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Original Communications.

RECENT ELECTRO-THERAPEUSIS OF GOITRE, WITH IMPROVEMENTS IN APPARATUS.

By DR. CHARLES R. DICKSON, Toronto,
Electro-Therapist to Toronto General Hospital, Hospital for Sick Children, St. John's Hospital and St. Michael's Hospital.

[Abstract of paper read before annual meeting of American Electro-Therapeutic Association, in New York, September, 1894.]

About five years ago I formed the opinion, that for the treatment of goitre we had at our disposal an agent which, properly and rationally employed by competent operators, should prove safer, more efficacious and acceptable than any other in a majority of the various forms of this trouble. Electricity had been on trial with very varying results, but it seemed to me that the discrepancies were attributable to the apparatus employed or to the operator, and that we did not fully appreciate its value.

The literature on the subject was conflicting, misleading and most disappointing. Electricity was discredited, and other methods advocated fraught with gravest menace to the patient's future health, usefulness and happiness, in the event of recovery, from the immediate results of the procedures, and recent literature shows little improvement.

Here, surely, was a promising field for research, and I determined upon a careful investigation.

The immediate vicinity of Toronto is not goitrous, yet as a recognized medical and surgical centre it draws many cases from an extensive territory around, and in the great majority of these cases the best known therapeutic measures adopted by the general profession have already been resorted to. My connection with Toronto hospitals places me in a most favorable situation with regard to the supply and character of this clinical material, and a number of our prominent practitioners have very kindly referred to me their private as well as their hospital patients, thus

testifying to the unsatisfactory state of the therapeutics of the thyroid as well as to the success of my labors. This is most gratifying to me, and greatly to the credit of my professional brethren, well illustrating their broad and progressive spirit in contrast to the opposition to methods electrical manifested in other quarters. Improved apparatus and methods have retrieved past failures, and rendered possible results hitherto unattainable.

The discussions elicited by my former papers disclosed a decided variance of opinion as to the value and range of applicability of electrical treatment, and demonstrated the need and incalculable usefulness of our Association. I have again to report progress and state the deductions from a year's further experience. My aim has been to shorten the period of treatment, while extending the interval between *séances*, to improve technique and to discriminate the treatment most appropriate to each case.

The percutaneous method, using strong currents by means of flexible clay electrodes, has received considerable attention. I have found it very tedious, and have come to the conclusion that its chief utility lies in combating the hyperæmic condition, in reducing simple hypertrophy, in stimulating liquefaction and absorption of recent fibroid growth, and lessening the œdema of older cases preparatory to more active measures. It may also be employed where puncture would not be well borne, and occasionally to alternate with puncture treatments.

Thyroid hyperæmia occurring at the menstrual period or during pregnancy, and disappearing at their termination, does not call for interference, unless there be accession of size at each period or gravid state. Galvanization of the sympathetic should then be resorted to, with occasional clay pad percutaneous treatment if necessary. This remark also applies to goitrous cases of amenorrhœa, whether primitive or secondary.

In the slighter forms of hyperplasia, the clay electrode treatment is indicated, the positive electrode at the back and the negative over the goitre, starting with 20m.a. to 30m.a. The patient will, after a few sittings, gradually tolerate 100m.a. to 150m.a. for ten or twelve minutes two or three times a week.

In vascular forms, by diminishing excessive blood-supply and stimulating absorption, we induce a process of partial atrophy. The negative electrode, a large clay pad, is placed at the shoulders, while the active surface of the positive (a properly insulated platinum needle) is introduced within the capsule of the gland alongside a tenotomy knife. Of course, a local anæsthetic is first used. From 50m.a. to 150m.a. should be employed for eight to ten minutes every ten or twelve days.

In distinctly fibroid forms, the nutritive process may be lessened by the positive puncture, with occasional resort to the negative needle to hasten absorption. In some advanced fibroid cases where, owing to the small proportion of healthy tissue left, the process of absorption and atrophy was slow, I have hastened matters by the formation of a central cavity or artificial cyst. This I have done by large negative needles, treating it as an ordinary cyst and maintaining drainage. It requires specially careful manipulation. In very large fibroids, I frequently discard the clay pad, and use instead a second needle in another portion of the growth.

Thin-walled unilocular cysts are the most amenable to treatment. The positive pad is placed at the shoulders, while the negative electrode is an insulated canula, through which the cyst is aspirated and a solution of chloride of sodium introduced. From 50m.a. to 100m.a. is employed for ten minutes, the cyst again emptied and firm pressure maintained by broad adhesive straps. A single treatment may suffice, but frequently in the thick-walled and

multilocular varieties drainage must also be kept up to permit escape of the fluid effused subsequent to the operation. The aim is thus to obliterate the sac by exciting adhesive inflammation of its walls.

Thick-walled fibro-cysts are often very rebellious. Following the above treatment I have introduced a solution of zinc sulphate through a tube which carries a positive platinum wire, and employed 50m.a. to 75m.a. for ten or twelve minutes. I have also used a zinc positive electrode.

When the contents of a cyst are not sufficiently fluid to pass through the canula, some of the saline solution should be forced in, and currents of 50m.a. to 100m.a., or, if the patient will tolerate it, and it is necessary, 150m.a. to 200m.a. employed. This will liquefy the contents, which may be withdrawn immediately or at the following *séance* eight or ten days later.

Puncture of the thyroid, apart from electrical treatment, is not devoid of danger. Considerable dexterity is required, and a slight error may prove disastrous. When in addition to this we consider the power of the agent employed, it will easily be understood that great care is requisite both during and subsequent to the operation. Cleanliness and strict antisepsis are imperative. Drainage should not be unnecessarily prolonged.

With regard to exophthalmic goitre, I have nothing novel to offer. I meet very few genuine cases, and think that the Fellows fully appreciate the value of galvanization of the sympathetic and other electrical methods.

I have modified the canula and attachment of the Potain aspirator by enlarging the lumen to permit the easy passage of No. 3 drainage tubing. I have had the tube of the canula constructed of platinum. It may thus be used with the positive pole; and I have added a second stopcock, which renders it independent of the reservoir.

As the use of chemical solutions corrodes

metal parts, I employ for injection a second bottle, with tubes of glass leading to and from it. I have also furnished it with a third tube to facilitate the introduction of the solution. Provision is also made for emptying the sac after treatment without polluting the contents of reservoir.

The possession and care of the necessary apparatus, and the ability to employ it skilfully, minute acquaintance with fundamental laws, and a proper estimation of the power of this agent, are only a few of the factors which militate against the electrical treatment of goitre by the general practitioner, and he will be wise if he resist the temptation to use it.

Finally, the keynote of success is discrimination.

Society Proceedings.

MONTREAL MEDICO-CHIRURGICAL SOCIETY.

Stated Meeting, November 2nd, 1894.

G. P. GIRDWOOD, M.D., PRESIDENT, IN THE CHAIR.

Case of Primary Carcinoma of the Liver.—Dr. MARTIN read for Dr. Adami the report on this case as follows.

During the last session of the Society I brought before the Montreal Medico-Chirurgical Society a case of true adenoma affecting the liver of a woodchuck, and arising primarily, as its structure amply demonstrated, from the parenchyma of that organ.

I have now to describe you a case of very similar nature in the human liver, only here the adenoma has taken on a malignant character, and secondary growths have developed elsewhere.

The specimen was obtained at a post-mortem made at the Royal Victoria Hospital on September 4th. The subject from whom it was obtained, J. B., aged 45, entered the hospital under Dr. Stewart, complaining of weakness and loss of flesh, with pain and swelling in the abdomen. He had been addicted to good living and excessive use of alcohol, and there was a doubtful specific history. About a year before admission there had been a violent attack of jaundice, from which patient gradually recovered.

The liver dulness extended from the fifth rib

to two inches below the costal margin, the edge was sharp, while the anterior surface presented a nodular mass the size of the fist, movable with the liver.

This lump in the right side, noted now to be in connection with the liver, was first observed five months ago.

Without dwelling fully upon the condition of the other organs, it may be added that there was much ascites. The patient was tapped twice, and each time a blood-stained ascitic fluid was removed containing both red and white corpuscles and urea; it was highly albuminous.

With this history a diagnosis was made of cancer of the liver. The autopsy fully confirmed this diagnosis.

In connection with the liver within the substance of the right lobe was the large pale-colored mass seen in the specimen handed round. Upon the surface were several semi-transparent nodules of new growth in the capsule, but upon section the only recognizable focus of new growth within the organ was the one large, well-defined mass. This mass was 10.5 cm. broad and 14 cm. long, sharply separated off from the surrounding liver tissue; it was placed anteriorly at the left extremity of the right lobe and to the left of the gall bladder. This last was greatly thickened and pressed to the right by the growth. Upon opening, it was found to be full of thick, brownish-grey purulent mass of mixed pus and bile, with such intense staining power that even now upon November 2nd the nail of my left index finger is stained from exploring the gall bladder of this case upon September 4th. In this mass lay several soft small faceted gall stones, which easily crumbled and broke down when handled. Two larger and firmer stones lay at the opening of the cystic duct, and appeared to completely block it.

The great omentum was greatly thickened and of a deep blood-stained tint, very nodular and brittle. The small intestines presented numerous semi-transparent nodular growths upon their serous surfaces. There were further numerous small nodules scattered through the mesentery, and imbedded in the fat. There was no sign of new growth anywhere within the intestinal tract.

Beyond œdema of the lungs and interstitial nephritis, there was little calling for additional remark.

Upon microscopic examination the new growths here described were typically carcinomatous, of the medullary type. The great size of the mass in the liver, as compared with the minute nature of the nodules elsewhere, appeared to indicate that in the liver was the primary growth, and microscopic examination proved the correctness of this suggestion. More especially towards the growing free surface the

mass could be seen to be composed of characteristic liver cells, large, tending to be cubical and pigmented, possessing a tendency to be arranged in an alveolar manner. Elsewhere, deeper down in the tissue, the cells became smaller and the collections were separated off from each other by well formed fibrous stroma. In parts there was a tendency for the cells to be arranged around a central lumen.

The sections, in fact, possessed all the characteristics of an adenoma, or new growths of the liver tissue which had taken on malignant characters. This malignancy was further demonstrated by the abundant new growths in the abdominal cavity.

Primary carcinoma in the liver may be of three types:

1. Generalized carcinoma, the cirrhosis carcinomatose, of Peres.

2. Localized carcinoma originating from the liver cells proper.

3. Localized carcinoma originating from the smaller bile ducts.

A fourth form, not truly hepatic, invades the liver after primary origin in the larger bile ducts.

Here in this case we are dealing with the second form, that is to say, with a true liver cell cancer, which is of sufficient rarity to be placed on record.

Finally, it is interesting to observe the relationship that in this case appears to exist between the inflammatory disturbance of the gall bladder, which dated back a year, and the cancer which has arisen in close juxtaposition to the inflamed bladder. The suggestion is that some relation exists between the two. It is noticeable that the gall bladder itself exhibits no cancerous growth; it is only chronically inflamed, but immediately outside it, in the region that is of congestion, and over-nutrition of the tissue has originated this new growth.

Primary Carcinoma of the Kidney.—Dr. MARTIN then exhibited a specimen which had been removed from a private case of Dr. McCarthy's, who, with Dr. Finley, in consultation, had diagnosed primary carcinoma of the kidney. The autopsy confirmed this diagnosis. The kidney shown appeared enlarged, the capsule, Dr. Martin declared, was in some parts stripped off with difficulty, and on section a large cancerous tumor was seen infiltrating the medullary portion, filling the pelvis, and extending to the suprarenals. Thrombi were found in the renal vein, although the vena cava was free.

Dr. A. LAPHORN SMITH presented the following specimens, and related the histories of the cases:

Case 1.—Multilocular Cyst of the Right Ovary.—The tumor measured 24 inches in circumference. The patient, Mrs. L., nullipara, married two years, never pregnant. Abdom-

inal enlargement first noticed sixteen months ago. On examination, all the evidences of ovarian cyst were found. Operation was performed on September 4th, the tumor removed without any difficulty, and she made a rapid recovery, returning home twenty-five days afterwards.

