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Original Communications.

DYSTOCIA DUE TO A VAGINAL CICATRIX.

M. WALLACE, M.B., TORONTO.

Mrs. S., æt. 27; Russian; a strong muscular woman, was seized with the pains of labour on the evening of September 5th, 1883. I saw her for the first time at 11 p. m. when she had been in labour for about two hours. The pains were severe, and she was losing blood freely. I immediately made a vaginal examination. The finger on entering at the depth of an inch and a half encountered a dense resisting band of tissue situated transversely in the vagina, attached to the anterior wall beneath the pubic arch, and extending upwards and backwards into the hollow of the sacrum. It was raised above the level of the surrounding tissues in front about half an inch and in breadth about three-fourths of an inch, posteriorly it was not so prominent, and separated in a fanlike manner into three or four ridges which joined similar prolongations from the opposite side. The lumen of the vagina was narrowed so as to barely admit the tips of three fingers, leaving a narrow slit-like opening in the median line. Through this orifice with hard rigid edges, the finger encountered the os well dilated, the membranes protruding, and the head presenting in the first position. The membranes were immediately ruptured, and the pains soon increased in severity. The head descended until it pressed upon these bands when its progress was arrested. After waiting some time, the pains continuing forcible, and the hæmorrhage, contrary to my expectations, continuing to be profuse, and the head remaining fixed, I sent for assistance. Dr. Nevitt arrived about one a. m. Following his advice I waited about an hour longer, and then perceiving that the head had not advanced, and the hæmorrhage was still considerable, chloroform was administered, the bladder emptied, and the forceps applied. Strong traction was made during the continuance of the pains, and the head began to press down upon the cicatricial bands which grew tense and thin with sharp wire-like edges. Posteriorly, when the bands were thinnest and most stretched, the finger-nail was used to scratch through that one which offered most resistance. After an hour's hard pulling one of the bands gave way with a perceptible noise, and soon afterwards the child was delivered. The dense broad band under the pubic arch was apparently not softened or dilated by the passage of the head, the dilatation being at the expense of the cicatrix on the lateral and posterior vaginal walls. The placenta and membranes were immediately expressed by Credé's method. The hæmorrhage was pretty free, but the uterus contracted well, and it was soon controlled. Carbolised water was immediately injected, the vagina carefully and thoroughly explored and lacerations searched for. Beyond a slight tearing through a cicatricial band on the

left lateral wall of the vagina towards its posterior portion, none could be found. This laceration was not apparently of a serious nature, but seemed to be merely through the cicatrix, and not to reach the vagina proper. The child was still-born, and had apparently been dead for some time, as the skin was macerated and the cord purplish in colour, and so soft in consistence as to tear on lifting it.

Fifteen minutes after the expulsion of the placenta the woman had an attack of vomiting, but afterwards was very comfortable; her pulse was good; she was free from pain, and had no hæmorrhage. The vomiting was attributed to the chloroform, of which she had taken a considerable quantity.

On calling the next day I found her fairly comfortable, except that she had vomited once or twice. I advised her to suck small lumps of ice, and gave her small doses of bismuth and pepsine. The vagina was washed out with a solution of carbolic acid. The next day the vomiting continuing I ordered a mustard poultice to the pit of the stomach.

On returning the same evening I found the vomiting still going on, about every couple of hours. I then prescribed drop doses of vin. ipecac with bismuth and pepsine, with no better result, and on the following evening (third day) on finding the vomiting still persistent I tried atropine with morphine, which at once quieted the stomach, and the relief continued during the fourth day; but the retching commenced again on the fifth day. During all this time there was scarcely any elevation of temperature; the bowels had acted nicely, and the vagina had been washed out every day with the carbolic solution; above the band that had remained, the accumulation of discharges of blood and debris were removed by the finger, before the nozzle of the syringe was introduced. This accumulation was always exceedingly fœtid and disagreeable, and could not be removed except by using the finger.

On the fifth day a consultation was called and Drs. Barrick and Nevitt met me. There was a good deal of pain in the left inguinal region, tenderness extending down the left thigh, over the femoral vessels, but there was no hardness over these, and no swelling—nothing to indicate phlegmasia beyond the tenderness. Scarcely any change was made in the treatment; she continued to vomit as usual but the appetite became improved and about the seventh day she began to convalesce very well, with occasional vomiting.

On the ninth day, about 7 o'clock in the morning, they sent for me, and when I arrived I found she had lost quite a quantity of blood, per vaginam, of a pure red (arterial.) The flow had ceased when I arrived, and consequently, I left her quiet, giving directions to have her left at perfect rest, and kept cool, no noise or visitors. She felt well all this day, and the next, the tenth day, she sat up awhile, and also felt well all night until she got up; early on the morning of the eleventh day I was sent for. They stated she had got up and fainted. When I came to the house I found her in a state of collapse; quite cold; face pallid and ghastly; rapid breathing; lips blue, and finger-nails blue; pulse not perceptible at the wrist. I diagnosed internal hæmorrhage, or heart clot, and sent for Dr. Barrick; but, notwithstanding the exhibition of stimulants, she expired at 2 p.m. No post-mortem.

This woman could speak no English, and was surrounded by people who could give no information of her previous life or habits. It was not until the fourth or fifth day after delivery that her husband appeared, and gave the following history:—The woman had been delivered of two children previously. On each occasion the labour had been tedious and difficult, and had been terminated with the aid of instruments; the children were still-born. At her second labour she had suffered severely, and her recovery had been slow; for weeks

she lay in bed expecting death, but had eventually convalesced.

She was for a long time unable to hold her water, which continually dribbled away from her. This, however, ceased in time, and she became pregnant with her last child.

I was not able to obtain a post-mortem examination. The diagnosis halted between thrombosis and hæmorrhage—possibly from some undiscovered laceration of the vagina or uterus. The latter was carefully sought for, and if present, would scarcely have escaped observation. The symptoms closely corresponded to the account given by Playfair of thrombosis, and I am inclined to consider that this was the immediate cause of death. The case has many points of interest, which, unfortunately, I am not able satisfactorily to elucidate. What was the cause of the free ante-partum hæmorrhage? Would it have been more scientific to have incised the cicatricial bands instead of allowing them to dilate, and aiding this action by the application of the forceps? In view of the fact that the cicatrix was dilating, and that the forceps did not prevent incisions later if required, I think the course pursued was rational and proper. The cause of the vomiting was obscure. Coming on immediately after recovery from anæsthetisation it was attributed, of course, to the chloroform. But why should it persist? There was no marked elevation of temperature, and no chills, and the pulse not greatly disturbed, nor the appetite interfered with. The symptoms, progress, and mode of death, were not diagnostic of septicæmia.

FIBRO-MYXOMA.

BY WM. OLDRIGHT, M.A., M.D.*

At a time when there is so much research and discussion as to the etiology, pathology, life, and classification of tumours, it has occurred to me that it might be profitable to show and make a few remarks on one which I assisted in removing, and which was placed at my disposal by Dr. Ball, of Toronto, the gentleman who requested my assistance in the case.

History.—Mrs. G., of middle age, had noticed a "lump" growing in the thigh for several years; she could not say definitely how long, but at any rate it was five years or more since she first noticed it. It had caused no pain, but great inconvenience from its weight, size, and situation.

It was situated in the upper and inner aspect of the right thigh; was semi-elastic and lobed. Our diagnosis was that it was either fatty or fibroid.

Its removal was attended with greater loss of blood than I have usually met with in the removal of tumours similarly situated. The blood was dark in colour, and flowed from veins which ramified in the connective tissue which held the lobes of the tumour *in situ*. These lobes were three in number: two of them were partially separated from the third by the adductor brevis, which was found crossing the tumour. Two of the lobes were found to occupy a large cavity below the adductor, and the other a cavity above that muscle. They were connected together by a somewhat organized mass of connective tissue of fibrous character, some of the bands of it being of a yellow colour.

During the operation, we were obliged to stop to arrest hæmorrhage by compression, and plugging the cavity first emptied with cold sponges and maintaining firm pressure for a short time. The cavities alluded to had been formed by the slowly increasing pressure of the lobes of the tumour, and remained quite distinct after these had been enucleated; they were separated by a distinct ridge arising between them. I may remark, *en passant*, that the existence of these cavities prevented any attempt at union by the first intention, and that they necessitated semi-daily washing out by in-

* Read before the Surgical Section of the Dominion Medical Association.

jection of carbolic solutions. The woman made a slow but good recovery.

The operation was performed about a year and a half ago; and I am informed that a fresh tumour has formed and is growing with greater rapidity than the other—at least its growth is noticed more.

The form of the tumour and the mode of connection of its lobes to each other and the surrounding tissues, I have described already. Its colour was a pinkish or reddish white, with a semi-gelatinous or mucoid appearance, approaching in parts a resemblance to the tissue of the umbilical cord, but not so white. It weighed about seven pounds.

Histology.—Sections were made by my friend, Dr. Graham, in connection with his class, and were found to consist, as described to me by him, of fibrils, and in their interspaces polygonal, nucleated cells, with processes running from them. I regret that I was not able to bring these sections with me, owing to Dr. Graham's recent absence from town.

Mr. Foster, an undergraduate in medicine, made for me some sections the day before I left home, but as they appear to have been taken from a portion of the tumour which does not so well show the myxomatous characteristics, I will wait, and hope to show on a future occasion to those whose interest may be such that they might desire to watch the history of such cases, the sections first referred to, together with those which I expect will be made of the tumour yet to be removed.

I show, however, two of the lobes of the tumour, the third being in Dr. Graham's possession.

I will not add much to the remarks already made in speaking of the history and histology of this case, especially as this latter point will no doubt be discussed by gentlemen who have made a special study of the histology of tumours, and one of whom has made and examined sections of this tumour; and another of whom has told me that he has recently been much interested as to the etiology and causes of recurrence of these and other similar tumours.

On this latter point, as one of great practical importance to the operating surgeon, I would say a few words.

It is stated by Dr. Packard, of Philadelphia, in his revision and annotation of the labours of Paget, Moore and Langstreth, in Holmes' Surgery, that: "Myxomata must be looked upon as non-malignant growths. That they produce death directly, either from the organs in which they are situated, *e.g.*, the brain, spinal cord, or their membranes, or from their enormous size, when in other situations, is true, but they show no tendency to the metastatic involvement of other organs, a feature so constantly observed in malignant growths. They frequently exhibit a very obstinate tendency to local return after excirpation, and this peculiarity does not seem to be due so much to any failure in the operative treatment as to a persistent and inherent tendency of the surrounding connective tissue, and this tendency is more striking when the original tissue is developed from adipose tissue . . . Pure myxomata show less tendency to return than the mixed growths."

I would draw special attention to this last remark of M. Packard. I may add that, in the case referred to, the lobes came out clean, and that after their removal and the suppression of hæmorrhage, and during the time of waiting to see that they did not return, and to allow of glazing of the surfaces, we took plenty of time to examine carefully that no portion of the growth was left behind.

