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CANADA
MEDICAL & SURGICAL JOURNAL

JANUARY, 1879.

Original Communications.

A CLINICAL LECTURE

UPON A CASE OF

CONTRACTION OF THE RIGHT SIDE OF THE CHEST,
AND GREAT ENLARGEMENT OF THE SUPERIOR HALF
OF THE ABDOMEN—GIVEN DURING THE
SUMMER SESSION OF 1878.

By R. P. HOWARD, M.D., ETC.,

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REPORTED BY DR. VINEBERG.*

GENTLEMEN,—Owing to the obliging disposition of the young man who accompanies me to-day, and who came from a distance for my opinion, I am enabled to show you a case of unusual interest. Its nature has been the subject of some diversity of opinion amongst the many physicians who have examined the patient; and though it is probably an example of a not uncommon pathological combination of lesions, it must be admitted that considerable obscurity and difficulty now surround it, as seen for the first time more than two years since its invasion.

It will be necessary to give you as fully as possible the history of the case as related by the patient, who is a young man of much intelligence, and he will then be examined before you.

* A few additions have been made to this lecture since it was delivered.
—R. P. H.

W. McD., 19 years of age, printer, gives the following history from memory :

Had always enjoyed good health up to January, 1876. He then first experienced shortness of breath when walking, but had not any cough, and although looking ill, thought nothing of it. In the following May he had a slight cough, from taking cold, this continued about three weeks, but under the use of squills, prescribed by a physician, disappeared entirely. When he first consulted his medical adviser, great enlargement of the epigastric and hypochondriac regions was noticed, but its nature was not made out and seven weeks treatment did not remove it. During the succeeding thirteen weeks the swelling remained stationary. The patient, who was not under treatment, continued at his employment, and on November 1st, the cough having returned, he sought advice from the brother of his former attendant, who considered that he had tubercular disease of the right lung, but made light of the enlargement of the body above mentioned. He never had suffered pain in his side, nor, as far as he remembers, did he experience any until the winter set in ; but during that season he, on two or three occasions, experienced attacks of severe pain in *left* mammary and hypochondriac regions, which lasted eight or nine hours, and was deep-seated and of a stitch-like character. The cough lasted all through the winter, and was of varying intensity ; it frequently continued all night. He thinks the expectoration was chiefly of a frothy mucus, except during four weeks, when it was dark-green and purulent, and was always free from blood.

The treatment during that period embraced, amongst other things, blue mass, iodide potassium, frequent blisters, and local applications of iodine, and mercurial ointment. In May, 1877, œdema appeared in the lower extremities, the eyelids were puffy in the morning, and his urine contained some albumen ; but the dropsy disappeared in August. He visited Boston in July of that year, and saw some of the most eminent of the physicians there : one of whom aspirated the right side of the chest posteriorly, but obtained no fluid. No opinion was given him respecting the nature of his case, but he was ordered

to avoid medicine and work, and to live nutritiously. He made a second visit to that city in October, when, on comparing his person with a sketch taken at his previous visit, no change could be perceived. He then weighed 142 lbs. Since July, 1877, he has been free from cough, except for a couple of days together, and only after exposure; his breathing has improved, and œdema of feet and legs has continued stationary. Since the œdema first set in he has had to urinate eight to ten times during the day, and once during the night. His immediate family history is as follows: Both parents, four brothers, and four sisters, are alive, and with the exception of two of the latter, are all healthy. One sister has been the subject of some lung affection, and another is epileptic.

June 11th, 1878.—Present Condition.—Stature, 5 feet 9½ inches; weight, 150 lbs; fair complexion; pale; not badly nourished. Taking off his shirt, we note the following:—

Inspection and Measurement.—Notable deformity of thorax; left half larger and fuller than right, which is flattened and retracted; the right shoulder and nipple on lower level than the left; posterior border of right scapula projects, and dorsal spine presents a lateral curve, with the concavity to the right; semi-circular measurement a few inches below nipple—right side, 15½"; left, 17½"; at nipples, right, 15 6-8"; left, 17"; axilla, right, 15 6-8"; left, 16 1-8". Expansion of the entire right half of chest very deficient; that of left very marked.

Percussion elicits hyper-resonance over entire left chest— anteriorly, this note extends to right of mesian line as far as border of sternum; inferiorly, it coasts obliquely along close below left nipple, into lateral region, at level of 7th space; posteriorly, the left infra scap-region, over about 2½ inches vertically, emits a flat note. In the right infra clavicular and axillary regions resonance is of dull, hollow, almost amphoric quality, but below the level of, and corresponding accurately with, a horizontal line drawn around the chest from the 3rd intercostal space, the stroke sound is flat, and the resistance great over the rest of the entire right chest.

Auscultation.—Exaggerated respiration over left chest, with

comparatively feeble vocal resonance and fremitus. Blowing respiration, increased vocal resonance (pectoriloquy) and fremitus exist over whole right half of thorax, are most marked above the level of third interspace; all respiration ceases to be audible below 9th rib posteriorly; a fine, sharp bubbling is heard at end of inspiration in 4th right interspace from sternum into axilla and shade off superiorly. Heart's impulse and sounds more perceptible in lower sternal region, and at right border of that region, than at usual site inside of left nipple.

Extending the examination to the abdomen, we are struck with the great enlargement of the upper zone, the epigastrium and both hypochondria being occupied by a firm, smooth, resisting body, which gives a dull note on percussion, as though the entire liver were very much enlarged. The fullness is most prominent in the epigastrium, especially over its left half. The dull percussion note over this enlargement extends not only over the whole upper abdominal zone, but blends superiorly with that present in the right mammary, in the cardiac and lower part of the left mammary regions, and encroaches inferiorly upon the middle abdominal zone. The hollow percussion resonance of the stomach is masked by the flat note of the resisting mass which seems to be in front of it. A horizontal depression exists around the abdomen, corresponding to the lower margin of the dull and prominent region, and divides the belly into two portions. The lower portion is smooth, its walls tense, and in the erect posture fluctuation is perceptible as high nearly as the umbilicus. In the recumbent posture on the left side, sudden palpation appears to displace fluid and permit the enlarged liver to be felt by the fingers. Owing to the tenseness of the parietes, the lower edge of the liver cannot be distinguished. Superficial epigastric and mammary veins very numerous and tolerably enlarged; lower extremities, up to buttocks, pit upon pressure; no œdema of scrotum; slight puffiness of eyelids. To the above physical examination, which you have just witnessed, may be added the following facts:—Patient micturates eight or nine times in the day, and, if awake, once or twice during the night. The urine is normal in colour, free

from albumen, tube casts and renal cells. About four pints passed daily. His breathing is short, especially when exerting himself, but he is free from cough and expectoration. His blood of rich red color; red corpuscles collect into rolls, are abundant, of uniform and fully average size; while they are tolerably numerous, but not excessively so; small granules present in moderate amount.

In forming an opinion as to the nature of this case, we will begin with the chest, the right side of which is so much retracted and smaller than the left.—What are the conditions known to produce marked retraction of one side of the thorax with dull percussion resonance?

1. Infiltrating carcinoma of the lung; 2. General collapse of one lung, both rare affections; 3. Chronic pleurisy, with retraction; 4. Chronic phthisis, both common affections, and 5. Cirrhosis of one lung, a comparatively rare affection.

Let us endeavor to determine which of these conditions obtains in this young man.

1. Carcinoma of a lung, especially when diffused, may produce retraction of the side of the chest. But the circumstance that the patient has suffered from his disease for over two years, and that, instead of losing flesh and becoming weak and cachectic, he is gaining weight and strength, is quite incompatible with the existence of infiltrating carcinoma of nearly an entire lung; a disease which is uniformly progressive and usually fatal in from two to two and a-half years. And there are several other facts opposed to such a view.

No mediastinal tumour, so frequently present in pulmonary carcinoma, exists, for the dull percussion note does not extend beyond the middle line—rather it falls short of it—nor are the veins on the front of the chest and shoulder, and at the root of the neck, enlarged and varicose; there is no contraction of one pupil, no alteration of the voice, no œdema of the neck and of the affected side of the chest; in short, the pressure signs of intra-thoracic tumour are wanting.

Hæmoptysis and red or black currant jelly-like expectoration have not occurred. There is no enlargement of any of the

external lymphatic glands. And, although there is enlargement of the liver, I will assign reasons by-and-by against the malignant nature of that enlargement. Pulmonary carcinoma then may certainly be excluded.

2. *General Collapse of the Lung* may be excluded, for there is no evidence of aneurismal or other tumour in the chest to compress the main bronchus which admits air to the lung. The physical signs are not those of mere collapse—viz., feeble respiratory murmur, without decided blowing or hollow quality, mere diminished percussion resonance, or slight dulness; absence of markedly increased vocal resonance and vibration. On the contrary, the percussion note is somewhat hollow superiorly, and almost wooden with marked resistance inferiorly; respiration is quite blowing, and vocal resonance and vibration are much intensified.

3. *Chronic Pulmonary Consumption*, using the term in Laennec's sense, sometimes develops a form of fibroid transformation of the lungs, attended with contraction of one side of the chest; indeed, this is the most frequent origin of at least one form of pulmonary cirrhosis. But not wishing to assume that this form is identical with that which succeeds simple inflammation of the bronchi, lungs, or pleura, I will speak of it by itself. Consumption is but rarely attended with great retraction of one side of the chest, and very seldom with the degree of general retraction and deformity present in this case. Signs of softening or excavation will usually be present in the apex of the affected lung, and disease will almost always be found co-existing in the apex of the other lung when retraction obtains. The history will generally record hæmoptysis, recurring diarrhœa, colliquative sweating, unremitting purulent expectoration and steadily progressing loss of strength and flesh. Such are not the clinical features and history of our patient, and chronic phthisis may therefore be ignored.

There remain, then, but chronic pleurisy with retraction and cirrhosis, or fibroid degeneration of the lung, and it is difficult to decide between them.

Fibroid Degeneration, or Cirrhosis of the lung, resembles in many respects this case.

That disease affects one lung usually, and the other remains healthy and enlarges; pain in the affected side and hæmoptysis, night sweating and diarrhœa may be wanting, and often are; cough may also be absent at first, especially if it originates in pleurisy; which it is admitted does occur sometimes, and no doubt our patient had pleurisy. This loss of flesh and strength is often not at all in proportion to the cough, the extent and character of the physical signs, and the duration of the disease. The previous health may have been quite good up to the time of the attack, and the general nutrition, the well-developed frame and muscles may indicate a healthy and vigorous constitution.

