recognition and Operative Interference." In Medicine Dr. L. F. Barker, of Baltimore, will give a paper on "The Future of Therapy." In Obstetrics Dr. R. W. Garrett, Kingston, will open the discussion on "Puerperal Infection." The important subject of Interprovincial Registration will be brought before the Association by Dr. J. Arthur Williams, of Ingersoll. Dr. Roddick, of Montreal, will also speak regarding it. Members desirous of presenting papers are requested to forward titles of the same to the Secretary, Dr. H. C. Parsons, 97 Bloor Street West, as soon as possible.

Editorials.

THE MEDICAL FACULTY OF THE UNIVERSITY OF TORONTO.

The original Medical Teaching Faculty of the University of Toronto was abolished in 1852. After several conferences between the authorities of the University and the two schools in Toronto, the Faculty was again made a teaching one in 1887. The Toronto School of Medicine co-operated in the scheme, while Trinity refused to do so. The Government declined to grant any aid to the new Faculty; but complaints were soon made that it was not entirely self-supporting. The late Chancellor and certain members of the Senate investigated the matter, and decided to make it absolutely self-supporting in every respect. In accordance with such decision the Faculty has to pay for house-room and for all lectures received from the Arts professors. The total revenue received from the Medical Faculty last year was about \$6,000. This year it will probably be about \$7,000.

THE MCKAY BILL.

There were rumors in the air that the University of Trinity College desired to be federated, and also that Trinity Medical College wished to come into closer relationship with Toronto University. Many friends of both institutions were much pleased, and looked with interest for further developments. We put it very mildly when we say that the text of the proposed bill was a surprise to the friends of the Provincial University. The medical graduates—without exception, so far as we know—are opposed to it on the following grounds:

Section 1 would abolish the Medical Teaching Faculty.

Section 2 would improperly restrict the Senate in the choice of examiners.

Section 3 would exclude certain teachers of medicine who render such assistance to the Senate, especially in matters pertaining to the curriculum in medicine.

Section 4 would disfranchise 1,800 graduates in medicine.

THE CONTROVERSIAL POINT OF VIEW.

Much has been said about the bitterness that has entered into the controversies. We have but little to say now about the utterances of individuals who have expressed rather strong opinions in various directions. We would rather refer to the official statements of the Senate and of the Faculty, which have been fair and dignified. We would like to consider Trinity Medical College as a friendly rival, which might in time join its forces with those of the University Medical Faculty; but we have to say, with some regret, that we think it unfortunate that the Trinity Educational Committee did not appeal to some corporate body of Toronto University before going to the Legislature with a bill so radical and distasteful to all friends of the Faculty which they wish to abolish. While we have no desire to attack Trinity as to its equipments and teaching ability, we can speak of the Toronto School of Medicine with less hesitation. While we have much respect for the work done by that institution in the past, we, at the same time, have to recognize the fact that it was far behind the Toronto University Faculty of to-day, and would have been far behind if it had remained in existence until the present time. Therefore we think it would be a disaster to abolish the University Medical Faculty and re-establish the Toronto School of Medicine. It would certainly not be in the interest of higher medical education to do any such thing.

We cannot in a short article like this refer to all the matters that have been discussed; but we think the Ontario Legislature should bear in mind the important fact that the University Medical Faculty does not cost the Province one dollar. No ingenious manipulation of figures can prove anything otherwise. Some of us who have watched the course of events very carefully have a fixed conviction that the Government has been niggardly towards the University Medical Faculty.

Apart from the moneys paid to the Arts Faculty for lectures, the profits derived from the fees for examinations and degrees in medicine go into the general university fund, from which the Medical Faculty is precluded from deriving any benefit.

We have no wish to injure any of the medical colleges. We would like to see no obstacle placed in the way of those who

desire to take advantage of the facilities afforded by the University—especially in any of the departments of science. We have every desire to see closer relationships existing between these colleges and the University. While agreeing to everything that is fair on these lines, we desire to see the Medical Faculty preserved in its entirety. We believe, in expressing such desires, that we are speaking for the large body of the graduates, and also for the friends of higher medical education throughout Ontario.

THE BOER AND THE BRITON.

The *Lancet* (English) thinks that man for man the Boer is vastly superior to the Briton, both physically and morally. It says that we may have good reasons for wishing that lead may be lighter than snow, but that such reasons will avail nothing if the facts are against us. The thorough fitness of the Boer is supposed to be due to the fact that all his habits of life are good. He lives chiefly in the open, and always takes plenty of exercise without being overworked. He obtains a goodly portion of his food by hunting, which not only strengthens his body, but gives him constant practice with the rifle. His life is, in all respects, one of moderation, and generally free from worries. The Boers are not total abstainers, but drunkenness is rare among them. They are also, on the whole, a very moral people. Thus they are, to a large extent, free from sexual diseases and drunkenness which incapacitate so many British soldiers.

We are inclined to think that the *Lancet* in speaking in such terms of the Boers is indulging in a little bit of exaggeration. We have our doubts as to whether the Boer is so much superior to Tommy Atkins man for man. The Boer is a dirty, cruel, cunning, half-civilized, stupid creature—and, what is certainly very important, a good shot. He is probably the "slimmest" sniper in the world; but we do not believe that he is a better soldier than the Briton. Nothing has occurred in the war up to the present time to show that the Britisher is inferior to the Boer, or any other soldier in the world. The troops shut up for months in Mafeking, Kimberley and Ladysmith, weakened

by hunger and disease, more than held their own against attacking parties outnumbering them by two, three, or four to one, and better equipped in all respects. There has not been one instance in the war in which a force of Boers making an advance, has taken a position, entrenched or otherwise, held by an equal number of British troops. But, of course, an Englishman must do a certain amount of grumbling, or its equivalent, and the *Lancet* is probably the most English of the English medical journals.

TRINITY MEDICAL ALUMNI ASSOCIATION.

The eighth annual reunion of the members of the Trinity Medical Alumni Association will be held in this city on the evening of May 18th. The Executive Committee having decided that the gathering shall partake of a social function alone, there will in consequence be no reading of scientific papers and discussion thereon this year. The attention of all interested herein is directed to the following excerpts from the constitution of the Association:

The Alumni Association includes active, associate and honorary members.