I may add, that by some it is thought that the tendency to return is supposed to be due to an infiltration—entirely local—of the surrounding connective tissue with the mucoid elements originally concerned in originating the growth.

HARVARD CENTENNIAL.*

J. A. MULLIN, M.D., HAMILTON.

The Dominion was represented by Drs. Howard, Osler, F. W. Campbell, of Montreal; Atherton of New Brunswick; Dr. Aikins of Toronto School of Medicine. With the latter he had the pleasure of travelling from Niagara to Boston. He spoke of the pleasure they had enjoyed in listening to the eloquent address of Dr. Oliver Wendell Holmes, which was delivered before a large and select audience in the Hall of the Technological Institute. Near the lecturer were seated Sir Wm. MacCormac, Dr. Lyon Playfair, Dr. Marion Sims, the elder Dr. Bowditch and the distinguished surgeon Dr. Jacob Bigelow, Drs. Dalton, Fordyce Barker, and Shrady of New York; and representatives of the profession from Philadelphia, and a large number of States. The representatives from the Dominion were honoured with seats on the platform.

Dr. Mullin referred to certain parts of the address in which the orator spoke of the honoured members of the profession in Boston who had instituted the Medical College, and of those who had been prominent in conducting it to its present distinguished position; to the family of Warren, which name in four generations had been honourably associated with the destiny of the Harvard Medical School. The first was Dr. John Warren, a younger brother of Dr. Joseph Warren who fell at Bunker Hill to whom Dr. Holmes alludes in these lines, in one of his poems:—

"And I heard through all the flurry, Send for *Warren*, hurry, hurry;
Tell him, here's a soldier bleeding, and he'll come and dress the wound.
Ah, we knew not till the morrow told its tale of death and sorrow,
How the starlight found him stiffened on the dark and bloody ground!"

He directed attention to that part of Dr. Holmes' address which refers to the splendid collection in the Museum left by the late Professor John Collins Warren, and where he said there "was formerly a small scrap said to be human skin which had been subjected to the tanning process, and which was not the least interesting of the series. I have not seen it for some time, and it may have disappeared, as the cases might happen to be open while unscrupulous strangers were strolling through the Museum." Perhaps this was the quarter whence came a certain specimen lately exhibited to catch the popular vote, though fortunately without success. He also referred to the closing part of the address, in which is described in eloquent words, the new building into which the white light pours from all points upon the student of science, situated in the midst of other noble edifices devoted to Science, Art, and Religion.

Dr. Mullin then gave an account of a hurried visit by Dr. Aikins and himself to the Boston City Hospital, which in its general plan, and the position of the several wards bore a marked resemblance to our own Hospital; here they were very courteously received by Drs. Cheever and Eddy and the house-surgeons, and had an opportunity of passing through several of the pavilions and noticing the excellent arrangements for ventilation; they also witnessed the operation of tracheotomy by the surgeon Dr. Cheever, for the relief of a child that had been brought in a few moments before suffering from croup. Shortly afterward on entering one of the rooms in the pavilion constructed for the admission of cases of infectious disease, they found the child in bed breathing an atmosphere of steam which was supplied by an ingenious contrivance connected with one of the steam radiators that heated the room.

They also visited the Massachussets General Hospital, which, under the direction of the able House Surgeon, Dr. Whittemore, is one of the best managed hospitals on this continent. They had the good fortune to be present when Dr. Bigelow arrived in company with Sir William Mac-

*Abstract of an Address read before the Hamilton Medical and Surgical Society.

Cormac and Dr. Lyon Playfair. They were afterwards joined by Drs. Shrady, of New York; Osler and Howard, of Montreal; Dr. John Collins Warren and other prominent surgeons of Boston. Dr. Bigelow performed his operation for crushing a stone, and washed out the fragments, using the instruments and apparatus which that surgeon described in an article that appeared in the American reprint of the *Lancet* for January, 1882. Drs. Bigelow and Whittemore passed through several of the wards, showing also the apartments for the nurses in a separate building, which provided very happily a sleeping apartment for each, and cosy parlours where they may assemble when off duty. Dr. Bigelow conducted them to the theatre, where post-mortem examinations are made in the presence of the students, and showed the excellent arrangements by which this room was ventilated and maintained free from mortuary exhalations.

Dr. Mullin then distributed amongst the members catalogues of Harvard Medical School, which had been kindly sent to him by Dr. Wm. P. Whitney, curator of the anatomical museum, calling attention to the admirable arrangements for the prosecution of medical studies provided in the new building, which, at an expense of about $300,000, had been erected and equipped by generous subscriptions of the citizens of Boston and presented to the Medical Faculty. He spoke of the pleasure and profit with which he had visited the museum, and referred particularly to a beautiful collection of wax models illustrating, with life-like fidelity, various diseases of the skin. He called attention to the admirable course of study pursued in Harvard Medical School, where students are conducted in successive years through the various branches of medical education; to the manner in which certain studies are allotted to each year; and to the large amount of practical work through which a knowledge of the different branches is acquired; and spoke of the course as one well worthy of our imitation.

He concluded by referring to the many courtesies which the members of the profession from this Dominion had received from Drs. Warren, V. P. Bowditch, Chadwick, Whitney and other members of the profession in Boston, and to the very great pleasure he had enjoyed visiting Harvard College, in company with Drs. Osler and Shrady; they were escorted by Dr. John Collins Warren, the fourth who has honourably maintained the name of the family, in connection with the Harvard Medical School. Under his pleasant guidance they visited the Library, the Museum, the Gymnasium, and the large Hall, in which many of the students assemble each day for their meals; upon the walls of which appear the names and portraits of many well-known in the history of the United States, and amongst the figures in the stained windows he noticed that of our own Hampden by the side of Leonidas. They passed along the Appian Way, down past the house where Dr. Holmes first saw the light, and around the ancient oak, under which Washington stood when he took command of the Army of the Revolution; they had the honour of visiting the rooms of the Porcellian Club, and were *cordially* welcomed by its members.

Selections: Medicine.

THE DIAGNOSTIC VALUE OF RENAL TUBE CASTS.

BY ROBERT SAUNDBY, M.D., EDINBURGH.

Although the profession is generally impressed with the notion that the presence of tube casts in the urine is a valuable clinical sign, I fear this remains, to a very great extent, a barren theoretical doctrine which bears no fruit in practice. This failure is probably due to the want of precise rules for drawing correct inferences from these structures when they are found.

Busy practitioners sometimes tell me that they have no time to look for casts, but there would be no room for this excuse if the proper method of seeking them was

more generally known, as it need not be a very difficult or tedious operation.

Probably the discovery of casts in the urine of patients suffering from jaundice, diabetes, secondary congestion of the kidneys, or even in more transitory conditions, as in the urine of Weston during his famous walk, has tended to throw doubt upon their value as evidence of renal disease, yet properly understood these facts are by no means opposed to the view that renal tube casts are the best, and perhaps the only certain indication we possess of the state of the epithelium lining the renal tubules. I believe that rightly interpreted they give us a large amount of trustworthy information of the highest importance in diagnosis and prognosis.

Since it has been shown beyond dispute, that albuminuria may occur, not only in acute diseases but in a large number of chronic maladies apart from renal disease, and even under certain circumstances in healthy men, it has lost its significance as evidence of Bright's disease. Moreover, we know that Bright's disease may be present and progress to its termination without albuminuria, so that we are obviously in want of some more trustworthy criterion. In the present paper it would take too long to repeat the objections which I have previously shown to exist against each of those characteristics, which, taken collectively or variously grouped, make up the clinical picture of Bright's disease in its various forms. But while I wish to accentuate the value of tube casts, which have been too much neglected, to the injury of practical medicine, I would not be understood to ignore the value of such important elements of diagnosis as the quantity and quality of the urine, dropsy, cardiac hypertrophy, pulse tension, or retinal changes, each one of which has received careful attention from me in previous papers.

Method of looking for Casts.—The great secret in looking for casts with the microscope, is to use a low power. They are not very small objects, being usually at least one thousandth of an inch in diameter, so that they can be readily seen with a magnifying power of 60 to 80 diameters. I am in the habit of using for this purpose a Hartnack's microscope with the tube drawn out, ocular No. 3, objective No. 4, wide aperture. The urine should be allowed to stand for some hours in a conical glass, covered to protect it from dust. Daylight should always be used for making the microscopical examination. The lowest stratum of urine should be drawn up with a pipette, and six drops placed upon as many object slides, which are then covered with cover glasses, and examined successively. If no casts can be found on any of the six slides, I think, as a practical rule, we may conclude that none are present; but it is generally prudent to repeat the examination of another specimen of the urine, at a future date, before expressing an unqualified opinion. When, however, I have satisfied myself that no casts are being passed in the urine, I do not hesitate to tell my patient that he is not suffering from Bright's disease, or that for the present the morbid process is in abeyance. The absence of casts is most valuable in the diagnosis of cases of functional albuminuria, such as are often met with in young men, and are frequently associated with digestive derangements. My experience of these cases enables me to say that, as a rule, no casts are to be found in the urine, although it may be loaded with albumen; at the most, a single hyaline cast may be found in one stray specimen of urine. On the other hand, I believe casts are always to be found in Bright's disease, in at least greater numbers than this.

The differential diagnosis of these cases is important, because I can confirm Dr. Moxon's favourable opinion of them. So far as I have been able to watch my cases, all have got well, or have much improved in health. It is, of course, an open question whether such cases do not show a tendency to Bright's disease, which, later in life, may become manifested in actual organic disease. As I have elsewhere suggested, this is a very probable view. My last case of this sort was the son of a victim to Bright's disease, and as the hereditary character of the latter condition is indisputable, I confess that I regard my patient's remote future with grave anxiety.

Varieties of Casts.—Casts of the renal tubules are usually described as of three kinds:—1, blood casts; 2, epithelial casts, and 3, hyaline casts. There are besides various compound varieties, in which blood or epithelium may adhere to or form part of a hyaline cast; and the term granular is often used to describe epithelial or hyaline casts which have become opaque and granular from fatty-granular degeneration.

Finally, casts differ in size, and at one time considerable importance was attached to the difference, but at the present it is not held to be of any practical significance.

Blood Casts.—These casts indicate, as might be supposed, the escape of blood into the tubules of the kidney. It is now admitted that the almost constant source of this hæmorrhage is the capillary tufts of the Malpighian bodies. The blood, in its passage down the tubes becomes coagulated, and taking the shape of the tube in which this occurs passes out into the urine. Such casts are important indications of the source of the blood in a given case of hæmaturia, proving, for example, that the blood does not come from the pelvis, as in calculus of the kidney, or from any lower portion of the urinary tract. These casts are seen in the early stages of acute nephritis, and at any period and in any form during the occurrence of congestion of sufficient intensity to cause hæmorrhage. They must, therefore, be regarded only as evidence of intense congestion and not as significant of any stage or form of Bright's disease.

Epithelial Casts.—There are two main types under which the renal epithelium appears in the urine in the shape of casts of the renal tubules. In the first the cast is made up of a number of distinct small round granular cells, like leucocytes, but of smaller size, and which are, as their appearance suggests, the result of proliferation of the renal epithelium. These casts are met with in acute and subacute nephritis, and always indicate an active degree of inflammation in the kidney with proliferation of the renal epithelium.

