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# THE CANADA MEDICAL RECORD.

VOL. XIII.

MONTREAL, JUNE, 1885.

No. 9.

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### *Original Communications.*

#### A CASE OF PARTIAL EPILEPSY.

By L. D. MIGNAULT, A.B., M.D., C.M., Professor of Anatomy University of Victoria, etc., etc.

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

The occurrence of cases of transient or partial epilepsy are by no means rare, and, though less striking and so to speak, impressive than the convulsive forms, are still worthy of study, and from the mildness of the morbid process seems much easier to arrest, and perhaps cure, than the former variety.

The multiplicity of manifestations of this disease may often mask its presence and, as in the case here cited, may almost be overlooked by the patient himself.

On the 12th of last February I was summoned to see M. H., æt. 40.

He occupied a private ward in the Hotel Dieu, and came to be treated for what is called biliousness. I gave him the usual treatment, a purge, and subsequent doses of nitro-muriatic acid, and the patient left the hospital, apparently feeling much relieved, and returned to his home in Boston.

About the 25th of the same month patient returned, and complained of renewed attacks of biliousness.

The patient a few days afterwards mentioned incidentally that he suffered from occasional attacks of vertigo and fatigue. It was only some days later that he described, after several questions, the nature of these vertiginous attacks.

The seizures occurred as follows:—On a sudden, without preliminary warning, he would lose consciousness, and, being possessed of a fixed idea, would set to work to execute it mechanically. He generally fancied that it was necessary for him to go to bed. Accordingly he would seek some room where he knew a bed was situated, and would undress and get into it. As often happened, being a teacher in an orphan asylum, he would manage to crowd himself into a child's cot and would, to his intense disgust, suddenly resume consciousness and find himself cramped and stiff from the exertion.

On another occasion, while waiting for a train at a railway station, he started off to walk along the track. As he crossed a bridge stepping from sleeper to sleeper, he was loudly shouted at by several persons, but he was still unconscious, and pursued his way for about four miles when he was both astonished and amazed to find that he had wandered so far away from his destination. This feat was all the more remarkable from the fact that my patient was very lame from hip disease in childhood, and wore a boot with a cork sole which replaced the shortening of the diseased leg.

He states that the duration of these fits is from a few minutes to an hour, and that they generally occur in the day time and very irregularly. He only has had them since the last two years, and they occur simultaneously with disordered digestion and torpid liver. No premonitory symptoms ever occurred. From the statements of eye-witnesses the patient at these times becomes very pale, the eyes are wide open and have a fixed expression. He answers quietly and reasonably any question which may be addressed to him, and will often even apologize for the trouble he is giving. The

patient, who is an intelligent and serious man, avers that he has not the slightest consciousness of what occurs.

Upon questioning patient as to his history he states that at 18, while a student at college, he suffered from epileptic seizures of the convulsive form, and that they disappeared after two years of treatment. They did not interfere with his general health; and he attributed them to fatigue after severe study. Patient belongs to a healthy family, and there is no trace of any neurotic disposition.

The pathology of epilepsy came to my aid in the diagnosis of this case.

Assuming, with modern authority, that epilepsy is the result of sudden and acute anemia of the cortex, with congestion of the medulla, we may presume that in this case there is simply acute anemia of the cortex, without notable congestion of the bulb.

As it is probable that the conscious centres are located in the cortex, and moreover that all mandates of the mind are communicated to these convolutions, it is easy to explain the absence of conscious control, and the occurrence of mechanical actions. The cortex—the bond of union between mind and matter, so to say—paralysed, and the great ganglia in perfect condition, the movements are simply like the reflex spinal movements, and are called on in precisely the same manner. The diagnosis of this case seemed at first rather difficult, and I was at first inclined to believe it a case of *catalepsy*. The absence of rigidity however, and the history of the patient led me to class it among those cases termed *partial epilepsy*, and in a late number of the *New York Medical Abstract* several such cases are cited, and thus named.

The treatment employed ultimately was based upon my pathological ideas, and then alone was it successful.

I tried at first the anti-epileptic mixture of Brown-Sequard for two weeks, and the attacks were of frequent occurrence.

I then thought of treating the cerebral anemia, and gave the patient  $\frac{1}{2}$  gr. nitro-glycerine thrice daily. I followed in this the idea of Hammond of New York.

The results were excellent. The fits ceased, and patient passed 3 weeks without a single seizure. At the end of that time he noticed a copious deposit of lithates in the urine, with a

diminution of that secretion, and the following day two seizures occurred; both were very brief in their duration. I prescribed a mixture of pot. bicarb, and all went on well as before.

The patient left shortly afterward for Boston. At last accounts he was still well, and whenever the urine became loaded he had recourse to the potash mixture, and so the fits were averted.

#### ATMOSPHERIC MATERIES MORBIS.

By HENRY HOWARD, M.D.,

Consulting Physician and Government Visiting Physician to the Longue Point Asylum.

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

GENTLEMEN—We don't know, and perhaps we never will know, what were the characteristics of primordial matter, whether if atoms or molecules or both atoms and molecules.

But this, physical science teaches us that matter, as it now is, is one, only differing in degrees, and that it is indestructible; that mineral matter furnishes the material for the vegetable matter; and that the vegetable furnishes the material for the animal. This evolution of matter shows how it is that all matter is one, only differing in degree, both structurely and chemically, and as it differs in degree so must it necessarily differ in its various phenomenon or forces or functions.

Mineral matter in itself differs in degree, structurely and chemically, and the same can be affirmed of all vegetable and animal matter; and it is because of its phenomenon that we judge of the different degrees of matter, and that we place the nervous system of man as the highest degree of matter because of its phenomena, mind and consciousness, which we find to be of a higher degree than is mind and consciousness in any other animal.

We find, then, that physical science teaches us, that all the different degrees of matter have their own peculiar structure, consequently, that each has its own peculiar phenomenon or force or function, such as psychic, motor, and sensorial phenomenon.

Under the foregoing circumstances let us consider what do we mean by the term atmospheric materies morbis. Do we mean that there is matter floating in the air, either mineral, vegetable, or animal, which is of itself a morbid or destructive matter, when coming in contact with either animal or vegetable organisms, or with both animal and

vegetable organisms. There is no physical proof that such would be the true definition of the atmospheric *materies morbis*.

Is it the phenomenon, or force, or function, of this floating atmospheric matter, to whose morbid effects we attribute the results we consider to be due to an atmospheric *materies morbis*? It is impossible, for if such were the case no living organism, be it animal or vegetable, could exist surrounded with such destructive forces. I cannot conceive, nor do I see any proof, that there is any such thing as an atmospheric *materies morbis* till one is generated.

That great physical scientist, Professor Tyndall demonstrated by the most conclusive experiments that the atmosphere was filled with floating matter, which, under favorable circumstances, when it came in contact with other matter, generated or produced a very low living animal organism. He also proved that another of its phenomenon was to transmit or conduct rays of sunlight to illuminate our planet; and, again, that this atmospheric matter could be burned by flame,—all these facts Tyndall established by experiments. But he did not demonstrate the physical characteristics of this matter as to whether it was mineral, vegetable or animal matter, or a combination of all three.

Now, as I have already said, it is an established physical fact, that under certain circumstances in the natural order, mineral matter furnishes the material for vegetable matter, and vegetable matter furnishes the material for animal matter,—it therefore follows, from Tyndall's experiments, that this matter in the atmosphere must be vegetable matter, which, under favorable circumstances, causes decomposition of matter, of generates or produces living animal organisms, which may, or may not be, according to circumstances, a *materies morbis*, a germ of disease, and afterwards become an *atmospheric materies morbis*.

This is in accord with the well-established physical law of latent forces in matter, the existence of which we are frequently ignorant of till two forces come in contact with each other, and we have an explosion; it may be dynamite, it may be a fit of epilepsy, it may be an attack of mania, it may be a chick from an egg, or it may be a germ, a *materies morbis*, that, before its forces were exhausted, would slay its tens of thousands. but, fortunately, in time these forces are exhausted. If I am logically correct in my physics, it follows

that the atmosphere, of itself, is innocent of generating a *materies morbis*, but that it contains matter which, when coming in contact with suitable soil,—the two forces meeting—result in a low living organism, which may or may not be a *materies morbis*, a germ of disease. What the characteristics of this germ will be must depend upon the nidus, which is the recipient of the atmospheric matter. It is only thus can we account for the different forms of germs, those of phthisis, of typhoid fever, of cholera, of yellow fever, pneumonia and septicaemia.

Now, I do not deny the fact that any germ once formed may not be carried from one locality to the other by means of atmospheric air, as well as by any other mechanical means, such as the hands, water, or clothing; but I do maintain that there is no physical evidence that atmospheric matter, or any other matter, can of itself generate a living organism—in other words, that there is no spontaneous generation.

It may be asked, why, then, use the spray or any other antiseptic treatment in surgical operations? I reply that an open wound, caused by a surgical operation on animal structure, appears to be a most suitable nidus for the atmospheric matter to come in contact with, to produce the germ of septicaemia, and the carbolic spray or other antiseptic, which has proved so successful in operative surgery, probably so changes the phenomena or function of the atmospheric matter, as to prevent the generation of the septic germ; moreover, no surgeon can be sure that there may not be septic germs in the locality in which he is operating. Under any circumstances antiseptic precautions can do no harm.

Here it appears to me that the question naturally suggest itself, how so many persons fall victims to these germanic diseases, typhoid fever, cholera, and while so many living in the same surroundings escape from these maladies.

It certainly must be due to the fact that the organs or tissues, with their functions, of the victims, must be in an abnormal state before being the recipient of the atmospheric matter, and in which a nidus is prepared, that evolves the germ and that those that escape do so because they possess normal organs, tissues, and consequently normal functions, whose forces will destroy a living germ coming in contact with them, and under no circumstances will such organs or tissues form a nidus for atmospheric matter or

generate a germ. Germs are not generated in living healthy organs or tissues.

I see no reason to doubt but that the germ theory has passed from a theory to a scientific fact, but I believe that the genesis of germs is, as I have explained, dependent as much on the nidus as upon the atmospheric matter; it is the two latent forces coming together that creates the germ, and upon the nidus depends the characteristics of the germ; moreover from the reasons already given I consider no germ nidus can exist in normal animal or vegetable matter.

Which of us have entered upon this world's stage of existence with normal organs and tissues and, if any, have we so lived in accord with nature's laws, as to maintain, cultivate and develop those organs? If there be any, then, of such I consider them proof against all germ diseases. These are they who live in plague-stricken cities without danger of disease.

To guard against epidemics by means of quarantine and cleanliness is perfectly in accord with nature's laws, and neither would require to be enforced if all persons were properly educated in these laws. But what use of such precaution, if, in our greed for riches, we, hour by hour, and day by day, exhaust our nerve forces by over-work and anxiety. Not entering upon the field of labor, as all men should, to be in accordance with nature's laws, to struggle for existence, but to struggle for riches, affluence and power, and for the gratification of our abnormal selfish desires. Under such pressure it is no wonder that our vital or nervous system, breaks down, and we become fitted to be the victims to the first epidemic, to the first materies morbis that enters our system, either by means of digestive or respiratory organs.

Will quarantine and cleanliness alone save the worn-out and exhausted laborer, servant, tradesman, merchant, or professional man, all of whom are slaves to labor, and taking but little rest to recuperate their lost physical forces. Will it save the over-worked teacher and school children who are starving for air and exercise? What will it do for those whose very pleasures are of most exhausting nature, robbing themselves of the proper time to recuperate their lost forces, rushing half mad through the ball room when they should be enjoying "Tired nature's sweet restorer, balmy sleep—" these poor slaves of a false social system who have not the moral courage to live in accor-

dance with nature's laws? And what will it do for the unfortunate inebriate?