Graduates in medicine of Trinity University, Fellows by examination of Trinity Medical College, teachers past or present of Trinity Medical College and the undergraduates' representative on the Executive Committee are eligible for active membership. Undergraduates of Trinity Medical College are eligible to become associate members. Honorary members are those elected as such at any general meeting.

The objects of the Association: The furtherance of medical science, and to foster an *esprit de corps* and fraternal feeling among the graduates and undergraduates.

REGULATIONS, ETC.

The general meetings are held annually in Toronto on the day appointed for the conferring of medical degrees. Yearly dues fifty cents.

All alumni are requested to send their present address or other items of interest to the General Secretary.

ALUMNI GOLD MEDAL.

The Association offers annually a gold medal under the following conditions: Only graduates and members of the graduating

class in Medicine of Trinity University or of Trinity Medical College or Fellows of Trinity Medical College who are members of the Association in good standing can compete for this medal. The medal may be awarded annually for the best thesis on any subject pertaining to modern medical science. All these must be sent to the General Secretary of the Association on or before the first day of May, 1900, signed only by pseudonym, the name of the writer to accompany his thesis in separate cover. The awarding of the medal shall be determined by a committee of three, to be appointed annually by the Executive Committee of the Association. The theses standing first and second respectively in merit shall be read by the writers and the medal presented at the annual reunion. If in the opinion of the judges no thesis of distinguished merit has been submitted, the medal shall not be awarded.

It is certainly interesting and gratifying to know that the competition for the Trinity Medical Alumni Gold Medal is each year becoming more keen, the participants last year doubling that of the previous year. It is also worthy of note that the competition is not confined to the younger men and the more recent graduates. Amongst others who sent in theses last year were men who had been in practice all the way from ten to thirty-five years, evidencing the fact that the efforts of the Association in this respect are thoroughly appreciated. It is to be hoped this year that more of the men who have recently been doing post-graduate work will enter the competition. Announcements in regard to the annual banquet will be mailed to the members at an early date.

J. ALGERNON TEMPLE, M.D.,
President.

GEORGE ELLIOTT, M.D.,
General Secretary,
129 John St., Toronto.

CANADIAN MEDICAL ASSOCIATION.—At a largely attended meeting of the profession in Ottawa the other evening, it was decided to hold the meeting of the Canadian Medical Association on the 12th, 13th and 14th of September, 1900. The meeting was unanimous in the desire to make the Century gathering of the Association the best meeting ever held. A large sum of money was subscribed by those present for the entertainment of visiting members, making it a certainty that those in attendance will have, if possible, even a better time than they have ever before had in the Capital City. The President, Dr. R. W. Powell, of Ottawa, has recently heard from Mr. Edmund Owen, of London, England, the gratifying information that he will deliver the Address in Surgery.

Obituary.

JOHN RICHARDSON, M.D.

Dr. Richardson died at Winnipeg, of appendicitis, March 5th, 1900, aged 27. He was formerly a resident of Brockville, took a portion of his medical course at Queen's College, Kingston, and completed it in Manitoba University, Winnipeg. For a time he practised in Dakota, but for the last three years was located in the Prairie Province.

ARTHUR WELLINGTON BIGELOW, M.D.

We announce with deep regret the death of Dr. A. W. Bigelow, one of the brightest of the somewhat large Canadian medical contingent of Chicago. He received his medical education in the Toronto School of Medicine, graduated M.D., Victoria University, 1885, and M.B., Toronto University, 1886. Soon after completing his course he commenced practice in Chicago, where he soon came to the front.

Personals.

Dr. L. M. Sweetnam, of Toronto, left home for a holiday of two months. He will spend most of his time in California and New Mexico.

Dr. Drake, of London, Ontario, has gone for a six months' trip *via* the Mediterranean. He will probably spend some time in Berlin and Vienna.

Dr. George McDonagh, of Toronto, was at Rome when last heard from. He expected to reach his office about the middle of April, when he will resume practice.

Dr. Charley Murray, of Toronto, also spent some time in Rome, and will probably return with Dr. McDonagh.

Dr. J. H. Elliott, formerly Medical Superintendent of the Muskoka Home for Consumptives, has been spending the last six months in Europe, pursuing a course of study in some of the laboratories of the Old World. He has recently received an appointment to join an expedition to the east coast of Africa. This expedition has been sent out by the Liverpool School of Tropical Medicine. They are taking with them a fully equipped laboratory, and are to report upon the prevalent diseases of the country, more especially malaria. On Dr. Elliott's return he will visit Germany and spend some six months on the Continent, visiting the different consumptive sanitarium with a view to still better qualify himself for the work of the Consumptive Home at Gravenhurst.

Progress of Medical Science.

MEDICINE.

IN CHARGE OF W. H. B. AIKINS, J. FERGUSON, T. McMAHON, H. J. HAMILTON,
AND INGERSOLL OLMSTED.

Tubercular Septicemia following Parturition.

Doleris (Academy of Medicine in Paris) reports the case of a woman suffering from chronic pulmonary tuberculosis, who, in the sixth month, gave birth to a child that lived but a few hours. The following day the mother presented grave general symptoms, the physical signs of pulmonary tuberculosis quickly increasing. Fifteen days later she died. At the autopsy no grey granulations were found; the lesions at the apex of the lung consisted only of old ulcerative processes. Comparing this case with a similar one observed by him, Doleris asks himself whether in such circumstances death may be due to an eruption of the bacilli of Koch into the general circulation. To answer this question he took some blood from the woman above mentioned and injected it into several animals. These injections produced immediately the appearance of tubercular ulcers at the point of injection. When the animals were killed, it was shown that their principal organs were loaded with tubercular granulations. From these experiments Doleris concludes that in consumptives, parturition is followed by an aggravation of the symptoms due to a sudden mobilization of the bacilli which invade the circulatory system, and give rise to a true septicemia.

H. S.

Time for Vaccinating in Warm Countries.

Brouardel stated that vaccine loses its virulence owing to excessive or prolonged heat, and that in warm countries one must abstain from vaccinating during the months between June and November, since, in these months, one might use vaccine affected by too high temperatures, and so obtain only negative results.

H. S.

Stammering Cured by Temporary Craniectomy.

Ionnescou reports the case of a boy of thirteen years suffering from pronounced stammering. He had depression of the left half of the cranium. Temporary left hemi-craniectomy was performed with resection of a portion of the bony layer and loosening of the dura mater. The boy was cured in twelve

days, and has since had no difficulty of speech. This case seems to prove that stammering may depend on a cerebral compression due to arrest of development of the cranium.—Translated from *Giornale Internazionale delle Scienze Mediche*, by HARLEY SMITH.