Case 2.—Tubal Pregnancy.—Mrs. W., aged 25, married 3 years, mother of two children, the youngest one year old. Since the birth of her first child she had suffered from repeated attacks of what was probably pelvic peritonitis. Five weeks before coming under his notice she was suddenly seized with a severe pain in her left side and a fainting fit while walking in the street. She began to flow, and continued until time of operation. As she had not missed a period she was sure it was not a miscarriage, and in a few days was about again. Two weeks later she had another fainting attack, accompanied by sharp cutting pain, and a third one week before he was called to see her in consultation. On examination he found a mass the size of a small orange in Douglas' cul-de-sac, and it was exceedingly sensitive to pressure. Tubal pregnancy was at once diagnosed, and operation performed on October 20th. In order to make the recovery more satisfactory, he dilated and curetted the uterus, sewed up the cervix, and performed ventral fixation after the removal of the appendages. The dates of the various hæmorrhages were beautifully illustrated when the specimen was first removed by the clots of blood surrounding it. There was rather bright red blood recently escaped; dark and slightly organized clots, and old hard clots, more dense and firm. Dr. McConnell had made a microscopical examination, and had only been able to find blood-clot, but further search would be made for chorionic villi.

Case 3, Hæmatoma of the left Ovary—Chronic Salpingitis.—Mrs. L., aged 25, has been a chronic invalid since the birth of her only child, eighteen months ago. On examination, deep bilateral laceration of the cervix and on the left side near the uterus a lump about the size of a small orange. After a course of preliminary treatment for reducing congestion of the pelvic organs, operation was performed on September 6th. The uterus was dilated and curetted, the laceration was carefully repaired, and both appendages removed. The peritoneum and fascia were closed with buried silk and a layer of through and through silkworm gut stitches which had been passed previously were tied. The patient made a good recovery. The silk-worm gut sutures were removed four weeks after operation.

Embryo in Sac.—Dr. HUTCHISON exhibited a specimen of an embryo in its sac, surround-

ed by the liquor amni. It was of interest, he thought, from its rarity, such a complete picture of the early development of the human species not being often seen outside of textbook plates. The abdominal opening could be plainly seen and the small points marking the situation of the eyes, etc., etc.

Stated Meeting, November 16th, 1894.

G. P. GIRDWOOD, M.D., PRESIDENT, IN THE CHAIR.

Drs. J. E. Binmore, Felix Cornu, William Burnett and H. M. Duhamel were elected ordinary members.

Diaphragmatic Hernia.—Dr. ADAMI exhibited the specimen and gave the history of the case.

Dr. MILLS remarked that between the years 1878 and 1881, he, then a resident physician in the City Hospital of Hamilton, Ont., reported a case of congenital hernia through the diaphragm in an infant. He did not remember what organs had passed upward through the orifice, nor whether there were any other Canadian cases on record.

In reply to questions put by the President, Dr. Adami remarked that this would be considered of the congenital variety; that it would seem to be caused by the non-development of the left crus of the diaphragm; and that the most common position of the rupture or orifice in the diaphragm was the tendinous portion of the left side.

Pus Tubes and Hæmatoma in the same patient. Pus Tubes removed during an Acute Attack of Peritonitis. Double Hydrosalpinx, causing Severe Dysmenorrhæa.—Dr. A. LAPTHORN SMITH read the reports of these cases, as follows:—

Case I. Hæmatoma of Ovary with Double Pus-tubes.

Miss C. was referred to me as a case of fibroid tumor of the uterus and as being suitable for electrical treatment. This diagnosis was not without some foundation, for on placing the hand on the abdomen, one could detect a tumor or enlargement of the uterus, extending nearly to the umbilicus. By bimanual palpation the cervix was found to be small, but the uterus appeared large and wedged in the pelvis, and quite immovable. The tubes and ovaries could not be felt. On firm pressure the tumor was felt to be solid, or in places slightly elastic. The history rather supported the diagnosis. She was 26 years of age; had begun to menstruate at the age of fourteen, the flow always having been profuse. It had never been painful until six years ago, since which the pain of the periods had been gradually grow-

ing more severe, until she was at length compelled to go to bed every month. Latterly the pain had been much worse a week after the periods than it was during the flow. She had had several attacks of pelvic peritonitis during the last year. Electricity was discontinued, as the patient did not improve. Nothing remained for me then but to open the abdomen and remove the appendages, which would stop the pain and, it was hoped, arrest the growth of the tumor and the hæmorrhage. Preparations were also made for extirpating the uterus should the necessity for it arise. The abdomen was opened, after the usual preparations, on the 7th September. On introducing my fingers to search for the appendages, the latter could not be felt: the tumor was adherent to the pelvis, and it was covered to a large extent by adherent intestines. The adhesions were broken up, when for the first time it became apparent that the tumor was made up of several different elements. After some difficulty a pus tube was brought out, which was tied close to the uterus, but was so disorganized that the ligature cut through. I then came upon a slightly fluctuating mass, the size of an orange, which was also dissected out, proving to be a hæmatoma of the left ovary, but it broke while being delivered and its dark grumous contents escaped, welling up out of the incision. This was carefully sponged away, and the ovary was tied and removed. A large pus tube was then removed from the right side, and finally the right ovary, which was somewhat enlarged. Nothing now remained of the tumor but a normal-sized uterus, from which the peritoneum was completely removed, and from which there was a good deal of oozing. When this had been stopped, a glass drainage tube was inserted, and the abdomen closed by through and through silk worm gut sutures which were left in one month. Six ounces of bloody serum were pumped from the drainage tube, when the liquid becoming paler the tube was removed in forty-eight hours. The patient declared the following day that the pain which she had suffered for several years was entirely gone, and the pain of the operation was nothing compared to it. She was up in two weeks, and went home on the twenty-third day.

This case was especially interesting to me for several reasons: First, it bore out the truth of Apostoli's assertion, that a patient who cannot bear moderate doses of electricity has diseased tubes, and should be treated by surgery. Second, it bears out the truth of Lawson Tait's assertion, that one can never be sure of what he will find in the abdomen until he has his fingers in it, indeed I might add the words, "and sometimes not even then." When we remember that Lawson Tait has opened the abdomen more often than any other man who has ever lived, and when we consider what

enormous experience that meant, no one should consider himself infallible in this respect.*

Case II. Pus tubes removed during an acute attack of peritonitis. Recovery.

The patient was twenty-six years of age, married at twenty and had three children. She had never been well since her marriage, but had been getting very much worse since two years. Her last child was a year old, and she had no miscarriages. While pregnant with her last child she had suffered a good deal, and had had a bad recovery. During the past year she had had several attacks of peritonitis, confining her to bed for several weeks each time. Two weeks before, she was taken with an unusually severe attack, from which her physician did not expect her to recover. She was very emaciated, was constantly crying out with pain, in spite of large doses of opium, while her abdomen, which was covered with poultices, was very much distended, her pulse being thready and fast, and her temperature high. She was at once put on salines and large doses of quinine, with almost immediate relief of the pain and distension. But her temperature remained at 103. On examination, per vaginam, Douglas' cul-de-sac was found to be full of exudation, which was thought to be due to pus tubes and ovaries. As it was the opinion of all that she could not continue very long as she was doing, it was decided to operate that afternoon. The patient absolutely refused to leave her house, so the operation was performed there. Both tubes were dug out with great difficulty, being imbedded in layers of exudation in various stages of organization, but without rupturing them. One tube tore out of the ligament while extracting it, and both cut like cheese when the ligature was applied. Notwithstanding this, there was very little oozing. Owing to the very large area from which the peritoneum was stripped off, I thought it best to put in a drainage tube, which was left in only one day. The temperature took three days to fall to normal, and the pulse improved steadily, although she was not able to leave her bed for five weeks. When last heard from, she was improving steadily.

Case III. Hydrosalpinx and bound down tubes and ovaries, causing severe dysmenorrhœa. Removal. Recovery.

Miss B., 30 years of age, had been under my care for several years for severe dysmenorrhœa, and almost constant pain between the periods. Palliative treatment having proved of little avail, removal of the appendages was suggested, and she readily agreed to have that done. Coeliotomy was performed on the 13th

* Since writing the above, a paper by Dr. J. F. W. Ross, of Toronto, has appeared in the *American Journal of Obstetrics*, in which he reports several cases in which he removed large pus tubes from women who had been sent to him for fibroid.

October. Although the ovaries and tubes were covered with adhesions, the latter were easy to break, and both tubes and ovaries were removed, and the uterus attached to the abdominal wall. No drainage tube was used. The fascia was sewed with catgut, and the silk worm gut previously introduced was then tied. She made a successful recovery, being up in two weeks. On examining the tubes they were both found to be distended with fluid, which could be squeezed out of their uterine ends in a clear stream, but it was impossible to introduce the finest filiform bougie into the uterine ends at all, and only a distance of half an inch into the fimbriated ends. The tubes were bent by adhesions so as to form a number of knuckles, which were probably the cause of the severe pains every month. One ovary had a cyst in it, which ruptured while removing it, and into which one can introduce the end of the thumb. It apparently contained clear fluid. The other ovary has a thick hard surface, due apparently to chronic inflammation of the peritoneal coat. When the ovaries and tubes when first removed were placed in water, they were found to be covered with fringes of shreds representing the torn adhesions. Dr. Joseph Price had a quaint way of saying to his assistant, when he removed appendages like these: "Don't let these tramps out until they have seen the specimens in water, for fear they will go away saying that they had seen healthy ovaries removed."

It will be admitted that if one cannot relieve a woman in these circumstances by the means which were employed during three years of treatment, and if, at the end of that time, she is not able to keep a situation from this cause, we are fully justified in removing the appendages. My experience of tearing the appendages loose and leaving them to contract fresh adhesions has not been favorable, and I have never tried to save distended tubes by opening them and sewing them up again, as I feel sure that fresh adhesions would continue to worry the ovaries, and the tubes would refill. Pozzi and Polk have been doing it, but from recent reports of Polk's cases the result has not been satisfactory.

Primary Carcinoma of the Kidney.—Dr. J. G. MCCARTHY reported this case as follows:

The rarity of primary carcinoma of the kidney in the adult has induced me to give a short résumé of the clinical aspects of a case, of which the specimen has already been brought before the Society.

The patient, a female, aged 42, was married at 23, and has had eleven children, nine of whom are living. She first consulted me at the latter end of August for recurring attacks of pain in the back and loss of strength. The pain was severe, and extended on the left side from the lumbar region of the spine to the front

of the abdomen, and occasionally was felt down the left thigh. She attributed her ill health to the after-effects of her previous confinement. Notwithstanding the number of her pregnancies, and the arduous duties of a large family in one in poor circumstances, she had always been in good health. Two months previous to the birth of her last child, which occurred on the 3rd November, 1893, she commenced to suffer with attacks of pain in the back, and noticed for the first time that the urine was blood-stained and contained blood clots. Her confinement was normal. She was delivered of a healthy child at full term, and, I am told, went to her work on the morning of the fifth day. Two months later hæmaturia returned, and appeared at intervals in small quantities till June, 1894. The pains continued, and she felt weaker and found it difficult to attend to her household duties. In January she noticed a small growth on the left side of her neck, which gradually increased in size, and had occasionally been the seat of pain. The family history contained nothing of importance.

When first seen she presented a pale, careworn expression, and was somewhat emaciated. The tongue was clean; appetite good; no vomiting; bowels fairly regular, but she had previously suffered from obstinate constipation. The pulse was 115, small and compressible; temperature normal.

In the neck was a growth about the size of an egg, situated in the triangular interval between the sterno-mastoid and the trapezius above and parallel to the clavicle. It was hard and nodular to the feel, and quite mobile. The cephalic vein of that side was dilated, and pursued an unusual course across the front of the chest, over the first intercostal space to the sternum. I looked upon the tumor as most likely a secondary growth, originating in the cervical lymphatic glands. There were no signs of disease in the mouth, throat or thorax. The apex of the heart was displaced upwards and outwards to the lower border of the 4th rib in the mammary line. Percussion dulness was made out at the upper border of the 3rd costal cartilage, nearly two inches to the left of the median line, and extended from the apex to nearly across the sternum. There was no distension of the abdomen. Its walls were soft, flaccid, yielding readily to pressure. A portion of the large bowel, distended with fecal matter, could be easily felt beneath the abdominal parietes, extending from the ninth costal cartilage in the mammary line, downwards on the confines of the umbilical and left lumbar regions. Beneath the bowel, which I thought was the descending colon displaced forwards, could be felt a large growth, quite hard, non-fluctuating, with a smooth and rounded contour, having at its inferior border a smooth nodular projection.