I say quarantine and cleanliness alone will not save these people. Nature tired of their unreasonableness, will do in the future as she has done in the past, slay these people with her epidemics; she will not be mocked, the people must choose between nature's laws or sickness and death, or, worse still, folly and crime.

Within the past year there has been very much writing and great discussions on the subject of cholera, but, like all other medical subjects, with very few exceptions, it appears to me that medical men on these subjects, base all their reasoning upon false premises; the old empirical school seems to me to have the same sway now that it had half a century ago, when I first entered the profession, and it rather surprises me to see so very few of the young men of the present day, that make medical philosophy the basis of their medical reasoning; however, I suppose there are none now but admit that there is a cholera germ, a tonic germ, that may be generated in the manner I have explained, in certain animal organs or tissues, which, when generated, becomes a materies morbis, that may be taken into the system either by the respiratory or digestive organs. But what has never been proven, at least to my satisfaction is, as to the locality or tissues that forms the nidus for the atmospheric matter, which, with the nidus, produces the germ; or, the germ already existing, where becomes its nidus after it has been received into the system. There is no secret about the nidus of the germ of typhoid fever; not so with the nidus of the cholera germ: because of the diarrhoea, it has been assumed that it is in the alimentary canal, but do the symptoms justify such a conclusion? I know of no dying where the symptoms so much resemble the dying from cholera as those presented by a person dying from the loss of blood, there is the greatest analogy in both cases, and why but that in reality the person dying from cholera does die from loss of blood,—that is to say, the whole serum of the blood is poured out through the coats of the arteries, and ejected by means of the viscera, leaving only in the vessels the red globules, which being deprived of the serum, soon coagulates, arresting the heart's action and resulting in death.

Now what must have taken place before the serum of the blood is separated from its red globules, evidently it must be preceded by par-

alysis of the vaso-motor nerves, causing paralysis of the vascular muscular fibres, particularly of the constricting fibres; then the vessels becoming relaxed the serum of the blood, being the most fluid, is poured out, while the red globules coagulate. So it appears to me that the action of the toxic germ of cholera is to cause paralysis of the vaso-motor nerves, and all the other symptoms of cholera are the result of that cause. Now all this does not prove that the nidus of the cholera germ may not be in some part of the alimentary canal, and the vaso-motor nerves be paralysed from the poison from that source, but I think it more probable, although I have no positive proof to offer, that the nidus be in some part of the great vaso-motor centre, the great sympathetic nerve or its ganglions. This is a question, however, that must for the present lie in abeyance, my object is to try and establish as a fact that the action of the toxic germ of cholera is to produce paralysis of the vaso-motor nerves, and, consequently, that the treatment must tend towards restoring those nerves to their normal states.

Dropsy, from heart disease, seems to me to bear some analogy to cholera: it is caused by serum being poured out, as in cholera, from the blood vessels, and in its last stage death is generally preceded by serous diarrhoea. May it not be probable that here also we have paralysis of the vaso-motor nerves, and, as digitalis has proved such a potent remedy in dropsy, might it not prove equally efficacious in cholera. Dr. Stewart, in his very scientific lecture on digitalis points out its valuable therapeutical effects upon dropsical effusion and in arresting serous diarrhoea, I presume by giving tone to the vaso-motor nerves. He says: "The action of the digitalis on the circulation in full medicinal doses may be summarized as follows:—

1. It makes the ventricles beat more powerfully.
2. It makes them beat slower.
3. It contracts the arterioles.
4. It raises the blood pressure."

Here we have physical phenomena produced by digitalis, the very opposite or antagonistic to the phenomena produced by the toxic germ of cholera, therefore it should be a remedy for that disease. But the question arises, would the digitalis produce these therapeutical effects where the case was cholera poisoning?

I don't know! From the well known action of ergot upon the vaso-motor centres and their

peripheræ, we would naturally look to it as a remedial agent in cholera, and electro-therapeutic treatment in the hands of an experienced electrician appears to me worthy of consideration. In fact any treatment that would be likely to restore the paralysed vaso-motor nerves to their pristine state of constricting vaso-muscular fibres should prove the best remedy for the treatment of cholera.

My chief object in bringing this short paper before the Society, was as an effort to stimulate discussions on medical subjects, from a physical stand-point. Medical empiricism has had a long reign, it must now give way to medical philosophy, the basis of which is physical science, or experimental philosophy.

## *Society Proceedings.*

### MEDICO-CHIRURGICAL SOCIETY OF MONTREAL.

*Stated Meeting, Feb 6th, 1885.*

T. G. RODDICK, M.D., President, in the Chair.

*Sarcomatous Disease of the Femur and Acetabulum.*—Dr. RODDICK exhibited the specimen and related the case. The patient, a young man, sprained his hip five years ago by falling through a trap in a hayloft. He appeared to recover completely, but in a few months became lame, and had pain, at times getting better. A year ago he had to take to crutches. Last June Dr. R. found roughness of the bones of the joint, and indistinct fluctuation in Scarpa's space. Nothing was done at that time. He was sent to the country, where he remained for two months, returning to hospital last October. The abscess was now opened.

He had hectic fever and lost flesh. He went away, but returned again in January, with suppuration about the joint. Becoming worse, it was decided to amputate at the hip-joint, which was done. There was no hemorrhage of any consequence, but the patient never rallied, and died twelve hours later.

Dr. SUTHERLAND exhibited the following specimens:—

1. *A Gall-bladder containing thirty-two stones.*

This was removed from a subject (female) in the dissecting-room of Mc Gill College. Three or four of the stones were very large, measuring an inch square.

2. *Bladder and Kidneys of a man from whom,*

two months previous to death, Dr. Roddick had removed a vesical polypus by median cystotomy.

The bladder was much dilated and extensively hypertrophied. The ureters also were seen to be dilated. The kidneys were in a state of suppurative interstitial nephritis, or typical surgical kidneys.

3. *Malignant Disease of the Stomach, showing obstruction at the pyloric orifice.* A portion of the liver, the gall-bladder, ducts, duodenum and pancreas were also shown. Secondary deposits were seen in the latter and in the glands. The bile ducts were pervious. At the autopsy the following was noted: Emaciation and jaundice; 160 ounces of bile-stained fluid was removed.

The liver appeared small and the stomach very large, extending seven inches below the ensiform cartilage. On raising the left lobe of the liver, a large hard mass was felt, which involved the pylorus and apparently part of the duodenum. On slitting up the stomach after its removal, the mucous membrane was seen to be pale and anæmic. At the pylorus was a thick ulcerated ring, studded with little red granular ulcerations, and occluding the entrance into the duodenum, preventing the passage of the little finger. A mass about the size of an egg was situated in the pancreas, near its head—probably a secondary deposit, as it was not actually ulcerating. Jaundice was produced by small masses in the gastro-hepatic omentum pressing on the hepatic duct.

Dr. GEO. ROSS said there were several points of interest in the clinical history of this case. The gentleman came to him a year ago complaining of dyspepsia; his general health was not good; he said he had been failing. Improvement followed upon treatment. He saw him again in the spring, when he complained of vomiting at intervals of some length. There was no pain after meals, or ever. At intervals of one, two or three days he would have heartburn and an uneasy feeling; he then would get over a basin and empty his stomach. He would have no nausea, or pain, or retching. On examination, the stomach was found dilated, extending below the umbilicus. Its movements were plainly visible, and splashings could be heard. The patient was anæmic, and becoming thinner. Malignant disease of the pylorus, with dilated stomach, was diagnosed. No tumor could be felt. He was advised to enter hospital in order to have the stomach regularly washed out. Coming to hospital some weeks later, no dil-

atation of the stomach could be made out; it was not subsequently present. He had occasional vomiting of frothy material containing *sarcine ventriculi*. He became more comfortable under treatment, though he lost flesh. There was never any pain. He remained in hospital about a month. After this he gradually became jaundiced, and continued to lose weight. At no time were there symptoms of gastric trouble, except the occasional vomiting. There never had been any hæmorrhage. A short time before death, an indistinct fulness could be made out at the pyloric end of the stomach. It proved to be scirrhus, as was shown by slides exhibited under the microscope by Dr. Johnston. Dr. ROSS said the pylorus would not admit the little finger, and why there was a dilated stomach at first, and not later, was not easy to explain.

Dr. KENNEDY said that perhaps the circular muscles at the pylorus, from irritation, were spasmodically contracted, but when the disease advanced they might have been destroyed, and so relieved the spasmodic closure of the orifice.

Dr. ROBT. BELL (Ottawa) then read a paper by Dr. Percy W. Mathews, on "*Notes on the Diseases among the Indians of York Factory, Hudson's Bay.*"

Dr. O. C. EDWARDS, late secretary of this Society, and now in medical charge of Treaty No. 4 Indians, Indian Head, North-West Territory, being present, made a few remarks on some of the diseases among the five thousand Indians on his reserve. Syphilis was very prevalent, and one of the most powerful agents in weakening the Indians. Years ago they led a wandering life, had plenty of food, and were well housed in huts made of buffalo hide. Now, having entered into treaty, they are placed on reserves, making themselves practically prisoners of war. Coming in contact with the whites, they have become infected with syphilis, and as they very seldom apply for treatment, it has spread. The Indians attribute their present condition to the extermination of the buffalo. The Government has tried to make them agriculturists, with but very little success. Phthisis is a most fatal disease, and is usually accompanied with hemorrhages. They apply for assistance, but it is almost impossible to help them, owing to their being badly housed, and they will mix what one gives with their own medicines. Along with this is the noisy "tom-tom" constantly going on outside of any sick man's house

or tent. Prolonged lactation is common. A squaw often nurses her child till it is three or four years old. An Indian has as many wives as he can keep, often five or six. They appear to be exempt from toothache. They are great tea drinkers, and often mix tobacco with the tea. They smoke a great part of their time, swallowing the smoke, which they let out again by the nostrils. They never have inflammatory rheumatism. He has only seen one case of epilepsy, and that was a half breed. Measles comes as an epidemic, and is almost as bad as smallpox. For snow-blindness they apply tea leaves. In the month of March, one must protect their eyes against this. Dr. Edwards said that prior to meeting with the whites they were very moral and honest; now they don't know what these virtues are. He has visited Indians who still live by hunting, and far away whom he found honest and moral.

Dr. HY. HOWARD remark that Butler, in his "Great Lone Land," said there was no such thing as impurity or dishonesty when he travelled among them.

Dr. ROBT. BELL'S experience was that the civilized are immoral. Squaws think they are benefiting their race by having a child to a white man. Labor is effected while on the knees, and is of short duration. He knew of one squaw who was drawing a load of wood, and who, after a halt of half-an-hour to have her baby, proceeded on with her load. Menstruation comes on when about 12 or 13 years old. They are not very regular, often skipping three or four months, caused by hard ships and bad food. As a rule, they lose very little.

Dr. PROUDFOOT said he had been a good deal among the Indians up by Lake Huron, and found phthisis to be very fatal with them.

Dr. F. W. CAMPBELL had noticed that phthisis had killed a good many of the Micmac Indians of the Bay of Chaleurs.

Dr. TRENHOLME said he knew of a French Canadian woman in Montreal who was a grand mother at 25 years of age.

*Stated Meeting, Feb. 20th, 1885.*

T. G. RODDICK, M.D., PRESIDENT, IN THE CHAIR.

*Abnormal Muscular Slip.*—Dr. TRENHOLME exhibited a man, aged 45, having an elevated congested-looking mark about 15 inches long, running

obliquely from under the clavicle to the ensiform cartilage.