A Rare Complication of Progressive Locomotor Ataxia.—By PLOOS VON AMSTEL.

Möbius believes that syphilitic infection is always the primary cause of progressive locomotor ataxia. Erb has found in his cases of tabes, 89 per cent. due to syphilitic infection; Strümpell, 90 per cent.; Martineau, 90 per cent.; Rumpf, 85 per cent. Other authorities who believe in the syphilitic origin of locomotor ataxia are Oppenheim, Eisenlohr, Marinesco and Fournier. If we do not accept the theory of Möbius, or that of Strümpell, that tabes is a post-syphilitic intoxication caused by the syphilo-toxine, we cannot at least deny that in many cases syphilis is the primary cause of tabes, in spite of the statements of von Leyden, the principal antagonist of this theory, and of Virchow.

M. V. J.—, of Rotterdam, was affected with locomotor ataxia several years ago. He admitted having had syphilis seven years before the beginning of a rheumatism of the two legs, which was followed by the ataxia. The inguinal glands are swollen. Besides the old symptoms of tabes in this case, there is also found an insufficiency of the aorta, which did not exist in 1897. This complication is very rare, but not so rare that one may not be struck by the coincidence of these two conditions in the same subject. Of late, syphilis has frequently been found as the cause of an aneurism of the aorta. Étienne has found that out of 346 cases of aneurism of the aorta, syphilis had preceded it in 70 of these. Fränkel found syphilis in 11 out of 30 cases. When we consider the relation existing between insufficiency and aneurism of the aorta, we are safe in saying that syphilis has caused this complication of tabes; so that progressive locomotor ataxia and aortic insufficiency are both only the results of an antecedent syphilis. Von Leyden does not accept this conclusion. Ruge and Hüttner found in 6½ per cent. of 138 cases of tabes an insufficiency of the aorta. In two of these cases an aneurism existed also. As early as 1879 Rosenbach and Berger noticed the co-existence of aneurism of the aorta and tabes in seven cases. Grasset and Letulle found them together in two cases. Albespy has found lesions of the mitral orifice in ataxic subjects.

I believe that we can make the following conclusions from the literature on this subject, and from our observations:

1. Progressive locomotor ataxia is not an idiopathic disease,

but a result of syphilis, whether we consider it as a "Nachkrankheit" (after-sickness), or as a post-syphilitic intoxication.

2. Aneurism and insufficiency of the aorta are not chance complications in ataxic subjects, but are caused by the syphilis—they are also "Nachkrankheiten" of the syphilis.—Translated from *Lyon Médical* by HARLEY SMITH.

Chloretone.

Dr. T. A. Dewar, Detroit, in February number *Therapeutic Gazette*, advocates this new drug as a valuable local anesthetic and antiseptic. He mentions a case where a man had his arm severely lacerated. He washed the wounds with a saturated watery solution of chloretone. This so anesthetised the parts that he inserted thirty stitches with practically no pain. The wound was dusted over with chloretone crystals and dressed with chloretone gauze. In three days the dressings were removed, when the wounds were found to be in a healthy condition. There was an excellent recovery. It was used on a scalp wound which had become septic with pus and swelling. The wound was filled with chloretone crystals and dressed with the gauze. In a few days all the sepsis and swelling was gone.

Saline Treatment of Dysentery.

Dr. W. J. Buchanan, Bhagalpur, Bengal (*Brit. Med. Jour.*, February 10th), claims excellent results in the treatment of dysentery by salines. In the majority of acute cases the duration of the treatment was eight to twelve days. The number of relapses were very small under this method of treatment. Out of 555 cases there were only six deaths and 69 relapses. A saturated solution of magnesium sulphate, or one ounce of sodii sulphatis in four ounces of aquæ fœniculi were the mixtures used. Of either of these, enough was given three or four times a day to keep up free but gentle purgation. When bright stools are passed, without a trace of blood, or mucus, the saline must be omitted, and resumed again at once should they reappear in the stools. In chronic and relapsing cases, a few doses of the saline is given, and this followed by bismuth and soda. Whenever the blood and mucus appear, a return is made to the saline. By this treatment the chronic cases do well.

The Classification of Infectious Diseases.

Dr. W. H. Thomson, of New York, in the January number of the *Am. Med. Quarterly*, discusses very fully the ambiguity of the terms infectious and contagious. When it became known that Asiatic cholera was not contracted by coming into close proximity with one who had the disease, the term contagious

was replaced by infectious. This term was very vague in its meaning, as one might be infected by close contact, as in the case of small-pox, or by some intermediate channel as in cholera, or by living in a given locality as in ague. To avoid some of the confusion the writer proposes that all communicable diseases be divided into three classes. The first would be the contagious, and contains all those diseases that may be contracted by close proximity, as typhus fever, scarlet fever, small-pox, measles, diphtheria, mumps, whooping cough, roetheln, etc. The practical lesson in these cases is thorough isolation. The second class contains the non-contagious communicable diseases. This class includes those that are contracted by simple nearness to the patient, as typhoid fever, tuberculosis, Asiatic cholera. The means of prevention in this class is not isolation, but measures directed against the intermediate means of infection. The third class of communicable diseases contains those that gain entry into the system through some wound or abrasion, and are designated the inoculable. This class contains erysipelas, tetanus, hydrophobia, syphilis, and ague through the bite of the mosquito. The writer suggests that for these three classes the term communicable diseases be employed to the exclusion of the indefinite terms contagious and infectious; the communication being directly, indirectly or by inoculation.

Babinski's Toe Phenomenon.