The tumor extended upwards into the left hypochondriac region and downwards to the left iliac fossa through the left lumbar region; it inclined forwards towards the umbilicus, receding as it did so from the anterior abdominal walls. It could be tilted forwards, without occasioning any pain, by pressure behind over the region of the kidney; in other directions it was quite fixed. Percussion dullness extended to the lower border of the 6th rib outside the nipple line, and posteriorly over the region of the kidney a slight bulging was noticed.

There was no dilation of the superficial veins, and no oedema of the extremities. The urine was examined on two different occasions. The quantity excreted, though not measured, seemed normal. Nothing could be inferred from the sp. gr. or color. It was acid in reaction, and contained neither albumen nor sugar; but, when examined microscopically, blood cells were distinctly visible and urates were present in large quantities.

The disease progressed without any apparent signs of hæmaturia. The patient became more emaciated: there was some increase in the size of the tumor, and the exacerbations of pain towards the end became more frequent and more severe. A slight rise of temperature was noticed, on two occasions, to 100° and 100.3° F.

The last two or three weeks were marked by an uncontrollable diarrhoea. The patient now took to her bed, and from this out, the loss of strength was very rapid, and the emaciation extreme, and she died on the 31st October. Dr. Finlay saw the patient with me at the latter end of her illness, and agreed with the diagnosis.

Remarks.—The invasion of the cervical glands of the left side of the neck, the freedom from disease of the other superficial lymphatic glands, is worthy of note. It was this that gave me the first clue to the possibility of malignant disease. I ordered the patient to bed, and made a thorough examination in search of the primary growth. It was only after this was localized that any mention of hæmaturia was made by the patient. In tracing the course of this secondary infection from the primary disease in the kidney, I believe that it was conveyed by the lymphatics of the kidney to the thoracic duct and by this channel to the lymphatic glands of the left side of the neck. I feel more inclined to this opinion after noting, at the post-mortem, the condition of the retro-peritoneal glands in the neighborhood of the kidney.

Hæmaturia had appeared early, had never been profuse, and for the last five months of the illness, was reduced to a mere trace, which required a microscopical examination to determine.

At the post-mortem the transverse colon was

noticed to be uncovered by the great omentum, and extended downwards from the hepatic and splenic flexures to a point below the umbilicus. Although the intestine was at that time quite empty, from the severe diarrhoea that had preceded death, I think now that possibly that portion of the large bowel, which could be so distinctly felt in life, was part of the transverse colon from its mid-point below to the splenic flexure, which in its abnormal position ascended almost vertically in front of the tumor.

Another point which I might mention, though I consider it merely as a coincidence, was the acidity of the saliva. It was tested with strips of litmus paper, placed over the orifices of the ducts. I made four tests at intervals of a few days. Three times the reaction was acid, once neutral.

Pathological Report.—The whole growth manifests the ordinary character of a primary medullary carcinoma of the kidney arising from the epithelium of the renal tubules. It shows in places the true glandular form of carcinoma, first described by Waldages, and indicated clearly, from microscopic specimens, how the tumor cells proliferating from the kidney epithelium becomes gradually smaller and like atypical cells of this organ, while the stroma of the cancerous mass takes its origin from the intertubular connective tissue.

The progress of the case has likewise been of interest, inasmuch as its advance by the lymphatics is the more unusual form of primary renal carcinomata, but the growth in the neck is undoubtedly to be regarded as secondary to the kidney affection, metastases having formed through the thoracic duct and by retrograde advance to the lymphatic glands.

Primary cancers of the kidney do not, as a rule, form secondary growths, and when these occur it is usually by the blood stream. Here the vena cava seemed free, but we are by no means certain as to the condition of the lungs, being unable to examine the thorax for metastases.

Only a partial autopsy was permitted, and that of necessity a hasty one. The abdomen was opened, showing a meagre panniculus. The visible coils of intestines were reddened and the transverse colon displaced downwards and to the left. A large mass was found beneath these intestinal loops, occupying the umbilical and left lumbar regions chiefly, and reaching for about one inch to the left of the vertebral column. This was discovered to be the left kidney and adrenal converted into a large tumor, which lay partly twisted on itself, so that the convex border of the kidney lay rather downwards than outwards. The tumor was easily and rapidly removed, *in toto*, there being no dense attachments to any neighboring organs, but merely thin, loose adhesions.

During removal it was observed that some of

the retro-peritoneal and lumbar glands were involved, and that a thrombus partially filled the renal vein. The vena cava was found free as far as could be ascertained. There was not enough time allowed to dissect up the thoracic duct.

The tumor on removal presented a large mass, divided at the junction of its uppermost and second growth into two unequal parts. The greater and lower portion had the usual renal shape, and was surmounted at its upper end by the remaining portion of the tumour which, as it were, fitted like a cap on top of the kidney.

That this was supra-renal was borne out by its position and relation to the kidney, as well as by the fact that the renal capsule could be stripped off between the kidney and the upper mass. To make further certain, there was no other evidence to be found of adrenal in the neighborhood.

The adrenal was, however, partly joined to the kidney by several areas of new growth, these being the channels of transmission of the growth from the kidney to the other organ.

On removal the whole mass weighed 1250 gram.

Measurement of the kidney alone was $7\frac{1}{2}$ inches long by 5 inches broad, and $2\frac{1}{2}$ to 3 in thickness.

Adrenal alone measured 4 inches x 3 inches x $1\frac{1}{2}$.

The kidney capsule presented numerous dilated lymphatics filled with granular material, and was fairly easily stripped from the organ.

Section into the kidney showed that but little renal tissue remained, the cortex in the upper half being about half its normal thickness and less, and in some places so thin that the contents of the tumor were almost protruding. In the lower portion, however, not only was the cortex about the normal size, but there was further some evidence of medullary pyramids and calices. The hollowed out areas thus left were filled with a large quantity of cheesy looking pulaceous material, composed of fatty cells and free fat globules, granular detritus, cholesterine cells and remains of old hæmorrhages. The pelvis of the kidney and upper part of the ureter were filled with the same mass of degenerated cancerous material, and the renal vein showed the presence of a cancerous thrombus along nearly its whole course.

The adrenal was similarly affected, and its outer covering, which was greatly thickened, formed a kind of capsule to the enclosed mass of detritus, resulting from the retrograde changes and hæmorrhages within of the cancer which had involved this organ in virtue of its contiguity.

Microscopic examination of the remnants of kidney tissue showed masses of columnar and polyhedral small cells of epithelial character,

distributed in various portions and situated amid a fibrous stroma. In many places very little evidence of tubules could be found, the whole renal tissue being overrun by the neoplasm. Where, however, tubules or glomeruli could be found, it was evident that from here the growth had taken its origin, while the fibrous stroma arose from intertubular connective tissue.

Sections of the involved suprarenal showed the walls densely infiltrated with cancerous tissue, so much so, that there was but little evidence of the original normal adrenal tissue.

Secondary Enchondroma in a Bitch.—Dr. ADAMI eighteen months ago had exhibited before this Society the rare condition of an enchondroma of the mammary gland occurring in a bitch. The animal, after its removal, kept in very fair condition for some time; but towards the end of February last, a swelling was noticed in the abdominal cavity, which was thought to be of an obstetrical nature. It, however, continued to grow, extending in a rather transverse direction. There was gradually increasing difficulty of locomotion, and about three weeks ago the animal was killed in the laboratory and a post mortem performed. A hard tumor was found in the abdomen attached to the mesentery; it was not adherent to any of the abdominal viscera, except a portion of the liver, which was found separated from the rest of that organ. Examination showed it to be an enchondroma, hard at the edges, with bony matter scattered here and there; while the whole central portion was essentially myxomatous. It appeared to be attached to the mesentery and to have started there; but we had then these peculiar relations between the tumor and the liver to explain, and altogether it seemed more reasonable to conclude that the growth commenced in the liver, extended until its weight caused that part of the organ which contained it to break off from the rest, and then attached itself to the mesentery. The tumor weighed ten pounds, while the animal in health did not weigh more than twenty pounds, and probably something less than that at the time of the autopsy, as it was much wasted. In addition to this large mass, other secondary growths were seen in the form of cartilaginous nodules in various portions of the lungs, pancreas, abdominal glands and kidney. Dr. Adami regarded the case and specimen as interesting, first, because the condition of primary enchondroma of the mammary gland is a very rare one; secondly, because, in spite of the usual benign character, in this case it had been followed by secondary growths.

Dr. MILLS' experience of tumors in dogs led him to believe that any kind of a growth occurring in the mammary glands of dogs is apt to be followed by secondary growths. He

had had quite a number of these tumors examined microscopically, and then, in spite of their benign gross appearance, sarcomatous tissue was pretty generally found in them.

The Late Dr. E. A. McGannon.—The following resolution was moved by Dr. J. ALEX. HUTCHISON, seconded by Dr. J. J. GARDNER:

Resolved:—That this Society learns with feelings of sincere sorrow of the death, at the early age of 41 years, of Dr. Edward Aaron McGannon, of Brockville, Ontario.

A member of this Society since 1889, he attended its meetings, contributing papers and entering into the discussions.

He was one of the few members residing at a distance from the city who took an active interest in its deliberations.

His genial disposition and kindly manner made him the friend of all.

SOCIÉTÉ FRANÇAISE DE LARYNGOLOGIE, D'OTOLOGIE, ET DE RHINOLOGIE.

PRIMARY LARYNGEAL TUBERCULOSIS ACQUIRED BY COHABITATION.—M. CADIER, of Paris, reported several cases in which examination had demonstrated the fact that phthisis acquired by cohabitation begins oftenest in the upper portions of the larynx (the ventricular bands, the upper surface of the vocal cords, and the interarytenoid space). In the majority of cases the lesions remain for some time localized in the larynx, and may be diagnosed by an attentive laryngoscopic examination, while their progress may be arrested by topical applications and cauterization. It is indispensable, however, to begin treatment as soon as possible after the tuberculous inoculation has taken place.

RESULTS OF CASTRATION UPON THE FEMALE VOICE.—M. MOURE, of Bordeaux, called attention to the consequence of ablation of the testicles in man and the physiological relations existing between the genital organs and the larynx. He reported two cases of women who had submitted to ovarian castration, and who showed a marked lowering of the timbre of the voice, which at the same time became much stronger. He believed, however, that these changes were not constant, and that it was not easy to recognize them when they did occur, except in singers, and especially high sopranos. It is known that after a certain age the removal of ovaries or testicles has no effect upon the larynx.—*Semaine Médicale*, May 12, 1894.

INTUBATION OF THE LARYNX.—DR. BONAIN, of Brest, described the instruments invented by O'Dwyer, and insisted upon the importance of possessing these tubes, which he regarded as faultless. He had used them in 23 cases of croup, 21 following diphtheria of the pharynx, and 2 without apparent diphtheria in which the

diagnosis was confirmed by bacteriological examination of the false membrane. In one of the latter cases, a child of 11 months, recovery ensued when the tube had been in the larynx eleven days. There were 7 cases of recovery in children from 20 months to 10 years. According to M. Bonain, intubation presents the following advantages: 1. The simplicity of the operation, its rapidity, and the fact that it is readily accepted by the parents, requiring no special assistance and that it can be done in any surroundings. 2. The expulsive force of the cough, considerable when O'Dwyer's tube is used, which insures better drainage of the trachea and bronchi. 3. The rarity of pulmonary complications. 4. The bloodless character of the operation, preventing enfeeblement of the patient, especially the very young. 5. The fact that the patient can express his needs and wishes in a low voice. 6. The simplicity of the after-treatment, consisting only of alimentation and watching of the patient. 7. The rapid convalescence, without cicatrice of the neck. 8. The fact that the child is not obliged, as is sometimes the case after tracheotomy, to wear a canula for some time,—a permanent danger to the lungs.

