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CANADA
MEDICAL JOURNAL.

ORIGINAL COMMUNICATIONS.

Valedictory Address to the Graduates in Medicine and Surgery, Victoria University. Delivered on behalf of the Medical Faculty, by WILLIAM CANNIFF, M.D., M.R.C.S.E., Professor of Surgery.

GENTLEMEN GRADUATES,—Along the pathway of life we find placed here and there events of more than ordinary importance—events which may change our course in one way or another, or which are as eminences from which we may not only obtain a more extended view, but proceed with greater ease and success. Our whole life is a series of marches, each of which prepares for that which is to follow. The road we travel is like an ascent up a mountain, the summit of which is reached by successively gaining one eminence after another. We graduate from infancy to childhood, from childhood to adolescence, from adolescence to early manhood, and thence to mature life, when the full development of the body and mind is reached. Then, again, the mind graduates in strength and power as days and years add to the stock of knowledge and culture. In education there is ever an upward bent, as the student proceeds from the alphabet and passes one elevation after another toward the summit of his Parnassus. There is a common road which many travel, but there comes a stage in the journey when special routes will be selected. Those who desire to become learned in the law turn into one path; those who seek to unfold the mysteries of nature, in another; and he who would master the science of medicine turns into another, and pursues his course. Whatever be the way chosen, the student will still find a hill to ascend—from the A B C of the science until a point is gained, when he ceases to be a tyro. Then, no longer an apprentice, he is called to discharge the duties of a master-workman.

You, young gentlemen, whom I address to-day, have reached this important stage in your educational life. To-day marks an important event with you. Ceasing to be boys you assume the duties of men. No

longer under pupilage you are now members of the profession of your choice. I congratulate you upon having attained your majority. I congratulate you not merely because you have graduated into manhood and in medicine; but that you do so at such an auspicious period of our country's history. The Dominion of Canada under Confederation has just reached man's estate, and has been clothed with the robes of national power, and endowed with the functions of national life. She has received a diploma to practise the science and art of independent existence; and thus she has commenced to work out the grand problem of national success, just as you have been furnished with authority to work out your independent personal destiny. It is, I say, a happy time to be called to work and act for yourselves, as your country has entered upon the high way of prosperity. As I believe this Dominion will be fully able to meet the expectations of the most hopeful and trustful, so I believe you Graduates in Medicine, of Victoria College, will be found equal to the duties and responsibilities which await you in professional life, and that you will, like your country among the nations of the world, stand among your fellowmen and brother practitioners, at all times honest, just, upright, and inferior to none. But in order to be successful you must not only make use of your present acquirements, you must ceaselessly endeavour to add to your store of knowledge, not of medical lore alone, but of all knowledge which will assist to equip you for the duties of life. Although you now cease to be tyros and pupils under professors, you cannot cease to be students. It is one of the conditions of success in the medical profession that constant application of the mind be practised. The field of book knowledge, and of nature, must be both diligently cultivated.

Upon the elevated ground you occupy to-day, you may profitably look upon the past, and forward to the future, while you fail not to gratify, as you are justified in doing, your mind by contemplating the surroundings of the present. I have no doubt, in the past, during the time you have been engaged in the pursuit of the principles of the science of medicine, you have often experienced hours of hopelessness, of despondency, almost of fear. The ordeal through which you have passed before the College Examining Board, and the Board of the Medical Council, is well calculated to make one thoughtful, and consider whether he can possess himself of the knowledge, the power, and the courage requisite for successful passing. It is a cause of great gratification equally to us all, both teachers and students, that you have not been found wanting. Wanting neither courage nor success. I now speak of the graduating class of Toronto, and I have no doubt the same can be

said of the Montreal class. Out of the Government candidates who recently appeared before the General Board at Toronto, the number from Victoria College was equal to the total number from all the other medical schools in the Dominion. Of your members who presented themselves before the Council Board for final examination, a Board, the members of which consist of representatives from all the medical schools in the Province, and from the profession in all parts of Ontario, not one who had altogether studied his profession at Victoria College failed to pass his examination. And at the same, I believe I am correct in stating that in the primary class, the first five highest on the list for efficiency were from this institution. Having now passed through the long, trying months and years of your pupilage, and having so creditably acquitted yourselves at the dual examinations, you would be less than mortal did you not exult in your successes to-day. On behalf of the University, on behalf of the Medical Faculty of Toronto, and on my own behalf, I again congratulate you. But think not—I must warn you—that the major difficulties of life have been overcome. Your present position but enables you to set out upon the real duties of life. Your present attainments are qualifications which enable you to undertake the most solemn duties that can devolve on mortal man. Your successes to-day clothe you with responsibilities for the future, the magnitude of which cannot easily be over-estimated.

Will you permit me, your old teacher, one who has tried to be, and who will continue to be, your friend, to offer you a few suggestions respecting the duties which await you in the practice of your profession. I have already intimated that although you have now become doctors of medicine, you will have to continue to be earnest, constant students. In the past you have been concerned principally to prepare yourselves for examinations; hereafter you will strive more particularly to be prepared for every emergency in practice. In the past your source of information has been mainly the book and the lecture room; hereafter you will seek more especially to gain knowledge in the contemplation of disease. But while you thus gain personal experience, do not neglect the experience of others. Forget not, nor despise the ancient landmarks, for new and uncertain guides. By all means leave the first principles; but in proceeding take heed to your way that it be a true one. In the application of the principles of the medical science you are now supposed to have mastered, you must exercise all the sense you possess. *Common* sense all the time; *uncommon* sense, provided it be sound, as much as you can command. Aim to be natural, and eschew everything artificial. An air of mystery may suit a certain class of minds; but it is repugnant

to the educated and refined. The relations the physician sustains in life are in many respects singular. Although a private individual, he is in many respects a public man. His conduct, his success, his failures are the constant subject of public comment, and it behoves him to always comport himself with the dignity which belongs to his office. I need hardly tell you that your mission is a noble one. To relieve pain of mind and body, to remove disease and deformity, and to rescue from death, is indeed an excellent calling. And I would tell you to frown down and repudiate the statement sometimes carelessly and thoughtlessly, and sometimes simply, made, that the physician lives upon the miseries of others. This is an unfair, nay, a foul, way of putting the matter. The physician's calling is to relieve, to save, to spare from pain, and from death. He does not cause the pain, he does not create the disease. These come to the people independently of the physician; and often as a result of indiscretion, and in spite of his advice. And should he not live by his calling? Surely he works hard enough, he suffers anxiety enough, he feels responsiblity enough, his own life is uncertain and short enough to entitle him to the bread he thus earns.

At the very outset you will meet with a very trying difficulty, at least most medical graduates do. The chances are that for months, perhaps years, you will have but a limited amount of work to do as a practitioner. This is unquestionably a severe trial. After spending four or five of the best years of your life in hard mental work, and having invested a considerable sum of money in acquiring a profession, it seems very hard to have to wait quietly and patiently for an opportunity to exercise your qualifications and earn the bread of life. This is always a critical period. There is a strong temptation to depart from the noble rules which guide our profession, to obtain practice. But it is better to wait than to seek by unquestionable means the patronage of the public. The tree which grows the speediest is not the strongest, nor the longest to live. Public confidence, to be lasting and sound, is necessarily of a somewhat slow growth. By unseemly advertising, or unjustifiable promises to cure, one may secure an early practice, but sooner or later there will be a reaction. During this period of waiting, there is another danger frequently encountered. With little to do, the mind, after years of activity, becomes tired of inaction, and often seeks unnatural means of occupation and enjoyment. And, too frequently, a course of dissipation is entered upon, of mind and body. In this connection I would recommend to your consideration the advice given by Mr. Haliburton in his lecture to the young men of the Dominion. He argues, with respect to the habit of using spirituous drinks, upon all, to religiously refuse at all times either to

treat or be treated at the public bar. By adhering to this rule much evil would be abated. But, gentlemen, my advice to you is to entirely abstain. You can do without stimulants, and thereby you will escape a danger which has ruined so many of the medical profession. Instead of allowing this time to be wasted or misspent, you should employ it, as I have before said, to add to your stock of general and special knowledge; and in the effort to strengthen the mind in those properties by which close and correct observation and reasoning, so essential to a successful physician, may be cultivated. In addition to those subjects which particularly belong to your profession, you may to advantage make yourselves familiar with some other science or study. The field of literature, of science, and the fine arts, may give you abundant opportunity for increasing your store of information, and for strengthening the mind by pleasant recreation.

In the relationship of professional life you must be just; just to those who employ you, just to yourself, and just to your fellow practitioner. Remember that a great trust is placed in your honour, your skill, your attention. Fail not to deserve this confidence, to respond to the just expectations, so far as you possibly can. But at the same time be just to yourselves. The claims of your practice do not require a sacrifice of health, nor a forgetfulness of comfort. A reasonable public will not expect it. Then you must be just to your fellow practitioner. To do this, I would simply ask you to adhere to the old but everlasting rule—olden, but golden—to do unto others as you would have others do unto you; or, in more modern phraseology, when the reputation of a *confrère* is involved, or called in question—put yourself in his place. The public often seem to delight in bringing medical men into antagonism; and then cry out about doctors differing. It is a safe rule, and just, to offer no opinion upon a case which may reflect upon another, except in his presence, and the necessity for doing even this is exceedingly rare. Always remember that your office is to treat disease to the best of your ability, and not to express your views upon the treatment pursued by another. In cases of consultation be careful to befriend your brother, so far as you truthfully can. Above all, do not, by word or sign, seek to gain popularity by disparaging another. Such conduct is not only dishonorable, but it will sooner or later be visited upon yourself.

Perhaps some of you have sought the honorable position of Doctors of Medicine, not with the view of practising, but for the satisfaction of possessing such qualifications. With such there still rests great responsibilities. There is a lamentable amount of ignorance with the public as to sanitary laws, and the necessity of hygienic measures to secure the

best interests of the public and of individuals. Those of you who may not practice, as well as those who do, can aid much to educate the public mind up to the proper level. Some of you, I hope many, will become independent, and while I trust none of you will degrade the functions of your calling to a mere money-making work, I shall be glad to know that you have something more than barely earned the bread of life. Independence, from whatever source, may lead you to enter political life. To do so is a praiseworthy ambition. I believe that a larger number of medical doctors in our Parliament would be productive of good. I may say I think they are entitled by education and general fitness as much to high positions of trust as their brethren of the legal profession.

Finally, I would enjoin upon you, gentleness; a christian gentlemen is a true nobleman. Whether by the bedside or before the public, do not forget to behave yourselves as gentlemen—as members of a learned and cultivated profession. In kindness of manner, in sympathy, in consideration of the feelings and wishes of others, allow your better nature to prevail. The poor will have claims upon your care, and it is one of the privileges enjoyed by the medical man of being able to fulfil the requirements in acts of charity, of not letting one hand know what the other may do. Again, you will become the repository of family secrets. Those you cannot consider as too sacred. Indeed, reticence at all times with respect to your patients, is most necessary. It is not your business to satisfy impertinent curiosity.

From the suggestions I have made to you it is apparent that your future will be attended with difficulties and cares. These to some of you may seem almost overwhelming, but by adhering to the laws of christian brotherhood, your way will be made easy.

In bidding you good-bye, I may be permitted to say that your *Alma Mater* will ever watch your career with solicitous regard; and in return she will expect a filial attachment on your part. You will, I am sure, be glad to know that the prospects of the Toronto Medical Faculty are most encouraging. The staff, composed of members loyal and true, and with a reputation as teachers in advance of previous years, will be enabled more faithfully to fulfil their promises to the public, than in the past. The college building being hereafter situated in close proximity to the General Hospital, will afford increased facilities for the student to acquire a thorough practical medical education. Lastly, I would strongly urge you to become active members of the Medical Alumni Association, and attend its yearly meetings which take place at the time of the opening of the winter session.

This Association has already been highly beneficial to its members, and by your hearty co-operation it may become increasingly useful.

And when finally you have passed through the remaining journey of life, and the evening sun approaches the horizon, may golden light illumine the sky. May thoughts of the past be unattended with regret as misspent time and energy, and may the future be full of promise—full of those promises made unto the faithful christian.

MEDICO-CHIRURGICAL SOCIETY OF MONTREAL.

MEETING HELD, APRIL 1ST, 1871.

Dr. WILLIAM E. SCOTT in the chair.

Dr. WILLIAM H. HINGSTON read the following paper on "Skin Grafting."