The retraction of the side, when the whole or the greater portion of one lung is implicated, may be as great as in chronic pleurisy, and affect the entire side, although there is not usually (only exceptionally) such marked depression of the shoulder, tilting out of the inferior angle of the scapula and lateral curvature of the spine, as is seen in this case.

The physical signs indicate consolidation of the lung, and are the same as those present in this young man—decided dullness of hollow quality, with marked resistance anteriorly and posteriorly; respiration of blowing quality, pretty generally audible over the whole dull region, although, as in chronic pleurisy also, the respiration may, as in this case, be feeble and almost inaudible at the base of the lung, where a thick deposit of exudation matter separates the pulmonary from the costal pleura; and vocal resonance and fremitus are exaggerated all over the dull region except at the extreme base, as they usually are in cirrhosis. When they are not, it is probably because even the bronchial tubes are obliterated in the indurated and atrophied portion of the lung; a condition which will also explain the feebleness of respiration noticed in the patient in the infra-scapular region, which, though very dull on percussion, is almost silent as regards respiratory sound.

Now, while this case comports in all these respects with advanced cirrhosis, the following circumstances may be urged against that view:—

There is no history of previous pneumonia, recurring attacks of bronchitis, chronic tubercular disease, or exposure to the inhalation of irritating particles, which are the well-established antecedents of fibroid degeneration of the lungs. Even if it had been satisfactorily proved that that affection does occasionally owe its origin to the abuse of alcohol, to gout, rheumatism, or syphilis, none of these have obtained in the history of this patient.

Fibrinous Pleurisy is also regarded as a determining cause of pulmonary cirrhosis, and it is my opinion that our patient's illness began as pleurisy, but of that form which is accompanied with effusion, of which more hereafter.

5. Another explanation only remains—*Pleurisy*, followed by retraction of the side, a condition that sometimes resembles, in its symptoms and signs, fibroid degeneration or cirrhosis more than any other disease does.

Marked retraction of the chest, after pleurisy, occurs most frequently when the pus or sero-purulent effusion has opened into the bronchial tubes and been expectorated, or has perforated the chest wall and thus escaped. Sometimes, however, it follows absorption of the fluid, but the retraction is then not usually great.

Now, there are some serious objections to the view that this case is one of pleurisy followed by retraction; thus:—

There is no history of pain in the right side, fever, cough, or illness beyond dyspnoea, for the first four or five months. Taking that view, we are obliged to suppose that the first physician whom he consulted (for chronic dyspnoea and a recent cough), and who discovered the great enlargement across the epigastric zone, failed to notice the existence of pleurisy, probably with more or less effusion, although he had him under treatment for seven weeks, and under observation, in conjunction with his brother, who was also a physician, for a year afterwards.

The dyspnoea and great enlargement in the epigastric zone continued all summer, and then cough set in again, but attended with expectoration, and still no mention was made of pleurisy or pleural effusion, but of phthisis.

These are certainly objections to the theory of pleurisy with effusion, but, on the other hand, it may be urged. 1st. That that disease is sometimes quite latent, pain being altogether absent, the disease revealing itself subjectively chiefly by dyspnoea during exertion, and objectively by its physical signs. 2nd. That the pleural disease may not have set in till the fall; the dyspnoea may have been caused by the large tumour below the diaphragm interfering with the action of that great respiratory muscle. 3rd. That the doctors may not have chosen to inform the patient of the pleurisy; or, attaching chief importance to the tumour, they may have actually overlooked the presence of effusion in the right side of the chest.

But *what* are the circumstances favourable to the view that the thoracic affection was primarily pleurisy followed by retraction?

1. That it is by far the most frequent cause of general retraction of one side of the chest? On Friday last I saw an excellent example of it with Dr. Roddick, in a patient from whose right chest he had removed 80 or 90 ounces of serum four years ago. The retraction affected the whole right side superiorly as well as inferiorly, posteriorly as well as anteriorly. The appearance of the entire chest resembled very closely that of this young man:

2. The existence of dyspnoea from the beginning of the year till May, without cough, is reasonably and fairly explicable on the supposition of latent pleurisy with effusion.

3. The enlargement in the hepatic region noticed in May, may have been due to the displacement of that organ by the effusion (although it is quite possible amyloid degeneration of the liver may have also been present.)

4. The severe cough which often continued throughout the night, and lasted six months, may well have been due to the effusion having perforated the lung, and been expectorated from time to time.

5. The *degree* of the retraction being so considerable, and being attended with depression of the shoulder, lowering of the nipple and curvature of the spine.—Walshe, indeed, says, "That

none of these displacements are produced by cirrhosis alone :” and although this statement does not always hold good, (see case by Bastian, in Reynolds’ Syst. Med., vol iii., p. 857), yet it expresses a good general rule.

6. While the physical signs present may be equally well referred to “pleurisy with retraction,” or to “cirrhosis,” the absence of those characterizing dilated bronchi in the affected lung, favour very decidedly, the existence of the former affection.

7. The absence in the history of the case of hæmoptysis, of a peculiar purulent expectoration, and of diarrhœa, favours the view of pleuritic rather than cirrhotic origin.

8. So does the cessation of the cough and expectoration, and the steady improvement in flesh, strength and general health for the past 10 months. Cirrhosis, in the vast proportion of cases, progresses from bad to worse—although it does so very slowly. The cough and expectoration hardly ever cease for a long time, for months I mean.

9. Finally, there is one physical sign present, which is almost a proof of the previous existence of pleurisy with effusion, viz. : the horizontal line which the upper limit of dulness makes around the chest, from the sternum to the spine at the level of 3rd intercostal space.

Neither tubercular nor malignant disease ; neither cirrhosis, chronic pneumonia, nor tumour of any kind, could produce a horizontal line of dulness, unless in very exceptional cases.

For these considerations, then, I am of the opinion that the affection in this patient’s chest has been pleurisy with effusion, followed by general retraction of the right half of the thorax.

But a greater difficulty awaits us : What is the enlargement of the epigastric zone due to ? The situation of the enlargement—viz. : in the epigastrium, both hypochondria, more especially the right, and the upper part of the umbilical zone—its percussion dulness, blending above with that of the liver, spleen and heart, and extending continuously into the umbilical region below,—its uniform, resisting, solid feel—its superficialness, covering as it does the stomach, are circumstances that induce me to regard it as an enlarged liver.

The conditions, productive of such great hepatic enlargement, are chronic mechanical congestion, abscess, cancer, fatty degeneration, both forms of hypertrophic cirrhosis, hydatids, and amyloid degeneration.

Mechanical Congestion of the liver, from mitral or tricuspid disease sometimes produces uniform and considerable enlargement of the liver, but never, in my experience to the extent present in this young man, in whom, moreover, no valvular affection exists.

Pyæmic Abscess of the liver, consequent upon pleurisy might produce enlargement of the liver, but the entire absence of pain, and tenderness, which are always, and of jaundice, which is usually present in hepatic abscess; the absence of the general symptoms of pyæmia, viz. : irregularly recurring fever of intermittent type, rigors, profuse sweating, subcutaneous and articular suppuration, etc., and the short duration of pyæmic abscess which rarely outlasts three months, and generally ends fatally, will exclude that affection. I deem it unnecessary to discuss *primary* abscess of the liver, the result of hepatitis, a disease not infrequent in the tropics, but hardly known here.

Fatty Enlargement of the liver, so common in chronic phthisis, is rare in other wasting diseases, and in young and temperate persons. It is not attended with ascitis, and may be ignored in this instance. Moreover the enlargement appears to have existed before the protracted cough and expectoration set in.

Carcinoma of the liver, which might well explain the great size of the abdominal tumour, may be excluded, owing to the absence of the following symptoms: pain in and tenderness under pressure, of the liver; tumour elsewhere; enlarged glands, and that profound alteration of health and nutrition necessarily consequent upon the existence of a malignant tumour for two years. Carcinoma steadily pursues the evil tenor of its way towards cachexia, marasmus and death, and the last is not far off at the end of two years.

That form of *Hypertrophic Cirrhosis*, caused through obstruction of the bile duct by gall stones, cancerous glands, or pancreas, &c., and sometimes by malaria, and called *Biliary cirrhosis* may

be excluded, for the early and marked icterus of that affection has not existed in this patient. The presence of ascites in this case would also be opposed to the idea of *Biliary cirrhosis*, according to Hanot, but other observers have met with that symptom at least in the advanced stages. This young man has not resided in a malarial region, nor had ague.

Simple Hypertrophic Cirrhosis, if I may so term it, to distinguish it from biliary cirrhosis, although not generally described in systematic works, is an affection of which I have seen several specimens.

It is not *always* due to *obstruction* of the *bile* ducts, nor is jaundice a necessary symptom. It may present all the clinical features of the ordinary atrophic form of cirrhosis, except that the *liver* is *enlarged*, sometimes very greatly, instead of being reduced in volume. In an interesting example which occurred in this Hospital, and is discussed in Dr. Osler's Pathological Report for 1876-77, p. 571, the liver was uniformly enlarged, and weighed 6lbs 11½ oz. In some respects our patient's case conforms to cirrhosis with hypertrophy, viz. : in the uniform enlargement of the liver ; in the existence of ascites and of moderate enlargement ; and visible anastomoses between the epigastric and mammary veins and the last two are amongst the most reliable evidences of cirrhosis.

But the *absence of several* other features incline me to exclude that affection. Thus, the patient has not used either *strong alcoholic liquors or ale* ; he is young ; he has not had *hæmorrhage from stomach, bowels or elsewhere* ; nor a sub-icteroid colour of skin.

Finally, a more *probable* cause of enlargement of the liver exists to explain the case.

Two other causes of the hepatic enlargement remain, neither of which can be certainly excluded, but I will take up the least *probable* first.

Hydatids of the *liver*, produce a *slow* but very considerable enlargement of the liver, unattended by *pain* or fever, or, in many cases, by *jaundice* or ascites, or enlarged superficial abdominal veins.

The enlargement, however, as a very general rule, does not involve the *entire* liver, but one or other part of it, producing, in this way a tumour not having the natural outline of the liver, and possessing an elastic or even distinctly fluctuating feel, and perhaps presenting one or more projections upon its surface.

The case, perhaps, corresponds in many respects with these characters; but the hydatid disease is so rare in this country that I have never met with an example of it, and believe that the probabilities are in favour of another affection, now to be considered:

Amyloid degeneration of the liver resembles in many particulars this young man's case. It produces a *slow*, and often painless and *uniform* enlargement of the *entire* organ, usually without jaundice or fever. Enlargement of the superficial abdominal veins, and ascites may occur, although they are not at all constant; moderate ascites and œdema of the lower limbs are frequent. The spleen is also frequently enlarged as well as the liver, and it is so in this case, I believe; although it is difficult to make out its limits accurately. The kidneys, too, are apt to undergo amyloid degeneration, and albuminuria results.