Outside of diphtheria, intubation may generally replace tracheotomy in acute or chronic stenosis of the larynx, due to tertiary syphilis or tuberculosis, in subglottic laryngitis, and in burns and fractures of the larynx.—*Médecine Moderne*, May 5, 1894.

TREATMENT OF EPISTAXIS.—DR. C. MIOT, in discussing this subject, stated that positive interstitial electrolysis should be the method of choice when extensive epistaxis occurred from erectile or varicose tissue. It was also of value in the treatment of more limited hæmorrhagic areas. Electrodes of copper or silver were preferable. The intensity of the current should average from 16 to 20 milliampères, and the length of the *séance* from eight to ten minutes. Three or four applications were sufficient in exceptional cases, one or two in ordinary instances. Hæmostasis in this region is easily secured, although its vascular relations with the brain are important.—*Revue de Laryngologie*, June 1, 1894.

AMERICAN ASSOCIATION OF GENITO-URINARY SURGEONS.

ENLARGEMENT OF THE PROSTATE.—Dr. George Chismore, of San Francisco, read a paper on a "Modification of Bigelow's Operation for Stone in the Bladder, Designed to Meet Cases in which the Prostate is Enlarged." He called attention to the difference in the conditions present in the cases complicated by prostatic enlargement, to the intolerance of such patients to prolonged operative procedures and to trauma of the bladder. He advocated (1) local in preference to general anæsthesia; (2) short sittings;

(3) removal of any remaining fragments after the patient has fully recovered from the effects of the previous operation, and as soon as such fragments can be detected with the vesical sound. His procedure is as follows: The bladder is emptied, and from 1 to 2 ounces (30 to 60 grammes) of a 4-per-cent. solution of cocaine hydrochlorate are injected. The lithotrite should be introduced as carefully as possible, and if spasm is present, a short pause should be made rather than force the instrument in the face of this obstruction. As soon as the stone is found, it should be crushed as rapidly as possible, but no prolonged search should be made for remaining fragments, as this adds every considerably to the gravity of the operation. Any evacuator may be employed, but Dr. Chismore employs a very simple one devised by himself. Usually there are no after-symptoms, and the patient feels relieved at once. Occasionally there is some swelling of the deep urethra. If any fragments are left, the old symptoms gradually return. The operation of crushing these fragments may be done without anæsthesia. Dr. Chismore still employs Bigelow's instrument in cases of hard calculi, as his instrument does not possess the strength requisite for crushing such stones. He maintained that in all cases of vesical calculus, complicated by enlargement of the prostate, the operation described offers every prospect of success, and that any stone which could be removed by perineal lithotomy may be crushed with less suffering and with greater success by this method.

Dr. J. William White called attention to the gravity attending the use of a general anæsthetic in many of these cases, the effect of which was to cause congestion or actual inflammation of the already-crippled kidneys. When the integrity of the kidneys is open to question, he thought the method described would occupy an important place.

Dr. Francis Watson, of Boston, was inclined to consider the method a retrogression. The higher mortality of lithotripsy over litholapaxy is due to the retention of the crushed fragments, and he was unable to see how the same injurious effect could fail to follow Dr. Chismore's method if some fragments were removed. He was, however, most favorably impressed with the statistics given, and theoretical objections must be withdrawn when such a good showing can be made. Dr. Watson advocated, in the class of cases alluded to, the method so strongly indorsed by Reginald Harrison, of performing perineal cystotomy and crushing and evacuating by this route.

Dr. William K. Otis, of New York, favored supra-pubic lithotomy in cases of stone in the bladder, in the presence of considerable enlargement of the prostate gland, as this

operation gives an opportunity to inspect the bladder and provides for drainage. In many cases, however, he thought Dr. Chismore's method would be very suitable.

Dr. John P. Bryson said he employed the cystoscope with advantage in gaining definite information of the exact intravesical conditions present. Local anæsthesia is coming more and more into use, and in many instances is exceedingly satisfactory, while general anæsthetics are in many cases dangerous. Most fatal cases are due to traumatism of the prostatic urethra.

Dr. James Bell preferred the supra-pubic operation for stone in prostatic cases. He was struck by the large amount of cocaine employed by Dr. Chismore, and that, as stated by the latter, no symptoms causing anxiety had appeared.

SOME INFREQUENT SYMPTOMS OF DISEASE OF THE URINARY TRACT.—Dr. Alexander W. Stein, of New York, referred to cases of membranous casts from the bladder and urethra. The cause usually given is retention of urine. Of 50 reported cases, 45 were in women and 5 in men. The causes of retention in the females were either a retroverted uterus or pressure of the child's head during prolonged parturition. The prognosis is usually good; of 45 cases, but 9 terminated fatally. The case was reported of a man, 26 years old, who had frequent attacks of renal colic on the left side, and who on one occasion had retention for twenty-four hours; finally he passed a stone *per urethram* with relief of the retention. The attacks of renal colic continued. Later, he was subjected to litholapaxy for stone in the bladder. Still later, he began to pass "fleshy" masses of large size. The urine was loaded with pus, and was offensive. Improvement followed antiseptic irrigations of the bladder. The patient was lost to observation, and it was reported that he afterwards died. The cause of death could not be learned, but, as the termination was preceded by stupor, it was possibly uræmia.—*Medical News*, June 2, 1894.

BRITISH MEDICAL ASSOCIATION.

OPERATIVE TREATMENT OF GASTRIC AND TYPHOID ULCERS ASSOCIATED WITH PERFORATION.—Mr. A. PEARCE GOULD, in opening a discussion on this subject, stated that the pathology of the perforating ulcer of the stomach and duodenum was still obscure. It was common in young and anæmic women of the servant class, and also in middle-aged men. It was usually single, and situated on the lesser, and very rarely on the greater, curvature of the stomach. Its size was that of a sixpence or a shilling; it was of variable depth, the floor

being formed either of peritoneum or possibly of a thickened area, up to the size of the palm of the hand. The symptoms for the most part were agonizing pain after eating, frequent vomiting, hæmatemesis, and melaena. At times the patient made no complaint, and was unaware of suffering any departure from health. In truth, the symptoms were no sure guide to the extent of the disease. In the majority of cases cicatrization took place, although in 25 per cent. perforation occurred. In 85 per cent. the perforation was on the anterior aspect of the organ opening into the peritoneal cavity. Young servant-girls were especially prone to anterior perforation. He disapproved of Billroth's recommendation of timely laparotomy, excision of the ulcer, and suture of the wound, unless it was possible to establish an exact diagnosis. The surgeon's duty consisted in the prevention or arrest of peritonitis. The only hope of doing good lay in cleansing the peritoneal cavity. Hitherto too much stress had been laid on suturing the rent in the stomach and too little on cleansing the peritoneum. The following measures should be adopted: (1) simple washing out of the abdominal cavity; (2) suture of the ulcer; and (3) where that was impossible, suture of the stomach to the abdominal parietes. But he could not too often repeat that the success of these cases depended upon cleansing the peritoneum.

Experience alone could decide the precise period when the operation should be performed. If too long a time were allowed to elapse, the peritonitis became general and intensified. Moreover, under these circumstances, masses of lymph concealed the affected parts and interfered with the cleansing of the sac. The best site for the incision was in the middle line, as this gave the best access to the whole of the abdomen, while the seat of pain was no guide to localization. First among the fluids used for flushing he placed normal salt-solution, and then boiled water. He avoided acid or toxic solutions, and used the water hot, as he found it a powerful restorative. A vital step was the systematic flushing with a large exit-tube; where practicable he sewed up the ulcer, but attributed no particular advantage to paring or excising the ulcer. The stomach might or might not be washed out. The value of exploration with the finger was doubtful. When in doubt, drainage should be resorted to. If the collapse were not relieved by hot water, he practised intra-venous injection. He read the notes of six successful cases of operation in perforating gastric ulcer. With regard to perforation in typhoid ulcers he had collected, excluding doubtful cases, seventeen cases of operation with one recovery. The steps of the operation were the same as those for gastric ulcer. Statistics show that there were from $2\frac{1}{2}$ to 3 per cent. of perforation in all cases of

typhoid fever,—most frequently occurring in the ileum, often multiple, sometimes so small as to allow no escape of intestinal contents. They usually took place during the third week, but cases were known as late as the sixty-sixth day. The symptoms may be very marked or quite latent. Death may close the scene in ten minutes; the patient rarely survives more than two days. Recovery was exceedingly rare. He concluded by saying that the truest wisdom was the wise selection of cases.

Dr. R. Maclaren, of Carlisle, in operating for gastric ulcer, preferred to make his incision in the left linea semilunaris, four inches in length, which allowed good access to the stomach. He emphasized the point that cleansing of the peritoneum was all important. The conditions of success were system, perseverance, and a patient not on the verge of death from collapse. A detail of much importance in after-treatment was rectal feeding. Again, if the patient were much collapsed, he did not believe much in flushing. He described fully his method of cleansing the peritoneal cavity. In his opinion, the operative procedures in these cases were troublesome rather than difficult. For example, if the intestines were distended, more difficulty was experienced. Great mortality was, however, only to be expected. He mentioned a case, in which he had the advice of Dr. Heron Watson, where perforation occurred in connection with a typhoid ulcer. The only treatment adopted was that of making an incision over the caecal region and inserting a drainage-tube. The patient, although desperately ill for some time afterward, made an excellent recovery.

Mr. Rutherford Morison, of Newcastle, related a case in which he had operated for gastric ulcer on a woman of 23. She had had a large quantity of bread and milk for her supper, and one hour afterward was suddenly seized with acute pain. On examination the diagnosis was arrived at of gastric perforation, but one of the chief symptoms present was dullness in the flanks. The collapse was extreme. Two hours afterward the abdomen was opened in the middle line over the stomach and the omentum torn through, when a large quantity of fluid escaped, and an ulcer was found on the posterior wall of the stomach. Lembert's sutures were used. The abdomen was flushed out. The patient did well for five days, although there was great difficulty in managing her. Ultimately, however, she became very restless, passed into a collapsed condition, and died on the ninth day. He thought that the collapse at the time of operation in these cases was relieved by the operation and flushing of the abdomen. When the patient, however, was livid, any operation was certainly contra-indicated.

Mr. Gilbert Barling thought that some of the

expressions of opinion with respect to these cases were too optimistic, especially so in regard to typhoid ulcers. His experience was limited to five cases. In three of these he operated; in the fourth he regretted that he had not operated, and in the fifth the patient vomited pus and passed a large quantity of pus per anum, but after a perilous time ultimately recovered. In one of the cases upon which he had operated, recovery followed. He agreed that the less done in perforating typhoid ulcers the better.—*Lancet*, August 4, 1894.

ASSOCIATION OF AMERICAN PHYSICIANS.

TREATMENT OF CERTAIN SYMPTOMS OF CROUPOUS PNEUMONIA, PARTICULARLY IN ADULTS.—Dr. BEVERLEY ROBINSON, of New York, laid special stress upon the management of two symptoms of the first stage of the disease, namely, pyrexia and pulmonary congestion. He does not use the modern antipyretics, except in special cases. Phenacetin he regards as the best of these, for the reason that in addition to its antipyretic action it also induces sleep. The spirit of mindererus, potassium citrate, and magnesium sulphate he uses largely. Quinine, in doses of 2 to 4 grains (0.13 to 0.26 gramme) every three hours, is antipyretic. Cold sponging and cool baths are not especially efficacious; if the temperature of the patient is over 104° F. (40°C.), and the pulse is rapid and delirium is present, a tub-bath may be advantageously employed. He has seen bad results, however, following immersion in a tub-bath; sponging, with friction, is preferable. The advantage of the bed-bath is the avoidance of shock and exposure, and the ease with which it can be given. The bath should last from fifteen to thirty minutes, and is to be repeated whenever the temperature is over 103° F. (39.5° C.); prompt relief follows, the temperature falling to 100° F. (37.8° C.).