Dr. SHEPHERD believed it to be an abnormal muscular slip from the external oblique muscle to the pectoral.

*Ulcer of the Stomach; adhesion to the liver; abscess between.*—Dr. BELL exhibited the specimen, and Dr. RODDICK related the following history of the case: Mrs. J. sent for him three years ago for a profuse hemorrhage from the stomach. Ulcer was then diagnosed. One year later she had a second bad hemorrhage. A few months after recovery from this last attack she broke her radius, which united well. After a time she failed in health, became blanched, and felt as if she lost blood, though no more ever came by the mouth. On being sent for again, Dr. R. P. Howard was asked to see her in consultation. At this examination, they found the stomach dilated. Dr. Howard concurred in the diagnosis of ulcer of the stomach. The patient would eat, and, after a day or two, would vomit apparently all the food taken the couple of days previous. Washing out the stomach was suggested, and the case was handed over to Dr. Bell to carry this treatment out. Dr. Bell said that for a time his patient stood the treatment, but afterwards she declined to have anything further done. She only lived six weeks longer. He got permission from her friends to allow him to go to the vault and open her to examine the stomach. On the posterior wall of the stomach, midway between the œsophageal and pyloric openings, is an old ulcer; at this point the stomach is also adherent to the liver, and between the two is a sac containing pus, with an opening into the stomach.

In answers to questions, Dr. RODDICK said the stools never showed signs of blood. He fed her at one time for a month per rectum on peptonized foods.

*The Single Suture.*—Dr. ALLOWAY gave the following particulars:—Of the last thirty cases of parturition I have attended in primiparæ, eight have suffered from laceration of the perineal body sufficiently extensive to warrant the application of the *single suture*. In one of these cases, the suture was not applied until six hours had elapsed since the delivery. Union in all of these cases has been complete and permanent. In all of them I have employed the most perfect antiseptic course of post-partum treatment, to which I attribute a large share

of the success in obtaining primary union. The application of the suture was suggested and practised by me two years ago for the first time. In the *American Obstetrical Journal* of February, 1884, I have given a detailed description of the operation, a short epitome of which is all that is necessary here. A straight perineal needle three inches long should be used. I have had these needles for this operation made by Messrs. Codman & Shurtliff of Boston, and they can be obtained at Messrs. Lyman & Sons, Montreal. No other needle can be used with the same satisfaction. I use, absolutely, Snowdon's iron-dyed silk, No. 13. A strong needle holder completes the outfit necessary. During the examination of the wound, sponge it well of all blood clots with a solution of bichloride. Then pass the needle through the skin about half an inch from the edge, and at a level with the very beginning of the tear. With two fingers of left hand in the rectum, force up the recto vaginal cellular tissue and make the needle glide rapidly, though steadily, beneath this cellular tissue, as close to the wall of the rectum as possible to make its exit at a corresponding point on the opposite side of the tear. Now sponge the wound carefully again, and bring the edges of the wound together by tying the suture fairly tight. It will be noticed now that there will be some bulging or gaping of the part of the wound between the suture and sphincter ani, and will be very tempting to apply another superficial suture; but my advice is—*don't*, it will be frustrating the very object of the operation,—avoid all unnecessary sutures as you would other foreign bodies between the edges of the affixed surfaces. This gaping fissure will shrink away by the third day, and the two edges will come together in close union. I will now speak of one or two cardinal points which are absolutely necessary in doing this operation. First, be sure that the needle, in no part of its course, appears in the vaginal wound. The corners of the laceration at the entrance and exit of the needle, where the wound is sometimes deeply fissured and jagged, require especial care on this point. To guard against this, the thumb of the left hand should be kept always in the wound over the course of the needle, constantly feeling for it; and should you detect the needle in the surface of the wound in ever so small a part of its course, it should be withdrawn and deeper tissue taken up. After the needle has made its exit on the right side, it should not be completely drawn

through until the operator has again examined its track and become satisfied that the suture will be completely buried in all its course. If this care is not specially taken, and a part of the suture should gain entrance to the wound, a pus pocket will be very likely to form, and the operation will fail. A suture passing through the cavity of a wound is a foreign body, but passing around outside of the wound, it cannot interfere with union. The certainty of success of this operation hinges largely on this simple fact, and it should be well borne in mind. The suture is removed on the eighth day by dividing it with a scissors, and it will be found to give a loop of about three-quarters to one inch in length if the divided ends are reunited. The second point of importance lies in the after-antiseptic treatment; and I will certainly not hold the principle of the operation responsible for failure unless this point is carried out as advised. I hold this position on the same grounds as a surgeon of the present day who would not feel inclined to hold himself responsible for the successful issue of an amputation or severe lacerated wound, the after-treatment of which had been taken out of his hands and handed over to the tender mercies of an ignorant nurse and a few well-economized soiled rags. I cannot conceive why there is so much opposition to the dressing of puerperal wounds.

The main part of the post-partem antiseptic treatment consists in irrigating the wounded passage with a  $\frac{1}{1000}$  mercuric solution *once* daily. The first irrigation is performed the day following the delivery, and again at each morning visit until the eighth day, when the suture is removed and union found complete. In carrying out this procedure the patient is gently lifted, while lying on her left side, to the edge of the bed, the nates hanging just over the bedboard. A small rubber apron (a quarter of a yard square) is slipped under the hips and tied over the crest of the ilium. In this way a gutter is formed which carries the fluid as it runs from the vaginal passage into a receiving basin on the floor. The reservoir of the irrigator is then filled with the mercuric solution previously prepared. The nurse holds the reservoir in her hand at the proper level, and the physician introduces the glass tube into the vagina after he has first allowed some fluid to run into the basin to drive out the air. As soon as the nurse notices that the fluid has become exhausted to about an inch from the bottom of the reservoir, she informs the physician, and he

withdraws the glass tube from the vagina and allows the remaining fluid to run on and cleanse the external parts. A napkin is then applied, and the patient gently lifted back in the bed and allowed to remain on her back for a short time. I never allow the nurse to touch the parts under any pretence whatever. Her duty consists in giving the patient her prescribed diet and attending to the infant. A saline is administered every morning, and the bowels gently moved over a bed-pan adjusted by the patient herself.

I will now illustrate by these diagrams on the board that directly after a bad laceration takes place, and before the suture is passed, the vaginal passage is much elongated and the uterus slightly anteflexed. The uterus can now hardly be reached by the fingers without introducing the whole hand. We will now pass the sutures and draw somewhat upon the posterior wall, through which it passes, and you will find that the vagina shortens, the uterus comes nearer to the introitus, and, as the cervix is drawn slightly forward, the fundus leans backwards. Draw the suture still more, and fix it with a firm knot, and on now passing your index finger you will easily meet the cervix at its tip, and the fundus will have been thrown still a little further backward into what we would call a normal position. This series of facts I have demonstrated to myself on the living subject, and it serves to establish the ease with which a uterus may become prolapsed and afterwards retroverted, as it sinks in the pelvis where the perineum and vaginal wall have not been repaired, and the patient soon assumes the erect posture. I will now, by this wooden model, show how the suture is passed, and illustrate that it thoroughly controls the muscles in the perineum (the transversus perinei, bulbo-cavernosus, etc.), which exert any traction power on the laceration. This is independent altogether of the fact that, as the child becomes evolved, dilatation is so extreme that there is such calibre to spare between this extreme dilatation and complete involution that there can be practically no side traction upon the wound till the eighth or tenth day, when union will have become fairly strong. So that, really, all we want are two fixed points—one at each extremity of the wound—and that the cavity of the wound be cut completely off from the vagina (the drain-pipe to the uterus). Draw the suture tight and tie the vent, pass your forefinger

down along the posterior wall of the vagina, and you will find no wound, not even a fissure. The whole laceration is compressed like the mouth of a bag by a running string. The wound below is a *cul-de-sac*. The sides are in perfect contact, and as no discharges from the vagina can possibly enter it, primary union must ensue.

Dr. KENNEDY said slight tears were very common, and seldom could be avoided. These tears appear more at the time, and almost always do well without interference. In an instrumental case, there is much less danger of a bad tear if the forceps be removed when the head is well down against the perineum, allowing the natural efforts to complete delivery. He advocated stitching if there be much of a tear. Unless there were special danger of septic poisoning, he would not use injections.

Dr. BLACKADER dissented from Dr. Kennedy in leaving even a very moderate tear alone. He always mends such a rent for two reasons. It lessens the chance to prolapse, and it closes an open wound, thereby guarding against septic infection. Heretofore he has put in two or three stitches; lately he has tried the single stitch, as employed by Dr. Alloway, and with good results.

Dr. TRENHOLME believed a common darning needle would answer in this operation. He said that after a day or so the stitch got loose from the tissues being swollen when applied; to obviate this, Dr. Carson of Detroit employed the shotted suture—that is, a wire suture held on each side of the rent by a small bullet which could be pushed up the wire when it became loose. He (Dr. T.) uses the catgut sutures, and gets perfect satisfaction. He thought Dr. Alloway's purse-string suture would shorten the posterior wall of the vagina, and so favor prolapse and retroversion.

Dr. RÖDDICK said that Dr. Alloway's operation had this in its favor—it was easily done. He believed it to be an admirable method.

Dr. GARDNER had not yet tried the single stitch. He employs two or three stitches of silk. He intended trying the single ligature.

Dr. ALLOWAY, in reply, said that Dr. Kennedy's cases, where left alone, had to heal by granulation and not by first intention, as is the case when stitched properly. In reply to Dr. Trenholme he said that a common darning needle would be very apt to break in the forceps. As to Dr. Carson's shotted suture, he thought it very objectionable to

be interfering with the wound every day. Cat<sup>gut</sup> sutures are difficult to tie, and they may become absorbed too soon.

Dr. KENNEDY asked what length of tear Dr. Alloway would consider necessary to stitch.

Dr. ALLOWAY said anything over a quarter of an inch.

*Stated Meeting, March 6th, 1885.*

T. G. RODDICK, M.D., President, in the Chair.

*Congenital Looseness of all the Joints.*—The PRESIDENT exhibited a girl aged 4 years presenting this condition, and allowing of the production of partial dislocation of all the larger joints. Talipes of the feet could also be simulated.

*Decidual Cast of the Uterus.*—Dr. ALLOWAY exhibited a very perfect decidual cast of the uterus at the end of the sixth week of gestation.

*Neuroma.*—The PRESIDENT shewed a neuroma dissected from an amputated stump.

Dr. HINGSTON said he believed that the bulbous end of a nerve was a frequent cause of pain in the stump, and related a case in illustration.

Dr. GEO. ROSS read a paper on a *Case of Pulsating Empyema.*

Dr. HINGSTON said that when a student, in 1851 at the General Hospital, he saw a case of pulsating empyema, accompanied with metallic tinkling synchronous with the pulse, and evident at the surface of the back. The late Dr. Holmes, then clinical teacher, said at the time that it was the first case of the kind he had ever seen.

Dr. GEO. ROSS did not see how you could possibly have pulsation communicated through the fluid in a case of pyo-pneumothorax. The physical conditions which would cause amphoric phenomena would prevent pulsation being observed. To observe the latter the sac must contain fluid alone.

*Cases in Practice.*—Dr. SHEPHERD related the peculiar abnormalities seen by him lately in a healthy young man, age 22, who has transposition of the viscera of the chest and abdomen the right testicle hangs lower than the left.