M. M. Raymond Cestan and Louis Le Sourd, in the *Gazette des Hopitaux*, November 23rd, 1899, give a very accurate account of this phenomenon and its value as a diagnostic sign. The phenomenon is this, that in a normal condition of the brain and lateral tracts of the cord a pricking of the plantar integument induces a flexion of the toes, especially the great toes, upon the metatarsal bones. In cases of hemiplegia, or monoplegia of the leg dependent upon an organic affection of the central nervous system, when the plantar integument is pricked the toes perform an extension movement on the metatarsal bones. This statement has been called in question by some; and it is to make the importance of the phenomenon that the authors conducted their extensive researches at the Salpêtrière and the Hospital de Paris. This toe phenomenon is never found in the normal adult. This is the testimony of Babinski, Gasne, and the authors after years of research among those affected with all sorts of nervous diseases. In seventy-five cases of hemiplegia it was present in seventy, and the toes immovable in five; in thirty-five cases of spasmodic paraplegia it was present in all; in insular sclerosis it was found in nineteen out of twenty, and the toes were immovable to stimu-

lation in the remaining case; in syringomyelia it was present in six out of six; in Friedreich's it was detected in ten out of ten; in thirteen cases of epilepsy it was found in two, and in these there was organic disease in the brain. In hysteria, neurasthenia, general paralysis, polyneuritis, paralysis agitans, myopathies and atrophic paralyses there never was present the extension of the toes on the metatarsus. This goes to prove that the toe phenomenon of extension is of the utmost value in diagnosing organic disease of the brain in the motor regions and of the motor tracts in the cord. In order to reveal the sign to best advantage, the patient lies on the side, thigh flexed on body, leg on thigh and foot on leg, with the eyes closed. The foot resting on its outer border is tested by gently pricking the sole of the foot, when the toes, specially the great toe, slowly extends in motor and spastic paralyses; and flex, or remain unmoved, in functional nervous diseases, or in paralyses with atrophies, or lost reflexes, as tabes.

The Treatment of Rheumatism.

William Ewart, M.D., London, in *Brit. Med. Jour.* for March 17th, enters fully into a number of points in the treatment of rheumatism. At present it is not possible to assert whether the salicylates are specifics or merely strike at some of the symptoms. The latter view is favored by the facts that this treatment sometimes fail to relieve the arthritis and fever, or to prevent the cardiac complication. But these features may be due to idiosyncrasy and individual peculiarities of biochemical processes. The salicylates may act as a sedative for the pyrexia by some influence on the central and peripheral nerve system; or as an antiseptic or microbe destroyer; or as a metabolic or antitoxic remedy. There is some risk that if pushed too freely it may disagree with the kidneys and cause trouble. Another matter of much importance is one that the routine treatment by salicylates, to the exclusion of other features in treatment, has increased the frequency of heart diseases, according to Jaccoud and Prebram. It is claimed by good authorities that patients treated with sodium bicarbonate suffer less frequently from cardiac complications than do those treated entirely with the salicylates. Cardiac valvulitis is much more common than is generally thought to be the case. The heart may be affected in every form of rheumatic arthritis. It is a matter of observation that severe joint affections with effusion into them tend to save the heart. On the other hand, the rapid relief of joint symptoms, and the condition of blood that results from it, appears to be injurious to the endothelium of the heart. The skin, bowels and kidneys should be carefully attended to. A mild cholagogue, diaphoretic and diuretic

in action, is requisite. Alkalies should always be prescribed along with the salicylates, and the one to be preferred is some potassium salt, the bicarbonate or the citrate. These remedies should be continued for two or three weeks after the joint symptoms have subsided. Iodide of potash and soda are often useful in the symmetrical type, where the same joints on each side are affected. With regard to diet, meats and meat teas are contraindicated. Milk may disagree, and this may be overcome by adding to it a little salt. A temporary vegetable diet is useful. In the commencement the less food the better.

Electricity in Infantile Paralysis.

M. Le Dr. Lebon, Paris, in *La Clinique* of Montreal, for March, speaks very highly of the systematic employment. The treatment should be commenced as early as possible. If these little sufferers are left alone the muscles go on wasting. Electricity will not restore those anterior cornual cells that are destroyed; but alongside of these there are others more lightly touched by the disease. These cells are usually in great numbers, and the proper stimulation of these will effect excellent results. The only means at the physician's disposal for this purpose is electricity. It will not do to abandon the treatment in a few weeks. In these cases several months, or a year or more are required to accomplish the good it is possible to effect. The galvanic current should be employed from the first. Cord must be stimulated by using large electrodes, and having the currents descend the cord. The currents should be weak and not exceed 10 to 12 m.a. The duration of the application should vary from five to ten minutes. The treatment should be begun as soon as the febrile stage has disappeared. The application should be made every second day. In succession the paralyzed muscles must be galvanized. For this purpose a large plate, the size of the hand, is placed over the neck or the lumbar, as the upper or lower extremities are being treated. The other electrode is passed up and down the paralyzed muscles. The child's hand or foot may be placed in a basin of tepid water. Into this the negative electrode is plunged. The current should be about 10 m.a., and the application for each extremity last about five minutes. The results are most encouraging.

SURGERY.

IN CHARGE OF EDMUND E. KING, HERBERT A. BRUCE AND L. M. SWEETNAM.

The following most interesting cases are taken from the report of the French Association of Genito-Urinary Surgeons, which appears in the *Journal of Cutaneous and Genito-Urinary Diseases*, February, 1900 :

Urinary Disturbances in Appendicitis.

Dr. Duret said urinary disturbances in conjunction with appendicitis were observed when the appendix was ectopic and close to the bladder; this is rather frequent, as pelvic ectopia varies, according to writer, from 20 to 30 per cent. nearly. He does not refer to cases that are purely reflex. He divides the accidents into three categories. First, prolonged retention, dysuria pyuria, and even pyelonephritis. There is, however, no communication with the appendix. The latter lies near the bladder and gives rise to a pericystitis and a vesical infection *à distance*. These phenomena may even point to the abnormal situation of the appendix. Second, lesions accompanied by purulent collections. From the observations gathered, we may meet with pyovesical fistula when an abscess opens into the bladder, or pyo-stercoro-vesical fistulæ, and even pyo-stercoro-intestino-vesical fistulæ. The urine is purulent, may be fetid and contain foreign bodies. In some of these cases cure has been obtained by prompt operation on the appendicular focus, in other cases the fistula has required separate treatment. Third, this category includes cases in which perivesical calculi occur, whether stercoraceous, stercoro-urinary, or simply urinary.

Dr. Pousson said that the remarks of Dr. Duret had cleared the pathogenesis of an intestinal perforation into the bladder, which he had observed five or six years before. The patient, a large eater, subject to pains in the iliac fossa, passed gas and fecal matter from time to time by the urethra. Operation was made by suprapubic cystotomy, and an opening was found on the right side of the bladder and sutured. The speaker had never before been able to make a satisfactory explanation of the condition found, but believes now that the perforation had followed an appendicitis. He wished to add another class of cases of urinary disturbance due to appendicitis. He had had a patient suffering from anuria, was about to operate, when there came a large flow of urine, showing that the ureter was at fault, as the catheter left *à demeure* had previously brought no urine. Operation was deferred and patient died. On autopsy a collection of pus in the region of the appendix was found pressing on the ureter.