Our patient's history corresponds very closely with this description, although albumen was not present in the single sample of his urine examined by me; but he says it was found when his dropsy first appeared.

There is one important difficulty, however, in accepting amyloid disease as an explanation of this case; viz.: the fact that the enlargement of the liver was noticed six months before the winter cough and expectoration set in—the only symptom in addition to the enlargement observed by the patient being gradually increasing dyspnœa.

The usual *cause* of amyloid disease is chronic suppuration from disease of bone, tuberculous affections of the lungs and other organs, constitutional syphilis and the like, none of which can be said to have preceded the enlargement of the liver in our patient. The pleural sero-purulent, or purulent effusion, which I have inferred to have obtained at the beginning, however, may have occasioned, and would account for the amyloid degeneration.

But, inasmuch as it sometimes appears to originate in persons of a scrofulous diathesis, without suppuration, and sometimes cannot be traced to any cause whatever, the absence of a well-established cause in this case does not, in my opinion, justify us saying that amyloid disease is not present.—It *best* meets all the requirements of the case.

You see, then, how many difficulties surround the formation of a reliable diagnosis in this instance. Yet, I venture to believe the most probable view is, that chronic pleurisy with retraction and amyloid degeneration of the liver, are the conditions present. I admit the possibility of some rare form of cystoma, or sarcoma, in the liver; or of a tumour or aneurism, or collection of pus between the diaphragm and the liver, but have not time to discuss these clinical curiosities, some of which are beyond the power of diagnosis.

Hospital Reports.

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

Case of Gunshot Wound of the Brain.—Recovery.—Subsequent Death from Phthisis.—Autopsy.—Under the care of G. E. FENWICK, M. D. Reported by Mr. H. W. LLOYD.

C. G., aged 19, a sickly-looking lad, was admitted into the Montreal General Hospital on the 8th day of March, 1878, suffering from the effects of a small pistol wound situated a little above and in front of the right ear. This wound had been accidentally received the day before his admission to the hospital. The account he gives of the occurrence is as follows:—While sitting on the edge of his bed, and examining the barrel of a small-sized revolver, which he did not suspect to be loaded, an explosion took place, and the ball entered the skull through the upper segment of the right temporal fossa, piercing the muscle, bone and membranes, and passing into the substance of the brain. The barrel of the revolver was not more than a few inches from his head, and he believed it to be almost at

a right angle to it. The receipt of the wound was followed by a sharp pain at or about the point of entrance, accompanied by a ringing noise in the ears, slight dizziness, or a feeling as if he was floating in the air. Shortly after receiving the wound, vomiting set in, and continued at intervals for the ensuing 36 hours. During the straining while vomiting, a little blood would ooze from the wound. There was no bleeding in quantity from it at any time, but there trickled away an abundance of bloody serosity, in all likelihood from the arachnoid cavity. He was perfectly sensible, and continued so throughout, during his stay in the hospital. There was no sign of paralysis. The pupils were dilated, but equally so, and respond to a strong light. No pain complained of, except in the vicinity of the wound, which was lightly puffy and red. The wound itself was half an inch in diameter. The bullet was lodged in the substance of brain, possibly in the anterior lobe of the cerebrum, as the point of entrance was on a line with, but above, the junction of the anterior and middle fossæ, close to the situation of the fissure of Sylvius, one inch and a half above the external auditory foramen, and one inch and a quarter in front. Has not slept since the accident; is silent, perfectly quiet; has dozed, but sleep is uneasy and short; awaking with a sudden start, he fancies he hears an explosion, which arouses him. The second day after his admission he complained of frontal pain, not however severe, his pulse was 60 per minute. There was no rise in temperature; pupils were still dilated, but equal in size, and responded to light, contracting, however, rather slowly. There is no vomiting nor tendency thereto, and he takes nourishment, which, however, was restricted to milk. An ice cap was ordered to the head, a pledget of lint wet with water, and covered with oil silk, to be applied over the wound, and the following mixture was given.—

R. Potassii Bromd. . . . ʒij,
 Ext. Ergotæ, Fluid.. . ʒss,
 Aquæ, add ʒ. . . . ʒvi.

Sg.—A tablespoonful to be taken every four hours.

From this time he progressed favourably, so far as the head symptoms were concerned, the brain disturbance gradually subsided, and the wound healed. His temperature never was high; on two occasions only, at night, the thermometer registered 101, but it was usually a little above the normal standard. Pain in the head was persistent, confined to the right side, and there was troublesome constipation, which required the occasional use of salines. On the 30th March, the report states that the pain in his head is less severe, he takes food well, and a more generous diet was allowed, but he seems listless, disinclined to leave his bed; he is weak, and has notably emaciated. His pulse is 96, and his temperature is normal in the morning, with a slight rise at night. The ice cap was discontinued, as was also his mixture; he complains of cough, and expectorates freely; has slight night sweats, but sleeps moderately well.

His chest was examined, and there was found consolidation at the apices of both lungs, with evidence of softening. On inquiry, it was ascertained that some four years ago he suffered from a severe attack of pleuro-pneumonia coming on after exposure to cold and a thorough wetting, having been upset from a boat while fishing, and at the time nearly drowned. During the attack his life was despaired of, as it was severe and persistent. There was no attempt at resolution. His physician recommended change of air, but he remained in the city. Since that time he had suffered from several attacks of hæmoptysis, and the cough, with expectoration, has persisted throughout, with occasional night sweats, general symptoms of debility and steady emaciation. There is no history of phthisis in his family; his father and mother are still alive and enjoy good health, and all his immediate relatives are healthy. A tonic was prescribed, good diet and an expectorant mixture; and, with a view of giving him the chance of benefit of change of air, as the spring of the year had fully set in, he was advised to go to the country and live as much in the open air as possible, partaking of milk and eggs, with a moderate allowance of stimulants.

He left the Montreal General Hospital on the 27th April, and subsequently entered the Hotel Dieu Hospital, the disease

of the lungs progressed steadily, and he died on the 12th August, following.

As an illustration of the absence of all permanent brain disturbance, it may be mentioned that two days before his death he wrote a letter to his mother which was clear in diction, well composed and hopeful in character. He died apparently syncopal, as he had complained of feeling very weak, was more than usually languid, and passed away quietly and quite unexpectedly. Through the kindness of Dr. Angus C. Macdonell, physician to the Hotel Dieu Hospital, a *post-mortem* examination was secured, which adds additional interest to this unusual case.

Post-mortem examination made 24 hours after death:— Extensive disease of both lungs was found; the upper lobes were riddled with cavities of various sizes. There was no special examination made of the other viscera, as permission alone was granted to examine the brain. On reflecting the scalp, an oval-shaped opening through the cranial wall was observed. This opening was longer vertically than transversely. It was situated above the extremity of the great wing of the sphenoid, and involved the anterior edge of the squamous portion of the temporal bone, and also the anterior inferior angle of the parietal, it was almost closed by a firm, fibrous membrane. On opening the cranium, the inner surface of the dura mater, on the right side, was of a deep yellow color. This extended to the right surface of the falx cerebri, and also to the right half of the tentorium. The brain surface was likewise stained, but was not quite so deep in color. This was evidently due to effused blood, an extensive clot which had been absorbed. Near the point of entrance of the bullet through the dura mater were found several fragments of the inner table attached to that membrane. A large fragment of the inner table remained attached firmly to the posterior margin of the opening in the bone internally, being slightly tilted forwards, and had apparently changed the course of the projectile. The bullet entered the brain substance at the posterior margin of the right inferior frontal convolution, just in front of

the angle formed by the ascending and horizontal branches of the fissure of Sylvius. It passed upwards and forwards and out through the inner and anterior margin of the middle frontal convolution, resting between the brain substance and the falx cerebri. It lay surrounded by a firm membrane, and was one quarter of an inch in front of, and on a line with the anterior extremity of the corpus callosum. From the point of entrance through the *trajet* of the bullet, a firm membranous canal existed, around which, and for about three-quarters of an inch in extent, the substance of the brain was softened.

[We are indebted to Dr. James Bell, Assistant House Surgeon of the Montreal General Hospital, for the above carefully prepared record of the course and position of the bullet in this interesting case.—ED.]

Reviews and Notices of Books.

The Principle and Practice of Surgery, being a Treatise on Surgical Diseases and Injuries.—By D. HAYES AGNEW, M.D., LL.D., Professor of Surgery in the Medical Department of the University of Pennsylvania. Profusely illustrated. In two volumes. Vol. 1, royal 8vo, pp. x., 1062. Philadelphia: J. B. Lippincott & Co. London: 16 Southampton street, Covent Garden, 1878.

This volume forms the first part of Dr. Agnew's voluminous treatise on the Principles and Practice of Surgery. The author has expressed his views freely, based on his own experience and observation, which has not been limited, as he has had the advantage during the past quarter of a century of having under his charge surgical diseases and accidents in the hospitals of Philadelphia. Some of the enunciations here recorded are original in conception. They differ in some measure from the views and teaching of other surgical writers, still they bear the stamp or honest conviction based on careful observation. In wounds of the scalp, sutures are recommended. The author expresses a doubt concerning their injurious effect, and states

that "the popular notion that they tend to produce erysipelas, is without foundation." As a broad principle it may be regarded as very questionable advice, but admitting their usefulness, and occasional permissibility, the caution to avoid injury to the deep aponeurosis, in their introduction, ought to be mentioned. But in these pages, he not only gives his own views but those of other writers, so that the reader may have an opportunity of contrasting different methods of treatment in the management of their own cases, and of judging of their relative merits.

The volume begins with a chapter on Diagnosis, in which we learn the method of proceeding to arrive at a correct opinion of the nature of any given case. This forms an introduction to the rest of the work, which is divided into ten chapters. In the first chapter the subject of inflammation is freely discussed, the varieties of the inflammation such as what has been termed healthy and unhealthy. The former term might be considered contradictory, but it is very generally employed, and may be correctly regarded as indicating that condition, in which the morbid tendency to destruction of a part inflamed is resisted by a conservative force, ever present to save from destruction parts injured through accident or disease. Different degrees of inflammation, causes, nature, pathological changes, and termination are all given, together with special methods of treatment. The next chapter is on wounds, their varieties, hæmorrhage, nature's method for its control, closure of vessels, formation of thrombus, treatment of hæmorrhage from wounds, the various methods employed. These the author fully discusses, and after a careful description of compression, cauterization, torsion, acupressure, and the use of the ligature, he compares the relative value of each method, and gives a verdict in favor of the ligature; in this the majority of practical surgeons of any experience will agree; still, it must be conceded that there are circumstances in which the use of torsion, or the needle, will be advantageously employed. In continuation of this subject of hæmorrhage from wounds transfusion is mentioned and the mode of performing it described. The treatment of wounds, with a description of the various kinds of sutures is next given, and then we have a description of the after treatment of wounds. In this the author

admits the advantages to be gained by the antiseptic method, which he declares he is satisfied from his own observations to be superior to all other methods of treatment. The different kinds of wounds are next given : these are considered under the headings of incised wounds, lacerated and contused wounds, contused wounds proper, punctured wounds, and poisoned wounds ; under this heading will be found dissection wounds, malignant pustule, foot and mouth disease, glanders or farcy, hydrophobia, bites of poisonous insects and venomous snakes, and lastly gun-shot wounds. This is a most interesting chapter, especially that portion relating to the poison wounds of insects and snakes, as so little is to be found on this subject in other surgical works.