In the second type the cast is composed of a mass of epithelial cells crowded together so as to obscure their individual outlines, and often rendered more or less opaque by fatty granular degeneration. These casts are formed by the desquamation of the epithelium which is pushed off the basement membrane of the tubule by the inflammatory exudation from the venous plexus surrounding the tubule. They are usually of large diameter from being moulded in tubes denuded of epithelium, and they indicate diffuse inflammation of the kidney. They are met with in all forms of Bright's disease, in cases of recent inflammation, and in those acute attacks which so frequently supervene in the course of chronic Bright's disease. Laughans has shown that epithelial casts undergo a colloid metamorphosis, by which they become partially or wholly hyaline in appearance, and this fact explains one form of the compound varieties referred to above. When this change is complete such casts present the ordinary hyaline appearance of the third type, and in certain cases, by no means only or usually in lardaceous kidney, they are said to give the characteristic mahogany brown colour of lardaceous material.

Hyaline Casts.—This last variety is that most commonly met with, as it may be found in all forms of Bright's disease, and at any stage or condition in which the renal epithelium is the seat of irritation. They are usually homogeneous, transparent bodies, though they may be obscured by fatty degeneration; they are non-fibrillated, not acted upon by acetic acid, but soluble in pure water, especially when warmed. These peculiarities led Robin, Rovida, and Cornil and Ranvier, to reject the current view that they are fibrine casts; and many authorities (Cornil, Wagner, Rindfleisch, Beale, and Aufrecht) regard them as produced by an exudation or secretion from the epithelial cells of the tubules. Aufrecht in particular adduces the following facts in support of this view: after ligature of the ureter in rabbits, if the kidneys are examined within the first three days, the tubules contain many hyaline cylinders, although the epithelium is intact and the interstitial tissue and blood vessels do not show the slightest change; moreover, he once saw a cylinder made up of single irregular pieces, separated by fine bright lines, and some of the epithelial cells had fine bright rounded structures projecting from them. Strauss and Germont have recently confirmed this description, and it has also been supported by the observation of Cornil already quoted. But Salkowski and Leube, in their recent work on the urine, still adhere to the view that these structures are in reality fibrine, formed by the action of the dead epithelium upon the fibrinogen of the blood serum. This view is obviously based upon the theory of coagulation which we owe to Alex. Schmidt, and which has been recently called in question by the researches of Norris, Bizzozero, and Hart. But whichever view we accept, it is certain that Langhans' observation does not account for the enormous majority of hyaline casts, as he himself admits, but that these bodies are

always produced by the intervention of epithelium, either in a state of irritation or actually dead. This latter point is the most important, and though I am personally inclined to accept Aufrecht's view, I am quite content in the meantime to go no farther than the statement that hyaline casts are evidence of destructive changes in the renal epithelium.

This view is not contradicted by the clinical experience of their presence in the urine of diabetes, jaundice, or secondary congestion, as under these circumstances they are neither numerous nor common, and the first and last of these conditions are known to lead in many cases to structural alterations in the kidneys. In jaundice too Mobius has shown that persistent excretion of bile leads to destruction of the renal epithelium. Their occurrence under such abnormal conditions as during Weston's famous walk can be reasonably explained by assuming that the renal epithelium suffered under the abnormal strain on the whole bodily functions, but the cause being transitory the epithelium could be fully restored to health, as there is ample warrant for the belief that this tissue possesses a considerable power of repair within certain limits.

Indeed these facts are in themselves strong proofs of the correctness of the view for which I am contending, as they show that we have a means of recognising very early and slight derangements of the renal epithelium. As this tissue participates early in the changes in all forms of Bright's disease, and as primary interstitial nephritis with perfectly healthy epithelium is a pure pathological fiction (as the frequency of hyaline casts in that very form would suggest were there no more direct argument), we may often estimate the extent and gravity of the pathological changes by the number and persistence of these organic deposits in the urine.

I am very glad to find that my views upon this subject have found an echo on the other side of the Atlantic, and that able clinical observers like Kinnicutt, of New York; Tyson, of Philadelphia, and Millard, have expressed themselves of the same opinion.—*Birmingham Medical Review.*

A symptom which occurs in a good many cases of chronic Bright's disease, and in acute Bright's disease as well, though not in all, is dropsy. And by dropsy I mean the exudation of the serum of the blood through the walls of the blood-vessels, and the accumulation of it in the subcutaneous connective tissue and in the various serous cavities of the body. Such a dropsy is not by any means confined to Bright's disease. We may have it produced simply as a result of great anæmia. The constant occupying of one position is capable of producing a certain amount of dropsy. Thus, if a person stands on his feet all day, and day after day for a long period of time, he may get up a dropsy of the feet and legs simply as a result of maintaining this one position. Then, again, anything causing an obstruction of the veins is capable of producing such an extravasation of serum into the connective tissues. In the case of renal diseases it is not always easy to tell the exact reason for the formation of dropsy. It is supposed by some to be due to changes that have taken place in the composition of the blood, and especially in the composition of the serum of the blood. Others think that it is due to the loss of albumin, which passes away in the urine, and so leaves the blood extremely thin and allows it to exude through the vessels. Others believe it is caused by certain changes in the walls of the blood-vessels, or in the force of the circulation and the pressure of the blood. Some of these various explanations will answer well enough for some of the cases of Bright's disease, but none of them for all. In those chronic cases where we do regularly have changes in the composition of the blood, and also changes in the circulation, and often, too, changes in the structure of the walls of the blood-vessels throughout the body—in those cases it is easy enough to understand the dropsy. But in some cases of acute Bright's disease we find it difficult to understand the reason for the production of dropsy. There are some of these cases in which the patient was previously completely well, and yet within a few days he becomes affected with general anasarca, and there is an accumulation of fluid in the different serous cavities. Here it is difficult to understand why the dropsy should come on so suddenly and be so extensive. The importance of understanding the causation of the dropsy is not a mere matter of theoretical importance, but it is a matter of real practical consequence, for, if we could understand the cause in each

case, we should then know better what to do to get rid of it.—*N. Y. Med. Jnl.*

Inosuria.—M. Laboulbène in *L'Union Médicale*, in a short note desires to call attention to the apparently favourable action of inosite in the urine, following true saccharine diabetes. For many years he had noticed patients clearly glycosuric—have the characteristic sugar disappear from their urine, and in which the presence of inosite was clearly, though with trouble and difficulty, demonstrated. He gives three cases, the first a male æt 75, an active steady farmer, who for a year previous had complained of thirst, dryness of the skin and polyuria (4½ litres in the 24 hours), 44 grammes of sugar per litre was found in the urine. Under treatment in six months the quantity of urine was reduced two-thirds, and the sugar fell to 4.50 grammes per litre. One year afterwards the sugar entirely disappeared and the urine was reduced to 2½ to 3 litres a day. Inosite was unmistakably found at this time and continued for five years, during which the patient remained under observation. In other respects his condition was one of health. The second case was that of a woman, æt 50, of a nervous disposition; urine abundant, containing 30 grammes of sugar per litre; under appropriate treatment in six months the sugar decreased in quantity although the polyuria persisted; the sugar finally disappeared and inosite was found; she was relatively cured. The third case was that of a robust male; for eighteen months he had noticed great thirst and polyuria; 20 grammes of sugar to the litre; under treatment this gradually disappeared and two years afterwards he being in good condition, inosite was found. M. Laboulbène recollects two other cases of glycosurics whose health was notably ameliorated and in whose urine the sugar was replaced by inosite.

Dr. Isidor Mehrer, reports that in the post-mortem examination of a woman 45 years of age, dead by hanging; he was unable to find the slightest trace of the spleen. The other organs were normal and properly developed.—*Wien. Med. Pres.*

American Catarrh.—Morell Mackenzie, in the *Brit. Medical Journal*, upon the strength of observations made during his recent travels in America, considers that post-nasal catarrh is sufficiently prevalent to claim for itself the proud distinction of the national complaint. He found it widely diffused on the Atlantic seaboard and upon the Pacific coast, upon the arid plains of Colorado and the busy streets of St. Louis and Chicago; in the South and in the North; in Canada not so common as in the United States. The climate and the soil being so varied, he eliminates as etiological factors, but considers the abundance of *dust* a full explanation of the prevalence of the disease. The naso-pharynx anatomically acts as a dustbin and with difficulty gets rid of foreign particles, and owing to its relative insensibility the foreign particles deposited remain there longer without causing excessive discomfort and are likely to give rise to disease. Overheating of the houses and the consequent abrupt and excessive changes of temperature are also probable causes and heredity is not to be entirely excluded, though the fact that many foreigners contract the disease while making a short stay in America renders it probable that atmospheric conditions are more powerful than heredity.—*Maryland Med. Jnl.*

Danger from Flies.—Dr. Grassi is said to have made an important, and by no means pleasant, discovery, in regard to flies. (*British Medical Journal.*) It was always recognized that these insects might carry the germs of infection on their wings or feet, but it was not known that they were capable of taking in at the mouth such objects as the ova of various worms, and of discharging them again unchanged in their fæces. This point has now been established, and several striking experiments illustrate it. Dr. Grassi exposed in his laboratory a plate containing a great number of the eggs of a human parasite, the *tricocephalus dispar*. Some sheets of white paper were placed in the kitchen which stands about ten meters from the laboratory. After some hours, the usual little spots produced by the fæces of flies were found on the paper. These spots, when examined by the microscope, were found to contain some of the eggs of the tricocephalus. Some of the flies themselves were then caught, and their intestines presented large numbers of the ova. Similar experiments with the ova of the *oxyuris vermicularis* and of the *tenia solium* afforded corresponding results. Shortly after the

flies had some mouldy cream, the *oïdium lactis* was found in their fæces. Dr. Grassi mentions an innocuous and yet conclusive experiment that every one can try. Sprinkle a little lycopodium on sweetened water, and afterward examine the feces and the intestines of the flies; numerous spores will be found. As flies are by no means particular in choosing either a place to feed or a place to defecate, often selecting meat or food for the purpose, a somewhat alarming vision of possible consequences is raised. Dr. Grassi invites the attention of naturalists to the subject, and hopes that some effectual means of destroying flies may be discovered.—*Louis. Med. News.*

THE ANTAGONISM BETWEEN PARALDEHYDE AND STRYCHNINE.—The Italian Professor Cervello, has recently demonstrated an antagonism of action between paraldehyde and strychnine. His research included three forms of procedure: 1. After a dose of strychnine, a non-lethal quantity of paraldehyde was given. 2. After a dose of paraldehyde, a lethal quantity of strychnine was administered. 3. Both agents were simultaneously used. As a control experiment, the same animals were subjected to the effects of these agents alone. In this way a criterion was established by means of which the narcotic power of paraldehyde and the toxic activity of strychnine could be judged. By this method he demonstrated that paraldehyde arrested the action of strychnine, after the manifestations of poisoning began, or prevented the appearance of toxic symptoms. The antagonism was manifested in what order soever these agents were administered, and when they were given together. Cervello ascertained that it is not necessary to the antagonism that the quantity of paraldehyde given should be above the merely physiological limit, a relatively small quantity sufficing to neutralize the effects of a large dose of strychnine. In a rabbit weighing 1665 grammes (about three and a half pounds), four milligrammes of nitrate of strychnine (more than a lethal dose) were injected, and the symptoms of poisoning vanished under the action of a small dose (less than a drachm) of paraldehyde. To another rabbit, narcotized by a drachm nearly of paraldehyde, six milligrammes of nitrate of strychnine were given, and the animal survived. Strychnine appears to have no influence over the course of the narcotizing action exerted by paraldehyde, for the duration of the narcotic effect is practically the same when strychnine has and when it has not been given. There is, however, a difference as to the time when the narcotic effect produced by paraldehyde manifests itself—strychnine retarding the action, but not altering its character. The seat of the opposing actions is the spinal cord, strychnine increasing and paraldehyde lessening the reflex excitability of the gray matter of the medulla oblongata.—*Phil. Med. News.*

CITRATE OF MAGNESIA SOLUTION.—The following formula has been used for many years with entire satisfaction:—

For one bottle—

Carbonate Magnesia	120 grains.
Citric Acid	240 grains.
Water (previously boiled)	A sufficient quantity.
Oil of Lemon	5 drops.
Syrup	1½ fl. ounces.
Bicarbonate of potassium	30 grains.