*Stated Meeting March 20th, 1885.*

T. G. RODDICK, M.D., President, in the Chair.

Dr. A. L. SMITH shewed the following cases of skin diseases: 1st, *Tinea Tonsurans* in a state of kerion, the ulcerating patch being about  $3\frac{1}{2}$  inches in diameter. 2nd, *Specific Lupus of the Face*; the patient, a woman, was doing well under ap-

plications of acid nitrate of mercury. 3rd, *Specific Ulceration* on the leg of the last patient's husband. 4th, *Tinea Versicolor* over the chest of a delicate young woman.

*Case of Abdominal Section.*—Dr. TRENHOLME, who performed the operation, said this case was of some interest, inasmuch as a definite diagnosis was not only impossible before the operation, but the portions of the tumor removed, and now before the Society, have not yet been definitely determined as to whether they are the remnants of an extra-uterine foetation or of a dermoid cyst. A report upon their character will be brought before the Society at a subsequent meeting. The following are brief notes of the case:—

The patient, Mrs. O., of Ontario, a well-developed, fleshy woman, 46 years old, was married 31 years; no children. One abortion 25 years ago. For nine years after abortion suffered at menstruation. Twelve years ago had inflammation of the bowels. Ten years ago had another attack of a similar character. After this, enjoyed fair health till change of life occurred, seven years ago. Since this last period, was pretty well up to October last, when she had what was supposed to be inflammation of the bowels. Her health from this time onward not good, when, about the beginning of the present year, she was again taken ill with very severe inflammation of bowels, though, she said the disease seemed lower down in her body, accompanied with a good deal of irritation of the bladder and decrease of quantity of urine. Menstruation returned again last fall, but was scanty and at irregular intervals also, frequently accompanied by severe pains. *Present state.*—Debilitated appearance, pasty color; irritable stomach; scanty urine (2 or 3 ozs.), high-colored, no albumen; bowels regular; pulse weak (shabby) and rapid. Tumor felt over hypogastrium; per vaginam, tumor over brim of plevix, larger than a foetal head. Uterus  $2\frac{1}{2}$  in., and carried upward and backward. Tumor and uterus found closely united, but thought moveable. Diagnosis, fibro-cystic tumor of uterus most favored, but held to possibility of tumor being ovarian. *Operation.*—Assisted by Drs. Hingston, Kennedy, Perrigo, and Armstrong, made usual exploratory incision, and found no walls to cyst. Removed three gals, of fluid, and then found the debris of a dead foetus, which, with the placental debris, was scooped out with the hand. No ligatures were required to arrest bleeding, which was very slight. Abdomi-

nal cavity was well cleaned and washed out. Uterus and ovaries were normal. *Result.*—Patient never overcame the shock, and died twenty two hours after operation. No post-mortem was permitted.

In reply to questions, Dr. TRENHOLME said the woman's history did not indicate pregnancy, and that before operating her temperature was normal.

Several members who examined the debris gave it as their opinion that there were no foetal structures present. The bony piece was thought to be part of an ossified cyst wall. There was no sign of any of the long bones.

*Sarcoma of the Testis.*—The PRESIDENT exhibited the specimen and related the following history of the case: Patient, aged 48, had an attack of orchitis first in September, 1883; no cause could be assigned for this. He rode much on horseback in the woods, but there was no history of injury. In July, '84, he had another attack of inflammation in that testicle, which did not reduce in size. Last October it became very bulky. There was no disease in the cord. He was anæmic. No history of syphilis. Had had gonorrhœa ten years ago. Iodide of potassium and mercury was given for a month. After this, Dr. Bell attended him through an attack of phlebitis of the left leg. Sarcoma of the right testicle was diagnosed. Dr. RODDICK removed it, and a microscopic examination revealed it to be of the large round-celled variety of sarcoma. The tumor was as large as the fist. Slides prepared by Dr. Wilkins were shown under the microscope.

*Large Intra-uterine Myoma.*—Dr. WM. GARDNER exhibited the specimen and related the case.

Patient, aged 42, very pale, came to him with a history of severe hemorrhages for the past two or three years. No pain. An examination caused a great hemorrhage. The tumor could easily be felt in the hypogastrium, and by the vagina, in the uterus. After dilating well with tents, it was removed in pieces by means of the spoon saw. The operation lasted an hour and a half.

Not more than five or six ounces of blood was lost. A good many shreds came away after.

The uterus was thoroughly irrigated and drained with the double tubes. These were sutured to the lips so as to keep them in place. After eight days they ulcerated away, and were allowed to remain out for 24 hours, when the temperature rose to  $101\frac{1}{2}^{\circ}$ . The os was then opened, and

three or four ounces of bloody fluid escaped.

The tubes were again used as before. The patient made a good recovery. Dr. Gardner said that the irrigation was troublesome, but on it rests the success of the operation. Lawson Tait has lost 50 per cent. of these cases.

Dr. TRENHOLME said he had removed several of these tumors and never lost a case.

Dr. SMITH asked if ergot had been given in this case for a long time as recommended.

Dr. GARDNER replied that the patient's history and blanched condition indicated immediate operation. Ergot could not be depended upon, and, besides, the woman was poor and could not afford to lie up.

The PRESIDENT thought the woman's condition justified operative interference.

*Removal of a Uterine Myoma with the Cephalotribe.*—Dr. HINGSTON said that two weeks ago a lady came to him from the country suffering greatly from a large uterine myoma, which did not cause hemorrhage. The tumor was about the size of an infant's head, and sessile. He had seen Sir James Simpson use the cephalotribe in a similar case, so thought he would try it here. One blade was easily entered, but much coaxing was required to get in the other. A good bite was secured, and the screw applied. In this way one-half came away. Again the blades were applied, and half the remainder came away. Now the uterus was drawn down and out, and the rest of the tumor shelled out with the fingers. Patient made a good recovery. Injections of Condy's fluid were used.

Dr. GARDNER said he believed the vulsellum and spoon were the best instruments to use in these cases.

Dr. TRENHOLME remarked that both in this case and Dr. Gardner's an incision through the mucous membrane covering the tumor might have been all that was needed, as this simple operation has at times relieved pain and arrested hemorrhage.

Dr. SHEPHERD read a paper on "*The Musculus Sternalis and its occurrence in Anencephalous Monsters.*" He stated that the musculus sternalis was a supernumerary muscle which has always excited a great deal of interest among anatomists, and that its proper morphological significance was not yet fully determined. It was seen in about three or four per cent. of ordinary individuals, and its fibres generally ran at right angles and super-

ficial to the great pectoral. It was often bilateral but most frequently unilateral, and was subject to many variations. Frequently it had no attachment to bone, but lay superficial to the great pectoral, and was attached at either end to fascia. It often was inserted into the costal cartilages.

It might be continuous above with the sternal origin of the sterno-mastoid, and below with the fascia of the external abdominal oblique. Again, it might be continuous with the pectoralis major, and be associated with deficiency of that muscle.

It was often of small size, but occasionally it was quite a strong muscle, and could be seen under the skin in the living. Dr. Sheppard had seen it measuring five inches long, two and a half inches broad, and two and a half inches thick. For years it was considered to be a remnant of the rectus abdominis, which in many animals extends from the pubis to the top of the sternum, and was called the *sternalis brutorum*. This view had long ago been given up because the rectus abdominis lies in a plane deeper than the great pectoral, and is never superficial to it. Bourienne many years ago held that it was a prolongation downwards of the sterno-mastoid, a view still held by Henle and others. Hallette and Wilde regarded it as belonging to the same group of muscles as the platysma, and Prof. Turner, of Edinburgh, considered it to be one of the representatives in man of the great panniculus group which exists in most mammals. Darwin also held this view in his work on the *Descent of Man*, after referring to the views of Prof. Halbertsma, M. Testut and Prof. Bardeleben.

Dr. Sheppard stated that Prof. Cunningham, of Dublin, has lately in five cases traced the nerve supply of the musculus sternalis to the anterior thoracic nerve, and that he, believing that the nerve supply was the best indication for the proper classification of muscles, considered that the musculus sternalis belonged to the pectoral group. Prof. Cunningham also suggested that this was a new inspiratory muscle appearing in man, and that it was his impression that it occurred more frequently in females, due possibly to costal inspiration being more pronounced in them. Mr. Abraham, of Dublin, first pointed out, last year, that this muscle was very common in anencephalous monsters, as he had found it in six out of eleven specimens examined. Mr. Abraham looked upon it as probably an aberrant portion of the great pectoral muscle.

Dr. Sheppard said that he had examined six anencephalous monsters which were in the museum of the Medical School of McGill University, and wished to place the results of his dissection before the Society. In each monster he had found a well-developed musculus sternalis. In three the muscle was double; in two continuous above with sterno-mastoid, and in several it arose from the manubrium sterni, and was inserted into the costal cartilages. In all the cases there was a deficiency of the great pectoral muscle on the side where the supernumerary muscle was found, the abnormal muscle apparently taking the place of the absent portion of the pectoral. In several the muscle was of large size, and in part continuous with the fibres of the great pectoral. Nine muscles, in all, were found in six monsters, as three had double muscles. Dr. Sheppard had successfully traced the nerve supply of these muscles in all but two—that is, seven of the muscles were supplied by the anterior thoracic nerve; the nerve entered the muscle in its deep surface and could be traced back over the lesser pectoral through the costo-coracoid membrane to the internal anterior thoracic nerve.

Dr. Sheppard remarked that it was a curious fact this muscle should be supplied by a nerve which is at so great a distance from it, and not by the intercostal nerve, which in several cases pierced the abnormal muscle without giving any branches to it. He also stated that he had formerly held that the *musculus sternalis* belonged to the panniculus group, but that these dissections had caused him to alter entirely his previous views as to its homology, and that now he had little doubt that this muscle belonged to the pectoral group because: 1. Its nerve supply. 2. When present the great pectoral is generally deficient. 3. Its continuity in many cases with the great pectoral. 4. That it was in the same muscular plane as the great pectoral. Dr. Sheppard said that it was his belief that the nerve supply was the best guide we possessed for determining the homology of a muscle.

Dr. Sheppard was unable to explain why this muscle should be so common in anencephalous monsters, except that in these undeveloped beings there was a greater tendency to revert to previous conditions; but he said it was difficult to reconcile the fact that this muscle was an aberrant portion of the great pectoral and a reversion to some pre-existing muscle, as no known existing arrangement

of the pectoral group in the lower animals at all resembles the condition found in these monsters. He also stated that if this muscle was an aberrant portion of the great pectoral which had no animal representative, then Prof. Cunningham's theory, that it was a new muscle appearing in man, had some degree of probability. Dr. Sheppard said he was not prepared to accept this explanation, but awaited further light and further knowledge of comparative anatomy before pronouncing definitely on the morphological significance of the *musculus sternalis*.

After the reading of the paper, the specimens were exhibited to the Society.

DR. HENRY HOWARD said that Dr. Sheppard's demonstration was a further proof that man evolved from a lower animal, and did away with the theory of the creation of man as he now is.

*Stated Meeting, April 3rd, 1885.*

Dr. TRENHOLME second vice-president in the chair.

Dr. STEWART exhibited the patient and read the following account of a case of *Tabes Dorsalis* with exaggerated patellar reflex.

The patient (a man) who is forty-two years of age, complains of dimness of vision, flatulency, and of shooting pains in various parts of his body. He dates his troubles to a "cold" which he contracted three years ago. Among the first symptoms he noticed were the darting pains which have troubled him with more or less severity ever since. Two and one-half years ago he suddenly became aware that he saw objects double, and on shutting his right eye he was surprised to find that the vision of his left was markedly diminished. This diminution in the vision of the left eye steadily progressed until a few months ago, since which it has remained stationary. During the past five or six months there has been a steady and progressive diminution in the vision of his right also.