Injuries of the head form the subject of the third chapter, in which will be found first, a few general considerations, and subsequently, a description of injuries of the scalp, gun-shot wounds of the scalp, and their various complications, such as erysipelas, injury to the cranial bones, and injuries to the brain or its membranes, &c. The fourth chapter is devoted to wounds and injuries of the chest and abdomen ; in the fifth chapter wounds or injuries of the extremities are taken up and discussed. In chapter six we have the diseases of the abdomen, such as morbid growths, cysts, fistulæ, ascites, in which the method of performing paracentesis is described. Intestinal obstruction, intussuseption, organic change in the walls of the intestine, cicatrices, &c., and in this connection is considered the advisability of colotomy. In giving the statistics of colotomy, the author includes one case only of lumbar colotomy, as having been performed in Montreal, whereas there have been published five cases by the writer, and one by Dr. Ross. As to the results of these six cases, the first a woman, operated on by Dr. Fenwick, died ten months after the operation from a severe attack of cholera. The second, woman, operated on by Dr. Ross, is, we believe, still living. The third, a child of eleven years, operated on by Dr. Fenwick, for epithelioma extending up the rectum above the reach of the finger, is, or was alive two months ago, November, 1878. The fourth case was in a syphilitic woman. There was a long meso-

colon, and hence the peritoneal cavity was opened she died of peritonitis. The fifth case, likewise for syphilitic disease of the rectum, by Dr. Fenwick, recovered and is still living; and the last case in an aged man for cancer of the rectum, extending high up, also operated on by Dr. Fenwick, was greatly relieved, and lived in comparative comfort for seven months after the operation. We fully believe in the advisability of colotomy in cancer of the rectum, especially when the disease extends so high up the bowel as to preclude the chance of adopting other operative measures, although on two occasions we have removed the end of the bowel after Lisfranc. Here again, in speaking of excision of the rectum, our author is slightly in error. At page 435, he remarks: "In this country ten cases have been operated on—2 by Busche, 1 by Mott, 1 by Marsh, 1 by Bridden, 3 by Levis, 1 by Dr. J. R. Wood and 1 by myself."

Chapter VII. is on diseases and injuries of the blood vessels. In the next chapter we have the ligation of arteries. Chapter IX. contains a description of surgical dressings, and in the last chapter there will be found a description of injuries and diseases of the osseous system. The illustrations throughout the work are very clear and well executed. They number 897. Many of them are familiar, as they adorn the pages of other surgical works, but in saying this we do not wish to infer that they are misplaced, as they add much to the interest and usefulness of the work. Whenever an illustration is borrowed, it is duly accredited. Some of the wood cuts are from the Surgical History of the American War of Rebellion. These the author acknowledges to have received through the kindness of the Surgeon-General of the United States Army. A large number of the illustrations are, however, from original drawings by Mr. Faber. There is a very complete index, which adds to the interest of the volume. The statistical tables are of great use, as they are conveniently arranged for reference. We think a better classification might have been adopted, as the number of good things appear pretty well mixed. Nevertheless, this must be looked upon as a valuable addition to the many excellent treatises on surgery which have within the past few years issued from the press, and we shall look forward with interest to the completion of the work in the issue of the second volume.

Practical Surgery; including Surgical Dressings, Bandaging, Ligations and Amputations.—By J. EWING MEARS, M.D., Demonstrator of Surgery in Jefferson Medical College, &c., &c. With 227 illustrations. 8vo. pp. 279. Philadelphia: Lindsay & Blakiston, 1878.

This little book is dedicated to Prof. Gross, and is intended as a manual for students, to whom it is an object to have their work presented in as concise a form as possible. We venture to say, that the book, so far as it goes, fulfils the expressed intention of the author, and that students will find it a useful work during their accademical course, and, also subsequently in their professional career.

In these days hand-books of all kinds and descriptions are rained upon us. The student finds short and more or less useful compendiums on almost every subject, and it is possible that while to the diligent these may be very useful as aids to memory and as means of fixing more extended reading in the mind, to the indolent or superficial they may prove as snares and pitfalls.

The title of the present work might, we think, be improved, and it would give a more exact idea of its contents. If the word "comprising" were used instead of "including," for the book consists of nothing but four parts: one upon Surgical Dressings, one upon Bandaging, one upon Ligations, and a fourth upon Amputations.

These subjects are well and concisely treated, and short as the descriptions are, they cannot be accused of obscurity.

The first part, upon Surgical Dressings, is good, and ends with a description of the Antiseptic system of dressing wounds. The second part gives us a description of the various forms of bandages and their modes of application, and here, as well at elsewhere through the book, we recognize many familiar illustrations for which the author is careful to give his acknowledgment in the preface.

Parts III and IV, on Ligations and Amputations, respectively, are well written, and deserve careful study.

Altogether, this is a useful little book, which may be recommended without hesitation.

The Pathological Anatomy of the Ear. — By HERMANN SCHWARTZE, M.D., Professor in the University of Halle, pp. 174, with numerous illustrations. — Translated by J. ORNE GREEN, A.M., M.D., Aural Surgeon to the Boston City Hospital, and Clinical Instructor in Otology to the Harvard University, Boston: HOUGHTON, OSGOODE & Co.

This valuable work is a translation from the original German of the sixth part of Klebs' well-known hand-book of Pathological Anatomy, and constitutes a valuable addition to the literature of Otology.

The difficulties in the way of a successful study of the pathological anatomy of the ear are so great that morbid anatomists have, almost without exception, shunned a labour which promised so little return.

Since the days of Toynbee, however, there is a small but scattered fraternity of earnest workers, to whose patient investigations the writer of this work is largely indebted for the material it contains. This may be said, without in any way detracting from the merits of Professor Schwartz's own labors, for he is acknowledged to stand among the foremost in the field. To the otologist the work is of extreme interest and value. The translation has been carefully done, and "is issued both to show what has already been accomplished in this branch of otology, and with the hope of directing still further attention to pathological anatomy, the only solid foundation for a still further advance in our knowledge of disease of the ear."

All the morbid conditions to which the ear is liable are discussed as fully as the present state of knowledge will warrant, and the illustrations given are most interesting and instructive. There is certainly no other work on the pathology of the ear so complete and exhaustive as this one.

Essentials of Chemistry, Inorganic and Organic; prepared for the use of Students in Medicine. By R. A. WITTHANS, A.M., D.D. 12mo. pp. 257. New York: William Wood & Co., Great Jones Street, 1879.

This little work is in the form of questions and answers, by which it is expected that the student will be able to post himself in the necessary minutiae to pass an examination. It is a compendium solely intended for this purpose, and may be found of use to the advanced student. We do not think, however, that this style of work is commendable, except for the purpose for which it is apparently intended, namely, to refresh the mind already stored with chemical facts.

Extracts from British and Foreign Journals:

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

THE PAST AND THE PRESENT ;

OR, THE CONDITION OF THE SURGICAL WARDS BEFORE THE INTRODUCTION OF LISTER'S ANTISEPTIC METHOD CONTRASTED WITH THEIR PRESENT STATE.

BY PROF. DR. VON NUSSBAUM OF MUNICH.

Translated from the German by F. BULLER, M.D., M.R.C.S., Eng.

Up to the year 1875, I employed Lister's method occasionally. More often the ordinary plan of treatment, or the open treatment of wounds. In addition to this I often experimented with chlorine water, but from 1875 on, all my patients were "Listered." Fresh wounds were "Listered" immediately. Wounds which were suppurating and septic on admission, were cleansed with an 8 per cent. solution of chlor. of zinc, and then Listered. In this way a thorough and most satisfactory transformation has taken place, and my clinique once of evil, is now of good report.

THE PAST.

An offensive odour of decomposing pus pervaded the atmosphere of the wards, the patients were pale, sallow and wretched, many a countenance wore an expression of pain and distress. All the temperature charts registered such temperatures as 103, 105, 106, 107.

The wards were full.

Nearly all the patients soon after admission went through an attack of so-called hospital fever (Spital-gastricismus), which often reduced them very much and lasted, as a rule, two or three weeks.

Injuries of the head, complicated fractures, resections and amputations, in a word, nearly every patient

THE PRESENT.

Now the air of the wards is fresh and odourless, the patients have a healthy color and are happy; moans and lamentations are nowhere audible, although the morphine bottle has almost lost its vocation. The temperature charts read 98.2, 98.6, 99.5, 100.8.

In many of the wards there are only two or three patients, whilst formerly they were occupied by ten or twelve.

The patients eat and drink with enjoyment, the so-called "Spital-gastricismus" is rarely seen, evidently because the air is free from poisonous vapours.

THE PAST.

with a wound of bone became a victim of pyæmia, even flesh wounds were not exempt from the same evil.

Of seventeen amputations there were eleven deaths from pyæmia. Despite the open treatment of wounds, or the treatment by continued warm water baths, or by ferrum candens hospital gangrene, with its terrible results, had become so common that at least 80 per cent. of all wounds and ulcers were affected by it.

Nearly every wound took on erysipelalous action.

Of the numerous head wounds, most of which were of medico-legal interest, the large majority perished from pyæmia if there had been any bone injury. Some recovered after several attacks of erysipelas with severe fever, convalescence being thereby delayed for many weeks, and a further period of several months ensued, during which the patients thus prostrated were unfit to resume their employment.

During seventeen years no case of injury to the brain recovered.

In wounds of the neck, the stitches all cut through during the period of profuse suppuration, and if the patient escaped with life the process of healing by granulation lasted many months.

Penetrating wounds of the thorax always terminated fatally, with profuse and foetid suppuration, even though at the outset they seemed to promise well.

Penetrating wounds of the abdomen, laparotomy and operations for hernia in which the peritoneum was

THE PRESENT.

No pyæmia.