MR. PRESIDENT AND GENTLEMEN,—A few months ago British Medical Journals chronicled the importation from France, and the introduction into Great Britain, of a new method of treating intractable ulcers, by grafting upon, or imbedding in the sluggish granulations, small pieces of healthy skin taken from some other part of the body. The accouut was at first viewed with suspicion, for so much had been written on the treatment of ulcers, that it seemed unlikely a new method of treatment, differing from every one which preceded it, should thus suddenly be ushered into existence without any of that premonition usually observed in other discoveries.

Mr. POLLOCK, of St. George's Hospital, Mr. COWPER, of the London Hospital, and Mr. LAWSON, Mr. DOBSON, Drs. BARLOW, THOMAS WEMYS BOGG, VACY ASHER, and others, communicated their views and experience, so that it straightway became in its turn *à la mode*, to the exclusion of those other pet subjects which had exorcised medical minds, and had called forth all the resources of a refined and elaborate investigation.

At that time—now some months ago—I had an opportunity afforded me of testing M. REVERDIN's statement, for it is to him is due the merit. Two old inveterate ulcers, such as are met with in every hospital—that come in the autumn and leave somewhat better in the spring—were then under my care; indeed, one had been a torment and a rebuke to me for several years, coming with the snow, and going with it in the spring, improved, 'tis true, but with a large unhealed sore still remaining. The other was a still more inveterate case, although this was the first winter he had spent in the hospital. On both I performed skin-grafting, and the following is the history, as furnished by one of my students, Mr. WARD:—

G. H., a pale, and ex-sanguine old man, æt. 72, was admitted into St. Patrick's ward, on 7th February, 1871, for an ulcer on the leg

which, he said, had troubled him more or less for the past twenty-three years. The ulcer, at the time of admission, was deep and spoon-shaped, on inside of tibia, four inches in greatest length and 3¼ inches in greatest width, and was covered with an offensive, unhealthy-looking, greenish fluid; the granulations were few and pale, and the edges of the ulcer were thick and hard. Rest in the recumbent posture, tonics, and good food were ordered, and the local application of one part carbolic acid to forty of water. In a couple of days the ulcer was clean, and the bandage and red wash were substituted. 9th March—granulations were more healthy looking, and the edges were no longer thick-ribbed and indurated; the area of the ulcer had diminished, so that it now measured 3½ by 3 inches.

On the 11th Dr. HINGSTON made two parallel incisions into healthy skin, midway between the ulcer and the knee, joined there by incisions at each end; three small pieces, about the size of a grain of wheat each, were imbedded in the granulating surface—slight incisions having been made to receive them—equi-distant from the edges and from each other, and were held *in situ* by narrow strips of adhesive plaster and a bandage.

13th.—On removing bandage a large quantity of offensive, unhealthy-looking pus, which had been pent up, deluged the sore, and no trace of a graft.

14th.—No trace of graft visible.

15th.—A leaden-white shining speck is visible at site of one of grafts.

16th.—The other two grafts, or the product of them, distinctly visible.

17th.—Specks much increased in size; surrounding edge of cicatrix seems to manifest disposition to close in.

20th.—Ulcer closing rapidly from sides, and the upper graft has reached the advancing cicatrix, and has formed an isthmus with it.

25th.—Two of the islands of new skin are now promontories.

28th.—The three islands have reached the advancing circumference.

30th.—Ulcer entirely healed—except a space about the size of a pea, midway between the three grafts—twenty days after insertion of the grafts.

During the whole period the leg was kept elevated, and the patient was not allowed to leave his bed for a moment.

CASE II.

J. F., æt. 59, was admitted 30th January, 1871, to same ward, for an eczematous ulcer over right tibia, which had troubled him for upwards of six years, a considerable portion of which he had spent at intervals in the Montreal General and St. Patrick's Hospitals. The ulcer was treated in the same manner as the preceding, with some amelioration.

10th of March.—The ulcer is now 2½ inches in length by 2½ in width. Three small pieces of skin, about the size of a grain of rice, were taken from the neighbourhood of the ulcer and inserted, as in the preceding case, and in the same manner, into the granulating surface; small strips of adhesive plaster retained them *in situ*.

14th.—Traces of the skin-graft were distinctly visible.

15th, 16th, 17th, 20th, 25th, 28th, and 30th.—The progress observed was much the same as in the preceding case, but on 30th the ulcer was completely healed, leaving no lacuna as in the former.

In both these cases it was most interesting to see the small, shining islands of skin increase day by day—stretching out towards each other and towards the circumference, the latter now advancing to meet them, till islands became an isthmus in the one case, or joined the mainland and became a promontory in both.

The rapidity of cure was marvellous. I have never seen anything in surgery which interested me more. The ulcers, in both cases, were healed almost as soon as the incisions in their neighbourhood from which the grafts had been taken. No sooner had the grafted centres commenced to grow than the ulcer was observed to heal very appreciably from the circumference, the hitherto stationary circumference extending vigorously towards the central islands; and this, although the patients continued otherwise under precisely the same hygienic conditions.

That the cure is a permanent one, and not liable to those accidents which attend granulating surfaces, may be inferred from the circumstance that a month has now elapsed since the healing process has been completed.

Although the subject is in a measure new, it would seem—

1st. That a healthy condition of the granulating surface is necessary; every attempt at changing the surface of an unhealthy ulcer by skin-grafting having failed.

2nd. That the size of the graft is of no importance, and, taking into consideration the patient's feelings, the smaller the better.

3rd. That skin alone and no adherent fat, should be engrafted.

The method more recently introduced by Mr. FIDDES, of Aberdeen, would seem to simplify this process of grafting. Mr. FIDDES says "it is quite unnecessary to put the patient to the pain of cutting a piece of healthy skin from the body, for the purpose of transplanting it on the sore; all that is necessary to be done," he says, "is to take a long bistoury or razor and shave or scrape off the epidermic scales from the convex parts of the extremities, such as on the outer and convex aspects of the forearms and thighs, and place them on the healthy granulations,"

and then "brushing the scales off the bistoury with a camel-hair pencil," and "securing them *in situ* for three or four days by means of common adhesive plaster."

Mr. FIDDES' plan really appears to me to be more painful and troublesome than the other, but the result may be the same, for the new growth of skin is but the product of cell development—such, at least, would appear to be the view of SCHWANN—that epidermic cells are "nothing more than dried cells having a nucleus in them;" and, Mr. FIDDES, basing his views on the SCHWANN theory, says, "is it not possible that the scales may imbibe serum from the plastic lymph on the granulations and adjacent tissues, and from cells which ultimately go to the formation of skin?" And "the practice of placing epidermal scales on a healthy, granulating sore causes it to heal or skin over more rapidly, not only from the top, but also in the centre of it." The rapid closing in of the circumference of the cicatrix, so soon as the skin-grafting has taken root, is not the least pleasing and surprising feature in skin-grafting. I have no view of my own to offer, but shall only mention those that seem to possess *vrai semblance*.

Dr. HINGSTON then briefly mentioned the views of different writers, and concluded with POLLOCK, "that a tribute of admiration and gratitude is due to M. REVERDIN from the profession, for the boon he has conferred upon surgery, by the introduction of this original method of dealing with large and obstinate ulcers.

Dr. R. PALMER HOWARD contributed his experience on the subject by reading the following

CASES OF SKIN GRAFTING,

IN THE MONTREAL GENERAL HOSPITAL, UNDER DR. HOWARD.

MR. CHAIRMAN AND GENTLEMEN,—Having seen by the notice of the Secretary that the subject of Skin Grafting was to be brought before the Society this evening, I thought it might add to the interest of the Meeting were I to relate some instances in which the process had been employed by myself.

Case 1.—J. M., aged 24 years, was admitted on the 20th December 1870,—and transferred to my care 1st January—the subject of an ulcer upon front of leg, four inces long by an inch wide, which is surrounded by a smooth thin cicatrix, 13 inches long upon the inner side of the member, 8 inches long upon the outer, and about 5 inches broad, and the result of a lacerated wound received in September, 1869, by falling from the platform of an express railway car.

17th January.—The ulcer has been healing very, very slowly, little

reparative power is being exhibited. Two patches of skin taken from the arm were grafted in the ulcer; the layer having the diameter of a green pea upon its upper extremity, and the smaller about half that size upon its lower. An examination of the sore on the third day, (20th January) showed that the larger graft had retained its vitality, but was of a somewhat purplish hue; the smaller, white and moist, resembled a mass of concrete pus.

22nd.—The larger graft has a pinkish hue, as if its outer layer of cuticle had desquamated; the smaller is no longer visible.

On the 27th January, erysipelas attacked the leg and extended up the thigh nearly to the groin, and down the limb to the foot, where a phlegmam formed; the graft, although involved in the erysipelatous inflammation, did not perish. When the erysipelas had disappeared cicatrization began rather slowly around the margins of the upper graft, and the edges of the ulcer also began to exhibit more active healing power, as if the formative process had been stimulated by the engrafted skin. The lower fragment which, since the 22nd January, could not be distinguished from the surrounding granulations by me or the students, although the patient had always professed to be able to recognize it, became again visible, and covered with firm cuticle, and cicatrization began to extend around its margin.

About 14th February the ulcer had cicatrized completely at the side of the grafts, but the central portion, showing very little tendency to heal, the patient requested me to graft again. Two fragments about the same size as the former were taken from the arm, and when examined three or four days afterward, the upper graft was found adherent and alive, the lower one was missing. The bandage and plaster had slipped, and the graft had probably become displaced. A few days later the rays of new growth proceeding from the upper graft, met those developed from the margins of the ulcer on either side, and that portion of the sore was covered with a firm-looking cicatrix.

About the 11th March, as an area of the ulcer about an inch long and three quarters of an inch wide, remained open and healed very slowly, another graft of the size of a split pea, and taken from the arm, was applied to it. Three days later this graft was found adherent, and a week later the centre ulcer had healed.

March 30.—Examined the man to-day, as my quarter's attendance at the hospital will expire to-morrow. The cicatrix formed by the grafting process is much thicker, firmer and less tender-looking than the older cicatrix around it; and, although 72 days have elapsed since the first graft was made, tactile sensation does not exist on the grafts, nor indeed in any

part of the old cicatrix. It is quite perfect, however, in the margins of the original integument where they unite with the cicatrix.

Case 2.—My second case was that of a boy with a large ulcer covering about half the circumference of the upper three-fourths of the thigh and inguinal region, and another about three inches square in the umbilical region. He had been scalded several weeks previously; cicatrization was proceeding but slowly; the discharge was profuse, and the granulations flabby and exuberant—they bled freely when lightly touched.

On the 20th of February I grafted five fragments from the chest, and secured them as in the previous case. Some of them were about two lines in diameter, others half that size.

February 25th.—The graft on the smaller ulcer and three on the larger promise well; one missing.

March 7th.—Only the graft on the smaller ulcer can be seen.

March 17th.—Five similar portions of integument, of the same size as the previous series, and taken from the same neighbourhood, were grafted on the larger ulcer.

March 20th.—Two only of the last grafted visible.

30th.—Only the graft on the smaller ulcer remains visible. It has increased to about three times its original size by the growth of new skin from its edges, and a ray-like process of new integument connects it with a similar outgrowth from the surrounding margin of the ulcer. It has an opaque, white hue. The other nine grafts cannot be discerned.—(Reported by Mr. E. GAVILLAR.)

Case 3.—W. W., aged 42, entered hospital on 9th of March with an ulcer 2 inches in length and one in breadth, situated on the front of the shin. It was surrounded by a large dusky cicatrix which adhered firmly to the subcutaneous tissues; these were indurated and the shaft of the tibia was considerably enlarged in the ulcerated region, as if chronic osteo-periostitis had existed. The ulcer was raised above the level of the surrounding surface, was firm and devoid of granulations, and its edges indolent-looking. It was strapped for a few days with the view of bringing its surface to the level of the adjacent parts, and at the same time stimulating its surface to granulate preparatory to grafting integument upon it.

March 15.—Two portions of skin, each having an area about equal to that of a split pea, were taken from the patient's arm and secured in the ulcer.

20th.—Both fragments in view; of a reddish hue with purplish edges.

23d.—Each graft increasing rapidly at the edges, and now nearly of the diameter of a ten-cent piece.

25th.—The ulcer almost entirely healed. This man was not kept any longer under observation, as the wards were being emptied as much as possible for sanitary purposes.—(Reported by M. ALGUIRE.)