He injured his back a few years ago, but neither at the time nor afterwards does it appear that he suffered in any particular way from this injury. In 1875 he had two sores on his penis, but there is no positive evidence whatever that those sores were of an infecting character; otherwise his past history was unimportant. There is nothing of importance to be derived from the family history.

His present condition is as follows: There is

no paralysis or atrophy of any of the voluntary muscles, their mechanical, faradic and galvanic irritability are normal. All the superficial reflexes are more or less exaggerated with the exception of the plantar. The cremasteric reflex is especially exaggerated. The patellar reflexes are exaggerated as are also the triceps reflexes, but only to a slight extent compared with the patellar.

The organic functions of defecation and micturition are considerably interfered with, while the swallowing reflex is normal.

Shortly after urinating he is able by "pressing hard," to pass a number of ounces of urine. That the sphincter of the bladder suffers as well as the detrusor is shown by the fact that when the desire to urinate comes on, unless he is ready, the urine floats away in spite of all his voluntary efforts to retain it. Although not troubled with constipation, he has difficulty in expelling the contents of the rectum.

The "shooting pains" which trouble him are, for the most part, situated in the lower extremities. Sometimes, however, they have their seat in the hands, arms, trunk, face, neck, and even the ears. He has no delayed sensations, but he frequently experiences a sensation as if some one was pinching him or pulling from within outwards, a pain through his skin. There is no inco-ordination or disturbance of the muscular sense.

Dr. Buller's report of the condition of the eyes: "Argel Robertson pupil. There is very considerable atrophy of both optic nerves, with great limitation of the visual fields, especially of the left. The nerves are pale and of a blue gray colour. The blood vessels are very small. There is no evidence of a previous inflammatory condition." The functions of the remaining cranial nerves are normal.

Dr. Stewart remarked that there was no doubt that the man was suffering from *tabes dorsalis*, despite the fact of the marked exaggeration of the patellar reflexes. There were present two of the three characteristic symptoms of this disease—the lightning pains and the reflex immobility. In addition there was the optic nerve atrophy, the temporary diplopia, together with the bladder and rectal symptoms, forming a combination of symptoms that, at least up to the present, have only been described under the head of that myriad-sided disease, *tabes dorsalis*.

Absence of the patellar reflex, Dr. Stewart remarked, is looked upon as one of the most important and earlier symptoms of the disease. A few cases have been recorded where it has not been absent, but up to the present time he had not read of any case where it was exaggerated. On theoretical grounds it had been suspected that preceeding the stage of loss of patellar reflex in tabes, there is a period when it is exaggerated. Even were this supposition true, it would not aid us any in this case, for it is one of considerable standing, although still in the pre-ataxic stage.

The increased inflexes cannot be explained by disease of the lateral column, for there is an entire absence of any increased turicity, this symptom being next to the exaggerated reflexes the most trustworthy evidence of a sclerosing of the pyramidal strands.

Dr. Stewart concluded by stating that the honour of having made the diagnosis was Dr. Buller's, and it was owing to Dr. Buller's kindness that he was enabled to present him to the Society.

Dr. HY. HOWARD said that the expectation of mental symptoms depended on whether the lesion begins, high or low in the cerebro-spinal system for in ascending lesion death takes place before any dementia occurs.

Hence the important point is to know what centres are affected, and whether these be above or below the reflex centres usually implicated in Tabes.

Here it is interesting that the cortical substance having been involved some years, there is yet no impairment of mental powers.

Dr. CAMPBELL said that owing to the better knowledge in general, and especially of opthalmoscopic signs, cases of this disease were now detected, which formerly escaped diagnosis; but he did not believe such cases occurred with greater frequency to-day. He spoke of a case (which had been seen in consultation) by Dr. Trenholme in which a woman evidenced exaggerated sexual desire; subsequently become insane.

In answer to Dr. Trenholme, Dr. Stewart said, death was often due to exhaustion from the pains,

Dr. H. HOWARD said that Pneumonia was sometimes a cause of death due to implication of pulmonary trophic centres and respiratory tract.

In answer to questions as to treatment, Dr. Stewart said that though there was little evidence of syphilis, he had put his patient on anti-syphilitic

treatment. Electricity is useful to control the pains.

The flatulence was thought part of the disease due to paresis of intestinal muscles.

Some discussion as to use of ergot in Tabes followed and Sequin and Althans were quoted in support of its use. Dr. Stewart said that it was perhaps dangerous as Ergotism caused an apparently genuine Tabes.

In reply to questions as to Etiology, Dr. Stewart said symptoms (especially eye symptoms) no doubt preceded injury and heat referred to.

Dr. REED called attention to disturbances in function of urination as early symptoms in Tabes.

Dr. REED, spoke of 2nd attacks of measles in same patient, and spoke of two such recently observed by him.

Dr. CAMPBELL said, he had seen at least six such cases; and much more extraordinary, had seen scarlet fever recur within a few weeks of first attack. He also spoke of the severity of the complications in the present epidemic of Measles as Pneumonia, Pleurisy, etc.

Dr. KENNEDY followed to same effect and cited a case where scarlet fever measles and whooping cough were interchanged among the children of one family. Dr. Kennedy also spoke of a case where he diagnosed measles 10 days before the development of rash owing to catarrhal symptoms and a prodromal rash

Dr. CAMPBELL spoke of hooping-cough frequently following measles in this epidemic. He advised treatment with quinine with cures *in every case* within five or six weeks. He said the theory was that the spores deposited on fauces kept up irritation, and the quinine by causing profuse secretion led to these germs being washed away. This being theory, the practical point is that the treatment by quinine is very successful.

Dr. REED said that Henock found that "the measles usually followed hooping-cough; and that quinine had failed in his hands; he finding morphia most efficient."

Dr. TRENHOLME said that in his hands *Drosera Rotundifolia* (Parke D. Extr., and *Euco'yptus* had done good service in Hooping cough.

*Stated Meeting April 17, 1885.*

SECOND VICE-PRESIDENT, Dr. TRENHOLME in the chair.

TUBERCULAR LUNG WITH PLEURA FROM A CASE OF HYDROPNEUMO THORAX.

Dr. R. J. B. HOWARD exhibited the specimen and said that on opening the thorax the right lung was emphysematous and contained many gray granulations about the anterior part of middle lobe. Left pleural cavity contained a blood clot measuring 17 oz. vol.: on removing this the pleural sac was everywhere lined by firm buff-colored membrane nearly  $\frac{1}{4}$  thick. The pulmonary portion was equally thick, and binds the lung firmly down to the vertebral column. A small opening communicates with a cavity in lung: this opening being situated high up behind. So firmly attached was the lung that it had to be cut out: in doing this the cavity was opened. It occupied the whole upper lobe and would have held a hen's egg. Its walls were lined in the upper part by a smooth gray membrane, but the larger part of the walls were ragged and crossed in all directions by strands of tissue, in many cases consisting only of one or two vessels of considerable size. The cavity contained a good-sized clot. No open vessel was found. The lower lobe contained many *caseous* nodules.

Evidently the cause of death was hemorrhage from the pulmonary cavity into the pleural space in fact internal hemorrhage—a very unusual termination. The patient has had pneumothorax for months, and his chest was opened and drained about two weeks before. There was more fear that the operation might have caused or at least accelerated death: but I could find nothing to lend color to this view—in fact the obliteration of the pleural cavity from the bottom was commencing.

Dr. GEO. ROSS said he had first seen this patient about eighteen months ago, but that he had been in the hospital previously for months with phthisis and softening of the left apex. The day before seeing him he had been seized with severe pain in the left side accompanied with shortness of breath and distress. This continued for 24 hours. On examining, *pneumo-thorax* was found, thereof was no fluid. The left chest was distended with air, the heart pushed over, pulse rapid, and he was cyanotic. After a time fluid gradually replaces the air till the left side was full. He was then tapped of serous fluid, giving great relief and feeling much better. Went home, when he improved and gained weight. He came to the Hospital once a month to be examined.

After some months the chest again refilled and he became feverish. He was again tapped, a sero-

purulent fluid coming away. The fluid rapidly re-collected accompanied with fever and emaciation. An incision between the ribs was made by Dr. Roddick and a drainage tube put in. The fever lessened though some remained. Pulse was still rapid. He was improving, till one day he suddenly became pale and exhausted and blood leaked out by the tube.

But for this accidental ulceration of the vessel in the lung he thought this patient might have recovered. A similar case had been treated by Dr. Wilkins and himself ten years ago, who recovered and is now alive.

Dr. KENNEDY said that this case recalled one he had seen years ago, that of a man who died from fracture of the skull. At the *post mortem* the right lung was found collapsed and in a fibroid condition the side of chest sunken in and the viscera had adapted themselves to the altered shape of the chest. The organs appeared healthy and the man would have lived years but for this accident. He had been operated on for hydro-pneumo-thorax two years previously.

Dr. Godfrey said he had seen a similar case where a woman died seven years after from tuberculosis of the opposite lung.

*Stated Meeting April 31, 1885.*

Dr. TRENHOLME in the chair.

PIECES OF NECROSED BONE FROM AN ABSCESS AT SIDE OF POTTS CURVATURE.

Dr. SHEPHERD exhibited 8 small bits of bone removed by him from an abscess at the side of the spine. A second abscess was on the side—both following inflammation produced by a kick over the part.

Dr. ARMSTRONG then read a paper on Antiseptic Midwifery (Published in May No. of RECORD.)

Dr. KENNEDY said he did not believe in treating a natural process as if it were pathological—He spoke against the use of the spray, etc., in labour, and thought that antiseptic injections were very seldom needed. The giving of these injections, by the physician was lowering him to the position of nurse. He had read of poisoning following the use of injections of solution of bichloride of mercury.

Dr. CAMPBELL endorsed Dr. Kennedy's views. During his 23 years of practice he had attended 1700 cases of midwifery, and only had six cases of

septic trouble, using only ordinary precautions. Most of the cases of septic poisoning were among the better classes.

Dr. A. A. BROWNE said he had never seen antiseptic midwifery carried out. He thought the main things to attend to were cleanliness and having fresh air. In the Vienna Hospitals the fresh air was heated before going through the wards.

Dr. SHEPHERD said that of late years the term antiseptic treatment had a wider meaning than Listerism. Lister himself says that the spray is the smallest part of the treatment.

50 per cent. of deaths used to follow amputation of the leg, now the death rate is 5 or 6 per cent. The case is not—did a lot do well without *antisepsics* but do all? He has notes of 20 major operations dressed antiseptically without a death and all but one healed by first intention.

Dr. TRENHOLME in over a thousand cases of midwifery he had attended, never had a case of septic poisoning and only had two deaths, one from shock after delivery by forceps in a woman with a deformed pelvis. The second, a woman who got up and walked in the snow a few hours after delivery. He attributed his success to following as far as he could Dr. Goodell's teaching, which was to have his patients walk from the room they are confined in, into the room they intend remaining in during convalescence. Also getting the woman to sit up every day for a few minutes. This to favor expulsion of clots etc.

He was also very particular to see that the uterus after delivery was completely emptied of all membranes.

Dr. CAMPBELL said he always orders his patients to use an ordinary chamber instead of the bed-pan, thereby necessitating her sitting up.

#### CASES IN PRACTICE.

Dr. CAMPBELL related a case of a gentleman who had gonorrhœa  $\frac{1}{4}$  years ago, and who, about a week after marrying a perfectly healthy lady had a recurrence of a discharge similar to his old gonorrhœa. Dr. Campbell, asked would this be called a gonorrhœal discharge and be infective? Several gave it as their opinion that it was a case of non-specific urethritis such cases not being rare in newly-married men.