Drop the oil of lemon on the carbonate of magnesia, place the citric acid in a jar with the water, dissolve, add the carbonate of magnesia. When dissolved, filter into the bottle, in which the syrup has been previously placed; fill the bottle nearly full with water (previously boiled and filtered) and add the bicarbonate of potassium, when it must be at once securely corked. This preparation will purge actively and keep indefinitely.—P. W. B. in *Pharmaceutical Record.*

SYRUP OF COFFEE TO DISGUISE QUININE.—Roasted coffee finely ground, 4 oz., alcohol 1 oz., sugar 12 oz., boiling water sufficient. Pack the coffee firmly in a percolator provided with a cover, and pour on boiling water until eight fluid ounces of percolate are obtained. Then dissolve the sugar (in the percolate) by percolation, and finally add the alcohol as a preservative. The taste of two grains of quinine is said to be pretty well covered by a drachm of syrup.—*New Remedies.—N. C. Med. Jnl.*

J. M. Gordon, of Cincinnati, (*Pharm. Record*), states that the annual production of bromine in this country is from 450,000 lbs. to 500,000 lbs., the larger quantity being made from the salt wells of Virginia, Ohio, Pennsylvania, and Michigan. The estimate is one pound of bromine to every two barrels

of salt. The first production was in 1846 in Freeport, Penn. In 1868 when the manufactories at Tarentum and Natrona, Penn., and on the Kanawha River were started the price was $2 per pound. This has since been reduced to 28 cents.

Surgery.

ADHESIONS IN OVARIAN TUMOURS.

(Abstract of a clinical lecture at La Salpêtrière by M. Terrillon.)

In ovariotomy adhesions are to be dreaded as increasing the difficulty and danger of the operation, although not presenting a formal contra-indication to it. The old surgeons attached great importance to the diagnosis of adhesions. Their existence prevented the operation or suspended it when begun. Later, Walne made exploratory incisions which enabled him to note with the finger the mobility of the cyst. Bird, by sticking needles into the cyst at various points upon the abdomen—inferred from the movements of these needles during expiration and inspiration, the mobility of the cyst. Spencer Wells and Kœberlé showed that these difficulties were not insuperable and the re-action was so complete that certain authors have given to their existence an excellent prognostic value.

Most authors have heretofore studied the inflammatory adhesions. But there is another variety of equal if not greater importance, indeed they are the most frequent cause of unfinished operations. They are called adhesions by infiltration from the manner of their production. The ovary occupies the upper border of the broad ligament: it appears to be enveloped by the peritoneum on all sides except at its hilum or pedicle where it receives its vessels. When the ovary undergoes cystic degeneration it increases in size—developing most frequently into the abdominal cavity, losing its relations to the broad ligament; its vessels as well as the ovarian ligament are elongated and constitute the pedicle of the cyst. In other exceptional cases, as well as the growth into the abdomen, the cyst increases along the pedicle, descending in the thickness of the broad ligament, doubling its two leaflets, forming the tumour into two parts, one intra-peritoneal the other infiltrated into the broad ligament. This disposition constitutes a true adhesion, since the cyst is not free in its whole extent and does not present a pedicle. This variety has not been closely studied, though it has been vaguely indicated and often confounded with inflammatory adhesions.

Inflammatory adhesions are always the result of peritonitis, generally localized. Sometimes the inflammation is free and acute with the ordinary signs and cannot fail to attract attention. In a second variety the inflammation may be sub-acute or chronic, with no general signs, and pain causing but little anxiety, but close questioning will generally reveal its existence. A third form, the most frequent, is latent and no amount of questioning elicits information of its presence. Certain adhesions are easily broken down, others on the contrary are very difficult to destroy. In this respect adhesions may be divided into four varieties: the first soft and non-vascular, tearing without resistance and without hæmorrhage; the second are equally soft, but vascular, easily torn, only they bleed from both ends, especially from that attached to the abdominal wall. The hæmorrhage may cease rapidly or require ligatures. At a more advanced stage of organisation they are hard, cannot be broken down with the hand, requiring a blunt instrument as a spatula or handle of a scalpel, or even a cutting instrument. Further they contain vessels of new formation, more or less voluminous; hæmorrhage from them is more severe, hence they should be divided only between two ligatures. Finally more extended in surface, less lax, these fibrous adhesions become indelible. The peritoneal wall and the surface of the cyst are united by a thick, fibrous tissue, often very vascular, whose dissection is difficult and exposes the surgeon to tearing the peritoneum, to denuding the muscular masses of the abdomen, in a word, to destruction of tissue, of evil import. Indeed he may have to leave the operation unfinished. These are found only in old cysts and are rare now that operations are undertaken earlier.

The most frequent seat of adhesions and the least dangerous as well as the earliest is between the abdominal wall and the cyst. Epiploic adhesions are important from the bleeding to which they always give rise, and necessitate many ligatures. Adhesions with the intestine are rarer on account of the mobility of that organ, but

expose one to the danger of perforation in breaking them down. They may compel the surgeon to leave a portion of the cyst adherent. Vesical adhesions are formed early, and may as the tumour grows, drag that viscus upwards as far as the umbilicus where it may be wounded in the first incision, destruction of the adhesions may also as in the intestine, cause perforation. Adhesions with the uterus if formed early, displace that organ with the growth of the tumour. They are rare, but when they exist, are difficult to destroy, often being the cause of deep wounds of the organ, and may induce the surgeon to practice partial ablation or even to leave the operation unfinished. Adhesions may also form with the pelvic walls or at the upper part of the abdomen with the liver, spleen, stomach, &c.

The diagnosis of the nature and seat of adhesions is then a matter of importance. Unfortunately precise signs are absolutely wanting. Besides the immobility of the tumour, the most important information is obtained from the history, by the existence of old symptoms of peritonitis especially by localized and persistent pain, which is one of the best signs. They may be altogether absent, or a neuralgia may be mistaken for them. Vesical and intestinal troubles may be due to simple compression, uterine displacements may be due to the disposition of the pedicle. Urethral catheterism when it allows the catheter to ascend very high alone permits the diagnosis of a vesical adhesion.

All the other signs invoked afford no greater certainity. The mobility of the cyst sought for either by examination in certain conditions of light (Spencer Wells) or by percussion during forced inspirations and expirations is a sign contested by Boinet. So also with Lee's sign, the tumour distending and separating the recti muscles, if there are no adhesions, forms a manifest protuberance between these muscles when the patient is made to sit down. Bright has pointed out a symptom to which some authors attach great importance, the noise or the sensation of the crepitation of snow or new leather on palpation of the abdominal walls. This sign belongs especially to soft and recent adhesions (Phillips) or is due only to a granular condition of the cyst wall (Liégeois). The existence of adhesions may be presumed, signs may be found which render their presence very probable, but absolute certainty cannot be obtained. So every ovariotomist should expect numerous surprises and be prepared to meet with adhesions and their complications.

The second form of adhesion is that of *infiltration into the broad ligament.* It is seldom that the whole tumor is ensheathed in the broad ligament, most frequently it is only a prolongation, which may be developed in two directions, consequently giving rise to two symptomatic types with a series of intermediate forms.

In the first place the prolongation may be carried vertically downwards. It will separate the two sides of the broad ligament and be found in a cavity limited downwards by the levator ani, inwards by the lateral border of the uterus, in front of which projects the corresponding portion of the bladder. In the first period of its development, the cyst depressing the cellular tissue of the broad ligament will be free in its thickness and easily enucleable. But soon its relations with neighbouring organs becoming more intimate, it will depress the lateral vaginal *cul-de-sac,* will efface it, will make it protrude, will push aside the uterus and the ureter which passes alongside of the uterine neck and will compress either the *bas fond* or the lateral part of the bladder. Finally the utero-ovarian vessels situated on the border of the uterus will connect with those of the cyst, likewise the vesical vessels and those of the broad ligament, thus producing indelible adhesions. The difficulties presented by the extraction of such tumours is easily comprehended. Besides severe hæmorrhages, lesions of the bladder and ureters will have to be dreaded.

In the second case the cystic prolongation instead of descending vertically, is inclined backwards towards the sacral concavity. After having raised and effaced the posterior peritoneal *cul-de-sac,* it is insinuated under the mesentery and pushes back the intestine, this is then found in front of the cyst, a position giving rise to great uncertainty in diagnosis. Finally the prolongation may contract adhesions with the large vessels of the excavation or with the intestine.

The extraction of these prolongations will necessitate the opening of the broad ligament and the shelling out of the tumour. Sometimes this is easy, sometimes adhesions render it laborious, difficult and dangerous, from hæmorrhage and from torn peritoneum

giving rise to suppuration with its attendant train of septic disasters.

It would be useful to recognize beforehand the existence of these enclosures, unfortunately as in inflammatory adhesions, there is no certain sign. The immobility of the uterus, its deviation, the marked bulging of the tumour into the vaginal *cul-de-sac*, the effects of rectal and vesical compression would be presumptive evidence, were they not also found in tumours non-infiltrated, but simply depressing the broad ligaments. It is only during the progress of the operation that this complication can be recognized. All means must be employed to diminish suppuration and prevent the stagnation and resorption of putrid matters. More than ever the strength of the patient must be sustained and she be placed in a condition to resist this new cause of debility.