Case 4.—Mary Dillon, aged 50, was admitted on 24th March, 1871, with a burn which she had received on 1st of Oct., 1870, from a candle setting fire to her clothes. The raw surface reaches just above the nipple to within two inches of angle of the scapula, being 15 inches long. Below the clavicle it is about 3½ inches broad, on the shoulder 6 inches, and on the back 5 inches. It extends, also, up the side of her neck. On Saturday, 25th, transplanted seven pieces of skin which were taken from her abdomen; three placed below, and four above clavicle, each about a line in diameter. On 28th March found all pieces looking well; the sore discharges a great deal, has to be dressed every day. March 31st. Grafts all looking well, but one which is not visible. She is, of course, still under observation—(Reported by M. ALGUIRE.)

There are some points of interest in the above four cases of Skin Grafting upon which I will briefly remark:

Mr. Pollock and others have noticed the same temporary disappearance of the grafted portions of skin that occurred in my first case. As Mr. Mason has not done so, it has been suggested that the non-disappearance for a time of the grafts in any of Mr. Mason's cases may have been due to the rather larger size of the grafts which he employed than those Mr. Pollock used. But this explanation is proved not to be correct by my first case, in which a graft having a diameter equal to half that of a green pea ceased to be recognizable for many days and then re-appeared and set up active cicatrization about its edges.

That a healthy granulating state of a sore is favourable if not essential to the success of Réverdin's process has been insisted upon; and the failure of nine out of ten grafts in my second case was probably mainly due to the weak, flabby, and bleeding character of the granulations which covered the ulcer; a condition, by the way, common in extensive burns.

I believe little is yet known as to the usual period at which the transplanted skin acquires tactile sensibility. Mr. Pollock found sensibility absent in the graft nine weeks after its transplantation. It is still absent in my earliest case, although the graft is ten weeks old, and it is inter-

esting to know that in the same case no tactile sensibility exists in the oldest portions of the cicatrix, notwithstanding that probably 17 months have lapsed since their formation.

Mr. Lawson says that in a case of his the grafts acquired sensibility in 10 to 12 days; but I cannot help thinking some error of observation was committed. If the graft be touched too heavily or rudely, the impulse may be easily transmitted through the insensitive skin to the adjacent sensitive textures, and the erroneous influence may be drawn that sensation exists in the graft. This actually happened in my own case. About three weeks after transplanting the first graft in Case 1, I tried whether sensibility existed in the graft, and was told by the patient that it did; yet six or seven weeks later on carefully repeating the experiment in various ways, I found that no sensation existed in either the graft or the cicatrix.

Lastly that remarkable and encouraging circumstance, noticed by other observers, was observed also in some of my cases. I allude to the active manner in which the process of cicatrization started, as it were *de novo* on the margin of the ulcer simultaneously with or soon after the manifestation of that process on the edges of the graft.

April 1st, 1871.

Dr. REDDY asked if one of Dr. Hingston's patients, in whom sensation was good, might not have been mistaken as to the identity of touch.

Dr. HINGSTON replied that he tested the man by means of a sharp-pointed pencil, and he said he felt the pricking sensation distinctly, and described the character of the instrument employed.

Dr. CRAIK said that Paget believed the scooped appearance of old ulcers to be only apparent, and due to everted edges.

Dr. FRANCIS W. CAMPBELL said he had within the last day or two, scraped a number of epithelial scales from his arm and dusted them over the surface of a somewhat extensive ulcer, with a view of testing the value of that method. He was, however, unable to give any result so far.

Dr. TRENHOLME said that in regard to the sense of touch even in normal surfaces, a layer of dead or senseless epitheliam intervened between the object felt and the nerves of the skin, and did not act as a bar to the perception of fine impressions. With regard to the experiment which had been made by Dr. Campbell, from the suggestion of a Scotch surgeon, he thought that, reasoning from the mode in which skin grew, it was a difficult matter to conceive, how epidermic scales scattered

over a raw surface could in any way cause the growth of true skin. The external layer of the *cutis* is composed of cells which have already performed their office, and were in the process of being thrown off. As in the grafting of fruit trees the transplanted bud looses its epithelial layer, and the growth of the new bud proceeds from the germ below the external layer, so it may naturally be inferred that the growth of new skin by grafting occurs in a similar manner; the cells of the deeper layers of the true skin, which are in process of development, being the real origin of the new skin. The application of a blister has in some cases been followed by growth of new skin in the centre of the sore. This he thought was most likely due to the blister detaching undeveloped cells from the skin, which, by some chance, have been retained upon the surface till vital union has taken place, and thus they have become centres for developing new skin. The rapid healing over of the ulcer, when once the grafts have been vitally attached, and little islands of skin have made their appearance, may possibly be due to the fact that these little centres by their growth cause an increased supply of blood to flow to the part, open up larger arterial channels, and also, by this means, diminish the pressure of the edges of the sore, on the small vessels, terminating at its margin.

Dr. CRAIK thought the point was whether nerves were produced in the new tissue itself. Were nerve tendrils developed at the same time as the new skin, and did they become connected by nerve filaments with surrounding tissue.

Dr. HOWARD said in his cases the tactile feeling was very imperfect, even after a very lengthened period. Might this not be explained by the fact that he took the grafts from distant parts. In Dr. Hingston's cases he noticed that they had been taken from the neighbourhood of the ulcers, and as we know that similar parts of the body have similar structure, this fact might account for the increased sensibility in his case.

Dr. HINGSTON inquired as to the condition of the skin which grew from the circumference of the ulcers in Dr. Howard's cases?

Dr. HOWARD said it was very much like the grafts—it was thin. In one case, a long ulcer—the skin which formed on the long axis, was firmer than that which formed transversely.

Dr. HINGSTON asked if Dr. Howard did not think it was from the cells, and not from the skin, that the propagation took place.

Dr. HOWARD replied that as the grafts had in nearly all the cases disappeared in a few days, it could not be from the epidermic cells that

the reproduction occurred. It must, therefore, he believed, be from the vital portion of the skin.

Dr. HINGSTON said if his observations had been confined to his first case, he would have said that reproduction took place from the skin, but in his second case the grafts entirely dissolved, and were lost sight of. In a few days, however, they were again recognizable. Perhaps Pollock and Tibbs, who hold opposite opinions, might be right after all.

Dr. HOWARD said that in his first case, one of the grafts retained its original appearance, and was never lost sight of. In others, the grafts entirely disappeared, but eventually turned up again, and cicatrization took place from their bodies. He thought it not quite fair to argue that because the grafts disappear and re-appear that it was the epidermic scales which play the important part. He would rather argue for an opposite view.

Dr. KENNEDY asked if areolar tissue was included in the grafts?

Dr. HINGSTON: In his grafts a portion of areolar tissue was included. He gave chloroform while taking off the grafts.

Dr. HOWARD said his patients had loose skins, and a certain amount of areolar tissue was included, not more, however, than it was possible to avoid.

Dr. CRAIK asked whether Dr. Howard or Dr. Hingston had paid any attention to the placing of the pieces of skin in the same relative position with reference to the axis of the body as they had previously occupied, as he thought that the grafts would be much more likely to recover their functions rapidly if placed in a corresponding position in their new sites than if inverted. With reference to the particular part of the skin most concerned in the process of reproduction he was inclined to think that the intermediate layer, "basement membrane," had more to do with it than either the epidermic or the fibro-cellular layer. In the cases cited, both the epidermis and the fibro-cellular layer had been observed to disappear, and yet the graft was not dead, but after a time re-appeared and propagated itself vigorously. Under these circumstances it seemed most likely that the power of reproduction resided more particularly in the primary or basement membrane than in either of the other structures.

Dr. HINGSTON confessed that he did not pay any attention as to placing the grafts in a similar position to that which they occupied in their original site.

Dr. HOWARD stated he likewise had not paid any attention to this matter, and that although the theory of Dr. Craik was very ingenious, he hardly thought it correct.

Dr. FRANCIS W. CAMPBELL mentioned the Taliacotian operation as opposed to the theory advanced by Dr. Craik.

Dr. HOWARD mentioned that one of his cases, who had good sensation on the restored part three weeks ago, had a few days previously, when examined, no sensation whatever. He could not account for this, unless, indeed, in the first instance he had been deceived.

The thanks of the Society having been tendered to Drs. Howard and Hingston for their interesting papers, the Society adjourned.

MEETING HELD 15TH APRIL, 1871.

Dr. GEORGE W. CAMPBELL, President, in the chair.

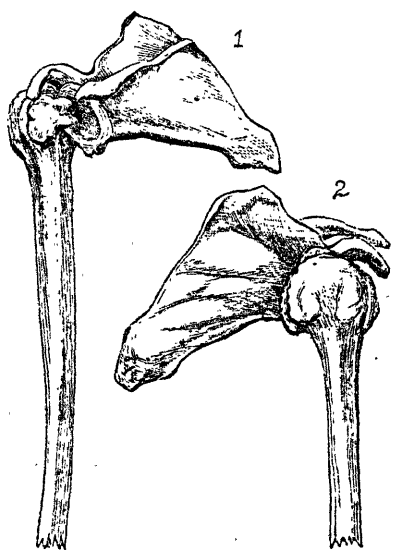
Dr. HENRY HOWARD, of St. John's, P. Q., who was this evening to have read a paper upon "Ventilation," was unable to attend; he, however, sent forward his communication, with a request that it might be read to the meeting. Several members having expressed a desire that the reading of the paper should be postponed till Dr. HOWARD was able to be present—this was agreed to, with the understanding that the Society should be called together upon any evening which would ensure the attendance of Dr. HOWARD. The time of the meeting was passed in listening to the following very interesting cases:—

DR. REDDY exhibited to the Society a specimen of unreduced dislocation of the shoulder with the following history.

W. L., aged 67, was admitted into the Montreal General Hospital, on the 5th April, 1871, suffering from senile phthisis with great emaciation and debility. On his examination it was discovered that there was an unreduced dislocation of the head of the right humerus. It appears that a little more than two years ago he had been working on a scaffold, serving masons, when the structure gave way and he was precipitated to the ground, fracturing his left leg and dislocating his right shoulder; he was taken home and placed under the care of a surgeon for treatment of the fractured limb. Unfortunately, the injury sustained by the shoulder was entirely overlooked and consequently no attempt at reducing it was then made. It was only after the lapse of several weeks when he found that the arm remained useless and immoveable that he first himself was aware of the dislocation, and then the efforts to reduce, which were made, entirely failed. At the present time, considerably more motion had been obtained than could have existed in the recent dislocation; the arm could be abducted from the side to the extent of about four or five inches, while rotation on the axis of the humerus could be performed through a pretty considerable area

of a circle. Owing to his emaciated condition, the head of the bone could be quite easily felt forming a rounded prominence immediately beneath the coracoid process, which was to be seen projecting just above it. Of course there was, as we should expect, great wasting, indeed almost entire absence, of the deltoid and pectoral muscles.

The patient died from exhaustion on 8th April, 1871, and the following day the entire scapula and humerus were removed. The appearances presented by the new joint and its surroundings, which are well represented by the accompanying wood cut, were as follows, viz:—the head of the humerus was thrown forwards and upwards and rested above against the coracoid process; the emptied glenoid fossa had become almost flat, and the cartilage on its face could hardly be recognised as such. To the inner side of this fossa is seen the receptacle formed for the head of the bone; it is about the size of the original glenoid cavity and is surrounded by small exostoses which project around it in almost all directions, tending of course still further to limit the amount of motion to be obtained. At one place the friction of the two opposed surfaces has produced complete *eburnation*, the bone there being white, polished and extremely smooth. Distinct new cartilage covered the adventitious joint and it seemed to possess a synovial membrane as well.



He was induced to bring this case under the notice of the society owing to the rarity with which an opportunity occurs for examining the

parts in similar cases. The Dr. remarked upon the completeness of the formation of the new joint in all its points, although from the excessive action in its neighbourhood and from the very nature of the position of the bones, it was impossible to have free motion. He deprecated the attempts sometimes made by surgeons for the reduction of dislocations of very old standing: he had occasionally seen most disastrous consequences follow this procedure, and even when the bones were replaced, in many other instances it was found that the functions of the joint were entirely lost. He was therefore in favour of using great caution in resorting to forcible measures for the remedy of luxations which had occurred long previously.

Dr. HOWARD remarked that from the long stalactiform growths, if he did not know the history of the case, he would infer that it had originally been an instance of partial dislocation from chronic rheumatic arthritis.