Aconite and aconitine act by diminishing the heart's action through its motor ganglia. The heart is slowed in a very alarming manner, and may be arrested in diastole; 1-150th grain (0.00043 gramme) of aconitine may produce serious results; hence he does not believe in its uses. The administration of small and repeated doses of antimony oxysulphuret, 1-32nd grain (0.002 gramme), every hour or two hours, is much superior to the use of aconite. It renders the sputum more fluid, and therefore easier of expectoration, and in this way diminishes the dyspnoea. It is also well borne by the aged and by children. It may be used in both the first and second stages of the disease. Nitroglycerin, by the mouth, or, better, hypodermatically, in doses of 1-50th or 1-25th grain (0.013 or 0.0026 gramme), is an excellent remedy in this disease. It strengthens the weak pulse, removes the cyanosis and relieves

the dyspnoea. Inhalations of oxygen in pneumonia usually give relief, but in some instances the dyspnoea is increased by its use. Especially in cases of general oedema have unfavorable results been noted. In favor of the right heart inhalations are, according to some authorities, of marked service, though the subject is still open for discussion. The abundant use of cold spring-water, Apollinaris, and other table waters is of service in promoting diuresis and diaphoresis, and in this way reducing the abnormal temperature of the body. Alcohol is beneficial in many cases, not only on account of its nutritive value, but also because it aids the respiratory function. It also gives nerve-force, controlling the adynamia and nervousness. There are only two contra-indications to its employment, namely, when the patient is plethoric and when there is hepatic engorgement and gastric catarrh. In these cases, small and repeated doses of calomel will act in the most beneficial manner. Digitalis or digitalin in small doses may be given to control an irregular heart; otherwise either is not to be used, on account of inducing vascular contraction. Strychnine by the mouth or hypodermatically, from 1-30th to 1-16th grain (0.002 to 0.004 gramme), is a very useful drug; at times, however, it may produce nervous irritability. Nitroglycerin acts by bleeding from the veins into the arteries, in this way taking the place of the old method of bleeding, which was often followed by excellent temporary results. In cases of threatened heart-clot, venesection, followed by injections of salt solution, may yield excellent results. Black coffee is of service when other remedies cannot be borne by the stomach, and may tide the patient over. Caffeine does not replace the use of coffee, for the reason that it is merely an alkaloid, and does not possess the nutritive value of the coffee.

Dr. Peabody, of New York, remarked that pain, with insomnia and cough, is an urgent symptom of croupous pneumonia, that could be controlled by the use of small doses of morphine hypodermatically, as grain 1-6th (0.01 gramme) repeated once or twice during the night. He objects to the too frequent use of water in reducing the temperature. He has very rarely found heart-clot as a pathological feature in this disease, and believes that many of the so-called cases of ante-mortem clot are in fact but post-mortem clots.

Dr. J. C. Wilson, of Philadelphia, believed that, owing to the varied clinical manifestations of pneumonia, the treatment must be largely expectant and symptomatic. Cold baths have not been satisfactory in his hands. Local applications of cold to the chest have been advantageous in many cases. In sthenic cases, with delirium and other nervous manifestations, affusions of from one-half to one gallon of cold water, poured over the head and shoulders,

will often act as the turning-point in the disease. Venesection proves beneficial in many cases of pneumonia by attenuating the toxæmia and removing from the blood a quantity of effete material. He indorses the use of small amounts of opium; as, e.g., 2 or 3 grains (0.13 or 0.2 gramme) of Dover's powder, for from every two to four hours.—*Universal Medical Journal*.

CONGRESS OF AMERICAN PHYSICIANS AND SURGEONS.

SEWER GAS AS A CAUSE OF THROAT DISEASE.—Dr. Beverley Robinson, of New York, thought it was a demonstrated fact that persons ill with diphtheria became more severely ill if compelled to inhale the air from sewers continually. In his opinion, if a person with catarrh of the throat and a tendency to inflammation of this region was exposed to sewer-gas, he would be liable to have an attack of inflammation. This he had seen time and again. The house-physician of the Willard Parker Hospital had recently informed him that, notwithstanding the large number of cases of diphtheria in that hospital, they had not been able to find the Loeffler bacilli in the air about the patients. It had recently been shown that many of the children in the Hospital for the Ruptured and Crippled had been going around the wards with the Loeffler bacilli in their throats, without showing any symptoms of diphtheria.

RECENT SUGGESTIONS IN THERAPEUTICS.

FOLLICULAR TONSILLITIS.—If seen early and no complications, Dr. Sajou's abortive treatment,—*ammoniated tincture of guaic*, 1 teaspoonful every two hours in sweet milk. If seen later, *calomel*, 10 grains (0.65 gramme); *soda bicarb.*, 20 grains (1.3 grammes). M. ft. chart. no. iii. One every three hours floating on teaspoonful of water. No liquid after for twenty minutes. Follow with 1 or 2 teaspoonfuls of *castor oil* with 10 to 15 drops of *turpentine* every hour (for first 12 hours) excepting hour of powders. Gargle and swallow teaspoonful of saturated solution of *sulphate of sodium* (C. P.). When powders are finished and worked off by *castor-oil*, alternate *sodium sulphate* with *pot. chlorat.*, 1 drachm (4 grammes); *ammon. mur.*, 1 drachm (4 grammes); *tinct. ferri mur.*, 4 drachms (16 grammes); *glycerin*, 1½ ounces (46.5 grammes); *syr. limonis*, 2 ounces (62 grammes). M. Teaspoonful as a gargle and systemic remedy. Reduce all doses for children, and dispense with gargles. (C. C. Slagle, *Therapeutic Gazette*, June 15, 1894.)

HÆMORRHOIDS.—Cleanse bowels thoroughly with repeated irrigations of *salicylic-acid* solution. Introduce into the rectum a suppository

containing 2 grains (0.13 gramme) of *cocaine*, and from ¼ to ½ grain (0.016 to 0.02 gramme) of *morphine*, about 15 minutes before operation. If patient is extremely sensitive, inject 1-per-cent. solution of *cocaine* into different portions of mucous membrane immediately before operation. Bring tumors into view by introducing *iodoform-gauze* tampon through small speculum. Inject saturated solution of *iodoform* in ether into cellular tissue adjoining each nodule. Injecting on both sides of latter causes formation of scar-tissue and shrinking of circumvenous tissue. Now substitute suppository containing 2 grains (0.13 gramme) *salicylic acid* for gauze tampon. Give *bismuth* and *opium* to prevent movement of bowels. On third day inject 2 ounces (62 grammes) of *olive oil* into rectum, giving *castor-oil per os*. During subsequent weeks, bowels should be kept loose. Treatment successful in eight cases. (Carl Beck, *New York Medical Journal*, July 21, 1894.)

LEMONADE FOR DIABETICS.—*Pure water*, 1000 grammes (1 quart); *pure glycerin*, 20 to 30 grammes (¾ to 1 ounce); *citric acid*, 5 grammes (1¼ drachms). To be taken in small quantities within twenty-four hours. (*Journal des Practiciens*, May, 1894.)

LOCAL ANÆSTHETIC SOLUTION.—*Cocaine hydrochloride*, *resorcin*, each 16 grains (1.04 grammes); *distilled water*, 2 ounces (62 grammes). Does not cause systemic disturbances sometimes produced by cocaine alone. (J. H. Lowrey, *New York Medical Journal*, July 21, 1894.)

LUBRICATION OF CATHETERS.—To facilitate exploration of bladder and urethra: *Powdered soap*, 50 grammes (1½ ounces); *glycerin* and *water*, each 25 grammes (6½ fluidrachms); *mercuric perchloride*, 0.02 gramme (⅓ grain). (Guyon, *Lancet*, July 28, 1894.)

MALAKINE IN RHEUMATISM.—Dose in acute articular form, 6 grammes (1½ drachms) in twenty-four hours. As much as 10 grammes (2½ drachms) may be given without danger if doses be sufficiently divided. Increases diuresis, facilitates elimination of uric acid, and lowers temperature. No untoward effects. (Montagnon and Ducher, *Loire Médicale*, July 15, 1894.)

Progress of Science.

TORSION OF ARTERIES FOR THE ARREST OF HEMORRHAGE.

Dr. Claude A. Dundore, of Philadelphia, in an interesting paper, describes this method, and credits Amusat with first having observed the effect of torsion of arteries in arresting hemorrhage.

He has used torsion in 113 cases of all kinds, with no signs of secondary hemorrhage, and with fewer cases of delayed tissue unions. He thinks that if the vessel is diseased, that torsion is safer than the ligature, which very often, even when little force is exerted in tying, partially or entirely severs the external coat, thus by hastening the sloughing of the end of the vessel, tending to produce secondary hemorrhage. In cases of diseased vessels, the limited method of torsion should only be used, and the end of the artery should not be rotated more than twice.

In plastic operations, the fact that we are enabled to close the wound without leaving a loop of catgut to irritate or produce sepsis and delay union is an advantage which cannot be too highly appreciated.

Doctor D. ends his paper by stating that he is satisfied that those who will give torsion their practical attention will be amply repaid and thoroughly convinced that as an agent for the averting of hemorrhage it is the equal, if not the superior, of the ligature in many respects.—*Internat. Med. Magazine.*

A NEW TREATMENT FOR HYDROCELE.

A new treatment for hydrocele is proposed by J. Neumann (*Wiener Medizinische Presse*, No. 45, 1893). It consists in the withdrawal of the fluid by means of a trocar and cannula, leaving the latter in the hydrocele sac to act as a drain. A slightly compressing bandage is applied over a small thickness of cotton. Healing is said to occur in a few days. The cannula is removed on the second or third day.—*North American Practitioner.*

FREEDOM FROM RECURRING APPENDICITIS AFTER EVACUATION OF THE ABSCESS AND RETENTION OF THE APPENDIX.

By JAMES M. BARTON, A.M., M.D.,
Surgeon to the Jefferson College Hospital and to the Philadelphia Hospital.

[Philadelphia Academy of Surgery.]

At the last meeting of the American Surgical Association I reported nine recoveries from operations for appendicitis in which the appendix was not removed. These were all cases of ruptured appendix with circumscribed abscess, with no general peritonitis and no symptoms of obstruction.

The operation consisted in opening the abdomen and using sterilized cheese-cloth to hold the movable intestines back and to protect the general peritoneal cavity while the abscess was opened and emptied. Drains were then introduced, some of the cheese-cloth permitted to remain, and most of the wound

closed. No attempt was made to find or remove the appendix.

Before considering the later condition of the appendix in these cases, I wish to report, briefly, five more cases upon whom I have operated in the same manner, all of whom also recovered.

Mr. B., aged twenty-three years, a patient of Dr. Cline, of Jersey Shore, Pa. He was operated upon August 24, 1893, on the seventeenth day of the disease.

William C. M., aged twenty years. The operation was performed at Jefferson College on August 28, 1893, on the third day of the disease.

Harry S., also aged twenty years. I performed the operation at the Philadelphia Hospital, September 4, 1893, on the seventh day of the disease.

Richard B., aged forty-four years. The operation was performed at the Jefferson College Hospital, September 17, 1893. It was the third attack, and the present one had existed for thirteen days.

Miss V., aged twenty-two years. The operation was performed November 10, 1893, on the third day of the disease. She was a private patient of Dr. M. B. Dwight, of West Philadelphia.

My object in bringing this subject to your notice is to exhibit several of these patients and to read reports from most of the others, to show that none, whose histories I have been able to follow, have been at all troubled by the retained appendix, and to learn if the experience of the Fellows of the Academy have been similar to my own.

It is becoming widely recognized that this method of operation is accompanied by a low rate of mortality. Richardson in this country, Tait in England, and Reclus and Schmidt on the Continent, as well as many others, content themselves in these cases of local purulent peritonitis with protecting the peritoneal cavity and draining. Others, however, still consider that no operation is complete without removing the appendix. In the March number of the *Annals of Surgery*, Fowler advises, in these cases, the removal of as much of the appendix as can be done without separating adhesions, but considers it necessary to remove the rest of the appendix at a second operation.

Of these fourteen cases, eleven were operated upon by myself during the last two years. All on whom I have operated in this manner have recovered, and none, that I am aware of, have had any trouble with the retained appendix since.

As the mortality has been much greater when I have removed the appendix, I now rarely do so unless the appendix is unruptured, or, if ruptured, only when general peritonitis has occurred.

Of these eleven cases I have been able to follow the history of eight, several of whom are here to-night for examination.

The three whom I have not been able to find were hospital cases; two of them were brought to the hospital by physicians. If either of these had had a recurrence needing surgical aid, I should probably have known it.