It is by possessing a knowledge of all these difficulties and in being familiar with all their varieties that we can at last destroy these adhesions and eliminate as completely as possible the dangers which arise during and more especially after the operation.—*Le Prog. Méd.*

Method of Reduction in Dislocations at the Elbow.—Mr. J. E Kelley gives the following method for reducing dislocations at the elbow-joint, especially in cases where assistance cannot be readily obtained:

The operator sits on a corner of a table, at the end of which the patient is placed upon a chair. The injured limb is drawn under the surgeon's proximal thigh, which rests, close to the joint, on the anterior surface of the humerus, while the olecranon is accurately placed on the anterior surface of the lower third of the distal femur, and the proximal foot is "hitched" behind the other leg, which is flexed firmly against the frame of the table. In order to obtain the most favorable fulcrum, the surgeon fixes his proximal elbow against the antero-internal aspect of his corresponding thigh, and, grasping the wrist of the patient with both his hands, reduction is effected by the simultaneous and co-operative action of the muscles of the arms, back, and thighs. Fixation and counter-extension are supplied by the powerful thighs of the operator, and coaptation is effected, with great nicety, by the backward pressure of the proximal femur against the anterior surface of the humerus, while the distal femur forces the olecranon forwards. Owing to the accuracy with which it can be applied, this power, which is incalculably greater than that afforded by the pressure of the fingers and thumbs (Boyer), is sufficient, when the forearm is steadied, to reduce an ordinary dislocation without the aid of extension. Additional adjusting influence is exercised by the inner side of the proximal thigh, which, by pressing against the anterior surface of the forearm, liberates the coronoid process from its position behind the lower extremity of the humerus, and allows the greater sigmoid cavity to resume its normal relation to the trochlea. Extension is supplied by the muscles of the upper extremities acting round the fixed point provided by the elbow of the surgeon, and, when his body is thrown backwards, additional force is derived from the muscles of the back, the glutei, and the other extensors of the thighs. This power may be applied at various angles in rapid and easy succession, an advantage which the surgeon experienced in the treatment of dislocations cannot fail to appreciate.

In the lateral modifications of the posterior luxations the reduction is generally effected by the same manœuvre which is employed for the simple form of dislocation, but should special coaptation be necessary, it is at the disposal of the operator, as, when aided by the powerful constraining pressure of the thighs, the proximal hand can supply sufficient traction and stability, while the other is unoccupied and in the most advantageous position to apply any additional manipulation, which may, if desirable, be afforded by an assistant. If the condition be such that the full extending force of both arms be required, the isolated rural surgeon can, with a little ingenuity, render himself independent of professional aid by fixing the bone of the arm or forearm, which is displaced inwards, by a bandage passing round his own loins, and by making lateral traction on the bone or bones displaced outwards, by another bandage attached to his foot, and passing over his knee, as over a pulley. By this simple apparatus the instinctive movements, which are essential to the reduction of the simpler luxations, are utilized for the treatment of the more complicated forms. —*Phil. Med. News.*

Encephaloid Cancer.—M. Sappey's researches go to show that encephaloid cancer is due to a profound alteration of the white globules of the blood. This alteration is at first essentially local. But in traversing the primitive focus of the disease, the white globules are altered, degenerated, and afterwards may take one of three directions. Some leave the blood capillaries, are deposited upon the diseased point and become the centre of formation of a tumour with a tendency to increase indefinitely. Others are carried towards the ganglions which soon undergo secondary degeneration. Others remain in the venous blood and propagate the cancer to all parts of the economy.

At every stage of cancer the beginning, the middle, and the end, the leucocytes are the actors. Primitive alteration of the white corpuscles. All physicians agree in recognizing that the organs which are richest in lymphatic vessels are those for which cancer seems to have a predilection. Consequent upon a cause which is yet unknown, the white globules contained in the lymph channels are modified in a limited point of these organs, become altered and degenerated. On contact with these degenerated globules, those which float in the blood become degenerated in their turn. The alterations of the first is revealed to us by the ganglions into which they flow, that of the second has heretofore escaped the attention of physicians. Four facts recently observed have permitted me to demonstrate clearly this cancerous degeneration of the white globules of the venous blood.

The first of these was an enormous encephaloid tumour situated in the abdomen. This tumour was encysted and the walls of the cyst were traversed by numerous veins some as large as a finger. I examined the blood contained in them microscopically; some of the white globules were still intact, others were altered in divers degrees. The normal leucocytes had a volume of 9 to 11 thousandths of a millimetre. Those which were degenerated were larger, being 15, 20, 25, m.m. They were especially distinguished by the segmentation of their nucleus and by a great abundance of fatty granulations which were substituted for the protoplasm. The cancer cells of the tumour presented the same characters as the degenerated leucocytes, but less clearly marked. To the cells coming from the blood there are added others originating from the degenerated epithelium of the glandular canals. The typical cancer cell must not be sought for in the tumour, but in the veins which leave it.

The growth of the tumour is rapid, because it takes the elements of its increase from an inexhaustible source. The secondary degeneration of the lymphatic glands is due in the first place to diseased cells carried from the tumour, and the lymphatics becoming diseased cease forming leucocytes. Their growth is consequently more limited than the original tumour. The lymphatic vessels from healthy parts may bring cells which become degenerated in the gland or the blood furnished the glands may supply cells for its growth. The cancerous cachexia is due not to a cancerous virus but to these degenerated globules circulating in the blood and emanating from the cancerous centre. Each of these degenerated globules is a cancer in miniature, an ambulant cancer, circulating with the blood current to all parts of the body and may be numbered by millions.—*L'Union Méd.*

Extirpation of the Kidney.—M. Ollier has performed this operation three times. In the first case, the operation was performed on account of pyonephrosis in a young woman, believed to be due to obstruction of the pelvis of the kidney by calculi. The extirpation was rendered difficult by adhesions of the capsule to the adjacent parts, and it was found necessary to decorticate the organ. Though the operation was long and tedious there were no untoward symptoms, and the patient recovered. The patient now complains of pain in the liver and left iliac fossa, and at two periods there has been excessive salivation, amounting to more than a quart in half a day. The second operation was performed on account of a cyst containing about four gallons of fluid. The patient died on the third day. The third case was one of sarcoma of the kidney. All went well until the tenth day, when the child died suddenly in attempting to raise itself from the bed.—*Phil. Med. News.*

Direct Operative Interference in irreducible Luxations by Poinsot (Bordeaux). 1. In regard to the suitability of operative interference, luxations should be divided into recent, intermediary and ancient. 2. In recent luxations direct operative inter-

ference should be rejected. Exceptions made in section of the tendo achillis in luxations of the ankle, and of the lateral ligaments in luxations of the thumb. 3. In intermediary luxations subcutaneous sections constitute the first process to be employed. Arthrotomy should be reserved for those cases in which the vicious situation of the bone might lead to compression, absolute impotence of the limb and threaten its vitality, as may happen in certain luxations of the shoulder and knee, and also in the fingers, hindering the use of the hand. 4. For ancient luxations, in which subcutaneous sections fail, arthrotomy with or without resection is suitable for the ginglymoid joints as the elbow, knee, ankle, and also for the fingers, For the other enarthrodial articulations (jaw, shoulder and hip) osteotomy would be preferable.—*L'Union Méd.*

Sugar as a Dressing for Wounds.—Dr. F. Fischer says that in the Strasbourg Hospital, where he is assistant in the surgical department, Professor Lücke has since May used powdered cane-sugar as an antiseptic dressing to wounds. Hitherto, it has been used in combination with naphthalin (equal parts) or with iodoform (1 part to 5 of sugar). In cases of wounds united by suture, the mixture is put up in gauze and applied to the part; where there is loss of skin, the sugar is sprinkled directly over the part. The sugar-dressing is fixed in place by some layers of gauze deprived of fat, over which a layer of gutta-percha is applied, and the whole is secured by a bandage. The sugar-dressing may remain from eight to fourteen days without the sugar dissolving; the secretion from the wound is equally distributed through the sugar, and it is only when the layer of sugar is too thick (more than about one-fifth of an inch) that lumps are formed. The wounds have a healthy appearance under the sugar, the dressings are not offensive, and bacteria cannot be found in them. Healthy granulations, with no tendency to bleed, are developed; and cicatrization proceeds rapidly. In wounds united by suture, healing by the first intention has always been observed. Dr. Fischer is not able to say whether the sugar is decomposed, or what new products are formed. Writing in the *Allgemeine Medicinische Central-Zeitung* in reference to Dr. Fischer's communication, Dr. Windelschmidt, of Cologne, says that he has used sugar alone as a dressing with good results. He finds that for small wounds and ulcers powdered cane-sugar is not inferior to iodoform as a dressing, while iodoform is necessary in many cases, such as chancres and mammary abscesses. He calls attention to the fact that powdered sugar is a very old popular remedy in cases of fungous granulations, ichorous eczema, and erysipelas of the face. Whether the action of sugar is antiseptic, is not certain: that it is aseptic, is proved by its use in confectionery. In spite of his success, Dr. Windelschmidt has for several months desisted from the use of sugar as a dressing; partly because the patients found out the nature of the powder that was applied and ceased to trust in it, partly because they treated themselves, and so passed from his observation. He thinks, however, that sugar, like iodoform and naphthalin, has its sphere of application; and joins with Dr. Fischer in recommending that it be more extensively tried.—*British Medical Journal*, October 13, 1883.—*Med. News.*

Tannate of Sodium in Chronic Nephritis.—Lewin first recommended tannate of sodium in nephritis, and Ribbert's experimental researches demonstrated its action in causing decreased elimination of albumen.

Briese has used it, in four cases in Mosler's clinic, prepared as follows: ℞ Solution of tannic acid, 2 parts to 100; add solution of bicarbonate of soda (9 to 5) ad react. alcalin. S. Dose, one tablespoonful every half hour.

This mixture was not equally well taken by the patients. In some cases it caused gastric disturbances and vomiting. The daily quantity of albumen eliminated by the urine was not diminished, the nephritis went on, and the patients grew worse daily, and it was apparent that the remedy was, in these cases at least, of no value whatever.—*Centralbl. f. klinisch. Med.*, September 1, 1883.

Midwifery.

Means to Shorten Lingering Labours, John Morris, M.D., Baltimore.—There are three stages or conditions in which labour may become lingering, and to deal with these states successfully, different procedures must be made use of. First, labour

may be lingering when the head is delayed at the brim of the pelvis; second, when the os has dilated to some extent, and the head has descended into the vagina; and thirdly, when it has reached the vulva and impinges on the perinæum. It is usual to describe labours as occurring in the first and second stages, but I think the division I have adopted will serve better for the elucidation of the subject.