Dr. G W. CAMPBELL said it was to the credit of surgery that such specimens were exceedingly rare, in our own museum unique; he spoke also of the osseous projections in the neighbourhood of the new articulation, remarking upon the singular deformities sometimes produced by these sub-growths occurring near fractures and dislocations, and instancing a remarkable case of fracture of the neck of the femur, where, after a time, there was complete inversion of the toes instead of the usual condition of eversion.

Dr. ROSS, house-surgeon of the Montreal General Hospital, next exhibited the lungs of a patient who had died in that Institution from Empyema the day before. The right lung was entirely collapsed, very small, and covered with thickened pleura; a section was dense and uniform, the cut surface showing no tubercle. The left lung was crepitant throughout, showing signs of old cicatrical puckerings on the extreme apex; on dissection it was found to be studded with extremely small, white miliary tubercles, equably distributed from base to apex; similar tubercles were also found in the capsules of the kidneys. At the post-mortem examination about five ounces of mixed serum and pus were removed from the cavity of the right pleura.

Dr. HOWARD stated that the patient, a man of 69 years of age, had been admitted into the Hospital, under his care, on the 11th February last. At this time there was wooden dulness over the whole of the right side of the chest, together with 3 inches of enlargement. Respiratory sounds were nearly absent over this area, with the exception of the space from the clavicle to the nipple; here there was to be heard blowing breathing, feeble and remote. This phenomenon he looked upon as very

singular, and one that might lead to the supposition that there was consolidation of the lung; he believed it was in reality the air-sound from the primary bronchi in some obscure manner conveyed thus to the surface. Over the left lung the percussion was hyper-resonant, and the breathing exaggerated; still the lung was found post-mortem loaded with miliary tubercle. It is an acknowledged fact that we are frequently unable to diagnose the presence of miliary tubercle from any known physical signs. This patient was put by him at first upon Iodide of potassium (counter-irritation) and good diet; this was persevered in for six weeks, and no perceptible diminution having occurred in the fluid, he was tapped, and eighteen ounces of limpid serum were draw off; air then entered in small quantity, and the canula was immediately withdrawn: this led to the belief that the lung was bound down, and thus could not re-expand when permitted to do so by the withdrawal of the fluid. After this a clear note was got to the third rib, which afterwards extended an inch lower, but soon the dulness again extended. He then got Pil. Addisonii, two, twice a day for a week, when he was tapped a second time, with the result of getting only eight ounces of still limpid serum; air entered, but very slightly, and that only during efforts at coughing. After this his health soon began to fail, and hectic and cough set in, and he died on the 14th April. Dr. HOWARD drew attention to the peculiar points in this case, and the nature of the problem it offered for solution. It certainly was a case of pleurisy with effusion, together with acute tuberculosis, in an old man of 69 years of age. Niemeyer and his school would say that the pleurisy was the result of the presence of tubercle, but he (Dr. H.) could not positively agree with this, but was more inclined to look upon it as a case of sub-acute pleurisy in an old man, which, in consequence of the patient's feeble vital powers, had ran a chronic course, and ended in extensive effusion, and that the development of the tubercle was subsequent to this. Dr. H. remarked that he had once tapped the chest of a young man six times; the three first times the fluid was clear and limpid, but it afterwards became purulent.

Dr. CRAIK asked whether the tapping in this case had been performed to relieve urgent dyspnœa, or whether only to give the lung a chance to expand?

Dr. HOWARD was only sorry he had not tapped after a fortnight, instead of after six weeks—there was no dyspnœa, but it was done in accordance with the well-authenticated surgical rule, to relieve the lung before it should become irremediably compressed.

Dr. HINGSTON agreed with Dr. Howard that the tubercle did not pre-

cede the pleurisy; he would ask what were Dr. Howard's views with reference to mercury as an absorbifacient.

Dr. HOWARD would be loath to give a scientific explanation of the *modus operandi* of Addison's pill in such cases, but, practically, was fully convinced of its power in promoting absorption.

The President agreed fully with the last statement, and would say that the *combination* in this prescription seemed to be what produced the desired effect; for neither the mercury, nor either of the other ingredients —no matter how pushed—could produce a similar effect as with the three together.

Reviews and Notice of Books.

A Practical Treatise on the Medical and Surgical Uses of Electricity. By GEORGE M. BEARD, A.M., M.D., Fellow of the New York Academy of Medicine, and A. D. ROCKWELL, A.M., M.D. With one hundred and two illustrations. New York: William Wood & Co., 61 Walker Street. Montreal: Dawson Brothers. 1871.

That electricity is capable of being used as a powerful agent for good in certain pathological conditions, no clinical observer of any experience will, we think, deny; but whether they will be willing to endorse all the views set forth in this treatise is quite another matter, and one with regard to which we are in much doubt. We admit that experience is teaching us that the electric current may be used for more than local stimulation, and that the instances recorded in the volume before us have tended much to strengthen our views on this subject. Still, there is throughout the work a tendency to prove electricity useful in almost every complaint, a fault which is common to all who are styled Medical Electricians. We need hardly say that this fault is one which detracts much from an otherwise meritorious book, and tends to prevent a regular medical reader from taking an honest view of the work. We feel, however, that it contains much that is deserving of commendation, and that not a few practical hints may be gathered from its pages.

On the Wasting Diseases of Children and Infants. By EUSTACE SMITH, M.D., London. Second American Edition. Philadelphia: Henry C. Lea, 1871. Montreal: Dawson Brothers.

Upon a former occasion we drew attention to the merits of this work, and the appearance of a second edition within so short a period is a convincing proof that our estimation of it was not undeserved. The class of diseases treated of, are unfortunately of too common occurrence, and too

little understood. A thoughtful perusal of this work cannot fail to impart much practical information, gathered during a long experience by a thoroughly practical observer. It also cannot fail to arouse an increased interest in chronic infantile diseases—a class of affections full of sad interest from their frequency and fatality.

Body and Mind. An enquiry into their connection and mutual influence, specially in reference to Mental Disorders, being the Gulstonian Lectures for 1870—delivered before the Royal College of Physicians, London, by HENRY MAUDSLEY, M.D., London.—New York: D. Appleton & Co.—Montreal: Dawson Brothers.

The wonderful progress which Psycological Medicine has made within the past quarter of a century, has been such as to entirely revolutionize the treatment of the Insane. Instead of Asylums being prison houses for the confinement of those mentaly diseased they are now in reality Hospitals, where those so afflicted are treated not only humanely, but physiologically and therefore rationally. The savage barbarities of former times have, thanks to enlightened medicine, passed away, and insanity, regarded as a disease, freed from the prejudices and isolation which surrounded it, has come to be regarded as a part of general medicine, and with it will, we trust, go steadily forward in the march of improvement. Of those who of late years have contributed much to this object, no one has done more than the author of this little book. Possessed of a mind thoroughly capable of grasping the entire subject, comprehensive though it be, he has laboured steadily and perseveringly, to place Psycological Medicine in the true position which it should occupy—that of being a strictly medical study, and its treatment a branch of medical practice. The lectures contained in this volume are three in number, and are well worthy of a careful persual of all who take an interest in this subject. They are written in a style—terse perhaps—yet pleasant, and shew the intimate relationship which exists between the body and the mind. It will amply repay the close attention which its persual demands.

PERISCOPIC DEPARTMENT.

Surgery.

CAUSE OF GONORRHŒA.

Prof. W. A. Hammond, of New York, in his "Lectures on Venereal Diseases," asserts his belief, which he supports by cases, that gonorrhœa may be introduced either by the virus of hard chancre, or by the virus

of soft chancre, when the chancrous matter has been deposited for a certain length of time upon the mucous surface, without any abrasion being present, or without any chancre following. Vaginitis and urethritis may be induced by other causes, but true gonorrhœa owes its origin to the contagion of chancrous pus alone. He also believes that the gonorrhœa induced by the matter of a hard chancre will be followed by and may impart constitutional syphilis, just as if a chancre had been present. Dr. Hammond's opinions in this respect coincide with those of Hunter. The experiment of Ricord appeared to have finally decided the question that gonorrhœa was incapable of producing syphilis, and that they were totally different disorders. But the conclusions arrived at by Dr. Hammond are :

"1st. That the virus of an infecting chancre, when deposited on a secreting mucous surface upon which there is no solution of continuity, may give rise to gonorrhœa unattended by chancre, but which is syphilitic in its character, and capable of producing constitutional disease.

"2nd. The matter of such a gonorrhœa is capable of causing an infecting chancre, either by natural or artificial inoculation, which chancre is followed by constitutional syphilis."

Similar propositions are made about soft sores.

The observations and practical remarks of Mr. Morgan, of Dublin, confirm very much these observations. His experiments prove that the product of inoculation from a vaginal discharge in a constitutionally infected woman is the characteristic pustule and non-infecting chancroid sore, which is capable of propagation in this form from one individual to another; indeed, it seems pretty certain that contact with a gonorrhœal or vaginal discharge in a case of constitutional infection may produce a gonorrhœa or a soft sore if there was any abrasion of surface. Thus, a soft sore is not very unusually associated with gonorrhœa derived from the one contact; but the conception of gonorrhœa and a hard sore is very rare indeed. The subject is daily becoming a more important one, and the observations of Mr. Morgan, in Dublin, confirming by direct experiment the remarks of Dr. Hammond of New York, are entitled to careful consideration.—*Dublin Medical Press.*

FRACTURE OF THE CLAVICLE.

BY PROFESSOR LEWIS A. SAYRE.

The patient, a man of about thirty-five, a month ago was carrying a trunk, and fell with and upon it, fracturing his left clavicle at the junction of the outer and middle thirds. During the month he has been treated with bandages (including adhesive plasters?) which have been very tightly and sedulously applied—so tightly, that the marks of the

recently removed bandages are still visible. Most noticeable is a mark, as of a cord, under the left axilla, with a scar over the acromion of the right side, and galled places under the left arm. He has now imperfect union, with deformity, a large deposit on the anterior portion of the bone, caused by inflammatory action excited by the rubbing together of the two fractured ends.

Putting the knee between the scapulæ, and, grasping the upper part of the arm, drawing the shoulders backward and outward, the adhesions are broken up, the patient "hearing something crack." It is now nearly an inch from the top of the lower and outer fragment to the anterior face of the upper. When the ends are in opposition, there is still a considerable prominence at the seat of fracture caused by ossification of exuded plasma.

It has been said that, inasmuch as deformity necessarily results, no matter what bandages are used, how well applied, how admirably adjusted, or frequently re-adjusted, and since the deformity is as great with treatment as without—it has been held that it is useless to keep him in torture and encased in harness. But *I know* the contrary; union can be had without the slightest deformity. It can be reduced so as to show no deformity: if you can hold it in proper position, it is your duty to stay there and hold it until union occurs, unless you can contrive some appliance which will take the place of your hold. Use your own or any other contrivance, and, by the way, patented apparatus, together with the patentees, should be buried in oblivion by all honest-minded men.

Again, the indications, keeping the shoulder upward, backward and outward, are very well fulfilled, by keeping the patient constantly supine, with the shoulder of the fractured side unsupported, a pillow being placed between the shoulders. But this is impracticable, because lying four weeks in the horizontal position on the back would wear out the patience of Job; besides, such a degree of nervous irritability will be produced as will destroy the action of the digestive organs, and there will not be enough material made by the stomach to plaster the fragments together. We want, not medication, but supply; we must have the digestive organs, and consequently the general health, in good condition. Hence, all plans which permit of ordinary exercise are better than those requiring confinement to the house.

His former bandages have been applied so tightly as to interfere with the venous current of the arm. Hence we will have to apply a bandage to the whole limb, which, especially the hand, is now blue from venous congestion. One roller should, at the elbow, make several turns, in the

form of a figure-of-eight, so as to allow free motion of the joint. [This bandaging of the arm is, in general, unnecessary.]

For the bandaging proper, take a piece of adhesive plaster, of about four inches wide, and apply one end to the inner side of the belly of the biceps, about the middle of the humerus; then carry it in front of the arm and around the trunk behind, coming around the right side and beneath the nipples, or mammæ, as the case may be. The plaster is not to completely encircle the arm, as that would girdle the circulation. The arm is now about parallel to the axis of the body, and *cannot be brought forward.* Next, a small compress is to be pressed up in the axilla. A second strip of adhesive plaster, as wide as the first, passes from the right shoulder around and across the back behind the lower part of the arm and beneath and without the elbow. By now pulling the loose end of the bandage forward, inward and upward, the first bandage retaining the centre of the arm fixed in position as a fulcrum, the shoulder is carried upward, and on the principle of the lever, backward and outward, the *point d'appui,* in the centre of the arm, in conjunction with the axillary compress, securing the fulfilment of the indications. On making this traction the deformity, in ordinary cases, wholly disappears, to reappear the moment it discontinues. The same second plaster is then to be carried from the elbow, across the outer side of the forearm, flexed at an angle of about forty-five degrees on the arm, across the breast and back to the right shoulder. The ends of the fragments, instead of being an inch asunder, are now almost in apposition. "It doesn't hurt now, does it?" Patient (very emphatically.)—"No, sir." A third piece of plaster passes around the wrist, suspending it, and then both ends pass over the seat of fracture, retaining a small compress there. This last plaster is commonly unnecessary. If the appliance be too tight, as indicated by thumping at the wrist, slacken it, or nick the plasters so that the circulation may not be interrupted. Stitch the plasters if there be a tendency to slip. One application of the plasters will commonly be all that will be required in each case.