Purulent and Tuberculous Urine.

The finding of the tubercle bacilli in the urine is not indispensable in order to establish the diagnosis of urinary tuberculosis. The purulence, with absence of every kind of micro-organism, should be a sign of diagnostic value. The various methods of search, microscopic, cultures, inoculation of animals, are merely confirmatory, according to Dr. Noguès. Examination of the sediment is the easiest method, but the least sure. The centrifuge helps. Cultures are not sure, though of great value, and if the medium remains sterile, where the ordinary media are employed, there may be an almost absolute certainty that the urine is tuberculous. The inoculations on animals in doubtful cases are of still greater value. In the experiments carried on by the author there were two varieties of cases. In one set of cases no bacilli, but there were found micro-organisms of diverse forms, but the clinical evolution permits the diagnosis of tuberculosis. This group included five cases, all negative. But it would be a mistake to conclude that there was no tuberculosis.

The second group of experiments includes those urines in which neither bacilli nor other micro-organism could be found microscopically. In these cases out of 22 cases inoculated, in 15 the animals succumbed with characteristic lesions. Thus a purulent urine and absence of micro-organisms is a sign of great value in favor of tuberculosis. But should we generalize them and say in the absence of tubercle bacilli and all other micro-organisms that we always have a tuberculous urine? No; we should take into account the possibility of the presence of anaerobic microbes which may occur under similar conditions.—By DR. NOGUÈS.

Surgical Intervention in Certain Forms of Medical Nephritis.

The beneficent results obtained by the various operations upon the kidney in the suppurative nephritis and pyelonephritis and their comparative harmlessness has induced the author to attempt to apply surgical measures in certain nephrites, hitherto looked upon as medical cases, which threaten the life of the patient. He was able in the case of a woman suffering from a nephritis with profuse hematuria and alarming symptoms of uremia to check the disease by a nephrotomy. The patient, before operation, had diminished flow of urine, a small percentage of urea, and a large proportion of albumin. After the incision into the kidney, the secretion of urine was re-established, the albumin diminished, and the urea increased in amount, and the uremia disappeared. Although a fistula remained, the improvement maintained, but after closure they

returned but with less violence. He further presented results in 24 instances of intervention in nephritis, complicated by grave symptoms. In 9 cases of nephritis with hematuria, there were 7 nephrectomies, with 2 deaths and 5 recoveries, 1 nephrectomy with recovery, 1 simple exploration with recovery. In 4 cases of subacute infectious nephritis there were 4 nephrotomies with recovery. Eight cases of acute infectious nephritis: 3 nephrectomies with recovery and 5 nephrotomies with 2 deaths and 3 recoveries. As to the therapeutic results, in the first set the hematuria disappeared at the same time the urinary secretion and elimination of urea were re-established. The pain abated in the nephralgias. The albumin disappeared in the cases of subacute nephritis, and the fever and other symptoms in the severe infectious cases also disappeared.

The older objections to operative interference were that the lesions were likely to be bilateral; also, the difficulty of determining the affected side when unilateral. In the cases cited the disease was unilateral and the new methods of diagnosis with cystoscope and catheterization, together with the array of cases, certainly answers these objections. Further, the mode of action of the nephrotomy is explained by the suppression of the intrarenal tension. The happy results which ablation of the affected kidney may have upon the amelioration of the condition of its congener in nephrectomy, is explained by the cessation of the veno-renal reflex, nephrectomy here playing a role analogous to the enucleation of one eye in sympathetic ophthalmia.—By DR. POUSSON.

PATHOLOGY AND BACTERIOLOGY.

IN CHARGE OF J. CAVEN, W. GOLDIE AND J. AMYOT.

Usefulness of the Diazo-reaction.

James R. Arneil (*Amer. Jour. of the Med. Sciences*, March, 1900), following Warthen's report of 1893, upholds the usefulness of the Diazo-reaction, insisting on the original method of Ehrlich.

Solution A—

Sulphanilic ac.....	1
Hydrochloric ac.....	50
Distilled water	1000

Solution B—

Sodium nitrate	0.5
Distilled water	100

Forty parts of A are shaken up with one part of B. Equal

parts of this mixture and urine are mixed, then overlaid with strong ammonia.

A positive reaction is indicated by a red color, but more important is that the foam must be tinged with a *pure pink*, no matter what the density is.

Applying this to some 405 selected cases of typhoid, tuberculosis and other infective diseases, he is struck with its importance in prognosis.

Cases of tuberculosis giving the reaction on several consecutive days will run a short course.

Cases of typhoid not giving the reaction are always very mild, while disappearance means a favorable course.

Reappearance after the usual course of the disease points to a relapse or the outbreak of tuberculosis.

In 158 cases of gastritis the reaction was obtained but once.

Isolated Glands near the Uterus.

J. C. Hirst (*Amer. Jour. of the Med. Sciences*, March, 1900) concludes from original research and a study of the literature of the isolated glands occasionally found near the serous coat of the uterus:

1. In the uterus of an adult were found embryonal epithelial inclusions from the mucous membrane of the uterine body (Müller's duct), situated in the peripheral subserous layer of the myometrium.

2. Isolated glands and cysts, included in the uterine wall, and originating from the mucous membrane, are provided with a cytogenic tissue sheath, but not invariably.

3. This cytogenic tissue is found accompanying remains of the Wolffian body *only* when adenomatous proliferation is present in them; and this applies both when it occurs at the normal site of the paroöphoron and in transposed portions of it.

4. Adenomata with glands and cysts *in scattered arrangement* (compact arrangement presupposing proliferation) are to be considered as from the mucous membrane as soon as they are provided with cytogenic tissue sheaths around the glands.

5. The epithelial ducts in the uterine and tubal wall, which have heretofore been characterized as aberrant canals from the Wolffian body, have not been proven as such, and are of uncharacteristic anatomical structure. For this diagnosis we must have specific figures of the paroöphoron or connection with Gaertner's duct.