When labour is tardy in the beginning, the os dilating very slowly, the pains feeble and irregular, and the head high up, means may be carefully employed to hasten its progress; but if the woman is cheerful and hopeful, interference may be delayed. This delay must not be suffered to extend, as Churchill and others have recommended, for twelve or sixteen hours, for, if the woman's powers, are allowed to become exhausted in the first stage, instrumental interference becomes a necessity in the second. In the condition described the os is frequently dilatable, but the membranes do not come down to act as a dilating wedge. In these cases it is good practice to detach the membranes around the cervix, and Braun, of Vienna, recommends the introduction of an elastic catheter between the chorion and the walls of the uterus for this purpose; but this can be much better effected, in my judgment, by the cautious use of the finger. After the membranes around the cervix are detached in this way, if gentle pressure is used around the whole margin of the os with the soft part of the finger, gently stretching it, the bag of waters will commence to project, the os will gradually dilate, and the pains become effectual. I have seen many cases of labour in this stage expedited by this plan. In some instances the membranes rupture prematurely, and the head becomes the dilating force. These cases are usually very painful; but they can be greatly hastened if the finger be swept cautiously around the os at each pain. In cases of tardy dilatation of the os, due to rigidity, in which the woman suffers acute pain, the administration of opium is most beneficial, and should always be resorted to. A hypodermic injection of ten drops of Magendie's solution, or thirty or forty drops of McMunn's elixir, given internally, acts like a charm. Ineffectual contractions do injury to the woman, and when you cannot advance labour you had better arrest it. I do not think the administration of chloroform is wise at this stage.

There is occasionally a form of unequal, spasmodic contraction, well described by Velpeau, which is sometimes confined to the fundus, sometimes to one of the angles, or to a portion of the anterior or posterior wall, or one of the sides of the uterus. The pains are very acute, but merely exhaust the woman's strength, and, unless an anodyne is administered, labour will be prolonged indefinitely. Belladonna has been used and much praised as a remedy in this condition, but in my hands it has proved utterly useless. Brown's colpeurynter introduced into the vagina, and fully distended with hot water by means of Davidson's syringe, is, beyond doubt, the speediest and best means to produce relaxation of all the parts and hasten the labour. It is astonishing how rapidly the os will dilate by the means of this instrument. I have seen by its use in cases of eclampsia, apoplexy, hæmorrhage, etc., the os sufficiently dilated in a few hours to admit of the application of the forceps, and a rapid termination of the labour. My experience in cases of this kind has taught me its usefulness in normal labour. The colpeurynter may be emptied and re-filled every half hour until dilatation is effected.

There is a condition of the uterus which retards labour and gives rise to trouble. The os is dilated to some extent, but the fibres of the cervix above it contract, forming a rim or band. Barnes' hydrostatic bags can be used with great advantage to relax the contracted cervix and allow the descent of the head; but in ordinary cases of contraction I think the colpeurynter serves a better purpose.

The long forceps are frequently resorted to when the head remains for a length of time at the brim of the pelvis, but their application will seldom be necessary if the means I have indicated be cautiously and judiciously employed. I have not found it necessary to perform what is termed the high operation more than three or four times in a midwifery practice of more than thirty-seven years. In addition to the measures I have suggested at this stage the patient must be kept out of bed in a vertical position, and not suffered to bear down or make any muscular effort. There is no doubt that the erect posture is the best before the head descends into the lower strait. The conservation of the woman's

powers, too, at this period is of the greatest importance.

There is usually no danger to the life of the mother in the first stage of labour as long as the membranes remain intact, and, on this account, it may be argued that interference is not necessary; but this view I hold is both inhuman and unscientific. Inhuman because it condemns the woman to unnecessary suffering; and unscientific because it leaves agencies unused and powers unaided, which, if employed, would shorten a painful and vital process.

In what I term the second stage, that is when the head has descended into the pelvic cavity, there are two conditions of lingering labour. In the first, though the os may be pretty well dilated, the labour is retarded by the firmness, dryness and want of distensibility of the vagina. Free injections of hot water are useful at this time, and if the membranes be intact it is good practice to rupture them. When the vagina is extremely dry and hot, after the use of the hot water douche, the introduction of a large cotton tampon saturated with glycerine and lard serves a good purpose in softening and dilating the parts. I would add, that if inertia exists at this point, the administration of a drachm or two of the extract of ergot aids the other measures most effectively. But if the arrest of the head is due to occipital-posterior positions it is unsafe and unscientific to administer ergot—the forceps is the only alternative. In these instances there is very little amniotic fluid and no bag of waters is found, indeed I have seen many cases which might absolutely be termed dry labours. After the rupture of the membranes, if strong external compression be used and the os gently stimulated and stretched by the pulpy part of the finger, the pains will be prolonged, the voluntary powers of the woman excited and strengthened, and the labour progress to a speedy close.

The second lingering condition in this stage is when the head is very low down in the pelvis; the os dilated to the size of a half dollar, and found far back toward the sacrum, the head of the child being covered as with a cap by the thinned neck of the uterus. This is a most painful state, and calls loudly for assistance. The membranes, if not ruptured, must be punctured immediately, the os stretched and drawn forward toward the pubis, and strong external pressure used during each pain. Ergot is not generally necessary in this condition, but if the pains are ineffectual, its administration is most beneficial; the labour is accelerated; the woman's voluntary powers are evoked; pain follows pain, and the case has a rapid and happy termination. One of the most trying features in these cases is the intense pain in the region of the sacrum. This can be greatly alleviated by the application to the spine of an embrocation of chloroform and oil of peppermint.

The most powerful aid in all these cases is forcible external compression. A number of mechanical contrivances have been used to support the abdominal muscles, and secure regular and equal contractions of the uterus, but they are awkward and cumbrous, and do not at all compare in usefulness with the intelligent human hand.

The third and last stage of lingering labour is where the head has descended to the perinæum and owing to inertia of the uterus, or exhaustion of the woman's vital powers, or to the rigidity of the muscles of the perinæum, the labour is indefinitely arrested. Hamilton reports a case in which the perinæum was supported in this condition for one hundred and twelve hours. Ergot may be used at this point combined with external compression, but if delivery does not take place speedily the forceps should be applied. Beattie's straight Dublin forceps is the best, being light and easy of application. These are simple tractors and can do no possible harm. I have observed that if we fail in manipulations with the forceps the labour appears to be arrested and the woman's voluntary powers cease to act, consequently unless one feels convinced that the case will be terminated speedily by instrumental interference, it is better not to attempt it. I have frequently endeavoured to extricate the head by passing two fingers into the rectum, but have failed in this manœuvre for the reason that the force necessary to be employed is likely to injure the soft parts. The proper management of the perinæum is very important. I have been practicing for years a form of attenuation from the very moment that the head commences to impinge upon the outlet, and I believe that I have greatly assisted the efforts of the woman. If the head is still within the uterus at this point, it is good practice to make a sweep with the finger

and push the os over the occiput. I generally deliver the patient on the left side, as that position is better for the touch and use of the hand, but sometimes I have thought I found good results from placing the woman on her back and allowing her to have a few pains in that posture.

In conclusion, I would state that the great advantage of the procedures briefly suggested in this paper is, that should they fail, they do not interfere with the after-use of the forceps, but rather prepare the way for their easy application. Moreover, I hold that, if properly employed, they prevent those two *bêtes noirs* of modern obstetrical literature, lacerations of the os and perinæum. In addition to this, I believe that post-partum hæmorrhage, that worst complication of midwifery, may also be averted, for it is the weary, out-worked uterus that floods, not the fresh and vigorous organ.—*Am. Med. Ass. Jnl.*

Corrosive Sublimate in Midwifery Practice.—M. Tarnier has used a solution of bi-chloride of mercury as an antiseptic with great success (*Journal de Therap.*, February 15th, 1883; *Glasgow Medical Journal*, August, 1883). He requires every nurse and student, or any one who has to approach the patient to wash his hands in the solution. When the patient is taken into the hospital she has a bath, if it is found convenient. The whole of the genital region is then bathed in a 1:2000 solution and the vagina is thoroughly injected with the same; a compress soaked in the same solution is then placed over the parts. During labour the injection is renewed every three hours, and after delivery another injection is given and the parts sponged. If the labour is normal and everything goes on well the parts are simply sponged with 1:80 carbolic solution and covered with a compress soaked in the same. The sublimate solution is however used if any portion of the membranes remain in the uterus, if there is sloughing or if the lochia turn fœtid. The vaginal injection is given from five to six times a day. Of 350 women treated this way only one died. Under the influence of the sublimate solution the lochial discharge loses all trace of fetor in one or two days and the fever rapidly diminishes. No case of salivation was met with among the patients or attendants.—*Maryland Medical Journal.*

Dr. Montgomery concludes an article in the *Med. and Surg. Reporter* on the value of external examination and manipulation as a means of diagnosis in obstetrics as follows: Since the discovery of the pulsations and their varying frequency, it was seen that the greater rapidity was invariably associated with female children, and the contrary with male. Upon this Frankenfeld proclaimed the theory, in 1859, that the sex of the fœtus in utero could be foretold as soon as the pulsations were distinctly countable. In fifty cases he predicted the sex correctly in all; twenty-two being boys and twenty-eight girls. The average pulsation for the boys was 124; for the girls, 144. It has been found later, however, that the size of the child was much to do with the frequency of the pulse. My observations in the Philadelphia Hospital lead me to place great reliance upon the table formulated by Dr. Wilson, of Louisville, which is as follows: From 110 to 125, almost certainly male; from 125 to 130, probably male; from 130 to 134, doubtful; chances in favour of a male; from 134 to 138, doubtful; chances in favour of a female; from 138 to 143, probably female; from 143 to 170, almost certainly female. — *Weekly Medical Review.*

Dr. T. N. Bradfield, in the *New York Medical Journal*, reports a case of a young girl suffering from an immense hæmatocele, for whom hot vaginal injections were ordered to be continued for an hour, three or four times a day. After six weeks use numbness was complained of down the inner sides of the thighs, pain in the knees, and a constant tingling in the toes. These symptoms gradually increasing until a week later the power to stand or walk alone was completely lost. The injections were discontinued for eight or ten days, with some return of strength and other decided improvements, with a relapse, speedily following a renewal of injections. Dr. Emmet had not met with a similar case, and suggested as a probable cause pressure upon the pelvic vessels by the large tumour. But the woman had suffered for two years with this tumour, and symptoms of paralysis supervened only after the injections, and improved on their cessation.

M. Ferré reported the case of a young hysterical woman and a morphiomaniac, who

became pregnant, and in due time was delivered. The attempt was made to gradually reduce the dose of morphine, but each time the dose was lowered severe uterine colic came on, which prevented the discharge of the lochia. For 80 hours after birth the infant did not sleep, and even during pregnancy the child strangely resented the absence of morphine.—*Gaz. des Hôp.*

W. D. Babcock, in the *Am. Jnl. of Obstet.* recommends a pad of absorbent cotton placed around the umbilical cord in place of the nasty, greasy bits of rag usually employed. In his hands it has proved satisfactory.

THE
Canadian Practitioner,
(FORMERLY JOURNAL OF MEDICAL SCIENCE.)

To Correspondents.—*We shall be glad to receive from our friends everywhere, current medical news of general interest. Secretaries of County or Territorial Medical Associations will oblige by forwarding reports of the proceedings of their Associations.*

TORONTO, DECEMBER, 1883.

OUR PROVINCIAL UNIVERSITY AND ITS ENDOWMENT.

All members of the profession, and especially those who are graduates of Toronto University, must feel deeply interested in the discussion now going on with reference to that institution.