By this method you may get a cure so perfect that, as has happened to me, you cannot persuade people that it was fractured at all, and cannot find its seat yourself. It is perhaps better to have some one see it with you, or allow the patient to go about untreated for a few days, until he is satisfied that it is really fractured. A fracture should be set the moment it occurs, if possible. In the case of the clavicle, it can be done at once, and that is an amen to the matter. Do not wait in fractures for nine days before doing anything, as was until recently the teaching of the schools. Another advantage of this method is, that by it we avoid

the irritative fever which is apt to follow fracture. Of the thousand and one inventions which I have tried, none has given such satisfaction as this, of which I have had a fifteen years' experience. I must disclaim all originality of the idea. The credit of it belongs to some one whom I heard propose it at a meeting of a medical society, and whose name I know not. For little children, there is none so good as this. Dessault's bandage, thirty yards long, entangles the young one in such a labyrinth of bandage, and requires such frequent adjustment, that using it you will be apt to conclude that it is a very bad fracture to treat, and had better be let alone.

With this treatment any one can go about and attend to his or her business at once, and until union. I believe, that if perfect apposition be secured, union by first intention may take place in bone as well as in soft parts. Do the best you can; but always believe, in your own mind, that shortening need not necessarily occur.—*New York Medical Gazette.*

TREATMENT OF HEMORRHOIDS.

Dr. John H. Packard, Surgeon to the Episcopal Hospital, Philadelphia (*N. Y. Med. Journal,*) says, that one principle should govern us in all the palliative measures adopted in any case of piles: namely, to prevent straining. And this may be carried out in various ways. Besides the adoption of a proper diet-table, embracing simple but nutritious food, well cooked, and not highly seasoned, there are four points to be attended to. By means of medicine we keep the bowels easily moved; ℥ ss. or so of sulphur, mixed with cream or molasses, every morning before breakfast, will do this. Or by very small doses of Epsom-salts, by Vichy, Congress or Bedford water, we may accomplish the same end. The second measure is mechanical: the patient is intructed to have made a board, with an opening about five inches wide by fourteen long, to place over the ordinary privy-seat, which allows the nates to bulge down too much; this will in a great degree prevent the protrusion of the relaxed rectum. The third is the use of astringent suppositories, to be used after each stool. He has found the perchloride of iron, grs. j, ij, or iij, made up with cacao-butter, to answer best, unless the piles are inflamed, when the acetate of lead is more soothing. The fourth element of the treatment is the employment of a hemispherical block of ivory or vulcanized rubber, about as large as half a billiard-ball, attached to a spring of properly adjusted strength, and this again fastened to a belt. When in place, this supports the parts, and in cases of great relaxation prevents their descent in walking; the comfort thus afforded is very great.

Medicine.

ALTERATION IN THE URINE FROM THE USE OF CARBOLIC ACID.

By J. A. Waldenstrom.

Although this remedy has for a long time been used at the Academical Hospital in all forms of suppuration, with a view to checking decomposition of the pus, in three cases only did the urine exhibit any change which could be ascribed to the action of the carbolic acid. The first patient came in with a gangrenous phlegmon in the entire of the right leg. The largest portion of the skin and subcutaneous areolar tissue had sloughed away, so that it was possible to see the soleus muscle almost from its origin to its insertion. To arrest decomposition of the pus, the diseased bone inside the moist warm dressing was enveloped with a piece of lint dipped in the ordinary carbolic acid oil. In consequence of the nature of the affection, and of the patient's advanced age, the prognosis was very bad, and when, after the lapse of eight days, simultaneously with the complete separation of the dead areolar tissue, the urine assumed a dark red colour, the case was regarded as hopeless. It was reasonable to suppose that the change in colour had its origin in a resolution of the blood, but, notwithstanding the employment of all the chemical re-agents, its presence could not be detected in the urine, which was clear and of a strongly acid reaction. On Professor Almen, who kept the urine for closer examination, informing me that it contained carbolic acid in large quantity, I intermitted the use of the solution of the acid in question for a day, when the urine resumed its normal appearance, but as soon as the carbolic acid was again employed, the dark red colour returned. The advantage of employing carbolic acid (for preventing decomposition of the pus, and so the occurrence of septicæmia), and the possible injury from it (in producing a nephritis) made me doubtful whether I should desist from the use of it or not. However, it was tried for some days longer, but the pieces of lint were first wrung out in a dry towel before they were laid upon the sore, and as soon as this precautionary measure was adopted, the urine preserved its normal colour.

The second patient resembled the one just spoken of in every particular, not only as regarded the seat of the complaint and its extent, but also in respect to the behaviour of the urine in relation to the greater or less quantity of carbolic acid which was used in the dressing. The third case was a middle-aged woman with a very extensive periostitis in the right thigh. The pus that escaped on incision was thin, blood-coloured, and easily underwent decomposition. The suppuration in the large cavity was profuse and of a fœtid character. With a view to check

decomposition of the pus, as much as two tea-spoonfuls of a solution in oil of the acid was one day injected into the cavity, the latter having been previously rinsed out with water containing carbolic acid. The consequence was, that next day the urine possessed a tarry colour. Some days later, when the urine had regained its usual appearance, the same injection was repeated with a precisely similar result. The urine was then more closely examined and was found to contain both albumen and the colouring matter of the blood. The latter had already disappeared next day, but the albumen continued, although in small quantity, for a few days. Death occurred as a consequence of septicæmia. A similar transitory presence of albumen in the urine was also observed in a patient who used carbolic acid internally for a syphilitic cutaneous eruption.

From what has been stated we see then that carbolic acid is not as harmless as it is often represented to be. Separated by the kidneys, it acts as an irritant on these organs and may give occasion either to an hyperæmia alone, or to a parenchymatous inflammation, which is not an unimportant complication of the other affections, even if they are not so serious. Neumann's investigations on the action of carbolic acid on dogs poisoned therewith, also show that a considerable fatty degeneration in combination with a molecular breaking-up of the cells of the iver, hyperæmia of the kidneys with a turbidity and separation of the epithelium in the urinary passages are the changes constantly met with on *post-mortem* examination.

This obliges us to take the greatest precautions in the use, whether internal or external, of carbolic acid, and frequently to examine the urine in order to be able instantly to withhold it on the occurrence of a state of renal irritation. In solution in oil, too, carbolic acid appears to be more readily absorbed than in an aqueous solution, so that we should, in affections such as the two first brought forward, where the acid comes into direct contact with a large granulating surface, prefer the latter form to the former in using it: unless it be made weaker than usually employed (one part in six to eight.)

The cause of this altered colour of the urine, which is met with only in the external use of the remedy, we do not know with certainty, but it probably depends on the presence of some unknown oxidised products of carbolic acid. It may be assumed that this oxidation takes place prior to the absorption of the acid, because, otherwise, we should find the alteration in colour of the urine in cases of its internal use also.

DIAGNOSIS BY EXAMINATION OF URINE IN OBSCURE FORMS OF URINARY DISEASE.

By Sir Henry Thompson, Surgeon and Professor of Clinical Surgery to University College Hospital.

I wish to call attention to a mode of obtaining a diagnosis in some rare and doubtful cases of disease of the urinary organs, when all other modes have failed. I described it first in my clinical lectures at University College Hospital, some years ago, as a means of observation which had never to my knowledge been recommended or practiced, and which I had adopted systematically, and which I have since found of extreme value in some exceptional instances. Thus, for example, we not seldom meet with a patient whose urine, usually containing a small or varying quantity of blood and pus, presents more or less albumen, but relative to the precise origin of which it is desirable to be certain. Some of the deposit produced is of course due to the admixture named; and while we may be right in believing the quantity to be equal only to the blood and pus in the urine, we cannot be certain whether some of it may not be due to renal changes. In such a case, the other signs, and the symptoms also, are often insufficient to enable us to say whether they are due solely to vesical disease or to pyelitis, or whether there may be some renal affection, not to say constitutional albuminuria, complicating the conditions named. On the other hand, the symptoms may apparently indicate only an affection of the bladder; there may be no symptom of disease involving any higher portion of the urinary tract; nevertheless, the experiment to be described may prove the kidneys to be almost solely the seat of the malady. Few cases present more of obscurity than some of those with the characters thus briefly indicated.

The proceedings may be described as follows. A No. 6 or 7 flexible catheter is introduced into the bladder while the patient is in an upright position, and the urine drawn off is placed in a vessel apart. By means of an elastic gum-bottle containing a few ounces of warm water, the bladder is washed out two or three times, with about an ounce or two at a time, until the outflowing fluid is perceived to be quite clear. The catheter being left *in situ*, fresh urine from the kidney, untainted by any admixture, will now pass by drops into a test-tube placed to receive it; and a specimen, therefore, of true renal secretion, unqualified by vesical products, will be furnished in about five minutes, sufficing for a chemical analysis and useful to a certain extent for microscopical observation. By this simple process I have been enabled to solve the question of disease of the kidneys in some cases in which hitherto doubts as to their implication existed; and have often had the satisfaction of demonstrating that

the secretion obtained direct from the organs was absolutely free from any sign of disease, where they had previously been suspected to be the seat of grave mischief. But there is one sort of fallacy on applying this test which is occasionally to be met with. An illustration of it exists at this moment in the case of a man now in my ward at University College Hospital. If the bladder easily bleed with instrumental contact, as occasionally happens, the process may produce a slight admixture of blood in the urine so obtained, barely enough to tint it, but sufficient perhaps to occasion a considerable deposit to heat and nitric acid. It should never be forgotten, in estimating these products, that, for equal quantities of blood and pus, the former produces a much more bulky deposit of albumen than the latter. Of course, then, this disposition to slight bleeding, as a result of the procedure, and any augmentation of albumen so caused, is of itself strong evidence of vesical rather than of renal disease. I should say that the accident just named is one of rare occurrence.

—*Brit. Med. Jour.*

Materia Medica and Chemistry.

THE AFTER-TASTE OF QUININE.

The *Dublin Medical Press* says, in practice there is often experienced a great difficulty in getting patients to take quinine, because of its after-taste, which to some is simply unbearable, and when antipathy thus exists, combined with a difficulty in swallowing pills, the therapeutic value of an important drug is lost. We find, that the fact may not be generally known, that the mastication of some acid fruit, as an apple or a pear, will permanently remove the disagreeable after-taste of quinine. The first mouthful of fruit should be well masticated and rolled through the mouth, so as to cleanse the teeth, &c., and then ejected. The second morsel may be swallowed, when it will be discovered all taste of the quinine will be removed.

PERCHLORIDE OF IRON AND MANGANESE IN NECROSIS, FISTULOUS SINNSES AND HYDROCELE.

Professor Marcacci, in an essay on this subject in *an Italian Medical Publication*, arrives at the following conclusions. 1. Perchloride of iron and manganese, injected into fistulous sinuses, destroys the pyogenic membrane, modifies the state of the walls, and favors cicatrisation. 2. In necrosis, it acts on the confines of the living bone, stimulating its

vessels, so that the detachment and separation of the dead bone are facilitated by the formation of new vessels in the living. 3. In hydrocele, it soon modifies the inner surface of the tunica vaginalis, which becomes filled with plastic exudation, attended with more or less inflammation, according to the quantity and strength of the injection used. 4. It is not necessary that the tunica vaginalis should be distended by the injection; it is sufficient that the liquid be brought into contact with all parts of the membrane. 5. Very little pain is produced by the contact of the solution, but it is not the less efficacious. 6. A weak solution is sufficient, which should be kept in two minutes. 7. In seven cases of hydrocele in which the injection was used, hard œdema followed, but was not a serious complication.—*L'Imparziale*, January 16th, 1871.—*Brit. Med. Jour.*

ROYAL SOCIETY OF EDINGURGH.