6. We have shown that the formation of the subserous adenomyomata from these incorporated glands of the uterine mucous membrane is possible

PEDIATRICS.

IN CHARGE OF ALLEN BAINES, W. J. GREIG, AND W. B. THISTLE.

Pathology of Acute Chorea.

H. Campbell Thompson (*Clin. Journal*, September 13th, 1899) reports a pathological examination of a case of acute chorea of eighteen days' duration. The movements had begun in the arms, but in two weeks had affected the whole body, being so violent as to be relieved only by chloroform and to make it almost impossible for the patient to take food. The day before death obstinate vomiting set in; the patient became exhausted and her movements less violent, the temperature rose to 104° and death followed.

Post-mortem showed hyperemia of brain and cord and a few minute hemorrhages into the white matter of the brain; the heart showed a recent acute inflammation of the endocardium. Cultures from the inflamed valve, bacteriological examination of the valve and attempts to obtain micro-organisms from the blood were all negative.

Importance of Prolonged Rest in Bed after Acute Cardiac Inflammations in Children.

Emmett Holt (*Archives*, December, 1899). Three reasons why cardiac inflammations are likely to be especially serious in children: 1. The frequency with which both the endo- and the peri-cardium are involved. 2. The great tendency to acute dilatation. 3. The liability of these attacks to be complicated by pneumonia.

The cardiac muscle in children has by no means the resistance which it attains in later life, and therefore dilatation comes on more readily and progresses more rapidly. This must be the chief consideration in the treatment of acute attacks, both during the period of acute inflammation and for a considerable period afterwards. To minimize the injurious effects we must secure as nearly absolute rest as possible, not only at the time, but for two or three months after. He then gives the history of three cases. In two of them both the endo- and the peri-cardium were affected, both were complicated with pneumonia, and both were nearly fatal in the acute stage. Prolonged rest was insisted on and several years after their hearts were in very good condition. The third case illustrates the usual sequel of events where children are allowed to be up and around after the acute symptoms have subsided. Death occurred seven months after the initial attack from progressive cardiac failure.

A Clinical Study of Laboratory Milk in Substitute Infant Feeding.

Louis Starr (*Archives of Pediatrics*, January, 1900). Laboratory milk is theoretically the most perfect substitute for normal human milk, but in his practice clinical experience does not bear the theory out. His results after two years' study of laboratory milk; three classes are made: (a) The satisfactory—healthy children fed from birth with perfect success. Three cases only. (b) Partially satisfactory—cases in which the gradual change in health conditions necessitated a change of food; no active illness was caused. Sixteen cases. (c) Unsatisfactory. The cases are numerous under this heading and result in some acute disorder of undoubted diabetic origin. These disorders are: 1. Acute gastro-intestinal catarrh, indicated by pyrexia, vomiting and diarrhea. 2. Infantile scurvy. This is an exceptional result, but a case is given to show that it does occur.

Numerous cases are given to prove his contention. What is the reason that laboratory milk does not agree? In the process of preparing the milk, the cream is separated and then added to an alkaline solution of the proteids and sugar. In a word, the natural emulsion is destroyed. This in some way lessens the digestibility of the proteids and leads either to malnutrition or to irritative diarrhea.

He gives numerous instances to show that home modified milk mixtures will often agree when the laboratory preparation fails, the reason being that in the home modification the natural milk emulsion is not broken up.

Chronic Interstitial Nephritis and Arteritis in the Young, and Family Nephritis; with a note on Calcification in the Liver.

Brill and Libman (*Journal of Experimental Medicine*, Vol. IV.). This form of nephritis in children has been overlooked, yet out of 65 cases of nephritis in children, collected by Heubner, four were cases of contracted kidney. He states that there are recorded cases of *post-mortem* reports on 30 cases of interstitial nephritis. The following case was observed by the authors:

Ida W., aged 14. One sister, aged 19, has an advanced interstitial nephritis. A brother, aged 24, has a slight systolic murmur at the aortic orifice.

Previous History.—Always weak and undersized; could not run without getting out of breath. One year her face and feet were swollen during the whole winter.

Present History.—The day after a fright she had hemiplegia; since then continued headaches. Hemiplegia still present.

Physical Examination.—Undersized girl, poorly nourished, bad color. Tongue coated. Left hemiplegia with some rigidity. Sensation diminished in the lower extremities.

Heart.—Apex beat in the axillary line. Action forcible and tumultuous. Systolic murmur at apex, also at the aortic orifice. Second aortic accentuated and reduplicated. Radial pulse tense, artery thickened and tortuous. Liver dulness extends from the fourth space to the lower border of the ribs. Urine, neutral, albumin 1.4 gms. to the litre; uræa, $6\frac{1}{2}$ grs. to the ounce; hyaline and granular casts and a few pus cells present. After a long illness, with temperature, during which patient was comatose, she died.

Post-mortem. — Pulmonary edema; brown induration of lungs, hemorrhages into lungs, spleen and mesentery; lobular pneumonia; cardiac hypertrophy; general chronic arteritis; chronic congestion of liver with calcific deposits; acute splenic tumor; catarrhal inflammation of the gastro-intestinal tract; chronic interstitial nephritis (small, red kidney). Main points of interest: 1. The occurrence of an advanced primary chronic interstitial nephritis at the age of fourteen years. 2. Its presence in other members of the same family. 3. The extensive and marked arterial changes present. 4. The hemorrhagic diathesis, and especially the occurrence of a large hemorrhage in the mesentery. 5. Calcific deposits in the liver. 6. The latency of nephritis in children. The author thinks that many of them are treated as diabetes insipidus; others are treated for anemia without the cause being ascertained; others do not present themselves until a fatal termination is near at hand.

Correspondence.

MEDICAL MEN IN SOUTH AFRICA.