No Hospital gangrene.

No erysipelas.

Injuries of the head scrupulously treated by the antiseptic plan, after the head has been shaved and cleaned with ether, the wound disinfected with an 8 per cent. solution of chloride of zinc and drainage tubes inserted in the deeper parts, heal as a rule by first intention, so that treatment in hospital is much abridged. This holds good even in cases of injury to the brain.

Cases often recover without fever, in which during the first two or three days brain substance escapes through the drainage tube and the bone is much depressed.

Now, the wounds of the neck being disinfected with chloride of zinc, stitched with catgut and suitably provided with drainage tubes it seldom happens a stitch cuts through. The suppuration is rarely profuse and the healing process is speedily accomplished.

Penetrating wounds of the thorax often heal rapidly without any elevation of temperature.

Penetrating wounds of the abdomen, in which proper drainage can be secured, now heal without any untoward symptoms. We perform laparotomy without any fear of an unfavorable result.

THE PAST.

wounded, almost all died with the too obvious signs of septicæmia. The icteric skin, the scanty dark colored urine, the fœtid breath and high temperature were the ordinary forerunners of an inevitable collapse.

Ovariectomy was followed by the same train of symptoms and a like result, even when an uncomplicated operation and the absence of symptoms indicating peritonitis seemed to warrant a favorable progress.

In cases of resection and amputation, the mortality from pyæmia was, as already mentioned, something appalling. Although everything seemed to be going on well for several days, a sudden and violent chill, followed by perspiration, put a damper on all hope of success; for in the course of a few hours all the healthy granulations had disappeared, and in the place of a creamy pus was a watery fœtid ichor. Pleuritic stitches, shortness of breath, liver pains, and swelling of the joints soon became manifest, indicating the different localities in which metastases had occurred. The lungs and pleura were the favorite seats of pyæmic deposits. In some post-mortems we found as many as one hundred abscesses and infarctions distributed throughout the body, some of them were found even in the muscles of the extremities. In seventeen years of clinical service I had never once seen a patient recover if a metastatic deposit occurred after a chill, although every remedy recommended for pyæmia received a fair trial, from Quinine and purgatives to infusion and transfusion of blood, removal of affected bones, &c., &c.

THE PRESENT.

Operations for hernia we consider to be devoid of danger, provided the intestine is not gangrenous.

In these cases we have never met with septicæmia.

We have successfully performed the radical cure of hernia, by stitching the neck of the sac firmly together with catgut and cutting away the sac itself.

The operation of ovariectomy is three times as successful as formerly. The healing of the wound now takes place in quite a different manner, and we have repeatedly observed cases in which during the short period of twenty or thirty days convalescence, the temperature did not once exceed 100.4 and the patient never felt unwell.

Cases of resection, in which there is not free suppuration and septicæmia before the operation now heal for the most part by first intention. If such cases are already in a septic condition one or two applications of chloride of zinc often suffices to bring about the antiseptic state, and if we succeed in this, healing takes place in an astonishingly short space of time and the condition of the patient improves in a most satisfactory manner. Oedematous infiltrations wherever occurring, loss of appetite, unhealthy color of the skin, &c., &c., all these disappear entirely in the course of a few days. Amputations now usually heal in from eight to ten days by first intention, an event which I have never once observed in the previous seventeen years. The pain which used to occur during some hours or days after amputation is now unknown. The patient now and then complains of a slight burning sensation, after amputation; generally there is entire freedom from pain, cheerful demeanour, and a good appetite.

The patient recovers in about one-tenth of the time formerly required.

THE PAST.

I even tried inunction of strong perchloride of mercury salve, as recommended by Heime, until enormous ulcers and bloody stools occurred, but the slight benefit seemingly thereby obtained, lasted only a few hours.

As things were I scarcely ventured to make an incision into the joints, and when impelled thereto by dire necessity, death from pyæmia was the usual result.

Incision of joints now performed, with so much success, is the best test of the merits of the two methods of treatment.

Incision of joints and laparotomy have done more than any other surgical procedure towards overcoming the last rival of the antiseptic method. I refer to the "open treatment," for no surgeon would now think of trusting to the open treatment of incised joints. In my humble opinion, the inefficacy of the open treatment is hospital gangrene such as raged in my wards, was enough to condemn it.

Ulcerations of the feet and legs necessitated a very long sojourn in the hospital, and were often complicated with erysipelas, hospital gangrene, and exfoliation of bone.

Those ulcers upon which I performed my operation of circumcision, did not suffer from relapses, but this operation is so severe a measure, that it is only justifiable in very bad cases, upon the principle that the remedy must never be more dangerous than the disease. The duration of treatment in Hospital was almost interminable.

THE PRESENT.

Incision into joints can, as is well-known, be made antiseptically without danger. In inflammatory affections the sooner this is done and the exudation allowed to drain off the better will be the result.

Anchylolysis then never ensues. The immediate and brilliant result of incising inflamed joints in which there was no exudation, and therefore no necessity for drainage, has often astonished me beyond measure; after incision the violent pain and constitutional disturbance disappear like magic. The immediate relief can, I think, only be accounted for by the relaxation of the joint capsule.

Ulcers of the feet and legs which formerly remained unhealed for an indefinite period, and furnished many victims to erysipelas, and hospital gangrene, recovered under the boracic lint treatment with extraordinary rapidity.

Wet boracic lint, covered with gutta-percha, cleans the foulest ulcers in five or six days.

The ulcer when thoroughly cleaned and healthy may be disinfected with an 8 per cent. solution of chloride of zinc; the surrounding skin washed with a 5 per cent. solution of carbolic acid, and the healing process much accelerated by Reverdin's "Skin Grafting." The treatment in Hospital of wounds

THE PAST.

If a case of amputation or resection was fortunate enough to escape pyæmia, it was only to suffer again and again from attacks of erysipelas or Hospital fever, or the wounds became covered with an unhealthy exudation which had to be destroyed by caustics or ferrum candens. I often felt like abandoning all operations in despair, but there was no choice, and I had to content myself as best I could with never-ending complaints, and petition after petition for the construction of a new Hospital as the only hope of doing away with this lamentable state of things. Still more remarkable are the mortality statistics. Among an equal number of patients, with the same hospital accommodation there were exactly twice as many deaths, and this is the most conclusive argument that can be urged in favor of the antiseptic treatment.

Formerly strong and healthy young people died from the most trivial wounds.

Nearly all complicated fractures, amputations and resections were fatal, for this reason alone it seems to me quite worth while to compare the pictures of the past and the present.

THE PRESENT.

and injuries which remain antiseptic, is very much shorter than it was under the old system. Nevertheless, it may appear strange at first sight that the average duration of days in hospital has not diminished. The explanation is easy. Many severe injuries, and complicated fractures, with purulent periostitis, laceration of muscles, &c., which used to perish from pyæmia in a few days, now escape with life after a long period of careful treatment. Many complicated fractures of the lower extremities, which formerly died in from 8 to 14 days, now remain in the hospital from 60 to 80 days, and at length recover and are able to resume their employment.

Although the death rate is now just half what it used to be, it must be borne in mind, that with the exception of the local treatment of surgical cases, everything else has remained unaltered. Of those who die, a large proportion are from the nature of their maladies, beyond the reach of surgical aid, such as tuberculous subjects and cancer patients who come to the hospital in the last stages of the disease; persons who have been fatally stabbed or shot, suicides, fractures of the skull, &c., &c., of so severe a kind, that neither the antiseptic nor any other mode of treatment can possibly be of any avail.

The antiseptic method has not only been of service to those who are treated by it, but all the other patients suffering from wounds or injuries, which, from their nature, cannot be healed antiseptically, also derive benefit, inasmuch as their surroundings are more favorable. They remain free from pyæmia and hospital fever, because the air they now breathe is vastly more free from impurities.

Popliteal Aneurism treated by Esmarch's Bandage.—Mr. J. Hutchinson, at a meeting of the Clinical Society of London, related the following two cases. The subject of the first was a robust gentleman, aged 26, who had never had syphilis. The tumour filled the right popliteal space, and pulsated strongly. There had been pain for three months, but the pulsation had been recognized only a month. He had been placed under Mr. Hutchinson's care by Mr. Drew. After three days rest in bed, ether was given, and Esmarch's banding was applied to the entire limb. It was put on tight below the knee, very lightly over the tumour, and tightly again on the thigh. The elastic strap was applied as tightly as possible in the upper third, and after a little time the bandage was removed. The tumour was left full of blood, which was completely stagnated. Anæsthesia by ether was kept up for an hour, and at the end of that time the strap was removed and a horseshoe tourniquet substituted. No pulsation returned in the tumour, but as a matter of precaution the tourniquet was retained for a few hours. The subsequent recovery was rapid and complete. The second case was less speedily successful. Its subject was a gunnery instructor from Shoeburyness, who had been treated by pressure for an aneurism in the calf two years previously. On that occasion, success had been obtained by thirteen days' compression. The aneurism on the second occasion filled the popliteal space, and was of the size of a large orange. It pulsated strongly. Esmarch's bandage, under ether, was used for one hour in exactly the same way as in the previous case, but with no benefit. The tumour beat as before. Three days later, another trial was made of the same plan, but on this occasion arrangements had been made, by relays of students, to keep up digital pressure after removal of the constricting strap. The man was kept under ether for two hours. At the end of that time the strap was removed, and during the change of hands it became evident that pulsation was still present, but it was more easily controlled than before. Manual compression was kept up for about seven hours, at the end of which time pulsation had quite

ceased. The tumour remained solid, and rapidly diminished in size, and the man left the hospital a few weeks later quite well. It was thought that in this case, although the Esmarch's bandage did not produce consolidation, yet it conduced to the cure, and certainly on neither occasion did it do any harm. Mr. Hutchinson stated that he had brought forward these cases, in neither of which was there anything original in the treatment, in order to elicit from surgeons statements of their experience and opinions in reference to this novel and important method. He acknowledged his obligation to his colleague Mr. Warren Tay, Mr. Price, and Mr. Bennett, for their assistance in carrying out the details.—Mr. Thomas Smith, by the use of Esmarch's bandage, applied as he had seen Mr. Croft applied it at St. Thomas's Hospital, had cured two cases, and had failed with two. In a recent case, no chloroform was given, and the bandage was applied tightly below and above the tumour, and left in place. He considered this better than constricting the limb by the cord—a proceeding which, on the continent, had been followed by permanent paralysis from injury to nerves. The pressure was more diffused by the bandage. In the last case, which occurred to a member of the medical profession, the bandage was alternated with pressure by a tourniquet over the artery, and the treatment lasted from 9 a.m. to 6 p.m., at which time great pain was felt in the swelling, and coagulation probably took place. Pressure was kept on for an hour and a-half after this, and the result was entirely successful.—Mr. Marrant Baker had had an unfavourable case in a man aged forty or fifty, where some blood had escaped from the aneurism, which he had treated successfully. After a preliminary imperfect application, the bandage was kept on for three-quarters of an hour, followed by half-an-hour's compression with the finger, and was re-applied for twenty minutes, and compression again kept up for nearly two hours. No anæsthetic was employed, no pain was complained of; and at the end of that time the aneurism was consolidated.—Mr. Maunder thought that there was no single certainly successful method of dealing with these cases. He had tried Dr. Reid's