At the opening of the Session 1870–71, Milre-Holme, M.D., LL.D., Vice-President, delivered an able address, in the course of which he noticed the death of Fellows of the Society in the past year, dwelling naturally upon those of Professors Simpson and Syme.

Professor CHRISTISON alluded to the notice that had been given of Sir James Simpson. As to the discovery of chloroform, he said the history of that had never yet been fully given. When fully given, it would constitute one of the most curious instances he knew of the gradual progress of discovery. There was one link which he thought, in justice to Sir William Lawrence, he should supply, as he could do it authoritatively. Sir William Lawrence, in the summer of 1847—the same year in the November of which Sir James Simpson made his great discovery—did repeatedly employ a solution of chloroform as an anæsthetic in his surgical practice, and ascertained that it was a superior agent to sulphuric ether. Had Sir William possessed that knowledge of chemistry which Sir James Simpson very properly held that every medical man should possess, he thought there was a strong probability that he would have anticipated Sir James in his great discovery. But the article had come to him recommended by the very absurd name of chloric ether. He (Dr. Christison) rather believed there was no such thing as chloric ether known; nevertheless there was an article which had been so called. It was recommended to Sir W. Lawrence under that name; it was tried under that name; and he was informed that both Sir William and his assistant saw that something more concentrated was wanted, and that they were busy considering how they might concentrate it when suddenly the discovery

of Sir James Simpson came forth and put an end to their enquiries. Had they been aware that the substance in their hands was nothing else than a solution of chloroform in rectified spirit, the solution of their problem would have been very simple indeed. In giving some reminiscences of Professor Syme, Dr. Christison said that the reason why that eminent man returned from London was not disappointment in regard to practice. His practice during the short time he was in London was a great success. His reason for returning was, that he found himself uncomfortably circumstanced in several respects, particularly as a teacher in University College. He was finally determined to leave the metropolis by his having been present when two of his colleagues were grossly insulted by the students at a great public meeting, and not the slightest attempt made by the Council then present, with Lord Brougham their Chancellor, at their head, to defend those professors from the insolence to which they were subjected.—*Proceedings of Royal Medical Society of Edinburgh.*

VERATRUM VIRIDE IN PUERPERAL CONVULSIONS.

By D. Colvin, M.D.

In reading the proceedings of the New York Pathological Society, I was much pleased to see that the use of the veratrum viride in puerperal convulsions was meeting with much favour. For the past five years I have used it in many cases with better results than from any other course which I had heretofore pursued.

But a few weeks ago I used it (not in such doses as were reported by Dr. Finnell to have been given by a homœopathist) in a case of eclampsia, where the consulting physician and myself could distinctly count the pulsations at one hundred and seventy per minute, and where no amelioration of symptoms could be obtained with the use of chloroform and the other ordinary remedies in use for this grave malady. I gave Squibb's Fluid Extract, beginning with five drops, and increasing the dose one drop once in two hours until a decided impression was made upon the heart's action. Seven drops at that interval were all that was required to sufficiently diminish the pulsations to bring about the desired result. Also I wish to say a word relative to the use of the same remedy in pneumonia.

For eight years past I can truly say that, with the exception of an occasional Dover's powder, I have quite exclusively relied upon the veratrum in the treatment of this disease.—*New York Medical Record.*

BROMIDE OF POTASSIUM IN LEUCORRHŒA.

Dr. A. H. Kinnear reports (*Chicago Medical Journal*) twelve well-marked cases of leucorrhœa, none of which were of less than six months' standing, where bromide of potassium was administered with excellent success in doses of grs. xx twice a day. Under this treatment the disease yielded in a majority of cases in one month. He also gave the remedy in a case of gleet, which resulted in a perfect cure in the course of a week.

REPORT ON THE ACTION OF QUINODINE AND CINCHONINE AS REGARDS THEIR INFLUENCE ON MALARIOUS FEVERS.

By J. Butler Hamilton, M.D., Assistant Surgeon, R.A., Allahabad.

"In consequence of a Circular from the Inspector General of Hospitals, ordering a strict trial to be made of alkaloids other than quinine, both as prophylactics, and in the treatment of malarious diseases, the following arrangements have been made:—

"Quinine in doses of 3 grs. per man per day is to be issued to all men of No. 1 Battery, 25th Brigade, and Staff Head Quarters, 25th Brigade Royal Artillery, consisting of 80 men; quinodine and cinchonine in similar doses being issued to the men of D Battery, 16th Brigade Royal Artillery, right and left Half-Batteries, consisting of 67 men each, on an average; and all cases admitted to hospital suffering from malarious diseases are to be treated with the alkaloids allotted to the division to which the man belongs, the doses (at first) to be the same in all cases as if quinine only was used."

This plan was most carefully carried out from the 3rd of August to the 16th November, 1870, under the constant personal supervision of myself; the drugs were administered daily by a careful Medical Subordinate, and were not in any way objected to by the men.

The solutions of the quinodine and cinchonine were made with dilute sulphuric acid, the dose being grs. iii to 1oz of water.

The following are the results:—

Quinine.

Head-Quarters and No. 1 Battery 25th Brigade, R.A.; strength 80 men. Admissions from Ague 7 = 8·7 per cent. of strength.

Cinchonine.

D., 16th B., R.A. Right Half Battery; strength 67. Admissions from Ague 13 = 19·4 per cent of strength.

Quinodine.

Left Half Battery; strength 67. Admissions from Ague 5 = 7·7 per cent. of strength.

From the above facts it would appear that quinodine ranks highest as a prophylactic, as the men treated with it show only 7·7 per cent. of admissions.

Quinine ranks next giving 8·7 per cent., and cinchonine undoubtedly last, showing 19·4 per cent. of admissions.

It must also be borne in mind that these men were all under exactly the same conditions, as to residence, food, clothing, exposure, night duty —in fact, three bodies of men more evenly situated in every way could not be found. Now, as regards the immediate action of the drugs, an undoubtedly tonic effect was produced by all. The action of quinine is so well understood, that it would be superfluous to touch on it. Quinodine seems to act nearly in every way, in a similar manner to quinine, and the cases treated with it in the ordinary way yielded as readily to the equivalent doses, as they would have done if treated with quinine.

Cinchonine did not give such favorable results; no doubt it has a certain amount of tonic, prophylactic, and anti-periodic power, but it was less efficacious and certain in its effects, requiring larger doses than either of the others; the paroxysms of fever returned oftener, and in many cases I had to omit it and finish the cure with ordinary doses of quinine. —*Indian Medical Gazette, March*, 1871.

Midwifery.

PROCEEDINGS OF THE GYNÆCOLOGICAL SOCIETY OF BOSTON.

Dr. Sullivan reported a case in which he had made an exploratory abdominal section, with the result of finding

GREAT HYPERTROPHY OF THE SPLEEN.

The history was a follows;—

Statement of Mrs. Carpenter's Case, written by Dr. Joshua Chamberlin, of Frelighsburgh, Province of Quebec, Sept. 20th, 1870.

"I was consulted by Mrs. Carpenter, in January last, (1870). She gave me the following history. She is twenty-eight years of age, was married at fourteen years of age, had a miscarriage at sixteen years; living child born at seventeen years; two children subsequently, and up to the birth of her last child, on the 15th of March, 1868, has enjoyed good health. The same day, after birth of last child, had alarming hemorrhage, which continued for several days, producing great prostration. There was scarcely any milk, and the secretion entirely subsided, and she had a long and bad getting up, and has never enjoyed good health since that date.

"Catamenia commenced about six weeks after confinement, 15th March, 1868, and have been irregular, accompanied with leucorrhœa.

"In July, 1869, the catamenia having been previously interrupted for two months, she began to experience a degree of fulness over hypogastric region, especially over the left side of the symphysis pubis and left iliac region, and supposed she was *enceinte*, and was not alarmed at her situation. This state of the catamenia continuing, the fulness over the above regions and enlargement kept gradually increasing until January last, when, upon being for the first time consulted, I found all the above symptoms increasing, and the fulness extending over the hypogastric, left hypochondriac, and abdominal regions, with apparent slight state of effusion. I found, upon examination per vaginam by the speculum, that there was subacute inflammation of the os uteri and excessive leucorrhœal discharge, and that there was a normal state of the uterus in all other respects. I treated the leucorrhœa with astringent and mucilaginous injections locally, and generally with ferri citr. c.strych., and have had no further return of the disease.

"The enlargement and fulness has constantly and regularly increased, and at the present time (Sept. 20th, 1870) there is a large tumour occupying the entire left iliac and hypogastric and left hypochondriac regions, and a portion apparently separated by a fissure or division on the left side of the linea alba, extending over a small portion of the opposite side. The tumour is of a much more flattened form than is usual in simple ovarian enlargement, extending from the left hypogastric and illiac regions, passing anteriorly under the crest of the ilium and symphysis pubis, then upwards on left side of the linea alba under the left false ribs, occupying the hypogastric and abdominal regions and left hypochondriac region. The entire tumour seems to be of semi-fibrous character and no attachments can be detected; but as it extends posteriorly to the left lumbar vertebræ, there may be some attachments posteriorly, though there are no symptoms warranting such conclusion, as there have been no signs of pressure upon the spinal column, as it seems to me would have been the case had such attachments and pressure existed upon any portion of the lumbar vertebræ.

"The treatment since she came under my supervision has been tinct. of iodine externally, hydriodate and chlorate of potassa alternated internally, and occasional apperients, with sedatives to allay irritation. She is now anxious and fully determined to have the tumour removed at the earliest possible moment, wishing to take her only chance for the prolongation of her life, which she is fully satisfied cannot long continue unless relief be afforded by the extirpation of the tumour.

"Upon examination, in consulting with Dr. Sullivan and Dr. Quimby, of Malden, Drs. Gilbert of Sherbrooke, and Brigham, of Philipsburgh,

and Dr. Smith of Frelighsburgh, after submitting the above details of the case, and after a personal re-examination by these gentlemen, I submitted the following query: What is the character of the tumour, and can it be removed by an operation? The patient should have the benefit of all doubts, if any exist in her favour, the more especially as she is so fully aware of the fatal termination of her case without the removal of the tumour on the one hand, and on the other the chances for prolongation of life if the operation can be successfully performed."

Dr. Sullivan's Statement.—"I saw Mrs. Carpenter October 25th, 1870, at Frelighsburgh, Canada. A small woman, extremely emaciated, very anæmic, countenance somewhat sallow, but not the sallowness of jaundice or cancerous disease; she presented the characteristic 'facies ovariana,' the 'hide-bound' face, which I should infer from the present case is not peculiar to ovarian disease, but may exist in connection with other abdominal tumours. I ascertained that there had been very little constitutional disturbance during the progress of the disease, the symptoms being gradual decline in strength with progressive emaciation.

"On examining her abdomen I was enabled to verify in every particular the previous statements, verbal and written, of Dr. Chamberlin, her attendant; his description being so careful and exact that it will be unnecessary for me to repeat it. There was some œdema of the lower extremities, and a slight sense of fluctuation in the abdomen, which contained something like a pint of fluid. In reference to this point, I may observe that after the patient was chloroformized, on percussing the abdomen the passage of an unbroken wave of fluid across the entire surface of the tumour was distinctly recognizable, thus rendering it improbable that adhesions existed between the anterior face of the tumour and the abdominal walls. The entire hypogastric region was filled with the tumour, which stretched from one ilium to the other, but the bulk of the mass was situated to the left of the linea alba, extending upwards, as described by Dr. C. The mass seeemed to be immovable, but as manipulation caused a good deal of pain, I could not be sure that this was the case. When the patient was under chloroform, it was found easy to push the tumour upwards for at least two inches, and to detect what appeared to be a firm adhesion to some of the tissues or organs situated behind the pubic bones to the left.