The position of matters (to speak briefly) is as follows. Our National University forms a part of our magnificent system of free education in Ontario. It is not governed by any one denomination or sect, but is free to all with no distinction as to creed, rank or wealth. At its inception it was nobly endowed and the results have been most gratifying. The evidences of the growth and success of the University and College are ample. The numbers of students have increased to such an extent that the authorities are now sadly perplexed in furnishing sufficient teaching, or even room for their large classes. In these rapidly advancing times the work is necessarily becoming much extended, especially in the Sciences. As the increased teaching required from the staff is largely of a practical character, the work lately has become enormously augmented, and it has been found necessary in consequence to appoint a number of Fellows to assist the Professors.

The Senate, after a careful consideration of the whole question last year, brought in a report recommending the establishment of several new chairs, the division of the work in some of the present departments, the erection of a new Examination Hall, and many additions to the equipments. These are actually necessary if the institution is to retain its condition of thorough efficiency.

Surely there can be no doubt in the minds of the public that, while this great Province is growing so rapidly and so substantially, the efficiency and usefulness of its National University must be maintained; and it requires no abstruse mathematical calculation to prove that a fund, which was amply sufficient twenty years ago, falls far short now, when during the interval the number of its students has increased threefold, and the work of its professors to a more than proportionate extent.

Where then is the required addition to the endowment to come from? Two sources are spoken of: first, the graduates, to whom some say an appeal should be made: second, the state, whose property it is and whose duty it is to maintain it properly. The alumni of Toronto University (as must necessarily be the case in every young country) are not a wealthy body and even if they were, could hardly be expected to endow an institution owned and controlled by the State. No one ever thinks of asking the ex-pupils of our Public or High Schools to contribute towards their support. The State should continue to support its own

University, and we are surprised that any opposition should be offered to such a course.

Many of the friends of the Rev. Principal Grant, of Queen's University, were considerably amazed and sadly disappointed at his recently expressed opinions on this question. The people of this Province had acquired the highest respect and esteem for this distinguished scholar not only on account of his great ability, but through reason of those broad and liberal views formerly enunciated on educational questions, which present so marked a contrast when compared with his recent utterances, in which he appeals to the selfish interests of certain classes, sects and localities. If he, and other worthy men, such as Dr. Nelles, Hon Mr. Allan, &c., are successful in their efforts to prevent giving any aid to Toronto University, the result will be to kill that Institution, while it adds no strength to the Denominational Universities. Such a retrograde movement would be sad in the extreme, and the dark wave thus set in motion would probably not stop until it reached and affected injuriously those excellent Sectarian Institutions of which these men are now the champions.

When we speak to the Medical Graduates of Toronto University we address a large and powerful constituency and we hope they will do all in their power to encourage our government to support properly, the great Copestone of our grand Educational system. To them we recommend for careful consideraton, the following sentence from the address of the Hon. Ed. Blake, Chancellor of Toronto University, recently delivered at the dinner of the Toronto School of Medicine, which we hope fully accords with the views of the great mass of the people in this province: "I will take leave to say that that institution, which has been and is being maintained at the public cost, and under the inspection rightly of the public eye, demands from friend and foe no more than this, that there shall be a vigilant inspection, and that there shall be also a hearty encouragement, and that whatever is essential to keep it in a condition of vigour and efficiency must be done by the province, so long as it maintains it at all."

THE TORONTO MEDICAL SCHOOL DINNERS.

The two dinners of the Toronto Schools given by the Students were probably the most successful medical banquets ever known in this city. As a pretty full report of the proceedings appeared in the daily papers, it is quite unnecessary for us to give minute details.

The Toronto School dinner took place in the Queen's Hotel, Nov. 13th. Among the guests who responded to toasts, were His Grace Archbishop Lynch, Hon. Ed. Blake, Rev. Dr. Sutherland, Rev. Prof. Clarke, His Worship the Mayor, Hon. Alex. McKenzie, Alderman Clarke, M.P.P., Rev. Dr. Castle, Mr. Bryant, (Galt Coll. Inst.), Dr. O'Reilly, Dr. Temple, Mr. Johnson, (Trinity Student), Mr. McInerney, (McGill Student), Mr. Herald, (Kingston Student), Mr. Mitchell, (London Student). Mr. J. W. Patterson, M.A., acted as Chairman, Mr. Bascom, 1st. Vice-Chairman, Mr. Hodgetts, 2nd. Vice-Chairman, Mr. Carr, Secretary. Dr. McFarlane, responded for the Faculty, Dr. Cuthbertson for the Graduates, Mr. McDonnell, for Graduating Class, Mr. Marty for the Ladies, Mr. Leeming for the Freshmen.

The Trinity dinner was also held at the Queen's, Nov. 22nd. Among the guests who spoke were His Honour the Lieut-Governor of Ontario, Rev. Prof. Clarke, Vice-Chancellor Mulock, Rev. Dr. Sutherland, Hon. Mr. Hardy, Hon. Mr. Anglin, Dr. Beaty, Q.C., Captain Geddes, Captain Baker, Dr. O'Reilly, Dr. Geo. Wright and others. Dr. Geikie, Dean, responded for the Faculty. Drs. Stark and Baines for the Graduates. Mr. Bingham was Chairman, Mr. Hoople, 1st. Vice-Chairman. Mr. Roberts 2nd. Vice-Chairman.

The numbers were unusually large at each, the speeches excellent, the songs very enjoyable, the catering exceptionally good, and nothing occurred at either to mar the pleasure of the guests, Professors or Students.

SANITARY GATHERINGS.

The meeting of the American Public Health Association took place in Detroit early in last month. The meeting was enthusiastic and successful, both as regards the amount and the character of the work done. The Canadian representatives were well received, and added not a little to the scientific success of the meeting. The courtesies extended to the Canadian representatives were heartily reciprocated by the Sanitary Congress assembled in London under the auspices of the Provincial Board of Health on November 16th. Valuable papers were read by prominent men on questions of vital interest; some local in their nature, others applicable, universally to the Dominion. The presence of ladies at the meeting in London is a harbinger of the more general interest excited in the minds of the people in regard to the laws of health and the systematic prevention of disease. We congratulate the Board of Health on the successful result of their Congress, and hope that it will soon be followed by other gatherings with equally successful terminations.

BRANTFORD CITY HOSPITAL.

Some time ago a meeting of the citizens of Brantford was held to take into consideration the erection of a City Hospital. A Committee was formed to make suitable inquiries, and were successful in obtaining a considerable amount in subscriptions towards that object. John H. Stratford, a wealthy and philanthropic citizen has offered to build an Hospital to cost $12,000, and when finished, to deed it over to the city. The conditions attached to this munificent offer, are that the Hospital shall be strictly non-sectarian; that it shall never be encumbered or mortgaged; that the Hospital affairs shall be managed by five Governors appointed by the Council of the City, the citizens and himself, or his heirs; and that for the present the name shall be "The Stratford Hospital." In addition to the building of the Hospital, he offers to provide $400 per annum to assist in its maintenance.

The public spirit and true philanthropy manifested in this offer are worthy of all commendation. The citizens will doubtless show their appreciation of this generosity by suitably equiping and maintaining the Institution, and prove to the world that Brantford has not one, but many citizens like Mr. Stratford.

It has always seemed to us, says the *Iowa State Medical Reporter*, that two of the branches taught in Medical Schools, and as a rule, first approached by Medical Students after matriculation, should be made entirely preliminary to the study of medicine proper. When Chemistry and Anatomy are mingled in teaching, with the practical branches, the student, however zealously he may labour at them, fails to possess the interest in them that he would, if he were by their study preparing himself to study the healing art. * * * But the student well or illy prepared has entered upon his course, and he will find that much is expected of him during the present and ensuing Courses of Lectures. He will find much to memorize, and we hope much to observe. Let him apply himself thoroughly to the fundamental branches, and study up each clinical case, he will be surprised to find how much of Pathology and Etiology will cluster around a single case, and how easy it is to remember the facts associated together, when they are brought into direct relation with a human being seeking relief from our art. * * * An institution peculiar to Medical Students is the 'quiz,' something between the cramming of academical schools, and a rehearsal; every student should join a

'quiz,' and should take every opportunity to 'quiz' and be 'quizzed.' Much trashy material will he thus handle, much that he memorizes will he have to forget, but he will acquire the habit of having his knowledge at instantaneous disposal, or as has been said, "get his brain well pigeon-holed and have the pigeon holes all labelled" and this will be of more importance to him as a physician than the temporary contents of those same pigeon holes.

During the past summer Mr. King, of the Toronto School of Medicine, while acting as Clinical Clerk for Dr. McFarlane in the hospital, received a pleasing and substantial token of gratitude from one of the patients. The patient referred to, who had a serious complication of diseases, did not remain long in the hospital, but removed to a private boarding house. While there Mr. King visited him twice a day, and carried out the treatment, which had been commenced in the hospital, and consisted chiefly in remedies to relieve his intense pain, especially hypodermic injections of morphine. The patient lived six weeks, and after his death it was found that he had left by will one thousand dollars for Mr. King, which amount was paid over last week.

The duties of the Medical Officer of Health for the city have been performed most satisfactorily by the present incumbent of that office. These duties have proved to be of a most laborious and exacting nature. That officer's time is so fully occupied by the incessant calls upon it that he is entirely precluded from all idea of the private practice of his profession. When the amount of labour involved is considered in connection with the annual salary conferred, it will be evident to every unprejudiced mind that the latter is utterly incommensurate with the former. Now that the time is approaching for the voice of the citizens to be heard, we hope that their sense of common justice will indicate the propriety of increasing the amount of the annual stipend attached to the office of their Health Officer.

University men are at present agitating the propriety of establishing a University Club in this city. Several preliminary meetings have been held, and others are in prospect. The idea appears to be feasible, and has many points to recommend it.

Six ladies have distinguished themselves as students in the South London College of Chemistry, where they have been studying with a view to passing the examinations of the Pharmaceutical Society. They intend to begin life as Druggists, and are amongst the first women who have been regularly trained at a public school for this end.

Ontario College of Pharmacy.—The opening meeting of the Alumni Association of the Ontario College of Pharmacy, for the winter term, took place on the evening of Nov. 13th. The attendance was large. Mr. E. A. Smith occupied the chair. A number of interesting papers were read and discussed.

MANITOBA MEDICAL COLLEGE.

This Medical College has been regularly established in Winnipeg. The introductory lecture was delivered by the Dean, Dr. Kerr, November 15th; and the regular work of the session commenced November 21st.

It is announced that the honour of Knighthood is about to be conferred upon a distinguished surgeon of Ottawa, as a mark of appreciation of his high professional attainments.

A Spiritual Visitor.—The *Virginia Medical Monthly* states that Sir John Rose MacCormack, has been passing the last few weeks in this country!

Meetings of Medical Societies.

TORONTO MEDICAL SOCIETY.

Regular meeting Oct. 25th, 1883.

The President, Dr. Graham, in the chair.

Drs. W. H. Aikins, Hearn and Pickering were proposed for, and Dr. Oliver admitted to membership.