plan twice; both times unsuccessfully. One was cured by digital compression, and the other by ligature. In his opinion, the objection to this bandage was that it was painful, and required an anæsthetic with its attendant risk.—Mr. Barwell agreed that no single method could be relied upon, but that the bandage was especially unsuitable in fusiform aneurisms. He had tried it in a bad case, where there was extensive arterial disease, with fusiform aneurisms in the axilla and brachial arteries; he made use of a sort of bridge to keep the bandage off the tumour, and applied it lightly above the swelling, allowing a small current of blood to pass. After an hour and a-half, there was no result; it was subsequently re-applied twice, but he was obliged finally to ligature the artery, tying it gently in consequence of its diseased state: the man was well in ten days. Mr. T. Smith objected that this method of applying the bandage, so as to allow the current of blood to continue—was essentially different from the plan under discussion.—Mr. Barwell added that on one occasion the flow was arrested for about one hour.—Mr. Herbert Page had tried the bandage without success in a case apparently well suited for it, and in the hospital at the same time a case of Mr. Lane's was treated in the same way with a like result. The plug in the distal arteries, which had been thought to precede clotting in the aneurism, was, in his opinion, a later event, and followed its cure. He alluded to a case of Mr. Pemberton's, where this method of treatment had been followed by gangrene.—Mr. Bryant related a case where the bandage was used for one hour, under the influence of morphia, by which time there was much consolidation. In two or three days, the aneurism grew worse; but the bandage under chloroform for three-quarters of an hour was followed by much improvement. It soon relapsed, and he then tied the artery. Gangrene followed in a few days, which required amputation below the knee. In his opinion, the bandage was responsible for the gangrene; and it constituted a serious, though perhaps not fatal, objection to its use.—Dr. Mahomed considered the bandage was contraindicated in cases of extensive arterial disease. He had found that, when

the bandage was placed on one arm, the volume of the other was much increased, showing that a considerably increased distension of the rest of the vascular system resulted. Where the cerebral arteries were diseased, this might be dangerous; but this objection did not apply to the ligature.—Mr. Gould alluded to two cases of aneurism treated in this way which he had examined. In both, the clot in the aneurism was loose; that in the artery, above and below, firm and fibrous. He considered that the coagulum in the aneurism was secondary, and he thought Mr. Bryant's case bore out this view. Here the clot, being soft, was broken up by the stream, which led to thrombosis and gangrene beyond. This difference in the clot he attributed to the imperfect nutrition of the walls of the sac. He still thought those cases would be successful where the opening was large and the vessel healthy.—Mr. Norton had tried the bandage without success in one case. There was extensive vascular disease, with double aortic murmur and three aneurisms. The treatment, though it failed, had none of the disastrous results Dr. Mahomed predicted, though the case was just such a one as those referred to by Dr. Mahomed. He considered the risk due to distension of the vessels as the result of compression small, indeed, when compared with the risk of a ligature where general vascular disease existed.—Mr. Heath agreed with Mr. Barwell that a fusiform aneurism was not amenable to this treatment, and with Mr. Gould in his theory of the action of this bandage. In Mr. Smith's case, however, the general state of the vessels was very unfavourable, yet a rapid cure resulted. It was quite possible that in Mr. Bryant's the gangrene was a result of the ligature, and not of the bandage. In a patient of his in whom the bandage had been twice applied, and in whom the artery had been ligatured, once in the usual way and once with antiseptic precautions, the result was of interest; the patient was strongly in favour of the antiseptic plan, from which he had suffered much less pain.—Mr. Hutchinson, in reply to the various speakers, said he thought the plan of treatment under discussion a valuable addition to the means at our disposal. It seemed impossible to

predicate as to the cases in which it was most likely to succeed ; but it seemed to be a trial in nearly all. He could not admit that Mr. Bryant's case proved that any ill consequences were due to the bandage. It had simply not cured. The gangrene came on after the ligature, and should be attributed to it, and not to the Esmarch bandage. He believed that, in different individuals, very different degrees of aptitude for coagulation were displayed by the blood, and hence chiefly the explanation why some cases were cured easily and others with difficulty. The tendency to coagulation might be helped by insisting on abstinence from fluids, as was done in both his cases, and by giving drugs, such as iodide of potassium, lead, and digitalis. Whilst fully admitting the great value of digital compression, he still thought that a trial should first be given to the bandage. He had had several very rapid cures by compression ; but he did not recollect any case of aneurism of similar size in which the patient had suffered less during the treatment than the first of these which he had just related. If ether were used, not chloroform, he believed that no danger was encountered ; and he felt sure that the anæsthetic made the treatment much less painful. He would strongly recommend that, in all cases in which the bandage was tried, arrangements to continue digital compression immediately after its removal should be made ; and that great care should be taken to prevent the blood from passing into the tumour on release of the limb from the strap — *British Medical Journal*.

On the Treatment of Diphtheria.—D. DE BERDT HOVELL observes in *The Lancet* the importance of giving a brisk calomel purge at the outset of diphtheria is, perhaps, not sufficiently recognised and acted on. Local applications are certainly useful, and the favourable effects of tonic medicines are a strong contrast to the very unfavorable, I had almost said disastrous, consequences of any contra-stimulant medicine. The necessity for the liberal and frequent administration of nourishment and stimulants is indicated by the great tolerance, or rather capacity, of the system to receive them ;

but, all said and done, we are still fighting an unseen and treacherous enemy, and are face to face with the fact that, until the expiration of twelve or more days, we are not secure from the fatal effects of a fresh deposit.

The late Mr. John Scott used to treat severe cases of cynanche with a "scavenger"—viz., calomel, jalap, and scammony, after which they usually got well. Looking at a diphtheritic throat one day, I said to myself, why should I not give this patient a scavenger? I did so, and remarked that the subsequent course of the disease was certainly cut short. I have since adopted the plan, and invariably found that the same good results have followed; the tendency to fresh deposits has much diminished, and in many cases is wholly prevented. I can call to mind more than one case in which the attempt at a fresh deposit was clear, but very feeble.

Unhappily I have seen a good deal of diphtheria at different times since its appearance in this country about twenty-two years ago, and have treated it, on the whole, not unsuccessfully, but it was only about a year ago that the above circumstances almost accidentally forced the conviction on my mind that *elimination of the poison* ought to be the first object in treatment.

How this elimination takes place through the bowels, I know not, but diphtheria is a disease of blood-poisoning, and there is no reason why the poison should not be eliminated through the bowels any less or more than in enteric fever—in throat fever than in bowel fever. I cannot refuse the evidence of my experience that since I have adopted the practice of purging at the outset the course of the disease has been invariably more favourable, nor the testimony of those who declare that the dejections thus produced are abominably offensive. At any rate, the practical effect of "the scavenger" recommends itself to my mind in a much higher degree than the scientific inaction of temporising and waiting til the disease has run its course, however masterly such inaction may appear; or than the inferior, but by no means futile plan, of trying to neutralise the effects of the poison. Invaluable as the scientific knowledge is, it ought not to stop short, nor rest content, without improvement in practice.

Elimination, then, (1) through the bowels, (2) through the kidneys. Chlorate of potash drinks should be given frequently, incessantly. Where the nose is affected, the same solution or that of permanganate of potash should be drawn up frequently through the nostrils, so as thoroughly to cleanse them. When the patient cannot swallow, nutrient enemata should be given four times a day; not too frequently if they are to be retained. For this, nothing is better than Dr. Munk's mixture, a tumblerful of milk gruel, a new-laid egg, a teaspoonful of brandy. By following this plan a boy under the joint care of my partner, Dr. C. Kingsford, and myself, twenty years ago, recovered, although he swallowed nothing for sixteen days, and severe paralysis, or rather paresis, ensued. He is now a fine strong man.

Possibly the adverse effect of depletory treatment has tended to deter from the administration of an aperient; but in this, as in many other instances, debility is a bugbear. In one severe case I had to give three doses of calomel and jalapin, and follow each dose with a black draught, and even then it was necessary to add one ounce of castor oil. The relief was as marked as the amount of aperients required to obtain it. The nourishment, stimulants, and tonics given subsequently seemed to be all the more thankfully received and gratefully recorded.

The tendency to rheumatism after even a slight attack of diphtheria should never be lost sight of. Possibly this is due to excess of fibrin in the blood; but of the fact I have certain experience.

Tapping the Lungs in Phthisis.—At a recent meeting of the Clinical Society of London, Dr. Theodore Williams communicated a case of bronchiectasis and lung excavation, in which an attempt was made to drain the cavity by tapping.

The patient, a man aged twenty-nine, had chronic pneumonia of both lungs, resulting in perfect resolution in one, and an induration and dilatation of the bronchi in the other. He subsequently had hæmoptysis to the amount of three pints, and lost two stone in weight. When admitted into the Brompton Hospi-

tal, in May, 1877, the symptoms were convulsive cough and fetid expectoration, containing large quantities of lung tissue, and so offensive in character as to cause frequent vomiting. There was also considerable pyrexia, the physical signs denoted consolidation of the base of the left lung, with commencing excavation. During his stay in the hospital the area over which cavernous sounds were audible, increased considerably. Various kinds of treatment were tried to relieve the cough, and to facilitate and disinfect the expectoration, but all with only temporary benefit; and as the patient appeared to be poisoned more and more by the retained expectoration, and exhausted by the cough. On October 16th, 1877, a medium-sized aspirator needle was passed between the eighth and ninth ribs, in the area of the cavernous sounds, and appeared to reach the cavity, but on exhaustion only a few drops of blood followed the operation, and the puncture was subsequently closed with lint. The patient afterward suffered pain in the infra-mammary region, but as his symptoms continued to increase, a fortnight later a second attempt was made to reach the cavern; this time the intercostal space below the scene of the first operation being selected, and a trocar and a large drainage-tube were introduced. On reaching the pleura a pint of brownish, fetid fluid escaped, which proved under the microscope to consist of broken down pus cells. Symptoms of collapse followed the evacuation of the fluid, and the patient was with difficulty rallied with stimulants. The abscess was washed out with disinfectants, but no improvement took place, and the patient gradually sank, three days after the operation.