"Examination per vaginum with the finger and sound revealed a quite normal condition of the vagina and uterus; the latter occupying its natural position, slightly but not abnormally anteflexed, not prolapsed, os slightly patulous, internal sphincter relaxed, indicating the previous existence of the diseased conditions recognized and treated by Dr. Chamber-

lin. No fulness whatever could be distinguished in either cul-de-sac, either while the patient was in the recumbent posture or examined while erect. The ascitic effusion was insufficient to cause bulging downwards of Douglas' fossa; neither was it possible to determine the existence of a tumour by any species of vaginal exploration, however carefully made. On this account I concluded that the tumour was probably not ovarian, but that if ovarian it had a long pedicle, and perhaps rested upon the iliac fossæ in such a way as to render its detection per vaginum impracticable On percussing the abdomen, there was dulness or flatness over the entire space occupied by the tumour, extending to the left lumbar vertebræ, and posteriorly as far up as the lower border of the left lung. Anteriorly, the area of the dulness extended upwards on the left side until it was lost in that of the hepatic, cardiac and splenic regions. In the right hypochondriac region there was present also an amount of deep seated dulness on percussion, less marked than that over the tumour itself, which was afterwards found to be due to enlargment of the right lobe of the liver. Pulse eighty; heart and lungs apparently healthy, as nothing abnormal could be detected on auscultation and percussion; no urinary difficulties. Drs. Gilbert, Quimby, Brigham, Chamberlin, and Smith having examined the case and confirmed the above facts, the question of diagnosis was formally discussed, when each of the gentlemen confessed his inability to arrive at any conclusion whatever as to the precise character of the tumour. The general opinion was, however, that the diagnosis lay between a fibrous tumour of the uterus or Fallopian tube, an omental tumour, or possibly, but not probably, an ovarian growth of some sort. It was clearly neither an enlarged liver nor kidney, not an enlarged uterus, and not a uterine outgrowth of any sort.

"All were agreed that the patient in her present state had but a short time to live, and that to comply with her earnest and reiterated request that the tumour should be removed if possible, was not only justifiable in a surgical point of view, but a duty to the patient. An exploratory section was recommended and decided upon by the common consent of all present, *nemine contradicente*, and was accordingly undertaken the same day.

"Patient took kindly to cloroform, which was very carefully administered by Dr. Smith, of Frelighsburg, and having been placed on the table an incision was made a little to the left of the median line, beginning two inches below the umbilicus and extending three inches downwards. The integument was first divided, then some cellular tissue on the director afterwards; as the abdominal parietes were very thin, a portion was lifted by the forceps, a small opening made through the entire wall, and the

division completed by the scissors, using the finger as a director. About a pint of clear serum escaped and a portion of the tumour, having a deep red, rather mottled appearance, was exposed to view. I was unable to diagnosticate its nature, and, on appealing to the gentlemen present, found them equally in the dark. On introducing the hand into the abdominal cavity, no adhesions could be detected, which, were there no others, would preclude the removal of the mass. The incision was then enlarged in both directions; on cutting upwards through the abdominal walls the right lobe of the liver was exposed, enlarged, and reaching downwards three or four inches below the ribs. It was then ascertained that the tumour was an enlarged spleen, but its detachments were apparently natural, though more extensive than usual, in consequence of the enlargment of the viscus and their being drawn downwards by its weight.

"Owing to the exsanguineous condition of the patient and the œdematous state of the abdominal walls, there was freer hæmorrhage than usual from the divided surfaces, but of a serous character. More than two hours elapsed before the oozing from these surfaces could be restrained with sponges and exposure to the air. When this had at last been accomplished to the satisfaction of all present, the wound was brought together with wire sutures and adhesive straps, and several bits of carbolized sponge were placed over the line of the incision, and confined by plaster and flannel swathe.

"Free hemorrhage of the serous character described followed every puncture of the needle. A small opening was left, at the bottom of the wound, for the discharge of serum or blood. The patient soon recovered from the effects of the chloroform, of which but eight ounces had been used. Beef tea and brandy were administered, the latter by mouth and per anum. She remained to all appearance comfortable until about nine P. M., when she rather suddenly expired, having conversed quite freely a few moments before. Permission was obtained to examine the abdomen only.

"Sectio cadaveris eighteen hours after death. Rigor mortis well marked; abdomen not at all tympanitic; divided surfaces in perfect apposition; no external evidence of hæmorrhage, dressings not even stained; sponges applied in the course of the incision a little stained on the surface applied to the abdomen, but not in the least saturated. On removing the sutures and exposing the cavity of the abdomen, not far from eight ounces of loosely coagulated blood were found underlying the incision, which was believed by Drs. Chamberlain and Brigham to have been exhaled from the capillaries during the last moments of life. The cavity of the pelvis contained a small quantity of serum tinged with blood, and the rest of the

abdomen about a pint of serum, which appeared to have been confined in some way by the pressure of the tumour and abdominal viscera. The tumour proved to be the spleen. There were no adhesions save the natural attachments enlarged. Weight, eight pounds. The liver was near double its natural size, weighing about seven pounds. Kidneys healthy; uterus and ovaries and other viscera the same."—*Gynæcological Journal.*

ON USING SHORT FORCEPS WITH THE PATIENT IN THE SUPINE AND LATERAL POSITIONS.

By ANDREW INGLIS, M.D., Professor of Midwifery in the University of Aberdeen.

Introduction of Forceps in Lateral Position.

In this country, the following has been long the ordinary manner of using the forceps:—The patient is placed on her left side, across the bed, with the breech projecting beyond the edge of the mattress, and with the knees drawn up. The halves of the instrument are then successively in accordance with the *lateral* curve of the pelvis, the left being entered from across the patient's right hip, and the right from across her left. While the patient is in this position, the orifice of the vagina, unless already considerably dilated by the head, looks so much forward that entry of the blades from the side has to be preceded by more or less forcible drawing back of the perineum. Accordingly, the hand is introduced with the palm towards the child's head, the perineum drawn back, and the blade inserted between the hand and the head. In the progress of the blade, the handle, at first pointing nearly laterally, passes in a direction almost transverse to the mesial plane.

Disadvantages of Introducing the Forceps in the Lateral Position.

In this position there is often a good deal of difficulty in bringing, as well as in keeping, the patient's breech *over* the edge of the mattress. During a pain, or the introduction of the hand, especially where chloroform is used, the breech may be retracted to such an extent as to require replacement before the operation can proceed; and all this is often many times repeated before the upper blade can be got in. Much trouble also sometimes arises from the patient extending her limbs. Again, this method of operating makes it necessary to force back the perineum, a proceeding, of itself, at least, an inconvenience; while the flexion of the limbs on the body, by drawing forward and making tense the perineum, raises to a maximum the difficulty of drawing it back. Moreover, there is needlessly imposed on the blade a course which deviates more or less

from the true curve of the pelvis. Altogether, a certain amount of decidedly rough usage of the soft parts is entailed, for which the method of operation is alone to blame. The whole proceeding is like placing a male patient on the left tide and then trying to *pass the catheter on him from behind.* That the lateral curve of the pelvis has to be attended to, does not in the least invalidate the comparison, for that curve is greatly tighter than the antero-posterior one, and does not, for its observance, require either that the patient should be on the side, or that introduction should be from behind. Besides, when the forceps are put in from behind, the posterior edge of the blade is pressed upon by the perineum, and the force used to overcome this pressure may be such as to lessen very materially the information derivable through the handle as to the position of the point; and, if this pressure of the posterior edge on the perineum be not strong enough, the tip of the blade will press on the anterior wall of the vagina, thereby increasing the force required for introduction, and diminishing still more the information derivable through the handle.

With some operations, the difficulty the adoption of this position entails, is to a certain extent got rid of by insertion of one-half of the instrument (the upper one) from the front; and this, as far as it goes, is certainly an improvement. When this latter method is followed, the lower half is put in from behind in the usual manner, and then the thighs being kept pretty close against the belly, the other half is introduced from between the limbs in the middle line, flat along the back wall of the vagina. After the blade, following the antero-posterior curve alone, has passed a short way in this direction, the handle, getting in its course backwards clear of the limbs, is brought across the back of the left thigh, and the blade is then easily made to observe the lateral curve also.

Introduction of Forceps in the Supine Position.

For some time I have adopted the supine position for the patient when the head is low in the pelvis. She lies close to, and nearly parallel with, the side of the bed, and with her head low. The left half of the forceps is the one first put in. If the fœtal head is near the outlet, introduction of the hand into the vagina is unnecessary; but if a little above the outlet, two fingers should precede the blade into the vagina to guard and direct. In entering the point, the instrument is held like a male catheter, though with the handle inclined slightly towards the right groin, and, as the blade is pushed on in the direction of the pelvic axis, the handle gradually comes nearer the middle line, and is depressed in exactly the same manner as that of the catheter. The second half is passed in the same way as the first.

Advantages of Introducing the Forceps in the Supine Position.

To begin with :—The use of the supine position in the manner I have just described,* saves all the trouble and the formidable appearance involved in the dragging down to the middle of the bed and placing across with the breech projecting over, that have to be gone through with the lateral. Then, again, there is little or no difficulty in keeping the patient in position; she has comparatively but little tendency to be restless, the disturbance to the soft parts being reduced to a minimum.

In proof that the disturbance to the soft parts is very slight, I may mention that I have, in more than one multifarious short forceps case, where inertia was the cause of the delay, introduced the blades and locked without the patient being aware of the use of instruments, though quite awake and expecting them to be applied.

In most short cases, after the blade has been passed a little way in, but little guidance will carry it on to the proper distance, and in the proper direction. The weight of the handle is, till the shank reaches the perineum, about all that is needed for the purpose, and the proceeding, if not then complete, as it usually is, can easily, by pressure, be made so.

Locking in the Lateral Position.

In a short forceps case, with the patient on her side, and the presentation good, locking should not be very difficult, yet the operator cannot always dispense with assistance. Whether the right or left half be put in first, the perineum may displace it; and, if the right one be put in first, not only must it be held in position, but also the left blade must be put in form behind it, thereby necessitating *an increase of all the disadvantages* of introduction in the lateral position, and a diminution of the chances of correspondence of the two halves of the instrument. Another difficulty also arises from the not knowing exactly the position of the mesial plane of the pelvis.

Locking in the Supine Position.

In locking with the patient supine there is much less trouble. As the first half put in must be the posterior, or left, having the lock on the anterior or pubic aspect, the handle of the right, as it is depressed, comes into position almost of its own accord, no assistant being required to

* I do not discuss the French, or lithotomy position, for various reasons. It has many of the objections in common with the lateral position, and some in an increased degree, and I am certain it will never be introduced into ordinary practice in this country.

touch during any part of the operation. Besides this, we obtain, by adopting the supine position, an accurate knowledge of the situation of the mesial plane of the pelvis, such as cannot be had if another posture be chosen.

Disadvantages of Traction in the Lateral Position.

When the patient is on her side, with the breech over the edge of the bed, an assistant is often required to hold her for fear she may be pulled out of it; and if strong traction be necessary when the handles are pointing forwards, her breech may be drawn round in the direction of the line of traction, so that the operator will have to pull in an increasingly constrained position; and, as the limbs must be flexed, the perineum is drawn forward, thereby obliging the operator to continue pulling still farther in the curve transit, and thus increase the constraint of his position still more. In fact, in this position the traction must be made by the operator, first towards him, then to the right, gradually round the corner, and at last away from him in a back-handed manner, the handles by degrees getting beyond the reach of his left hand just as his right is getting into a more and more constrained position, and therefore requiring more and more aid from the left; and this constraint of position and want of power must lead to much misdirected, and therefore unnecessary, violence. The perineum, moreover, has to be taken care of, and, if any considerable amount of traction be required while it is being distended, it is quite impossible for the operator to attend to it himself.

Advantages of Traction in the Supine Position.

If the patient be supine, and lying lengthways *close* to the edge of the bed, all these disadvantages may be avoided. As her whole dorsal surface is in contact with the bed, there is no fear of pulling her out of it, or, by traction, of putting her in a more disadvantageous position than at first; and, however far the curve of transit may have to be observed, the operator stands in such a position that he can obtain the greatest purchase over his work, and therefore can exert his power with the greatest amount of accuracy, both as to direction and force; but, besides this, as the limbs are extended the perineum is shortened, so that the head becomes sooner free than when the lateral position is adopted. In fact, the operator stands like a carpenter at a bench, and applies his traction just as he would make a back stroke with a long saw, an instrument which is capable of being guided with more accuracy than almost any other tool. By grasping with the right hand from above, between the

limbs, the handles of the forceps, traction should be made more or less horizontally, according to the position of the head in the pelvis; and, as it advances, the direction of the traction must be more and more upwards, till at last the handles are perpendicular. When they are so, the perineum will be found distended, so that little farther traction is necessary; and, by changing the forceps from the right to the left hand, the handles can, with the left, be easily deflected towards the abdomen, while the right hand can be put in between the limbs and spread over the perineum to regulate the exit of the head. Altogether, the supine position gives the operator the power of commanding the greatest amount of accuracy of performance of the operation, and also enables him to dispense entirely with assistants, for, unless the patient take hold of his hands, there is no movement she can make that he cannot control.