Dr. GODFREY said he knew of a young surgeon who contracted gonorrhœa aboard ship from the water-closet.

Dr. GURD mentioned a case where a young man got gonorrhœa from wearing a pair of trousers previously worn by a man who had that disease.

#### CHILD WITHOUT NIPPLES.

Dr. KENNEDY described the above condition lately seen by him in a boy, no rudimentary glands could be made out.

Dr. SHEPHERD said that more of such cases were recorded where deficiency was only on one side.

## Correspondence.

To the Editors of the MEDICAL RECORD.

Would you further oblige by putting in the subjoined in your next number.

When *Wonderer* was in a state of wonderment, when he asked in your March number: "What a Christian M.D., or, for the matter of that, a Homeopathic or Hygienic M.D. would do if called upon to attend a case of cholera morbus," I imagined that by that enquiry, *Wonderer* looked upon cholera morbus (simple as it might be) beyond the remedial powers of either the Homeopathic or Hygienic M.Ds. alluded to. I therefore—without the intention of evasion—mentioned what had been done with the more severe disease of Asiatic cholera under the inspection of Dr. McLouchlan, because, if the Homeopathic treatment was so beneficial in the more severe form of disease, *Wonderer* might be satisfied that the more mild disease would likely be as easily controlled. I may say that although cholera morbus, cholera nostras, Europœa or Canadian, cholera Indica, Asiatica, may generally be easily differentiated, still there are some cases of British cholera, or Canadian cholera morbus, closely resembling the severest forms of the disease which occur in Asia, or any other country. I have seen such cases in Montreal, one of which was attended with incessant vomiting, alternated with profuse rice-water stools, the pulse hardly to be felt. There were cramps in the lower extremities, and over all the abdominal muscles, which were as hard as a board, at times causing the patient to writhe in pain with what little strength remained. There was excessive thirst, and inability to speak or open his eyelids, cold, clammy perspiration, with cold breath, and other symptoms, indicative of apparent fatal collapse, yet this case gave evidence of

recovery within three hours after the administration of the 3d decimal dilution of the homœopathically selected remedy. Instead of promising to tell Wonderer how to treat cholera morbus, simply upon its being named, apart from the totality or key-notes of the symptoms, in the case, presented; I told him to study such works as I referred to, and stated that he would find therein the appropriate remedy for the key-notes or totality of symptoms, although not for the treatment of the individual disease by mere name that is, the homœopathically correct method of prescribing, whether the disorder is cholera nostras, cholera Britannica or cholera Asiatica. He does not require to consult authorities, for what they would give in cholera morbus, or dysentery, or nephritis. He comes closer to the root of the evil the other way, besides it gives pleasure to some minds to know that you are prescribing according to a law of cure.

I likewise thought that *Wonderer* had considered that the allopathic treatment of cholera morbus was something substantial, bulky and efficient, in doing good instead of harm, and not a delusion and snare, as he infers, when he says in your May number, viz., "I do not believe that any remedy has yet been discovered which exercises any appreciable effect upon the cholera."!!!

Well, there is no accounting for beliefs; in this correspondence I am replying to the person in your March number, whose identity is recognized only by the words, "*I Wonder*" and in your issue of May by the word "*me*." These are synonyms not generally considered worthy of reply, but I am not at all disposed to find fault, with even these idiosyncrasies. The summation of the logic of "*me*," then, is this, "That Dr." McLouchlan, and all Homœopathic Physicians are deluded, into "thinking they are giving remedies when they are not." I suppose that "*me*" believes that that assertion is very strong in condemnation of McLouchlan and Homœopathy. However, I am not disposed to find fault with his right of belief, facts are better than beliefs in my estimation, and McLouchlan's and other similar testimonies relate to *facts*, regarding the cases of cholera McLouchlan saw, he says: "that all were true cases of cholera, which would have sunk under other than Homœopathic treatment."

Yours truly,

JOHN WANLESS, M.D.

MONTREAL, June, 1885.

## Progress of Science.

### ON HÆMOPTYSIS AND ITS TREATMENT.

By SEYMOUR TAYLOR, M.D. Aberd., Physician to the North London Hospital for Consumption, &c.

In discussing hæmoptysis and its treatment, I would at the onset wish to state that the following remarks relate only to such cases in which there is a suspicion that pulmonary tubercle is present. It is probably a correct assertion that there is no complication in phthisis more alarming to the patient and his friends than a severe attack of pulmonary hæmorrhage. It is equally probable that of all the more grave symptoms of phthisis hæmoptysis is *per se* of less moment as regards its immediate danger than many others to which less attention is paid. In laying down this rule I refer mainly to an ordinary case of blood-spitting and such severe forms as suffocative hæmoptysis, in which an aneurysmal dilatation of a blood vessel suddenly ruptures, are not for the moment taken into consideration. The mental disturbance which a patient undergoes when suffering from hæmorrhage is one of the difficulties the physician has to meet; but in many instances this great factor is overlooked, and we concentrate our energies in prescribing astringents which often fail, and perhaps as often do harm. The treatment generally advocated is guided by arbitrary rules; and remedies are ordered often with no scientific knowledge of their action, but more in accordance with empiricism. It is generally acknowledged that hæmoptysis, in however slight a form, is one of the sure signs of tubercular phthisis; but it will be as well to admit that it may occur without the presence of tubercle, and also that it may be found in some cases of phthisis in which the presence of tubercles is of secondary import as regards the cause of bleeding; or, in other words, that hæmoptysis may arise from disturbances in the vascular current through the lungs, such disturbances being independent of the presence of new growth. On the other hand, not a few cases of rapid phthisis run their course to a fatal termination without their having been at any period any hæmorrhage whatever.

In a majority of instances I am of opinion there should be no undue precipitancy in employing many of the astringents usually advocated. It has certainly been my experience that in the early stage of pulmonary consumption a small amount of hæmorrhage has been rather beneficial than otherwise. A blood-spitting at this period is merely a method of nature to alleviate a congested apex. Consequently it is a congestion we have to combat, not the subsequent hæmorrhage. We see a similar course of events in epistaxis, in bleeding from the bowel, yet no medical man would think of applying astringents and styptics in these latter cases unless the amount of blood

lost be very great. On the contrary, he often finds painful symptoms, are dispelled by the very hemorrhage. But should such an occurrence happen in connection with the lung, we are told to give acetate of lead, gallic acid, and other astringents, which it is hoped will act on the vessels of the lung, a treatment which, I submit, is not correct, nor yet scientific. Our best treatment this period is to attend to the sufferer's general health and condition. Do not restrict him from gentle exercise, but at the same time distinguish between exercise and over-exertion; and let us remember that the former has a tendency to the promotion of a more perfect circulation, and this, I take it, should be one of our chief aims in the treatment at this period. The patient suffering from hemorrhage of the first stage has, I find, a better chance of speedy recovery if he pursues a healthy occupation than one who is ordered to be confined to his bed. Blood-spitting is quite as frequent amongst the in-patients as amongst those attending the out-patient rooms; and yet, owing to patients being admitted, according to priority of application, the cases are no more advanced in disease in the wards at Hampstead than they are in the out-patient rooms.

As regards climate, I believe we have in this country certain situations, the adaptability of which we have overlooked in our treatment of consumptives. It has been my experience that patients have derived much benefit from residence in the high lands around Buxton and the Derbyshire Peak. The few cases I have sent to that locality have certainly returned to town with much diminution in their worst symptoms, and notably with arrest of hemorrhage. On the other hand, I cannot speak so favorably of the results of residence at Bournemouth, Hastings, and other relaxing towns on our southern coasts. The treatment of the severer forms of lung hemorrhage occurring in the second and third stages is more difficult to determine. It is generally felt by the physician that some decisive treatment must be speedily adopted, some steps taken to at once arrest the copious bleeding. Notwithstanding this, I believe the experience of most practitioners will lead them to conclude that in a majority of cases the hæmoptysis stops spontaneously. We must remember the comparative rarity of death occurring from hæmoptysis. I have seen only one death occur during an attack. Other writers also confirm this opinion. For example, so careful and extensive an observer as Dr. C. J. B. Williams states that he has seen only three deaths from hæmoptysis. Again, the late Dr. T. Decock asserted that only 1 per cent. of the cases of hæmoptysis die from that cause, and even that is an average higher than I had expected. Taking these views as correct, I apprehend that the administration of large doses of gallic acid or of sulphuric acid is scarcely correct treatment. These drugs can have little or no effect on a

remote apical lesion. On the other hand, I assure I have seen them do harm by glueing up the intestines, and so favoring a continuance of the hemorrhage, by increasing the arterial tension. To my mind the administration of a purgative would be more rational treatment. A similar doubt as to the efficacy of some other astringent drugs has continually been under my consideration. With some medical men acetate of lead has great repute; others employ chloride of sodium in large doses. Alum has its advocates, and so has tartar emetic, and even mercury. The clinical records of the Paris hospitals have been used to endeavor to prove the efficiency of ipecacuanha. Hamamelis has become a fashionable drug. As a consequence one is embarrassed with the number of remedies, some of which have been almost lauded as specifics. But I am obliged to say my experience of their power for real good is not satisfactory.

As regards outward applications, the conclusion I have drawn from careful observation is that an ice-bag placed on the chest is a valueless proceeding. I have never yet convinced myself that the application of such excessive cold can astringe a ruptured vessel through a pad of muscular tissue, of bones, and also (if the hemorrhage be deeply seated) of condensed lung. Further, the ice-bag is almost invariably planted over the front of the patient's chest, wherever may be the seat of the hemorrhage. I am more than doubtful how this application, with its damp depressing discomfort when placed on the parietes of a man's thorax, even over the supposed seat of a hemorrhage, can have any effect in arresting the same. We seem by this step to overlook the one great factor, rests in staunching an internal bleeding. It precluded the patient from sleep, his mind is disturbed in consequence, and he apparently loses rather than gains from the treatment. Does it not seem more probable that the cold, acting on the superficial vessels of the chest-wall, would rather tend, if anything, to increase an internal disgorgement? On the other hand, I can with confidence recommend an opposite line of treatment—viz., the application of warmth. In three cases recently of severe hæmoptysis I have seen beneficial results from such steps. I applied hot flannels (at about 120° F.) over the angles of the ribs from summit to base of the thorax—in other words, over the sympathetic ganglia—and in each case with speedy and happy results. I cannot claim that this method of treatment is by any means novel. It was advocated by Dr. John Chapman in 1875 in an able paper; and I submit that it has not been adopted by practitioners so frequently as it deserves. We see the same principle adopted by obstetricians in cases of uterine hemorrhages, and there is scarcely a week passes but the medical journals contain reports of successful treatment of flooding by hot-water injections into the uterus, as opposed to the old-established practice of applying ice.