On post-mortem examination it was found that the lung contained a labyrinthine cavity formed by the breaking down of the walls of several dilated bronchi, one of which had been penetrated by the first operation. Overlying the cavity was a limited empyema, which the second operation had evacuated. The right lung was affected by recent pneumonia, the result of infection through inhaled secretion from the left, this being the immediate cause of death.—*Medical and Surgical Reporter.*

Iodoform as a Local Anæsthetic.—In a recent article in the *Wiener Med. Wochenschrift*, Dr. Moleschott says he has often relieved or removed the most intense gouty pains and other symptoms of gouty inflammation within twenty-four hours, by painting on the collodion. In rheumatic pains it is efficacious, but in the various neuralgies, (intercostal, sciatic, etc.) it succeeds excellently. Unfortunately, as most people know, iodoform has a disagreeable smell, which makes those using it objectionable to others. To obviate this Moleschott advises that the glass vessel containing the iodoform preparation (collodion, or, what he also uses, ointment) be kept outside the window, in a leaden box provided with a well-fitting cover, the opacity of the box having the additional advantage of retarding the decomposition of the iodoform by light. He also covers with gutta percha tissue the part anointed with the collodion; and if possible, only applies the iodoform at night, so that most of it is absorbed, or has evaporated, before the morning, and what remains (if the ointment is used) can easily be removed with soap and water. The use of iodoform sometimes causes cardiac palpitation, but Dr. Moleschott has also more than once found a weak, irregular pulse rendered stronger and more regular by small internal doses of iodoform, just as by small doses of digitalis.—*Medical and Surgical Reporter*.

On Insolation and Refrigeration.—Dr. KIRCHNER has recently carried out a series of experiments on animals with a view to gain an insight into the pathogenesis of the two allied processes, insolation and refrigeration. He deduces from them that the latter may be characterized as prostration of the vital forces, and, first of all, of respiration and circulation. The morphotic and chemical alteration of the blood resulting therefrom, particularly its impoverishment in oxygen, is the immediate cause of the derangements that directly threaten life. Warmth, on the other hand, acts as an irritant on animal organism, and when in excess leads to exhaustion. This constitutes the essence of insolation. As in the case of refrigeration, the foundation of the symptoms is the exhaustion of the oxygen

of the blood, which here too is the consequence of the failing respiration and circulation. The appearance of rigidity during exposure, either to cold or heat, indicates excessive lack of oxygen in the blood. This rigidity is, like the rigor mortis, an anæmic muscular tetanus. If, however, we put coagulation, or, in other words, coagulation of the muscles, out of the question, tonic muscular rigidity is not commonly met with in cases of refrigeration or insolation.

The deleterious action of extreme temperatures on the organism is heightened by other weakening influences which tend to impair the supply of oxygen and to exhaust the resisting power of the system. Here must be mentioned, particularly, the misuse of alcohol. In addition to these acute effects of the action of cold and heat, there are analagous chronic conditions, which must be ascribed to the gradual action of extreme temperatures in the organism. They are characterized by manifestations of anæmia or exhaustion, and in their higher grades partly constitute the basis of the tropical and polar cachexias. It is still an open question whether any other specific diseases owe their origin to the influence of heat and cold. The fact that abdominal typhus occurs most frequently during the latter part of summer and towards the end of winter, has not yet been satisfactorily accounted for; and, as in many cases, no external source of infection can be discovered, it is, in fact possible that the morphotic and chemical alterations of the blood and tissues, which have been proved to be the pathological effects of insolation and refrigeration, play at least a subsidiary role in the production of the infection.—(*Allg. Med. Cent. Zeit.*, No. 47, 1878).—*Medical Record*, N. Y.

The Surgical Treatment of Lupus.—

In an article by M. Hillariet, quoted in the *London Medical Record*, the writer says:—

“It was Veiel who first introduced acupuncture. The method consists in pricking the surface of the lupus with needles, either in bundles, or fixed in the same handle, but separated from one another by some millimeters. The needles, before being used,

should be heated to a red colour. This plan, is however, at the present time much less employed than the scraper and linear scarification. Volkmann invented the scraper, and published his proceeding in 1870. It consists in scratching the surface of the lupus with curettes of different shapes, but generally of small dimensions. It is necessary, in order to aid the action of the instrument, to raise up all the lupoid tissue, and one may be satisfied with the result when the curette comes upon more resisting parts; this is healthy tissue; the operator should then stop. It is generally necessary to repeat the operation one or more times a month until the healing of the lupus is complete. Volkmann and Hebra both advise cauterization of the scraped surface with nitrate of silver. This method of Volkmann's gives very good results, but it is not applicable to all cases of lupus, and I more often employ linear scarification. To practice this, a needle, slightly flattened, with sharp edges may be used. Or, following the example of Balmanno Squire, a scarificator with numerous blades, which he has expressly constructed, may be used. Personally, I find the needles most easy to manage, and I make the linear incisions separated by a few millimetres. I place my incision in such a way that some are perpendicular to the others, and I repeat the operation one or more times a month until the lupus is well. I have obtained by this practice very good results, and I believe that this method is destined to be of great service. It offers one inconvenience, that is, it gives rise to hemorrhage, which may be very abundant, and in patients with frail constitutions this may be injurious. I should say a great deal of this loss of blood may be avoided by applying to the lupoid surfaces, before operating, some convenient anæsthetic and afterward by the immediate use of perchloride of iron; this may be simply done by means of a piece of blotting paper, as recommended by Balmanno Squire. Another recommendation of linear scarification is, that it can be more easily and more promptly repeated than cauterization.—*Med. & Surg. Reporter.*

Copaiba in Cirrhosis and Jaundice.—The value of copaiba as a diuretic, and cholagogue is not sufficiently appreciated. The following case, reported in the *British Med. Journal*, by Dr. J. B. Massiah, illustrates it:—

W. D., aged 37, a clerk, was a spirit drinker for four years, seven years ago; and during the last four years and a half has had three prolonged and painful attacks of jaundice, with ascites and œdema of the lower limbs. On admission, three months ago, he was tawny, thin and rather weak. He complained of constant pain in the umbilical and lumbar regions. His fluctuating abdomen measured thirty-four inches in circumference, and the vertical hepatic dullness in the nipple-line was three inches. The urine was scanty, bilious, and exalbuminous.

During the first month he took bitartrate of potash and compound jalap powder; and the abdomen increased two inches, the urine remaining scanty. Then, under a scruple of copaiba thrice daily, rose on successive days, from one pint in twenty-four hours to three, four and five pints; while the ascites began to subside. Once, for a fortnight, he took half a drachm of tincture of belladonna thrice daily, for the abdominal pain, and the quantity of urine fell below two pints daily. The abdomen now measures thirty-three inches in circumference, and his general health is much improved.—*Med. & Surgical Reporter*.

Necrosis without Suppuration.—William Colles, M. D., in the *Dublin Journal of Medical Sciences* for December, 1878, reports the following case:—

“F., aged 15, healthy, was thrown from a carriage and received some bruises on the face; also there was a slight transverse wound, about one fourth of an inch, at the ulnar side of the left wrist close to the joint. Through this opening projected a small piece of very rough bone, which was considered to be the lower end of the ulna broken off and projecting. It could not be restored or retained in position. Two days later she was put under the influence of chloroform, but it was still found impossible to restore the natural form of the limb. It was therefore determined to remove the projecting piece.

With this view the piece was caught in a forceps, and a director passed behind it. It was found that the latter instrument could be easily passed for a considerable distance in all directions without obstruction from ligamentous or other attachments. On bending the hand backwards, and pressing the director inwards, there slipped out a portion of bone two inches long. On examining the forearm, the hones seemed quite naturally in their position, but perhaps slightly larger than those of the opposite limb. On examining the bone extruded, it was much smaller than would be expected in a person of her age; it was quite devoid of periosteum; no cartilage or epiphysary end, but a small rough deposit of new bone; the upper end irregular, jagged, but in no part did it present any appearance of its having been acted on by living parts; and on section—which was difficult, from the dryness and friability of the bone—the medullary cavity was the same as in ordinary section of bones.

“On further inquiry it was found that about eight or ten years ago the patient fell and received what was called a sally-switch fracture of both bones; this was treated by splints and rest; she recovered with perfect use of the limb, but there was a slight thickening of the bone.

“That this was a case of necrosis there can be no doubt; and if it was the result of injury, it must have been of only two days' duration, which is scarcely possible for the bone to die, to lose its periosteum, cartilage, and epiphysary end, and for a new case to be formed around the dead bone. Hence it was more probably the result of the fracture received so many years ago.”

—*Medical Record, N. Y.*

Gastro-elytrotomy.—A very interesting historical account of this operation, by Henry J. Garrigues, M.D., has been reprinted in pamphlet form from the *New York Medical Journal*. It was first proposed by Joerg in 1806, but his idea was an incision in the median line involving the peritoneum. In 1820, Ritgen, profiting by Joerg's suggestion, and improving on it, performed the operation by a lateral incision above Poupart's ligament and elevating the peritoneum. He incised the vagina,

however, instead of tearing it, and the operation was abandoned, and a living child being delivered by Cæsarian section. From 1823 to 1844 Baudelocque, apparently ignorant of his predecessors, championed this operation or some of his numerous proposed modifications of it, and performed it in two cases unsuccessfully. From this time it was forgotten, or mentioned only to be depreciated by the authorities on obstetrics, until 1870, when Dr. T. J. Thomas performed it, and delivered a living child. Dr. Thomas has since operated once, and Dr. Skene, of Brooklyn, three times, making in all five cases; of these, three of the mothers are still alive, and four living children were delivered; the fifth child was dead before the operation was undertaken, and the two women who succumbed were in *articulo mortis*. The necessity of tearing the vagina instead of cutting it is strongly insisted upon, as troublesome and even dangerous bleeding from the vaginal plexus is thus avoided. The operation cannot be repeated upon the same side, as it would be impossible to raise the peritoneum and lift the vagina. When the head is wedged in the pelvis, so that it cannot be pushed up, the incision of the vagina becomes impossible, and the operation is contra-indicated. The obstruction offered by the presence of a solid tumour in the vagina or uterus, or by atresia or coarctation of the vagina, may also be a sufficient contra-indication. Dr. Garrigues's conclusions are: 1. Gastro-elytrotomy ought, when possible, to be performed instead of Cæsarean section in all cases; and instead of operations by which the foetus is broken up when these would be particularly difficult, especially when the smallest diameter of the pelvis measures two inches and a half or less. 2. It does not require exceptional skill or rare instruments. It is, indeed, less difficult than ovariectomy and herniotomy. 3. Five assistants are desirable, and four indispensable, in order to carry out Thomas's plan.—*Medical Record, N. Y.*

Ergotin in a Case of Uterine Fibroid.—

(Note on the use of Ergotin in a case of Uterine Fibroid, by J. CRAWFORD RENTON, M.B., Extra Assistant Surgeon to the Western Infirmary, Glasgow :—

May 1st.—To-day saw Mrs. L., æt. forty-five. Patient complains that for the last six months her menstrual periods, have been increased in frequency, and the discharge doubled in amount; for the past three months she has hardly been free from the discharge, and at times it has poured from her, producing faintness. She also suffers from breathlessness on any exertion.