To the Editor of the CANADIAN PRACTITIONER AND REVIEW :

SIR,—It appears to me an anomalous absurdity that while our colleges, the older of which secured their charters from Great Britain, may license to practise within the boundary of the Province in which they are situate, the special right is preserved the home institutions to grant degrees permitting to practise in Great Britain *and her colonies*. British Columbia contested that right but her objection was overruled by the courts. We readily admit that the British practitioner, as we have seen him and known him here, is a fair sample of the gentleman physician; still, knowing as we do that their colleges have not had a uniform high standard, that some of our students who could not even present themselves for examination, and others that had been plucked in this country readily passed notably in Edinburgh, we are well satisfied that our Ontario examinations, especially that by the Medical Council, is quite equal to some of those at 'ome granting enlarged powers. If this is so, why should our graduates serving with the troops in South Africa be restricted in very large degree to field service? Are our colleges and our representatives doing their whole duty in allowing this injustice to be perpetuated? Would not a little sound reason remove this evidence of British prejudice and ignorance? This war presents opportunities for surgeons which should not be overlooked. We owe it to ourselves, our patients, our country, that we should reap what benefit can be derived, yet it appears that the young fellows that have gone are there in a degree on sufferance and under a ban. At the outbreak of this war over five hundred of our medical men volunteered. Some were on the army list, yet they were refused. At the same time the British War Office was advertising for civilian medical volunteers, many of whom were accepted and sent. We have, say, 2,600 men now on service in Africa, and, say, one hundred wounded lying in the hospitals at Modder River, Capetown, and elsewhere, and one and all of these are dependent on the kind offices of utter strangers, as far as medical relief is concerned. The Canadian Tommy Atkins is not allowed ministration by Canadian physicians without the burlesque of an English degree. Tommy has shown his pluck. The British public, the press, even old Cronje readily admit that, but he is still to be treated as "the poor beggar colonial." It is admitted that our surgeons in the field and on field duty have

done their allotted work "in first-class style." Yet outside this post of greatest danger he is not known. Thanks to our good friend, Dr. Roddick, the Canadian Medical Council will in time remedy this grievance, at least we hope so; but that will be "when this cruel war is over" and just a little too late. Now, sir, what I would like to know is if something cannot be done. Now, cannot strong representation be made to secure our rights just now, or are we going to sit still and allow the whole field to be monopolized? England has sent her consultant staff and that at immense expense. She has filled the ranks with her civilian surgeons. Is there no chance at all for Canadians who have had years of practical experience, and who have at least done camp duty? If an effort were made, even at this eleventh hour, I think something might be done. I read your article on "Surgery in Connection with the Canadian Contingents," and smiled a great big open smile at the idea of Dr. Grasett being "too old for service." I thought of Dr. MacCormac and his confreres, of Buller, Roberts, Kitchener, and as I did so I wondered if the person who gave this as an objection thought we were downright fools or only demented a bit—and I smiled again. I am, sir, yours truly,

P. PALMER BURROWS.

LINDSAY, March 4th, 1900.

ONTARIO MEDICAL LIBRARY ASSOCIATION.

To the Editor of the CANADIAN PRACTITIONER AND REVIEW :

DEAR SIR,—A short time ago, by request of the Board of Directors of the Ontario Medical Library Association, I mailed a circular letter to a large number of physicians in this city and throughout the Province, asking if they approved of application being made to the Legislature for an annual grant to the Library Association, to enable them to "purchase, circulate, and preserve the latest medical works." In answer to this letter over a thousand practitioners have appended their signatures, expressing their approval of the petition. A large number have asked for information in reference to the library, which time will not permit me to give by personal letter. If you will kindly grant me space in your journal I will endeavor to give the profession as much information upon library matters as possible in a short letter. I hope that those who wrote me will not consider me discourteous for not replying to their individual letters.

In April, 1887, at the regular meeting of the Toronto Medical Society, a committee consisting of the late Dr. Graham,

Drs. McPhedran, Powell, O'Reilly and Wishart, was appointed to take steps necessary for the formation of a medical library for the use of the medical profession. This committee, after a great deal of hard work, succeeded in securing the necessary information, and formed a joint stock company called the Ontario Medical Library Association, and under this name were incorporated by the Ontario Legislature under the "Act respecting Libraries." The late Dr. J. E. Graham was the first president and was most untiring in his efforts to promote the success of the library. He was ably supported by Drs. Wishart, Powell, McPhedran, Nevitt, and the late Dr. J. H. Burns, of Toronto, by Drs. Armit and Henderson, of London, and Drs. Rosebrugh and Mullin, of Hamilton. In a short time a large amount of stock was subscribed and the nucleus of our present library was formed. The Toronto Medical Society and the Ontario Medical Association, at that time, and since that time, have granted such aid as their finances would allow, and the Board of Directors tender their gratitude for the same.

The Council of the College of Physicians and Surgeons of Ontario provided the Association with library accommodation at a rental for years. As the library developed, and its usefulness became recognized, it was considered wise to open its doors to the whole profession in Ontario. At the present time any physician in the Province is privileged and invited to visit the library rooms in the College building, and to use the books there during his stay in the city. The library is no longer simply a reference library, but a circulating library, and any registered practitioner in the Province may have any book or journal upon application and upon payment of express or postage, and returning the book within two weeks.

A number of physicians have asked for copies of the regulations, catalogue of books and condition of membership. There are no printed regulations, but from the minute book I will endeavor to give the information in reference to regulations regarding the use of the library by the profession, and explain to them terms upon which they may become members of the Association. There is also no catalogue, for the simple reason that in order to have the complete list of books in the library in catalogue form, a new catalogue must necessarily be issued each year. Funds of the Association would not permit of this. Members of the profession in the city become members of the Association on paying for a minimum stock of \$15 in five annual payments, and by paying the annual fee of \$2.00 a year. Non-resident physicians may become members on the payment of minimum stock of \$15 in five annual payments, and the annual fee of \$1.00 per year. However, as stated above, non-resident physicians may have any book in the

library upon application for the same, without being a member of the Association, upon the payment of express charges or postage, and returning the books within two weeks.

It is far from the intention of the Association to make the library of use only to the members of the profession in the city, but it is the earnest desire that the profession throughout the province will avail themselves of the privileges we are enabled to concede to them. We are anxious to disabuse the minds of a great many of the prevailing idea that the Library Association is under control of, or is in any way connected with the Council of the College of Physicians and Surgeons. As above stated, the Library Association is a distinct organization and incorporated by the Ontario Legislature. When a practitioner non-resident in the city desires a book, we would esteem it a favor if he would make application to the librarian of the Medical Library Association, addressing the same to Medical Council Building. Should we have the book in the library it will be forwarded at once, according to the above regulations.