The Perineum.

One of the strongest inducements to adopt the supine position, is the power it gives of guarding the perineum. When a patient lies on her back, with her limbs extended in an easy position, but not apart, and the toes slightly turned out, the perineum it as slack as it can be. By drawing up the knees the covering of the whole breech is tightened, and the perineum is deprived of the power of borrowing from all around it, just in proportion to the amount of flexion; and this fact is so well known to surgeons, that in order to obtain a maximum amount of tension in the male perineum (as in the operation of lithotomy), they always take advantage of it. But in the female, during the passing of the head through the external orifice, this is not all that can be done to strain the perineal structures. By turning her over on her side, the skin of the hip she lies on is fixed, and the chance of borrowing from that side lessened to a greater extent than is compensated for by the resulting setting free of the sacral covering, which latter adheres to the bone and does not yield appreciably to accommodate any perineal strain. The free edge of the fourchette may still be tolerably lax, but by holding apart the knees (as by putting a pillow between them) the height of perineal tension is attained.

In discussing the advantages of this position, we have also to consider the form of forceps to be used. An improved knowledge of the shape of the fœtal and the maternal pelvis has led to the almost universal adoption of a curved blade to fit the head and to accord with the curve of the pelvis, and it is only to those who used such curved blades that these remarks can be of much service. As to the handles, there is also a modern improvement which is not so universally adopted as the sacral

curve, but which brings out in a marked degree the advantages of the supine position. I allude to the cross hold near the lock, which so many modern forceps have. This cross hold is produced in two ways, either by making a wide space between the shanks of the blades, or by putting projections for the fingers on the outside of the end of the handles which is near the lock; and as in using this cross hold, the hand and arm are in the line of traction, the greatest force and accuracy can be obtained in the supine position.

In conclusion, I will only add, that the importance of observing the supine position, when possible, and of inserting the forceps from the front, is not trifling. Not only is the perineum in some degree in danger in all primiparæ, but, in some multiparæ when extraction is difficult, the soft parts suffer from the liberties necessarily taken with them; it therefore is incumbent on us, under all circumstances, to use the best means which enable us to avoid irritating or impairing the vitality of these parts. It can only be in multiparous cases where the soft parts are lax, that we can dare to tighten them up without fear of a rupture; but even then there can be no special inducement to do so.

I have lately become aware that in some parts of Great Britain practitioners can still venture to operate in severe forceps cases without chloroform, and yet not excite the local popular indignation. Where such a deplorable state of matters exists, the use of the supine position would be a great boon. The patient is not pulled about at all to get her into position, a minimum amount of pain is inflicted, and the bed clothes are not disturbed from first to last; while, if the lateral position be chosen she must be pulled about a good deal, expects something dreadful to be done, suffers an unnecessary amount of pain, and must believe that she has had her person somewhat exposed.—*Dublin Medical Press and Circular.*

Miscellaneous.

Dr. CHARLTON, of the Newcastle Infirmary, (*Brit. Med. Journal.*) has found creasote so uniformly successful in checking the vomiting which sometimes occurs in Bright's disease, that he has diagnosed this malady where other symptoms were absent, by the cessation of vomiting under that remedy. As another diagnostic sign he states that "tenderness on pressure of the pneumogastric in its course through the neck is evidence of inflammatory disease of some of the organs to which it is distributed, whether it be stomach, lungs, spleen, liver, or kidneys." If only one side be affected, the nerve on that side will alone be tender.

Concerning the use of iodide of potassium in syphilitic skin diseases, Dr. McCall Anderson lays down the following rules:

1. The longer the interval which has elapsed between the contraction of the syphilitic taint and the development of the eruption, the more likely it is to be of service.

2. If the patient is cachectic, it is, as a rule, to be preferred to mercury, except in recent cases of syphilis, when the mercurial vapour bath, or some such treatment, is more likely to prove successful.

3. The more extensive the tertiary eruption, the more certain it is to yield to iodide of potassium; although to this rule there are numerous exceptions.

4. If there is any tendency to syphilitic disease of the nostrils or neighbouring parts, iodide of potassium should be withheld, or given with great caution, for, if it produces coryza, it is very apt to aggravate the morbid conditions of the parts.

5. Should be given in full doses.

In the explanation of the last rule, Dr. Anderson states that he considers ten grains as the proper dose in the majority of instances, while sometimes as much as thirty or forty, thrice daily, may be requisite. As a typical prescription he gives:

Ferri ammonio-citratis	℥ iij.
Potassii iodidi	℈ i.
Syrupi zinziberis	℥ vj.
Infus. gentian. co	℥ viij.
Aquæ, ad	℥ xxjv.

A tablespoonful in a large wineglassful of water thrice daily. *N. Y. Med. Gazette.*

TRINITY COLLEGE, TORONTO.

The Medical Faculty of Trinity College, Toronto, has been resuscitated, and the following gentlemen now compose the Faculty, viz.:—E. M. Hodder, M.D, F.R.C.S., Eng., Obstetrics and Diseases of Women and Children; W. R. Beaumont, M.D., F.R.C.S., Eng., Principles and Practice of Surgery; J. Bovell, M.D., M.R.C.P., Eng., Pathology, General and Special, and Medical Diagnosis; Norman Bethune, B.A., M.D., M.R.C.S., Eng., Anatomy, Descriptive and General; William Hallowell, M.D., L.R.C.S., Edin., Materia Medica and Therapeutics; Walter B. Geikie, M.D., L.R.C.S., Edin., L.R.C.P., London, Principles and Practice of Medicine; J. Fulton, M.D., M.R.C.S., Eng., L.R.C.P., London, Physiology and the Institutes of Medicine, I. Algernon Temple, M.D., M.R.C.S., Eng., Assistant on Obstetrics and Diseases of Women and Children; Archibald G. Malloch, B.A, M.D., Assistant Lecturer on Surgery and Surgical operations.

Canada Medical Journal.

MONTREAL, MAY, 1871.

A REVIEW OF THE TRIAL OF ANDREW HILL FOR MURDER.

We have received a pamphlet with the above title, which is a defence on the part of Dr. Worthington, of Sherbrooke, against a most unjustifiable attack of the presiding Judge, the Honorable Mr. Justice Short, on the evidence given before him by Dr. Worthington, at the trial of Andrew Hill for the murder of his wife, at the term of the Court of Queen's Bench, held in the town of Sherbrooke, in March, 1871.

At the inquest Drs. Austin and Worthington ascertained the cause of death to be hæmorrhage. On careful examination of the body two wounds were found situated on the right side of the vagina; these presented the appearance as of having been produced by some blunt instrument; the fatal wound led upwards by the side of the descending ramus of the pubis on the right side, stripping the bone of its periostial covering, and passing into the pelvis. The fact of the woman having fallen against the side of a bench and thence on to the floor, was brought out in evidence; but the nature of the wounds was such, as to induce the medical men who examined the body to declare on oath that they could not reconcile their appearance as of accidental origin.

With regard to the cause of the wounds in question, we must confess our utter incapacity at arriving at a satisfactory decision. We have read over the evidence with care, and cannot but feel that the whole case is wrapt in mystery. We are at a loss to account for two distinct wounds within the orifice of the vagina, one of superficial extent, the other deep, and showing that considerable force must have been used at the time to produce it. We say that we are at a loss to account for this extensive injury on any other hypothesis than that of direct violence. With regard to accident, or intention, the former could only occur under peculiar and unusual circumstances. The latter, of course, is feasible enough, but we should imagine could alone be undertaken, either by the woman being a consenting party, as when a person unacquainted with the anatomy of the parts, thrusts some foreign body into the vagina, purposely to procure abortion, or, on the other hand, if murder was the intention, the murderer being aided and abetted by a third party. These are the only conditions under which an injury similar to the one described, could have occurred.

In defence, the prisoner produced the evidence of two medical men who propounded the astonishing theory of the bursting of a varix. They had made no inspection of the parts, but appear to have rested their

opinion solely on the medical testimony as adduced by the Crown, conveniently overlooking the fact of the extent of the injury to the bone as well as the soft part. We can only say that, to our mind, supposition of the bursting of a varix occasioning so great an amount of injury is wild and extravagant, and should have been at once discarded. The Judge in this unfortunate case appears to have objected to Dr. Worthington's evidence as being positive and dogmatic.

Medical evidence before a Court of justice consists of testimony on questions of fact and on matters of opinion. A witness in giving skilled testimony is expected to be decided and positive, else his testimony is of nothing worth; he must base his opinion on such facts as are before him; he is not partisan, but should give his evidence fearlessly and freely, and that evidence, if within the bounds of common sense, should be respected. We presume it is the duty of a Judge to see justice fairly and honestly administered; but, in doing so, he can surely have no right to descend from his high position and asperse the character and professional standing of a skilled witness.

* * * *

The above was in type before the announcement of the death of the Honorable Mr. Justice Short, which has just reached us by telegraph, and, at first, we contemplated its suppression; but, on second consideration, we deem it a duty to our professional brethren to publish it, not so much as referring to the unfortunate personal differences which existed between two estimable gentlemen, but as vindicating a great principle involved. We have before expressed regret that conflicting medical testimony is too often seen in the Court-room. Such a course is alone calculated to lower the character and standing of our profession. With regard to the pamphlet before us, it is written in a mild and gentlemanly tone, and we must say that, after having perused the Judge's charge, which was published in the *Sherbrooke Gazette*, Dr. Worthington, in our opinion, was bound to reply in self-defence, inasmuch as that charge, as reported, was calculated to injure the professional standing of Dr. Worthington and place him in the light of an incompetent and unreliable man.

ROCKWOOD LUNATIC ASYLUM.

We have received the report of this Asylum for the year 1870, which is drawn up in an able manner by the somewhat recently-appointed Medical Superintendent, Dr. John R. Dickson. In a plain, emphatic style, he tells the commissioners what he has accomplished since his assumption to office, and for which we think him entitled to much credit. He pleads strongly for the removal of the connection between the Asylum

and the Provincial Penitentiary; and when he states that of the three hundred and thirty-five patients now within its walls, only forty of them are convicts, we believe that he has said all that requires to be said to convince every one that the sooner the connection is severed the better. We are totally opposed to the mixing of insane convicts with those who have not a criminal history—for, as the report says, "the non-criminal portion of our lunatics express great indignation if they discover that a convict lunatic from the penitentiary is permitted to associate with them, or even enter the same ward." If we remember rightly, this asylum was first started in the basement of one of the wings of the penitentiary, as a purely convict asylum, under the care of the late Dr. Litchfield, and that as numbers increased they removed to the Rockwood property. If the demands of Ontario have been so great that other than criminals have gained admission, till now they number more than the convicts seven times over, it is quite time that Rockwood took its place among the lunatic asylums of the country, and that, again, a purely convict asylum should be provided. We therefore hope that the suggestion of Dr. Dickson on this head will receive the attention it deserves. There are other admirable points in the report, which, did our space permit, we would like to refer to. At present we must content ourselves with congratulating Dr. Dickson upon his report.

NEW MEDICAL SCHOOL IN MONTREAL.

A number of medical men in Montreal have organized a new Medical School, which has been accepted as the Medical Faculty of the University of Bishop's College. The new Faculty open their first session on the first Monday in October next. The following gentlemen have accepted appointments in the new School, viz:—A. H. David, M.D., L.R.C.S.E., Professor of Practice of Medicine; William H. Hingston, M.D., L.R.C.S.E., Professor of Surgery; Robert Godfrey, M.D., Professor of Obstetrics and Diseases of Women and Children; Joseph L. Leprohon, M.D., Professor of Hygiene; Francis W. Campbell, M.D., L.R.C.P.L., Registrar and Professor of the Institutes of Medicine; Edward H. Trenholme, M.D., C.M., B.C.L. Professor of Materia Medica and Therapeutics; J. Baker Edwards, Ph. D.M.A, Professor of Chemistry, Practical Chemistry and Microscopy; Richard A. Kennedy, M.D., C.M., Professor of Anatomy; Wm. Gardner, M.D., Professor of Medical Jurisprudence; James Perrigo, M.A., M.D., M.R.C.S.E, Demonstrator of Anatomy; George Wilkins, M.D., M.R.C.S.E., Professor of Pathology.

At a meeting of the Quebec Medical Society held on the 13th May, 1871, the following gentlemen were elected office bearers for the ensueing year;—President, R. H. Russell, M.D.E.; Vice-President, Dr. H. Blanchet; Secretary, J. B. Blanchet, M. D.; Treasurer, J. T. Robitaille, M.D.