Her appearance justifies her statement, as she looks anæmic and the exertion of speaking tries her; she is a spare, thin, slightly-built woman. Her previous history shows that she has always had a copious discharge, and on one occasion, after a miscarriage she suffered from severe hæmorrhage. Her children are healthy and her family history good.

Examination per Hypogastrium.—On pressure patient complains of slight tenderness in the left iliac region. No enlargement of the uterus can be felt.

Per Vaginam—Cervix is found to be thrown forward towards the pubes, and posteriorly Douglas' space is filled by a large mass of dense consistence, which is slightly movable upwards. Os closed. Sound passes three inches. Heart sound weak, and a loud anæmic bruit is heard over cardiac region.—No signs of any pulmonary or other complication. Urine normal.

3rd.—Professor Leishman, to whom I am indebted for the above report of the pelvic conditions, saw the patient along with me, and coincided with me in recommending rest in bed, good diet and a trial of ergotin, either subcutaneously or by suppositories. He suggested in addition the introduction of a Hodge's pessary to give support and, if possible, to raise the tumour upwards and forwards.

4th.—Three grains of ergotin injected subcutaneously, but the patient suffered so much pain in her arm after it that we had recourse to suppositories, four grains in each. At first she had

two daily, but the discharge continued so profuse that we increased the dose to four, equal to 16 grains.

12th.—After having the above four days, she suffered from severe headache and sickness, but the discharge diminished, and for the first time for three months she was free from the drain on her system. She was now ordered to have two suppositories daily, and this was continued for a week, and then only one was used until the 26th, when the discharge commenced again, but not in the severe manner it had done formerly.

28th.—As several clots came away to-day, the dose was doubled.

June 5th.—Discharge quite ceased.

12th.—Patient is steadily improving; she has been allowed to rise and rest on a sofa. A tracing of her pulse at this period showed a very weak wave, and she was ordered Postans' citrate of iron and strychnine, the ergotine being omitted.

16th.—Four grains of ergotin resumed at night.

30th.—Discharge commenced and continued in moderate degree for ten days.

She mentioned that she thought there was a difference in the colour of the discharge, and she asked if it were possible the medicine were coming away in it.

She was requested to omit using a suppository for two nights, and to send a specimen of the menstrual fluid, as also of the urine, for examination. On being tested the former gave with potash a distinctly fishy odour, which was appreciated by other medical men who happened to be present (odour was not due to putrefaction); it was again examined the following month, and the same odour felt. The urine gave no such reaction with potash.

October.—Patient continues to menstruate regularly, and her general health has so much improved that she is able to attend to her household duties with comfort. She still uses the ergotin for five days previous to a period.

We think we may fairly ascribe the improvement in this case to the ergotin, and if further observation confirms the presence of the drug in the discharge, it will go far to establish its affinity for the uterus.—*The Practitioner.*

CANADA

Medical and Surgical Journal.

MONTREAL, JANUARY, 1879.

THE PRESS AS AN EDUCATOR.

We have been forcibly impressed with the influence of the press for good or evil, and we are inclined to believe that in very many cases it is a promoter of immorality. This, in a great measure, proceeds from the prurient desire of the general public for scandalous gossip. As a rule the public taste lies more in the line of what is horrible and shame-faced, than of what is instructive, of good report, or of moral worth. If a paper were published which excluded everything that was immoral, or the recounting of the misdeeds of misguided men and the punishment for crime. If its pages contained alone the fair side of humanity without any of its debasing qualities, it would be regarded as too tame, not worth reading, and therefore would have no circulation. No person would be bothered with such literature; so that for the purpose of securing ready sale and a large circulation, a paper must have a large supply of the horrible intermingled, with a view of pointing to a moral. On this subject the *Pacific Medical and Surgical Journal* remarks as follows:

THE PRESS AS A PROMOTER OF CRIME.

"The infectious tendency of vice and crime is universally acknowledged. Sporadic cases develop the epidemic diathesis in proportion to the publicity which is given them by the tongue and the press. Suicide offers a marked illustration. A consideration of this vice brings in view the influence of the press on the morals of society. Custom looks at the fair side and regards the press as a source of light, knowledge and morality. The other side does not appear, for there is no medium through which it can appear but the press itself, and the press will not publish its own shame. If the every-day expressions of individuals concerning the press could be embodied in one utterance, thunder would be gentle music compared with the report. If the press, or any considerable portion of it—we mean the *secular* or the newspaper press—were conducted with the motive of diffusing useful knowledge and cultivating morality, the case would be different. But unfortunately, though this motive may enter into its management, a newspaper is good for nothing unless it publishes every-

thing, good or bad; and hence its contents are gathered promiscuously from the public sewer, and it becomes a vehicle, not for choice and useful reading, but for everything true and false, clean and unclean. The question is, not what will most benefit the readers, but what will most benefit the publishers and increase the demand. Deeds of violence and blood are choice materials for extensive elaboration. Sexual misconduct and obscenity are hunted up with keen relish. Scandal, slander, rumors of private affairs true or false, advertisements of fortune-tellers, quacks and abortionists—such is the modern newspaper; the “palladium of liberty,” the messenger of intelligence and reform! Much is said of late concerning sewer-gas as a source of physical disease. We may regard the daily press with a few honorable exception, as a great moral sewer stealthily pouring into our domiciles the germs of moral depravity—the more dangerous because commingled with the current news which is as necessary as our daily bread.”

TROMMER EXTRACT OF MALT COMPANY.

Nothing can be more discouraging to the practising Physician than the gradual decline of patients from exhausting disease due to faulty assimilation, yet how common is this the case. The physician exhausts his *armamentarium medicorum* going through the whole category of tonics and nutrients, and still his patient passes on in a gradual, sometimes rapid course, from bad to worse.

We do not assume that the Extract of Malt is a universal panacea, but that it is suitable in the large proportion of such cases cannot be denied. The testimony of physicians in all countries is sufficiently pronounced to arrest the thoughtfulness of the practitioner and to induce him to believe that there is a means of relief ready and at hand for these very hopeless cases, in this malt extract.

Cod liver oil was, when first introduced, considered a cure-all, especially in debilitating maladies, yet there are cases in which this remedy, for it is a highly useful one, will fail most signally to give even temporary relief. Cod liver oil comes more properly under the denomination of a food, but there is such a thing as giving food to a stomach incapable of utilizing it.

Malt extract from its chemical composition seems suitable to these very cases when through some want, the assimilation of the food is not properly carried on. It is found to contain Malt Sugar, Dextrine and Diastase. During the process of digestion the starch is first converted into dextrine and finally into glucose, hence if the starch of the barley is already converted

into dextrine its final transformation into glucose is more readily effected than if presented to the digestive apparatus as starch. It may be on this principle that malt extract owes its digestible qualities. But then it contains that peculiar vegetable principle diastase, which is developed during the process of germination, one part of which is sufficient to change 100 parts of starch into glucose. It is declared by some that this principle diastase possesses the property of augmenting the digestive fluid of the stomach. The Trommer Extract of Malt Co. have prepared a number of combinations, such as Extract of Malt with hops, with Cod liver oil, with hypophosphites, with pepsin, and with preparations of iodine, phosphorous, manganese, iron and quinine. These are exceedingly elegant preparations and the formulæ are given with each so that the prescriber can without much research know exactly the dose and quantity of each drug he prescribes for his patient. We have no personal experience in the use of the Ext. of Malt, but there is abundance of evidence of its usefulness to be met with in the medical literature of the day. Mr. R. L. Gibson, the representative of the Malt Company, is in this City at present and is using every exertion to bring this valuable Extract and its combinations prominently before the public.

CANADA VINE-GROWERS' ASSOCIATION, COOKSVILLE, ONT.

We have received from Mr. James White specimens of three qualities of wine manufactured from grape juice by the above company.

This is a new industry in our country, and we understand that extensive vineyards are under cultivation which supply several varieties of grape capable of making an unlimited quantity of wine. The wine in some respects is superior to that imported, and as a Canadian enterprise is of vast importance to the prosperity of our country. The qualities which we have received are a white claret which is a full bodied wine, possessing a pleasant flavour and is nutritious and strengthening. We should suppose it would be very beneficial to those recovering from debilitating ailments such as fevers of all kinds, and other

exhausting diseases. We do not believe that wine or spirit of any kind is an essential aliment, but we are fully alive to the benefit to be derived by a prudent use of wine in those conditions of the system in which the assimilative powers are at fault from deranged function. We have made trial of the wine given to us by the Canada Association, and we believe it to be a pure juice wine palatable and nutritious; it contains much grape sugar and a sufficient quantity of alcohol to prevent fermentation if carefully kept from exposure. A second kind of this wine is called Madeira and very closely resembles the Madeira produced in the Island. There is also a port wine which is less fiery than the imported port, but very similar to it in flavour. These wines are comparatively cheap, and we think they might with propriety be introduced into use in our hospitals as they can be furnished at a little over one-half the cost of the lower grades of imported wines, being at the same time to our taste, quite equal if not superior to the better qualities of those wines.

Medical Items

LUNATIC ASYLUMS IN THE PROVINCE OF QUEBEC.

To the Editor of THE MEDICAL AND SURGICAL JOURNAL.

DEAR SIR,—Your readers being very interested parties as to the mode of procedure, to obtain orders for the admission of patients into either of the asylums, I beg to inform them, that by virtue of an order in council, passed in the month of November, 1878, at the suggestion of the Hon. Prov. Secretary, Mr. Marchand, under *no circumstances whatever*, can any *non-paying patient* be admitted into either of the asylums without a government order, and this order can *only* be obtained by making an application for it to the Hon. Provincial Secretary, Quebec. Where application is made to him, the applicant, at once, receives all necessary information.

Truly Yours,

HENRY HOWARD, M.D.

Govt. Med. Attendant, Lunatic Asylum, Longue Pointe, P.Q.

Montreal, 26 Berri st., Dec. 24, 1878.