We regret that some should think they are deprived of privileges which are extended to members of the profession in the city. The facts of the case will be understood when they know that the books are the property of the stockholders who have paid stock varying from a minimum of \$15 to a maximum of \$500 per member. In this way nearly \$15,000 worth of books and journals have been accumulated during the last thirteen years. It is now practically impossible to continue to add new books and journals to the library from the subscriptions of new members, most of those who are able and desirous of subscribing having already done so. With the object in view of keeping the library up to date, and providing the profession with the latest medical literature, we have thought wise to petition the Government of Ontario for an annual grant which will enable us to make the usefulness of the library more widespread than it has been in the past.

Again, in answer to the charge that we are building up a library for the use of the city practitioner to the exclusion of those in the country, I will simply draw attention to the following notice which is hung up in many conspicuous places in the library rooms:

“THIS LIBRARY IS FREE TO ALL”

“NON-RESIDENT PHYSICIANS.”

“ALL CITY PRACTITIONERS ARE REQUIRED TO PAY THE”

“ANNUAL FEE.”

I think the necessity for approaching the Government in this matter can easily be understood by all. We are all aware

of the fact that the average income of the medical practitioner is not large. I am well acquainted with the conditions which obtain in the country, and am safe in saying that the average physician's income in the country is not more than \$1,500 a year. With truth it can be said that the average income of the city practitioner is not greater. It is practically impossible under such circumstances for the less fortunate to provide himself with everything new which is published. He does well if he is able to provide himself with the necessary books, much less the journals, a comparatively full, but still incomplete, list of which would cost not less than \$100 a year. It is impossible for those with the largest incomes, even to provide themselves with all the literature.

We hope that all misunderstanding will be cleared up and that the profession both in the city and throughout the Province will join hands with members of the Association in endeavoring to place as much medical literature as possible within the reach of all.

I might add that this library, through the kindness of Dr. J. F. W. Ross, the President, in depositing \$100 in the Surgeons-General Library at Washington, is able to secure any works in that library for any member of this Association. This is well-known as the largest medical library in the world.

Every member of the profession in the Province can help us to secure a grant from the Government by explaining the necessity for such to his local representative in the Legislature.

I am, yours sincerely,

H. J. H. HAMILTON, *Sec.*

329 CHURCH STREET, TORONTO.

Book Reviews.

International Clinics. A Quarterly of Clinical Lectures on Medicine, Neurology, Surgery, Gynecology, Obstetrics, Ophthalmology, Laryngology, Pharyngology, Rhinology, Otology and Dermatology. By the Professors and Lecturers in the leading Medical Colleges of the United States, Germany, Austria, France, Great Britain and Canada. Edited by JUDSON DULAND, M.D., Philadelphia, Instructor in Clinical Medicine in the University of Pennsylvania. Vol. IV. Ninth Series. 1900. Philadelphia: J. B. Lippincott & Co.

The present volume of this well-known work is thoroughly interesting and instructive. Especially ably written are the chapters on Bronchial Asthma, Cerebral Apoplexy, The Heart in Chronic Interstitial Nephritis and the Treatment of Acute Conjunctivitis, from all of which can be gathered useful and practical knowledge, clearly and explicitly propounded. If the succeeding volumes are as good as this and the previous issues, then no medical library will be complete that has not this work arranged on its shelves.

A Text-Book of the Diseases of Women. By CHARLES B. PENROSE, M.D., Ph.D., Professor of Gynecology in the University of Pennsylvania. Third edition. Revised. W. B. Saunders. Price \$3.75.

This work purports to be a concise text-book, written for the medical student, and as such may be considered a success. Each of the organs peculiar to women is taken in turn, and the diseases to which it is liable, and their treatment, described. With the treatment advocated we are, in the main, in accord. The section on the repair of incomplete lacerations of the perineum contains some especially valuable description. We are very far from agreeing with the author's estimate of the value of ventro-fixation and ventro-suspension of the uterus for the treatment of retro-flexion. He states that fixation of the uterus to the anterior abdominal wall is not aimed at, as this "will interfere with the normal mobility of the uterus and the course of pregnancy and labor." He then describes the subsequent dropping downwards and backwards of the uterus, figures the formation of the band of tissue which is then formed—"from one to three inches in length"—reaching from the fundus uteri to the abdominal wall. In this way, he says, "the course of subsequent pregnancies and labors seems to be in no way interfered with," a statement with which we do not agree. Further, no reference is made to the cases of

strangulation of the intestine which have occurred round this artificially formed suspensory ligament. In writing on endometritis resulting from septic infection during miscarriage or labor, he makes the statement that "the treatment comprises frequently repeated intra-uterine douches, thorough curd-etting of the uterus; and, finally, hysterectomy in extreme cases." We consider this altogether misleading. The numerous headaches, backaches, menstrual pains and general neurasthenic symptoms, which form the complaints of so many weak women, are not specially dealt with. In fact, the work had better have been called an operative gynecology. The illustrations are all of them good, and many of them new. The index is full, which always increases the value of a work of reference. The mechanical execution of the book is good.

A Manual of the Diagnosis and Treatment of the Diseases of the Eye By EDWARD JACKSON, A.M., M.D., Emeritus Professor of Diseases of the Eye in the Philadelphia Polyclinic, formerly Chairman of Section on Ophthalmology of the American Medical Association; member of the American Ophthalmological Society; Fellow and ex-President of the American Academy of Medicine. With 178 illustrations and two colored plates. Price, \$2.50 net. 1900. W. B. Saunders, 925 Walnut Street, Philadelphia.

Dr. Jackson has given us another manual for the practitioner and beginner in ophthalmology, which surpasses with few exceptions all now published, and in regard to these few it is even more easily understood than they. The style is concise, but always makes clear his meaning. Great care is taken to elucidate the treatment and the mode of applying it. Also many little obstacles and peculiarities, which ever puzzle any but an oculist, are detailed so as to meet all inquiries. Thus there is no tautology, but at the same time the grouping of the diseases aids very much in systematizing them in the student's mind. Capitals and italics draw your attention to important facts, and thus act almost as accurate marginal notes, and hence facilitate references to any subject. Refraction, and the ocular symptoms associated with its errors, are so portrayed as to convince the most sceptical reader of their existence, and of the great necessity of having the refraction of the eye properly tested when certain nervous and apparently unaccountable conditions show themselves. In other words, refraction of the eye is most excellently done. Many formulæ are given. Throughout, Dr. Jackson has, in his whole plan of the book, most happily put himself in the place of the very reader he has written for. The plates of all kinds and the type are well executed and instructive.