Turning now to medicinal remedies, I must confess that we have only a few drugs which we may really regard as controllers of pulmonary hemorrhage; but these few are really valuable. We too often overlook the clinical fact that in hæmoptysis one of the most urgent conditions to treat is the great restlessness and mental disturbance of the sufferer. He is in a state of great excitement and alarm, a condition also imparted to his friends, and by them, as it were, reflected on the patient again. This point requires our skill and attention. We have at our command a drug, opium (and its derivatives) which acts like a charm. So far as my experience goes it should not be given if administered internally with any other remedy likely to retard or interfere with its full action. Give it in such doses that its physiological effects are produced. If the hemorrhage be very profuse digitalis may be added, but also in large doses, such as fifteen minims to twenty minims of the tincture, till its specific action on the heart is manifest and the frequency of the pulse materially diminished. As a result the patient is calmed, his excited circulation controlled, and he falls into a much-needed sleep. There is yet another method of administering the sedative—viz., by hypodermic injection; and I have found this plan most useful and efficacious. Four minims of the injectio morphinæ hypodermica are introduced into the subcutaneous tissue of the arm, or, as I have sometimes preferred, into the subcutaneous tissue of the chest immediately over the presumed seat of the hemorrhage, and repeated if requisite. The advantage of this method of exhibiting the remedy is its speedy action; the momentary and trivial discomfort of the operation is more than counterbalanced by the good results which ensue. Of the forty-seven cases the notes of which I have before stated form the basis of this paper, eighteen were adult patients suffering from severe pulmonary hemorrhage occurring in the second or third stages of phthisis, and were treated, by opium and digitalis internally or by morphinæ hypodermic injection, with good results in all. So far as I am able to judge of the effects of remedies the above method of treatment is happier in its immediate results than the administration of astringents and so-called styptics, which mainly affect the intestinal tract. Indeed, one of my chief desires in making this communication is to protest against the ordinary practice of prescribing drugs which probably do nothing more than produce a constipation, or the action of which on the circulatory system is more than open to doubt. There are, however, two other drugs which I have found extremely useful when opium is contra-indicated. I allude to oil of turpentine and the liquid extract of ergot. The former may be given by the mouth, the latter either by the mouth or by subcutaneous injection. I have seen excellent results from both in a few cases. The objection to turpentine is its nauseating effect, but its action in controlling hemorrhage is undoubted. My

experience of ergot has not been extensive, but I found it a powerful remedy in four cases of severe and continued blood-spitting.—*Lancet*.

### ON INTERMITTENT PULSE, AS A SIGN OF DISEASE, AND ITS TREATMENT.

By the EDITOR OF THE ASCLEPIAD.

This affection is due to nervous exhaustion of the vital nervous system, and in this day of emotional strain and excitement it must prevail in proportion to the causes of it. In itself, when it is not present in an exaggerated degree, intermittency of the pulse is often less dangerous than it seems. It does not, as might be feared, carry with it the necessary idea of sudden dissolution from heart disease, for, as I have elsewhere shown, the heart is the regulator, not the prime mover, of the circulation. The harmlessness of the symptom in its moderate development is best shown by the facts of its common occurrence after middle age, and by the long duration of life in many of those who present it.

Occurring in young adults, it tells the story of commencing failure of power. Occurring suddenly after any great event, which has told upon the mind, it may be a sign of serious import. In persons advanced in life, and in persons prematurely old, intermittency is often the herald of symptoms of nervous failure. In these examples the patient has sometimes a singular preconception of impending danger.

In the large majority of patients there is an unconsciousness of the intermittency. We listen to the heart, we hear the phenomenon distinctly; we ask the patient, at the moment, whether he is conscious of feeling anything peculiar; he tells you he is not. In such instances, the intermittent phenomenon does not cover more than what would be one or at most two natural periods of cardiac contraction, and there is a long interval before the return of it. But when the intermittency covers a period equal to five normal strokes, or when it is repeated in shorter periods several times in the minute, then the patient is painfully, often fearfully conscious of the fact. Then breathing becomes irregular, then there is difficulty in keeping the recumbent posture, then there is sleepless agitation, errible mental depression, a constant dread of death, sometimes with a singular longing for that event, and finally, death itself, not suddenly, but by a lingering and sinking asthenia. I have seen one well-marked case, in which it was impossible to attribute death to any other cause than intermittent cardiac action, and I do not remember any case where the symptoms, which long preceded death, were more acutely painful.

Persons in whom there is permanent intermittent action of the pulse pass through all acute diseases with less chance of recovery than others of similar age and like constitution who have no such failure. They sink more readily from surgical

operations, from falls and injuries, from influenza, from acute congestion of the lungs, from inflammatory attacks, and particularly from typhus and typhoid fevers. I would look upon a man's chance of recovery from typhoid if he were fifty years of age, and had a steady heart, as preferable to that of another man at forty, in whom intermittent action of the heart was developed before the occurrence of the disease, or in whom the symptom came on, as it sometimes does come on, in the course of the disease.

In adults, when the symptom is once established, it never, I believe, goes away entirely. It may be absent for long periods when the general health is good, but it returns on every occasion of depression of power, and is very easily re-induced by agencies which act deleteriously on the nervous system. Excessive venereal gratification, excessive smoking, deficiency of sleep, or dissipation, act powerfully in increasing the evil. In persons at or past middle age, the symptom, if it once be fully developed, continues persistently, and often to extreme old age. One of my patients, who died at eighty-six years of age, told me he had been discovered to have an intermittent pulse when he was forty-two, and that he had never failed to exhibit the phenomenon since that time. I have noticed often the hereditary character of the phenomenon. On the fact of heredity, there can, I think, be no doubt.

There is no known specific treatment for intermittent pulse, but whenever the symptom of intermittency is present, there are certain general lines of treatment which should always be enforced by the physician. In the case of young children, when the intermittency is clear, however infrequent it may be, the utmost care should be taken to avoid every source of mental emotional excitement. A child having intermittent pulse should not, under any pretence, be oppressed with study. He should not be subjected to any amusements which powerfully excite the mind; he should not at any time be exhausted by physical fatigue; he should be well fed, warmly clothed from head to foot, and above all things, should be allowed to have abundant sleep. Ten to twelve hours' sleep is not a moment too much. Moreover, such a child should never be put to sleep with stories which excite dreams or cause alarm. In adults, equal care should be taken, and, above all things, attempts should be made to remove impressions derived from any untoward event. Change of scene should be recommended, while a carefully regulated diet, abstinence from exhausting pleasures and abstinence from exhausting labor, especially mental labor of any one particular kind, should be encouraged. Good sleep is here again the most valuable of remedies. Eight hours of sleep out of the twenty-four are essential, nine hours are still better. Two other special points of advice are of moment. It not unfrequently happens that, by accident or by direct information,

patients learn the fact that their pulse intermits. Then they begin to feel their own pulse, and become charged with dread of sudden death. As the disorder is of itself mental, this watchfulness and fear will increase the frequency of the intermittency. With these patients, a word from the physician, timely and firmly spoken, is often the best prescription. He assures them, on the results of experience, that their malady is not of necessity fatal; he recommends them not to enquire after the symptom, and if he can succeed in persuading them to his views, which he may honestly try to do with all his influence, he will effect the most marked improvement in their condition. Again, it sometimes happens that patients conscious of the failure of the heart resort to alcoholic stimulants as a means of relief. For a moment, by its exalting the activity of the heart, alcohol affords relief, but the depression that follows calls the more rapidly for a return to the supposed remedy, and a fictitious benefit leads to a habit which excites structural changes and hastens death. Concerning aged people who suffer from what may be called chronic intermittency without consciousness of the symptoms, no special rule requires to be laid down. They are themselves usually too tired of the excitements of life to care for them, and if they are not, then the observance of the general principles applicable to children and adults extends equally to them.

Whenever with intermittency of the pulse there is anæmia with inactive condition of the bowels, and distention of the stomach and intestines with gas, it is very good practice to add, to the general rules of treatment, "a tonic," so called, and of all tonics Easton's Syrup of the Superphosphate of Quinine, Iron, and Strychnine, is one of the best. This syrup, which contains the thirty-second part of a grain of strychnine in a fluid drachm, should be administered in doses of a drachm three times daily, a little time after food, and the patient should be induced to look upon the remedy in the light of a food rather than a medicine. The syrup, under the careful observation of the practitioner, may be continued for two or three months at a time without danger. When there is much restlessness with the intermittency, as well as want of power, I am accustomed to administer one or other of the bromide syrups. The syrups of the bromide of Iron, Quinine and Strychnine, or of the Bromide of Iron and Strychnine, or of Quinine, and Strychnine without the Iron, replace Easton's preparation very effectively. The dose of these syrups is one fluid drachm.

There are classes of cases in which intermittent pulse is connected with great general prostration and premature breaking up of the body; cases in which there is some organic disease, such as chronic bronchitis, emphysema, senile phthisis, chronic degeneration of the kidney, or other organic change; or some general systematic disorder, such as diabetes or cancer. In any of

these cases the intermittent action is a terrible addition to the distress of the sufferer, and it may require to be treated itself as the worst present evil.

I have made many inquiries in order to ascertain if there be any one particular remedy which so influences the nervous mechanism of the heart as to exert an immediate controlling effect over intermittent action. The result of my research is that there is only one agent which can be said positively to influence it effectively—I mean to influence it *at once* in such determinate manner that an effect is seen to follow upon a cause. The agent to which I refer is alcohol, and the mention of alcohol brings up the whole question of its use in cases of intermittent action. In intermittent pulse this direct action of alcohol on the heart is shown with singular effect. I have seen in an extreme case, where the fact of intermittency was recorded ten times in the minute at least, a total cessation of the phenomenon within five minutes after the administration of six fluid drachms of pure alcohol in water, the circulation at the same time being rendered more rapid. This action of alcohol is so decisive that the patient himself soon becomes conscious of it, and unfortunately resorts sometimes to the remedy to his ultimate disadvantage.

Contrary to what I originally taught, I now recommend that the sufferer from intermittent pulse should abstain from every alcoholic drink known as a common drink or beverage. At the same time I would not withhold the occasional use of alcohol in extreme conditions, or what may be called emergencies. If after great fatigue or excitement or anxiety, there is sleeplessness, restlessness, and painful knowledge, on the part of the patient, of the hesitation of the circulation, half a fluid ounce to six fluid drachms of pure alcohol, mixed with warm water, will act, generally, in the most effective manner. It will bring rest, and often sleep. But it must be repeated only after an interval of seven or eight hours; if it be carried to the extent of producing the third, paralyzing or narcotic, degree of alcoholic stimulation it will have conferred evil instead of good.

In some instances, instead of prescribing common or ethylic alcohol, I substitute pure methylic alcohol. This is a much lighter spirit, and is eliminated more quickly from the body. The dose is the same as for common alcohol, and may be prescribed in precisely the same way, with the advantage that it may be more frequently repeated than the same dose of ethylic alcohol. It will be seen from these observations that I recommend the use of alcohol purely as a medicine. I do so most earnestly, under the conviction that whenever it is more than a medicine it is far more harmful than useful.

Tea does not produce intermittent pulse, but when the symptom is present it very seriously increases it; tea, in short, is an article of diet which in all cases of irregular action of the heart should

be scrupulously avoided. Coffee is less objectionable. Food should be taken by sufferers from intermittent action in moderate quantities and *frequently*. Long fasting is unspeakably prejudicial, and makes itself speedily felt by the patient, who suffers, while fasting too long, from an indescribable exhaustion, which is not hunger and not faintness, in the natural sense of those terms; but a strange mixture of both sensations, with a frequently recurring impression that if food do not immediately come death must. The nervous supply of the heart in these cases is sensitive to the least failure of power, and requires renewal every three or four hours during the working day. At the same time the system rebels against a large, oppressive meal difficult of digestion. Care should be taken, also, to protect the body from damp and wet. In a word, every such provision should be made as will sustain equality of the vital processes, so that the nervously disabled heart may neither wait long for new support nor be overtaxed with work.

[In our experience intermittent pulse in middle life is almost always connected with anxiety—usually pecuniary or business anxiety.—Eds.]—*The Asclepiad*.

## THE CANADA MEDICAL RECORD

A Monthly Journal of Medicine and Surgery.

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SUBSCRIPTION TWO DOLLARS PER ANNUM.