Of the eight whose histories I have been able to follow, none have had the slightest symptoms referable to the appendix since the operation. No tumor is to be felt and no tenderness. Indeed, they all appear to have been singularly free from diseases of all sorts since the operation.

Mrs. C., aged thirty years, is here this evening, and will permit us to examine the region operated upon. The operation was performed November 29, 1892, and though she has been using the sewing-machine steadily ever since, she has enjoyed the most robust health. The right iliac fossa is apparently entirely free from disease.

I also present Wm. C. M., aged twenty years. I operated upon him at Jefferson College Hospital, August 28, 1893. He has been in perfect health in all respects since the operation, and there is no evidence of disease in the right iliac fossa.

Harry S. has also been kind enough to come here. I operated upon him September 4, 1893, at the Philadelphia Hospital. He also has been in perfect health since the operation, and presents no evidence of disease anywhere.

Dr. Marshall, of Milford, Delaware, informed me a few days ago that the patient, Mrs. S., on whom I operated for him on February 26, 1892, has enjoyed perfect health ever since, and that on examination he has been unable to find any tenderness on pressure or any tumor in the right iliac fossa.

Dr. Beary, of the Falls of Schuylkill, reports that Mrs. R. T., on whom I operated for him, January 20, 1893, has been in perfect health since the operation.

Dr. Cline, of Jersey Shore, Pa., reports that Mr. B. has been in perfect health since the operation; indeed, in better health than for a number of years before.

Dr. Dwight, of West Philadelphia, reports his patient, Miss V., as in perfect health since the operation, and on a recent examination of the seat of the disease there is no tenderness and no tumor to be felt.

Dr. Chandler, of Centreville, Del., reports: "The patient, Mrs. M., on whom you operated for me, April 3, 1893, has made a perfect recovery, and has been perfectly well ever since." He adds, "that from the operations in which he has participated, he thinks the removal of the appendix in these cases is not required if good drainage is established. The appendix will take care of itself."

From the uniformity with which full and complete recovery has occurred in the few cases that have come under my care, it looks as though the appendix is not very liable to give trouble if permitted to remain. Indeed, I think it is quite likely, in cases such as we have been considering, that the opening from the appendix into the intestine is closed early in the attack—closed quite as firmly as any ligature would close it, and there is but little probability that fecal matters will ever be again able to enter the appendix, either to cause a fecal fistula to follow the operation or to start another case of appendicitis in the future.

If it were not firmly closed, the pus would never have broken through the walls of the appendix, or, having broken through, the resulting abscess would not have increased in size, but would have emptied itself through the appendix into the bowel.

To further illustrate the strength of this obstruction at the base of the appendix, I have observed, in several cases where fecal fistula followed appendicitis, that in none did the feces make their exit through the appendix, but through other portions of the intestines, showing that the inflammatory deposit closing the appendix was even stronger than the healthy bowel.

The mortality following operations for appendicitis is mainly due to general septic peritonitis and to intestinal obstruction.

If we look into the cavity of a fully-developed abscess, such as we have been considering, we can readily see how these complications may follow the search for or removal of the appendix. The cavity of the abscess is lined with a thick layer of grayish, poorly organized, aplastic lymph, filled with micro-organisms. The appendix lies buried beneath this lymph, and its cavity communicates freely with the general abscess cavity. The opening can occasionally be seen, and is often the only guide by which the position of the appendix can be recognized.

To tear up this fragile and infected lymph, and distribute it through the peritoneal cavity while searching for and liberating the appendix, would greatly increase the probability of establishing a general septic peritonitis.

Intestinal obstruction following operations for appendicitis is probably due to kinking of the recently separated intestines. As they reunite, covered and stiffened as they are by inflammatory deposits, they cannot adjust themselves as readily as at the first formation of the abscess.

To avoid any misunderstanding, let me state that it is only in cases of circumscribed abscess that I have been permitting the appendix to remain.

When the appendix is still unruptured, or when it has ruptured and general peritonitis

has occurred, or when obstruction is present, I am in the habit of removing it.—*Denver Medical Times*.

BORIC-ACID INJECTIONS IN GONORRHOEA.

CHRZASZCZEWSKI has had good results from washing out the urethra in the various stages of this disease with a 3 per-cent. solution of boric-acid at 40° C. (104° F.). He applied it by means of a Nélaton catheter (9 to 11 Charrier's scale), introduced as far as the prostatic part of the urethra, injecting a portion of the liquid, and letting it run out slowly, drawing the catheter out three to six centimetres, and again injecting a portion, without drawing the catheter a third time a similar distance, and injecting the balance. Every portion injected contains 100 grammes ($3\frac{1}{4}$ ounces) of solution. The injections should be repeated every second day.—*Przeład Lekarski*, No. 40, 1893.

THE EXTINCTION OF TUBERCULOSIS.

DR. GEORGE H. ROHÉ, in his presidential address before the Medical & Chirurgical Faculty of Maryland, called attention to the possibility of the extinction of tuberculosis. He considered it an established fact that without the inoculation of the bacillus of tuberculosis we cannot have consumption or any other form of tubercular disease; and if by any means this infectious agent can be excluded from the body, the individual is safe from the disease. The principal measures to accomplish this end must comprise, first, immediate destruction of the bacillus in the sputa or in other excretions when the case is not a pulmonary one; second, the disinfection of clothing and bedding, or other furniture liable to be contaminated with the infective material. Accessory measures must be considered, such as notification of the health authorities of all cases of consumption, public disinfection of infected houses and conveyances, and the establishment of special hospitals for the free treatment of indigent consumptives established.

The efficient carrying out of restrictive measures against consumption requires intelligent co-operation on the part of the public. Hence, the education of the laity upon the infectious nature of tuberculosis, and the importance of individual measures of prophylaxis, must precede any successful enforcement of legal enactment looking toward the restriction of the disease. There can be no doubt that the public press can give most effective aid in spreading such knowledge. It is the most powerful auxiliary of the sanitarian. The press makes public opinion. Public opinion makes laws, and until laws have the sanction of public opinion, it is futile to look for their successful enforcement. Popular societies, like the French "Ligue

préventive contre la phthisie pulmonaire" and the "Pennsylvania Society for the Prevention of Tuberculosis," are also useful and effective agencies in educating the people upon this subject. By concerted action on the part of physicians, sanitary authorities and the public, tuberculosis may be stamped out and become in the future a matter of interest only to the historian of human progress.—*Maryland Medical Journal*, April 28, 1894.

CASTRATION IN HYPERTROPHY OF THE PROSTATE GLAND.

When Dr. J. William White first suggested to the profession the operation of castration for the relief of hypertrophy of the prostate gland (Address at the Annual Meeting of the American Surgical Association, June 1, 1893, *Annals of Surgery*, August, 1893), on theoretical grounds, although strongly supported by experimental evidence, it is doubtful whether anyone appreciated the full value of the recommendation. Cases of prostatic hypertrophy are of extreme frequency. Sir Henry Thompson found that one man of every three over 54 years of age examined after death showed some enlargement of the prostate; one in every seven had some degree of obstruction present; while one in fifteen had sufficient enlargement to demand some form of treatment. In this country to-day, as shown by the last census, there are more than three millions of men over fifty-four; of these, according to Thompson's estimate, which genito-urinary specialists consider a conservative one, about two hundred thousand are sufferers from hypertrophy of this gland. This number seems very large, but the assertions of Thompson unquestionably express a general rule, and in fact every surgeon must have seen men in whom some prostatic overgrowth existed *before* the fifty-fourth year. The lives of such patients are threatened because, if the obstruction is not removed, the health is rapidly undermined by the retention of urine and the consequent fermentative changes, the deleterious influence of backward pressure on the kidneys, the frequent use of the catheter, and the loss of sleep incident to the incessant demands to void urine. Heretofore the surgeon has been unable to afford distinct relief from the distressing symptoms of an advanced case of this affection. If the patient's general condition would warrant the very considerable risk, some form of prostatectomy was performed. The suprapubic method was recommended for a time; but the difficulties encountered in its performance, the frequency of suprapubic fistula as a sequel, and the high mortality following the operation have led to its almost total abandonment. Perineal prostatectomy is also attended with considerable risk, on account of the free-hemorrhage, which cannot be controlled during the operation, and

the prolonged anæsthesia which is necessary. In addition to this, the operation is a bungling one, in which the enlarged gland is removed by cutting, scraping, or gouging, while the instrument is out of sight, and much of the time it cannot be guided even by the finger. Combined suprapubic and perineal prostatectomy enables the operator to reach and enucleate the gland with greater freedom, but it is an operation of such gravity that it would be contra-indicated in the very cases in which the demand for relief was most urgent.

Perineal prostatotomy is little more than a palliative measure, which does some good, temporarily, by draining the bladder and inducing slight contraction of the middle lobe of the prostate in the healing process. All of these operations confine the patient to bed for several weeks, which is, in itself, objectionable, and in addition require the use of the bougie for a long time afterwards.

In view of these facts it is not strange that surgeons should have presented Dr. White's suggestion to patients suffering from the consequences of prostatic hypertrophy, nor is it unnatural that such patients accepted this chance for relief from a condition that in many cases was rapidly and surely impairing the health of a person otherwise vigorous and, apparently, without this trouble destined to enjoy many additional years of life.

With the testes already or soon to become functionless, and with the contemplation of a long period of intense suffering which will be relieved only by death, sentimental objections pale into insignificance, and the problem of securing relief without placing the life in danger is the only one entitled to consideration.

Cases of castration based upon Professor White's deductions soon began to be reported. Ramm, of Christiania, Norway, recorded two in September, 1893; Haynes, Los Angeles, Cal., and White, Philadelphia, each report three cases; Finney, Baltimore, reports two cases; Smith, St. Augustine, Fla.; Powell, London; Mayer and Haenel, Dresden; Moullin, London; Thomas, Pittsburg; Ricketts, Cincinnati; Swain, Bristol, England; and Bereskin, Moscow, each record one case. Thus far eighteen operations have been published. All have been more or less successful, and usually the relief from the distressing symptoms and the shrinking of the prostate have been marvellous. The least favorable cases have experienced infinitely greater relief than has been obtained by any method heretofore employed. At least as many unpublished cases have been operated upon with equally favorable results. There have been no deaths from the operation: of course, few would be expected in the hands of competent surgeons.

To those familiar with these cases, the rapid shrinking of the prostate and the simultaneous

relief afforded the patient have been truly wonderful. The operation has therefore passed the experimental stage, and has legitimately established for itself a position among the most successful of operative procedures. Indeed, the results have been so uniformly favorable that castration may now be considered a specific for hypertrophy of the prostate.

It is necessary, however, to utter a word of caution here. Castration is not indicated in every case of prostatic enlargement or urinary obstruction. To secure uniformly successful results, one must be certain that the condition from which the patient is suffering is appropriate for the operation. Cases of prostatic abscess, prostatitis, tumors of the prostate and of the region of the neck of the bladder, and other forms of obstruction in the neighborhood of the prostate must be distinguished from true prostatic hypertrophy. Without careful discrimination, both the surgeon and the patient will be disappointed, and the operation will unnecessarily be brought into discredit.

As it stands to-day, however, in appropriate cases, it appears to mark an advance in the surgery of the prostate, which, when the gravity and the frequency of the condition of hypertrophy are recalled, together with the more or less ineffectual and always dangerous methods of treatment which have prevailed, must be a source of congratulation not only to Professor White but to the profession at large, and to thousands of patients who, having outlived their sexual lives and earned an old age of mental and physical repose and intellectual enjoyment, have had only a few short years of torment and misery to look forward to on account of this hitherto intractable disease.—*Editorial University Medical Magazine.*

CANCER HOUSES AND THEIR VICTIMS.

Dr. d'Arcy Power, in commenting on Mr. Shattock's recent statement, that cancer, like tubercle, may repeatedly show itself in certain houses, adds a series of cases of his own illustrating this point. Miss B., aged 45, lived in a certain house in the suburbs of London for thirteen years, and died of cancer of the stomach in 1884. Miss T., aged 47 years, who had lived in the house for twenty years, then occupied her bedroom, and died of cancer of the liver in 1885. Mrs. J., aged 67 years, who had lived in the house for eight years, now occupied the bedroom, and died of cancer of the breast and uterus in 1893. Each of these patients appeared to be in perfect health until they took one another's place as housekeeper to the barmaids of the establishment in which they had each lived for so long a time. There was no blood relationship between them. One of the sons of the house, a nephew of Miss T., has a keloid which has been removed three times.—*British Medical Journal*, June 9, 1894.