All communications and Exchanges must be addressed to the Editors, Drawer 356, Post Office, Montreal.

MONTREAL, JUNE, 1885.

## COLLEGE OF PHYSICIANS AND SURGEONS PROVINCE OF QUEBEC.

The semi-annual meeting of the College of Physicians and Surgeons of the Province of Quebec was held at Montreal on the 13th inst. The President, Dr. Lemieux, in the chair. There was a good attendance of governors, among them the Hon. Dr. Robitaille, ex-Lieut.-Governor of Quebec.

Reports from assessors of McGill, Bishop's, Victoria and Laval (Quebec and Montreal), were received and adopted.

The Report from the Board of Preliminary Examiners was read. Sixty-two students presented

themselves, of whom 29 who went up for the first time were successful; 10 who presented for the second time were successful; 17 were rejected on certain branches, while 6 were rejected for general deficiency.

The report of the agent of the College, Mr. Lamirande, was read. During the past six months, the College gained six cases, lost one, and five are still before the Court.

A petition from Mr. Tierney of West Farnham to be allowed to continue to practice medicine, on the ground of his having done so for 25 years, was refused, the College not being possessed of any such power.

A report on certain charges made against the College agent, Mr. Lamirande, was presented. It stated he was not free from blame, had acted beyond the scope of his authority, and recommended that his duties be more clearly defined.

A motion was made by Dr. Durocher, seconded by Dr. Rinfret, suggesting that at the preliminary examination for admission to study, the papers of candidates should not bear the name of the writer, but that of a *nom de plume*.

A report was presented from a committee appointed at last meeting to examine the financial condition of the College. Its consideration was postponed till next meeting.

A notice of motion was given to place the collecting of the annual dues again in the hands of the Registrar, and for this and his duties of registrar pay him \$400 a year.

On the report of the committee appointed one year ago to investigate the charges made by Dr. Lachapelle against Victoria College, the consideration of which was postponed from the last meeting, being brought forward, it was moved by Dr. Marsden, seconded by Dr. L. Larue, that the report of the committee be received. This was carried without discussion.

A notice of motion authorizing the President in certain cases to issue an interim license was brought forward and carried unanimously. The notice of motion for a Central Examining Board received a six months' hoist.

#### MONTREAL GENERAL HOSPITAL.

The annual meeting of the Governors of this Hospital, which was held on the 21st of May, was looked forward to with considerable interest, as the vacancy on the attending staff of physicians,

created by Dr. Osler's removal to Philadelphia, had to be filled. Although a vacancy on the outdoor staff had also to be filled, the interest centred in Dr. Osler's vacancy. The candidates were Dr. R. L. MacDonnell and Dr. F. W. Campbell, and the result was the election of Dr. MacDonnell, who polled 93 votes and Dr. Campbell 71 votes. Both sides we presume brought forward every vote in their power, and the number polled is, we believe, the largest in the history of the Hospital. If the contest had been an ordinary one we would have been content to have simply chronicled the result. It was, however, not an ordinary one. It was a contest between the old established Medical Faculty of McGill and the younger Medical Faculty of Bishop's College, the former being determined to maintain their monopoly, which, so far, they have been enabled to do, of the Indoor Staff. That the feeling among the Governors of the Hospital against this exclusiveness is very strong is proved by the large vote Dr. Campbell polled; and, although defeated for the time, we are satisfied that the day of victory is not far distant. We feel confident of this because, the principle for which Bishop's College is fighting is one which must in time commend itself to all who believe in British fair-play. It is a principle which has not been fought for the first time within the walls of our General Hospital. Other hospitals in our own country and abroad have felt the dead weight which attach to such monopolies, and the result has been their complete destruction. We believe a similar fate awaits it here.

#### THE DAVIS & LAWRENCE COMPANY.

Among the constant advertisers in the CANADA MEDICAL RECORD is the firm now known as the Davis & Lawrence Company. For many years they have occupied several of our pages, their steady support being, we believe, mutually advantageous. We have noted their onward progress, and have with much satisfaction watched their constantly-increasing success, reflecting, as it does, the greatest credit upon its management. From comparatively small premises in the city proper, they, a few years ago, moved into the Western suburbs, occupying there a building of considerable dimensions. This was soon found to be too small for their steadily-increasing business, and a few months ago they left their old quarters to

occupy a manufactory specially erected for them. This establishment, a cut of which we give, is not surpassed either in the United States or Canada. In extent it covers three sides of a square, having a total frontage on three streets of 404 feet, with an inner court in which is built the boiler house. It is four stories high, with the basement, and is built entirely of brick and stone, the St. Antoine street front being handsomely faced with sand stone. For substantial structure and architectural beauty it is doubtful if it is excelled by any factory building in Canada. Every modern improvement that would facilitate the business has been adopted, such as steam elevators, hand railways, machines for bottle-washing, bottle-filling, bottle-corking, etc.

Commencing at the top floor, which is set apart entirely for laboratory purposes, was found long rows of percolators for the manufacture of fluid extracts, pill-stamping machines, great copper boilers, huge tanks, and many other things too numerous to mention.

Hundreds of preparations are manufactured in this establishment, comprising Fellows' Syrup of Hypophosphites, which is so highly valued as a tonic in wasting diseases, etc., and which is so extensively prescribed; Murray & Lanman's Florida Water, the original and only genuine Florida Water; Brown's French Dressing, that favorite polish for ladies' shoes; "Maud S." Condition Powder, which is now taking high rank in the estimation of horse owners; Burnett's Standard Preparations, consisting of flavoring extracts, etc.; Lotus of the Nile, that Queen of Perfumes; The "Royal" flavoring extracts, new and popular; Ricksecker's elegant line of first class perfumes; Wyeth's splendid line of pharmaceutical preparations, which are so highly spoken of by physicians as being thoroughly reliable, comprising a full and complete line of elegant medicinal Elixirs, Fluid Extracts and Compressed Pills, besides their celebrated "Beef, Iron and Wine," "Chlorate of Potash Tablets," "Menthol Pencils," etc., etc. All these and many others are manufactured in this laboratory department. Descending to the next floor we find the bottling and packaging department and store rooms for finished goods; here also printing presses are at work, for this company do much of their own printing work. Again descending we come to the finishing apartments, shipping departments, sample room, and the handsome

and spacious offices. The basement is used for the storage of cased goods and as a bonded warehouse.

### VACCINATION.

The recent outbreak of variola in Montreal, an unfortunate occurrence in itself, has been attended by several most unpleasant circumstances. The non-isolation of the first case which arrived in the city, and was taken to the Hotel Dieu Hospital, has already been referred to. The quality, of the vaccine furnished by the officer of the Health department being called in question a committee of Medical experts was formed, who examined several of the large institutions where many inmates had been vaccinated, and found indisputable evidence of the introduction of septic matter into the wounds produced to receive the vaccine virus, and of course, several cases occurring together and with the same history, the conclusion was inevitable that the vaccine virus used had not been pure.

The result is particularly to be regretted, since in Montreal, among a certain class, there is already such a strong feeling against the adoption of that sure and certain preventative and, if carefully prepared, that safe preventative, of one of the most dreaded and loathsome of all preventible diseases. And yet in the face of such an experience as this we find the authorities that be fighting and squabbling over the appointment of a Medical Health Officer, evidently the prime consideration being nationality and religion rather than training, executive ability and knowledge of the duties pertaining to the office. Where will this sort of thing, if persisted in, lead us to?

### MEDICAL JOURNAL ADDRESSES.

We have just received from the Illustrated Medical Journal Co. of Detroit, Michigan, several sets of their Perforated Adhesive Medical Journal Labels. The list includes besides the Journals of the United States that are devoted to Medicine Pharmacy and Hygiene, those of the Provinces of Canada as well. Four complete sets will be mailed postpaid for fifty cents on addressing the publishers above named. They are just what every physician needs for addressing his Reprints for journal notice, and Medical Colleges for addressing their Announcements for a similar purpose.

## ACTIVE SERVICE IN THE NORTH-WEST.

It was not very creditable to our profession that of the two regiments called on active service in the North West neither took their gazetted medical officers with them, substitutes being provided. Where all the officers had to suffer some loss, either of business or income, the same should have been expected of the Surgeons. In the case of Dr. Mignault there was, however, a more valid excuse which was mentioned in a previous number. Since then Dr. Mignault has written us as follows:

"On the 2d of March, I had an attack of *hmoptysis*, after a rather long lecture in my anatomical amphitheatre.

The 65th was called out on the 28th of March. I consulted several physicians as to the advisability of my going, their opinion was unanimous, under the circumstances, against the journey.

I furnished my substitute with a complete *suit* and all necessaries for the trip.

Since then, feeling better, I wrote to Lieut.-Col. Ouimet, placing my services at his disposal, if required for the Battalion."

## PERSONAL.

Dr. O'Reilly, Medical Superintendent of the Toronto General Hospital, sailed in the *Parisian* of the Allan line for Europe on the 30th of May.

Dr. William Gardner has been elected Gynecologist to the Montreal General Hospital.

Dr. George W. Major has been elected Laryngologist to the Montreal General Hospital.

Dr. R. L. McDonnell has been elected a Physician to the Montreal General Hospital, in place of Dr. Osier resigned.

Dr. A. D. Blackader and Dr. F. W. Campbell have been elected Assistant Physicians to the Montreal General Hospital.

Dr. James Bell has been elected an Assistant Surgeon to the Montreal General Hospital.

Dr. William Stephen of Montreal has recently left the city for Vienna, intending to devote his attention to Diseases of the Eye and Ear. It is said that his intention is to settle in Buenos Ayres.

Dr. Wm. McClure (M.D., McGill) has been elected Medical Superintendent to the Montreal General Hospital.

Dr. Major, Laryngologist to the Montreal General Hospital, has gone to Vienna for a few months.

Dr. Finley of Montreal, Dr. Gustin of London and Dr. Eberts (M.D., McGill, 1885) have been appointed Resident Medical Officers of the Montreal General Hospital.

## REVIEWS.

*The London Medical Student and other Comicalities.* Selected and compiled by HUGO ERICHSEN, M.D. Detroit, Michigan, 1885.

It is almost half a century ago since the London Medical Student was published in the London *Punch*, and when we began our studies a quarter of a century ago it formed part of almost every medical students' library; lately, however, it has been difficult to obtain, and therefore has not been as much read as formerly. Dr. Erichsen has therefore done a thing to be commended in re-printing it, on this side of the Atlantic, for a more enjoyable medical sketch is not to be found. The medical man who can read it and not be convulsed with laughter is one to be pitied, for it is full of wit and humor as a nut should be full of meat. The remainder of the book is full of medical jokes collected from an immense number of sources. Many of these are splendid, and Dr. Erichsen has done the profession a good service in collecting them in so permanent a form. Altogether the book is well worth the cost, and it should be in the hands of every medical man in the Dominion. We predict for it a large sale. It can be ordered direct from Dr. Erichsen.

*The Oleates: An Investigation into their Nature and Action.* BY JOHN U. SHOEMAKER, A.M., M.D., Lecturer on Dermatology at the Jefferson Medical College; Physician to the Philadelphia Hospital for Skin Diseases; Member of the Pennsylvania State Medical Society; The Minnesota State Medical Society; The American Medical Association; The American Academy of Medicine; The British Medical Association; Fellow of the Medical Society of London, etc., etc., etc.

In this book Dr. Shoemaker gives an account of his investigation concerning the oleates. The author is certainly one of the best authorities on this new and very useful class of remedies.

The indication and method of preparing the different oleates are very clearly given. No physician pretending to treat skin diseases should be without a copy of this very instructive little book.