THE CANADA MEDICAL RECORD

PUBLISHED MONTHLY.

*Subscription Price, \$1.00 per annum in advance. Single Copies, 10 cts.***EDITORS :****A. LAPHORN SMITH, B.A., M.D., M.R.C.S., Eng., F.O.S. London.****F. WAYLAND CAMPBELL, M.A., M.D., L.R.C.P., London****ASSISTANT EDITOR****ROLLO CAMPBELL, C.M., M.D.**

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MONTREAL, FEBRUARY, 1895.**THE ANTI-TOXIN TREATMENT OF DIPHThERIA.**

From reports gradually coming in from reliable sources, it would appear that the anti-toxin treatment of diphtheria is more than a passing fad. Although it does not save every case, there seems to be no doubt that it reduces the mortality very considerably. The most satisfactory proofs come from the Children's Hospital in Paris, where the treatment is being tested by Dr. Roux himself, and where, in order that other things might remain equal, exactly the same treatment was carried out by the regular physicians of the institution. The result was that the death rate, which had remained steadily for years at a certain figure, has come down nearly one-half. There are, however, unfortunately certain sources of error which must be eliminated before coming to a conclusion. For instance, while the treatment was almost hopeless, only the most serious cases, such as those requiring tracheotomy, would be sent to the hospital; but on parents learning that by sending their children early to the hospital the new treatment was almost sure to save them, many cases in the early stage, and probably many cases which are not diphtheria at all, would be received, and those cases would have recovered under any treatment, so that the normal balance would be disturbed, and the anti-toxin treatment would receive credit to which it was not fairly entitled. Several of our leading prac-

tioners, such as Dr. McConnell and Dr. G. T. Ross, have assured us that they were satisfied that the remedy is a valuable one, as in every case the most marked improvement immediately set in, the membrane coming off and the breathing becoming easy. We think the same method should be followed here as we have noticed above has been followed in Paris, namely, to continue the best treatment hitherto known and to employ the anti-toxin as well. Everyone admits that the latter can do no harm, and those who have tried it believe that it does good. There is one obstacle to its trial being carried out on a large and conclusive scale, and that is the great cost; but this will probably soon be removed by the establishment in Canada of a serum laboratory. In the meantime we should petition the government to issue sharp and peremptory orders to the customs officials, to admit it free of duty until such time that it can be produced in sufficient quantity in the country. We cannot comprehend the calibre of the official mind which taxes anæsthetics, vaccine or anti-toxin.

SHOULD PHTHISIS BE STAMPED OUT?

Although Koch's tuberculin has not apparently fulfilled the high hopes held out by its inventor as a cure for the dread disease in man, it has during the past year come to be recognized as an infallible diagnostic agent of tuberculosis in cattle, and by its aid thousands of tuberculous animals have been discovered and slaughtered in Canada and the United States. The process is an expensive one, but Governments and individuals consider that it will pay in the long run to incur an expense of several million dollars even, in order that the disease may be stamped out from the herds, many of which are of the highest breed, the disease being more common unfortunately in high grade animals than in the commoner ones.

In view of these facts, does it not seem strange that so little has been done towards stamping out of this greatest of all scourges of the human race? It has taken many hundreds of years to find out that it was not an inherited disease, but that it was on the contrary acquired by contact only. But now that no educated person, either in the profession or even among

the laity, has the slightest doubt of its contagiousness, does it not seem strange that some effort is not made to restrict the number of centres of contagion? When the matter was brought up recently at the Montreal General Hospital by one of the Governors, asking that arrangements be made to put the cases of consumption in wards by themselves, instead of sandwiching them between other patients, who, though not infected with the dread disease, yet were, owing to their anæmic condition, in a very receptive condition for the attacks of the bacilli, one of the staff who opposed isolation received a lesson in bacteriology from one of the laymen. In a recent article entitled "The Consumption Scare," the writer strongly opposed isolation, on the ground of the hardships which it entails. But we have pointed out over and over again in the columns of this journal, that isolation of the majority of cases could be carried out with very little hardship by the Dominion Government voting a sum sufficient to maintain a national sanitarium, in which consumptives born or resident in Canada might receive free maintenance and treatment. This would doubtless prove so attractive that the majority of patients would apply for admission of their own accord. Supposing that even one thousand people availed themselves of such an establishment, the cost would not exceed two or three hundred thousand dollars a year. Can anyone deny that the gathering together of that many people under the best sanitary and therapeutic treatment, who are now acting as so many widespread centres of infection, would be a judicious expenditure of public money? If he does deny it, then he must place the value of human life and happiness far below that of the value of animals. The mere fact that such an institution existed would do more to educate the people to the danger of consumptive people spitting in street cars and on the floors of their houses than any amount of talking to them would do. In the meantime, if any more hospitals are to be built and endowed, why should the next one not be one for consumption? It would be equal to extending the capacity of the existing hospitals, many of whose beds are occupied by consumptives at present, to the danger of the other patients. We are glad to learn that one physician at least in this city is devoting his attention specially to consumption

with good success, and we hope ere long to see in the leading cities of Canada hospitals established where not only the poor would be treated by the hospital staff, but where those who can pay could enter for treatment under the care of their own physician, and either be cured or die without spreading their disease to other members of their family.

Why do we isolate the insane, for which we pay willingly nearly a million dollars a year? For the public good, to which they are dangerous. And yet are they any more dangerous than those in the last stage of consumption, who are daily producing one of the most fatal bacteria known? If it pays us to spend tens of thousands of dollars in keeping from our shores the national enemy Cholera by our quarantine stations, and to spend hundreds of thousands in isolating even those who are only occasionally dangerous to society, why should we not spend something on the isolation of those who, sound in mind, recognize the danger to which they are exposing their families and who would voluntarily apply for admission?

THE TYPHOID OYSTER SCARE.

An epidemic of typhoid fever having broken out in a Connecticut college, and the students having a few days previously partaken of some oysters which had been transplanted from the sea to a small branch of the Connecticut river, and remained there for two days feeding on sewage, forthwith the luscious bivalve has had its reputation destroyed by the epidemic being laid entirely at its doors. A great deal more is blamed on oysters than they are justly answerable for. We remember an old gentleman who consulted a physician for a headache, which he attributed to his having eaten one oyster the night before. The physician thought the explanation insufficient, when on further inquiry it appeared that the old gentleman had washed the solitary oyster down with a whole bottle of old port. So in the case of the Connecticut college attacked by typhoid, while admitting the possibility of oysters becoming infected by feeding on sewage containing typhoid bacilli, yet we think there were far more likely sources for it to come from. For instance, there were two cases of typhoid at a farm house a little way up the river; did the

farmer or some other with a typhoid infected well supply milk to the college?

During the course of a collective investigation held some years ago in Montreal, nearly all the cases in the city were traced to two milkmen who had typhoid infected wells, and as a result of the investigation one of them gave up his business. If, however, these oysters actually contained typhoid bacilli in their livers at the time they were eaten, would not the disease be much milder in those who ate them than if they had swallowed the bacilli in all their savage ferocity? It has been proved beyond a doubt that nearly all bacilli may be domesticated, so to speak, by being cultivated for a few generations in some animal's blood. May it not be that even such a humble animal as the oyster may serve a good turn in immunizing man against the attacks of wild typhoid bacilli? So that having had a few milder and milder attacks of typhoid from oysters, college students would become proof against all danger of being attacked by a fatal form of bacillus from milk diluted with water from a typhoid infected well. The oyster scare has been a serious matter for the thousands of poor oyster fishermen on the Atlantic coast, the sales having fallen off during the last few weeks as much as four thousand dollars a week. While admitting the possibility of oysters becoming infected by their food, we maintain that they are no more deserving of suspicion than the fish which live on sewage almost exclusively, but which, though eaten in far greater quantities, have so far never been accused of conveying typhoid to their patrons. We would respectfully suggest that a sharper lookout be kept upon the milk and water man, where ample cause for typhoid will in most cases be found.

THE PRACTITIONER OF ST. LOUIS.

The welcome which we always extend to newcomers to the ranks of medical journalism is all the more hearty in the case of the one whose title appears above, because the editor is one of our old students at Bishops College, Dr. R. C. Blackmer, who is now professor of Medical Jurisprudence in the Barnes Medical College of St. Louis. In his opening editorial

the editor repudiates the idea that his journal comes to fill a long felt want, or that anybody wants it. But he has something to say, and he says it remarkably well, and he is going to let the profession hear from him and his associate editors once a month. As a student Dr. Blackmer was a favorite with his fellow-students as well as with his professors, due to his geniality of disposition and originality of thought,—qualities which should serve him in good stead in his capacity of a medical editor. We trust that the *St. Louis Practitioner* will do its utmost to raise the standard of medical education in its own State by the formation of a State examining board, if there is not already one, and the compulsory registration of all diplomas from recognized medical colleges before their holders shall be allowed to practise. We wish Dr. Blackmer every success.

THE CANADIAN MEDICAL REVIEW.

We are pleased to welcome to our exchange list this the latest addition to the ranks of Canadian medical journals. Being edited by such men as Dr. W. H. B. Aikins, A. B. Atherton, J. H. Burns, G. Sterling Ryerson, J. Ferguson, Albert A. McDonald and Allen Barnes, we are not surprised to find that it is a bright and interesting periodical. Although there is always room for one more, we must admit that with eight medical monthly publications, the five thousand doctors of Canada are well supplied with reading, and, all things considered, they receive good value for their subscriptions. With a little more patriotism and a little more energy on the part of the profession, the medical journals of Canada might be greatly improved. For many physicians of Canada subscribe for foreign journals without taking even one of our own, and the majority never write as much as a letter to the home journals, nor contribute an idea, while the few who do write too often send their articles for publication to a foreign publication. Most medical men must have at least one original idea a year, which might be useful to the profession; why will they not jot it down and send it in?

CANADIAN MEDICAL ASSOCIATION.

Those who attended the last meeting of the above Association at St. John, N.B., were all agreed that it was one of the most successful in the annals of the Association. From recent information received from Kingston it would appear, however, that the meeting next year promises to be a still more successful one. The secretary has received letters from all parts of the Dominion, stating that the writers would be present at the Kingston meeting, which will be held on the 28th, 29th and 30th of August.

The American Electro Therapeutic Association, which comprises the leading authorities on the subject from all over America, both in Canada and the United States, will hold its annual meeting at Toronto, beginning the day following the end of the Kingston meeting, so that the members of the Canadian Medical can proceed next day to Toronto and be present at the Electro Therapeutic meeting, where all are welcome without being Fellows. We would suggest that as many as possible would avail themselves of the double opportunity. Few outside of the Association are aware of the advances which electricity has been making during the last few years as a therapeutic agent, and much valuable information might doubtless be acquired at small cost by attending the meeting in which men like Rockwell, Morton, Goelet, Massey, Newman, Dickson, and other well-known writers will take an active part. Every Canadian practitioner of medicine should make the attendance at the meeting of the National Medical Association of Canada at Kingston the one great event of the year.

ACKNOWLEDGMENT.

We have much pleasure in giving credit to Dr. J. B. McConnell of Montreal, for an abstract of his excellent article on the treatment of inebriety by nitrate of strychnine. The journal from which we copied it had omitted to say that it was an abstract of Dr. McConnell's paper, and our printer, not seeing any name mentioned, failed to credit it to anyone. We hope Dr. McConnell will consider it the greatest compliment we could pay him that we printed his article on its own merits without even knowing that it was his.

BOOK NOTICES.

ON PRESERVATION OF HEALTH IN INDIA. By Sir James Fayre, K.C.T.S., M.D., F.R.S., President of Medical Board India Office. London: Macmillan & Co., and New York, 1894. Copp, Clark Co., Ltd., publishers, 9 Front Street W., Toronto.

The lecture by such a distinguished author should be read by all who intend to live in the tropical climate. They would learn how life there may be rendered as safe as anywhere else.

SURGICAL PATHOLOGY AND THERAPEUTICS. By John Collins Warren, M.D., Professor of Surgery in Harvard University; Surgeon to the Massachusetts General Hospital. 832 pages, illustrated by 120 engravings and 4 colored plates. Philadelphia: W. B. Saunders, 925 Walnut street, 1895.

As the author truly says in his preface, the scientific portion of a surgical education was formerly regarded as something apart and ornamental, but it has now become an eminently practical feature of the student's curriculum. No young practitioner can be regarded as thoroughly equipped for surgical work who is not both a good pathologist and an expert bacteriologist. The confidence born of a knowledge of pathology and bacteriology enables him to assume grave responsibilities and to grapple successfully with the most complicated problems. It is from men thus equipped that we have a right to hope that the future Masters of Surgery are to be evolved. An attempt is therefore made in this book to associate pathological conditions as closely as possible with the symptoms and treatment of surgical diseases, and to impress upon the student the value of those lines of study as a firm foundation for good clinical work.

It is the author's hope that the following pages will present to a large number of practising physicians, in a readable form, many subjects that received but little attention when they graduated.

The illustrations by William J. Kaula are, with one or two exceptions, original. The drawings of microscopical sections are taken from specimens prepared for the purpose, and are intended to illustrate as closely as possible the results of modern microscopical technique.

We have carefully read over several chapters, and can say without hesitation that this work is thoroughly up to date and written in a pleasant and instructive style. The chapters on tuberculosis of the joints and on tumors are especially well written. We heartily commend this book to our most thoughtful readers. It may be obtained through any bookseller.

TRANSACTIONS OF THE COLLEGE OF PHYSICIANS OF PHILADELPHIA.—Third series, volume

sixteen. Philadelphia: printed for the College, 1894.

We welcome these transactions more than ever; the present volume contains many gems from the pens of the talented members of this Society. There are few societies in the world which can turn out such a volume as this at the end of every year.

A PRACTICAL THEORY AND TREATMENT OF PULMONARY TUBERCULOSIS, by Frank S. Parsons, M.D., editor of the Philadelphia Medical Times and Register. Published by the Medical Publishing Company, 718 Betz Building, Philadelphia, Pa. Price, 25 cents. Paper cover.

This monograph covers seventy-seven pages of a neat little volume. It treats of a subject of universal interest to all scientifically inclined persons.

The author views tuberculosis in a new light, and from a more rational standpoint than any that has recently been advanced. This work, it is safe to say, marks a new era in the study of this disease.

The first pages are devoted to an interesting introductory, illustrative of the present condition of medical thought upon the subject. The causation of tuberculosis is then taken up, and it is admirably and ably shown that the dominant theory regarding the tubercle bacillus as a causative agent is not based on the true pathological condition in the early stage of phthisis. Bacilli are to be regarded only as developments, existing because a favorable medium presents. This medium exists before the bacillus is demonstrable, and consists of the waste elements of the blood congregating in a locality through lymphatic obstructions or stasis.

In the pages devoted to a consideration of symptomatology it is suggested that, in view of the universal dislike of fats by phthisical persons, there doubtless exists a disordered condition of the pancreas, which condition may be congenital or acquired.

Dr. Parsons has based the treatment of consumption on the lines of this new theory, calling attention to the advantages to be gained by elimination, nutrition and oxygenation. The low price of the book places it in reach of everyone, and no physician should be without it.

PAMPHLETS.

INFLAMMATION OF THE URETERS IN THE FEMALE, by Matthew D. Mann, A.M., M.D., of Buffalo, from the American Journal of the Medical Sciences, August, 1894.

THE TECHNIQUE OF VAGINAL HYSTERECTOMY, by George M. Edebohls, A.M., M.D.,

Gynæcologist to St. Francis' Hospital, New York; Professor of Diseases of Women at the New York Post-Graduate Medical School; Consulting Gynæcologist to St. John's Riverside Hospital, Yonkers, New York. From the American Journal of the Medical Sciences, January, 1895.

NOTES ON MOVABLE KIDNEY AND NEPHRO-RHAPHY, by George M. Edebohls, A.M., M.D., Gynæcologist to St. Francis Hospital, New York, etc.

A NEW METHOD FOR ANCHORING THE KIDNEY. Read before the Columbus (Ohio) Academy of Medicine, Nov. 19, 1894. By R. Harvey Reed, M.D., Professor of Theory and Practice of Surgery and Clinical Surgery Ohio Medical University; Surgeon Protestant Hospital, etc. Reprinted from the Journal of the American Medical Association, December 22, 1894. Chicago: American Medical Association Press, 1894.

THE USE OF THE GALVANIC CURRENT IN ARTICULAR INFLAMMATORY EXUDATIONS. By M. A. Cleaves, M.D. Reprinted from the Times and Register, December 19, 1891. Philadelphia: The American Medical Press Company, Limited, 1891.

ELECTRIC LIGHT AS A DIAGNOSTIC THERAPEUTIC AGENT. By Margaret A. Cleaves, M.D., Instructor in Electro-Therapeutics, New York Post-Graduate Medical School. Reprinted from the Medical Record, December 8, 1894. New York: Trow Directory, Printing & Bookbinding Co., 201-213 East Twelfth Street, 1894.

THE DIAGNOSIS AND TREATMENT OF "FLOATING KIDNEY." By R. Harvey Reed, M.D. (Univ. of Penna.), Columbus, Ohio. Professor of Theory and Practice of Surgery and Clinical Surgery Ohio Medical University; Consulting Surgeon B. & O. and Big Four Railways; Surgeon Protestant Hospital, etc. A paper read by special invitation before the Sixth Annual Meeting of the Shelby County Medical Society, at Shelbyville, Ind. Reprinted from Columbus Medical Journal, April, 1894.

UNE MISSION EN BELGIQUE ET EN HOLLANDE: L'HYGIÈNE ET L'ASSISTANCE PUBLIQUES; L'ORGANISATION ET L'HYGIÈNE SCOLAIRES. Par le Dr. C. Delvaille, avec une préface de M. Grancher, Professeur à la Faculté de Médecine de Paris. Paris: Société d'Éditions Scientifiques, Place de l'École de Médecine, 4, Rue Antoine-Dubois, 1895.

LOIS DE LA CRÉATION DES SEXES; DES MOYENS DE S'ASSURER UNE PROGENITURE MALE. Par le Dr. A. Cleisz. Paris: Société d'Éditions Scientifiques, 4, Rue Antoine-Dubois, 1895. Tous droits réservés.

THREE CASES OF UTERUS BICORNIS SEPTUS ; WITH REPORT OF OPERATIONS PERFORMED UPON THEM. By George M. Edebohls, A.M., M.D., Professor of Diseases of Women at the New York Post Graduate Medical School and Hospital ; Gynæcologist to St. Francis' Hospital, New York. Reprinted partly from the New York Journal of Gynæcology and Obstetrics, April, 1893 ; and partly from the Transactions of the New York Obstetrical Society, Jan. 16, 1894.

POLYCLINIQUE DE L'HOPITAL INTERNATIONALE : DES APPLICATIONS DE LA MICROGRAPHIE ET DE LA BACTÉRIOLOGIE À LA PRÉCISION DU DIAGNOSTIC CHIRURGICAL. Par le Docteur Aubeau. Avec 24 figures hors texte en photogravure. Paris : Société d'Éditions Scientifiques, Place de l'École de Médecine, 4, Rue Antoine-Dubois, 1894.

LES NOUVELLES MÉTHODES DANS LE TRAITEMENT DE LA DIPHTHÉRIE. Par le Dr. de Crésantignes, Membre de la Société de Médecine et de Chirurgie Pratiques, Médecin du Ministère de l'Agriculture, Officier d'Académie, etc., etc. Prix 2 francs. Paris : Société d'Éditions Scientifiques, Place de l'École de Médecine, 4, Rue Antoine-Dubois, 1895. Tous droits réservés.

PUBLISHERS DEPARTMENT.

LITERARY NOTES

From *The Ladies' Home Journal*, Philadelphia.

—DR. PARKHURST'S first article to women in *The Ladies' Home Journal* has proved so popular that the entire huge edition of the February issue of the magazine was exhausted within ten days, and a second edition of 45,000 copies has been printed.

—LADY ABERDEEN tried a novel solution of the ever-vexing servant-girl problem in her homes in Scotland and Canada, and in the April number of *The Ladies' Home Journal* she will, in an article, explain the method she adopted.

—No Antikamnia "Habit." Some physicians may fear to prescribe Antikamnia in chronic cases for fear of some danger arising from its continued use. But in a letter bearing date Nov. 8, 1894, written to a friend, Dr. Hunter McGuire of Richmond, Va., says : " I do not see any reason why you should not continue to take Antikamnia which you say has done you so much good. I do not believe it will do you any harm."

—To be a constant reader of *Littell's Living Age* is to keep a mind well stored with the best foreign literature of the day. To have read it all one's life, if one has reached maturity, is to have a knowledge of philosophy, art, science and literature, which is of itself a liberal education. These numbers comprise what is most notable in the great reviews and monthlies, such as Sidney Whitman's article on "Count Moltke, Field-Marshal," Mrs. Alexander's "Recollections of James Anthony Froude," E. N. Buxton's interesting paper on "Stony Sinai," Prince Kropotkin's "Recent Science," etc., etc. The first number in February shows a delightful table of contents : "A Little Girl's Recollections of Elizabeth Barrett Browning, William Makepeace Thackeray, and the Late Emperor Louis Napoleon," by Henriette Corkran ; "The Queen and Lord Beacons-

field," by Reginald B. Brett ; "Treasure Islands in the Polar Sea," with Part III. of "The Crimea in 1854 and 1894," by General Sir Evelyn Wood, G.C.B., V.C., etc. The same issue contains also the first instalment of "The Closed Cabinet," a powerful short story which is concluded in the following number.

Any reader desiring to be in touch with foreign periodical literature cannot do better than subscribe for this invaluable magazine. A prospectus with special offers to new subscribers may be obtained by addressing LITTELL & Co., Boston.

—The March number of the *Political Science Quarterly* opens with an exposition of the legal question involved in the matter of "Municipal Home Rule," by Prof. F. J. Goodnow ; Mr. Edward Porritt presents another phase of the municipal question in explaining "The Housing of Workmen in London" ; Prof. Simon N. Patten offers "A New Statement of the Law of Population" ; Mr. H. C. Emery, of Bowdoin College, discusses at length "Legislation Against Futures" ; Prof. W. J. Meyers investigates the cost of "Municipal Electric Lighting in Chicago" ; Prof. J. B. Moore presents the first instalment of a sketch of "Kossuth the Revolutionist" ; and Dr. Frank Zinkeisen, of Cambridge, criticizes the views of Stubbs and other historians on "Anglo-Saxon Courts of Law." The number contains, moreover, the usual Reviews and Book Notes.—GINN & COMPANY, Publishers, Boston.

MALIGN TUMORS OF THE KIDNEY.

Thorkild Rovsing, of Copenhagen, makes a contribution toward the diagnosis and treatment of malign tumors of the kidney, based upon 7 cases observed by him, of which 5 were operated upon. Of these 5, in all of which nephrectomy was performed, death occurred in 3 shortly after the operation, while 2 recovered. In 1 of these 2 latter cases death occurred three years after the operation, from local recurrence, the primary growth being a round-celled sarcoma. The other patient, a man aged 59, with a spindle-celled sarcoma, was free from recurrence when observed one year after the operation. In both these cases no tumor of the kidney was to be discovered by means of palpation, while in the remaining cases a large tumor could be felt. The author, therefore, thinks that tumors of the kidney, which have reached such a size as to be distinctly palpable, are generally not worth operating upon, the operation itself being dangerous and the radical removal exceedingly difficult. The early diagnosis is, then, of utmost importance, and should be based upon (1) a careful examination of the history of the case ; (2) a thorough microscopical examination of the urine (in 3 cases observed by Rovsing the microscopical examination of the urine revealed the presence of elements of the growths) ; (3) palpation during narcosis (the least reliable of all means of examination) ; and (4) direct exploration by means of lumbar incision. Finally, the author calls attention to the fact that malign tumors of the kidney most frequently have their primary seat in the upper part of the kidney.—*Hospitals-Tidende*, Nos. 20-22, 1894.