Dr. Smith for Dr. Spencer presented patients—a family of four, all affected with a skin disease which had been diagnosed scabies and treated unsuccessfully with the Ung. Sulphuris. The President considered the diagnosis to lie between Pediculi, Molluscum Contagiosum, Impetigo Contagiosum and Scabies. It was probably the latter.

Dr. Cameron thought the affection was Scabies and suggested the cause of failure of treatment might be due to excessive strength of the ointment employed.

Dr. McPhedran presented two specimens of cancer of the uterus.

The pelvic viscera from a woman æt. 52, who died from uterine cancer. She was the mother of eight children. She had symptoms of the disease for two years but she was not seen till three months before death, when the cervix was found to be completely destroyed and the uterus fixed. About two months before death, the posterior wall of the bladder was perforated by the disease, after which, the urine dribbled away as secreted. This was however rather a comfort than otherwise as it gave relief to vesical irritability which for sometime previously had been a cause of much distress. The bowels acted naturally and without pain throughout.

On post-mortem examination the uterus was found destroyed slightly beyond the internal os. The upper part of the vagina and the whole of the posterior wall of the bladder including the orifices of the ureters were also destroyed. There was a good deal of infiltration around these parts, but the rectum was not implicated, nor were the ureters contracted by the deposit as in the case below. No history of cancer in the family.

The pelvic viscera, kidneys and ureters, from a woman aged 33½, who also died from cancer of the uterus. This woman had borne four children, the youngest four years ago. She had suffered from disease of the cervix, probably laceration, since the birth of her last child. During last winter, there was some ulceration of the cervix but its malignant nature was scarcely suspected. In May, when she first came under Dr. McPhedran's observation, the cancerous nature of the disease was unmistakable. The disease was confined to the cervix and amputation was therefore advised, but as immunity from return could not be promised the advice was not followed. No family history of cancer could be discovered. Nitric acid was applied at intervals with temporary benefit, though it always caused tenesmus. The fetor was lessened as much as possible by irrigating the vagina with a weak solution of carbolic acid, and the introduction of iodoform suppositories. To control moderate hemorrhages 2 or 3 oz. of saturated solution of alum, was thrown into the vagina and retained as well as possible in contact with the bleeding surface by elevating the hips. The severer hemorrhages were controlled by the application of nitric acid or liquor ferri subsulphatis. Vomiting, always more or less troublesome, became persistent towards the end, scarcely anything being retained during the last three or four weeks. Tenesmus caused great suffering for a few weeks before death. Occasionally an enema would bring away a small lump or two of fæces and relief would follow. Death took place from asthenia on October 18th.

Autopsy.—The body greatly emaciated and exsanguine. Many of the arteries were filled by decolourized fibrine. The transverse colon was V-shaped, the middle of it being behind the pubes but not adherent, nor was the great omentum, which was reduced in size in proportion to the great width of the transverse meso-colon. The stomach was vertically placed, the pyloric orifice being to the left of the middle line. The ureters and the pelves of the kidneys were dilated and filled with urine. The kidneys were very pale; the medullary part considerably atrophied. The body of the uterus was normal, but the cervix was completely destroyed. The bladder was healthy, but the disease had extended into the vesico-vaginal septum, and showed on the peritoneum between the uterus and vagina. Posteriorly the ulceration was more advanced, and had extended into the *cul-de-sac*. To this point a loop of the large bowel, formed of sigmoid flexure and rectum, and the apex of the vermiform appendix, which

was about six inches long, were adherent. These structures, as well as the tissues about the point of adhesion, were infiltrated with cancerous deposit. There was a good deal of infiltration on each side of the uterus; this pressed on the ureters, interfering with the flow of urine; hence their dilatation. The ovaries were also affected. Some of the sacral and lumbar glands were enlarged, but not much indurated. No secondary deposits were found in any of the other viscera.

The variety of carcinoma in these two cases is a matter of doubt which even the microscope may not settle. They may belong to the squamous epithelial, cylindrical epithelial, or medullary type. In thirty-four cases of amputation of the cervix for malignant disease Galabin says he found epithelial *nests* in five. In several others no nests were found, but the presence of large masses of cemented cells pointed to a probable origin from squamous epithelium. A few resembled in structure the cylindrical epithelial cancer, and evidences were found indicating that their origin was in the mucous glands. A small number of the thirty-four proved to be sarcomatous. (Diseases of Women. Galabin.) In the second case, the age, according to some authorities, would render medullary cancer improbable. The late Palfrey, of the London Hospital, saw only four cases of medullary cancer of the cervix in patients under forty years of age, and he confined the term epithelial cancer to the vegetating epithelioma or cauliflower excrescence, and gave the name medullary to all cases in which there were destruction of the cervix and infiltration of neighbouring tissues.

As to treatment, the first case was too far advanced when first seen for anything to be done but palliate the symptoms. In the second case, however, removal of the cervix and thorough cauterization of the stump by the galvanic cautery or with bromine, or zinc chloride, might have eradicated the disease; it would, at least, probably have mitigated its subsequent course.

At the last meeting of the British Medical Association, the treatment of uterine cancer was very fully discussed, and amputation of the cervix, when possible, followed by cauterization, was the plan very generally recommended. Many cases were reported in which such treatment was followed by immunity for several years.

Dr. McPhedran also presented the larynx of a boy, with the history of the case. (Will be published.)

Dr. Oldright in such cases recommended the administration of emetics and the inhalation of steam.

Dr. Holmes spoke in favour of turpeth mineral. Fordyce Barker considers it perfectly safe and efficient.

Dr. Cameron had used turpeth mineral without producing emesis; fatal purgation, however, resulted, He thought that in cases like that under discussion the larynx should be opened and artificial respiration tried, even ten or fifteen minutes after apparent death.

Dr. McPhedran stated that in August, 1882, J. H., an infant æt. 5 months, was brought to me for advice, on account of a croupy cough, which was growing worse. Though small the child was well nourished. It was directed to be kept in a warm room, in which steam was generated, and a sedative mixture ordered. Two powders of turpeth mineral, 3 grs. each, were also given to be used only if the dyspnœa at any time became severe. That evening, though the symptoms were not severe, one of the powders was given, only part of it was swallowed, the rest finding its way out of the mouth with the saliva. Very shortly there were symptoms of distress, and vain attempts at vomiting. As no vomiting occurred in fifteen minutes, the other powder was given with the effect of making matters worse. The child was seen a few minutes afterwards, and was found in much distress, and making fruitless attempts to vomit. The tongue was slightly whitened, and the throat filled with mucus. The bowels shortly began to move, the first motion being dark yellow, the subsequent ones consisted of white, lumpy mucus and water, with occasionally yellow particles. The discharge soon became almost continuous. Nothing could be swallowed, and enemas could not be retained. The pain and efforts at vomiting became paroxysmal, and grew less and less frequent. Death took place in twelve hours.

A few weeks before medicine from the same bottle was given to a child under two years old, suffering from diphtheritic laryngitis. It produced prompt, easy, and full emesis, without depression, and a similar effect was confidently expected in this case.

Dr. Sweetnam presented a tumour re-

moved from the abdomen of a woman; it was situated over the pubic symphysis.

Dr. Cameron presented interesting pathological specimens, and outlined their histories.

The meeting then adjourned.

TRINITY MEDICAL SCHOOL LITERARY AND SCIENTIFIC SOCIETY.

Inaugural Meeting, Nov. 10th., 1883.

The commodious theatre of the school was well filled by students and their friends, male and female.

The proceedings were opened by the introduction, in a neat little speech by M. McCullough, of the President, Dr. Sheard.

In replying to the introduction the President in a few well chosen words gave his opinion of medical students, a class of men who are not incapable of heroic, though unobtrusive self-sacrifice; a class to which he was proud to say he still belonged. When the position of President of this new society was proffered, his first thought was to refuse the honour because of his already numerous and burdensome responsibilities. But when he considered that it was a society of students and for students, he determined to accept the offer and show his appreciation of it by aiding the investigations and furthering the interests of the medical students not only of this school, but of Canada.

A programme had been prepared and was faithfully carried out, and included songs by individual students as well as college songs and choruses.

The President chose as the subject of his inaugural address the Science of Medicine and its Advance. He traced the history of medicine from its early Grecian home through the centuries to the present time, showing how it had steadily advanced to truth, through errors, and concluded a very interesting address by an eloquent and touching reference to the latest martyr to science, the death of the youthful Thuillier on the sandy plains of cholera-stricken Egypt.

Dr. Graham, the President of the Toronto School of Medicine Medical Society, who was present being called upon expressed the pleasure he felt upon being present and congratulated the students upon the cordial feelings of friendship that existed between the students of the two schools as well as between their professors. He looked upon Toronto as the great medical centre of the future and saw no reason why there should not in a short time be 800 or 900 students or even more receiving their professional education in the city. He pointed with just pride to our magnificent hospital, whose governing authorities showed every disposition to carry out the desires of the teachers, and facilitate and increase the clinical resources of the institution. The very rivalry which existed between the schools he looked upon as beneficial being an incentive to more thorough instruction. The inauguration of these societies in connection with the schools he regarded as an evidence of the desire on the part of the students to aid the efforts of their teachers and to supplement their endeavours by further study.

Dr. Burns, the territorial representative to the Medical Council, said that he was present there to-night as the representative of the profession at large, they could not all be teachers. In regard to the Council he said, that although at times exception had been taken to the examiners appointed, yet it had always been their endeavour to procure impartial though strict examiners. He hoped that if they could rid themselves of the present incubus of a building which they now possessed, that a commodious hall would be built in a central portion of the city, which would be suitable for such meetings as the present and for the accommodation of the other Medical Societies, which occasionally honoured Toronto with their presence.

Dr. O'Reilly, the superintendent of the General Hospital, was received with prolonged and voiciferous cheering. He stated that he had been invited to be present as a spectator, and was therefore not prepared with any subject of interest to the students. He referred to the large number of students now attending the Hospital and expressed his determination to carry out in the future, as he had endeavoured in the past, every improvement that would redound to the comfort, convenience, and the instruction of the students. He hoped for his own personal comfort that he would not be troubled with many more enthusiasts on the Hospital staff like Drs. Graham and Sheard. His carpenter had no rest. At present he was engaged in fitting up a new Pathological lecture room. He was pleased to see so

many freshmen this year and hoped soon to be better acquainted with them.

After singing the National Anthem the meeting adjourned.

HAMILTON MEDICAL AND SURGICAL SOCIETY.

The regular monthly meeting of the Hamilton Medical and Surgical Society was held on the 20th instant in the Royal Hotel. Dr. Leslie, President, in the chair, with the following members present :—Drs. Macdonald, Mullin, McCargow, Case, F. Woolverton, A. Woolverton, Lafferty, Malloch, Philp, Reynolds, and Robinson.

The minutes of last meeting were read and confirmed.

Dr. F. Woolverton, resident physician of the Hamilton General Hospital, presented the following pathological specimens :—The femoral and popliteal arteries, with an embolus extending from below the origin of the profunda to the middle of the popliteal space. The patient was admitted into the hospital under the care of Dr. Mullin, with a small ulcer and necrosis of the last phalanx of the great toe, which was thought to have been caused by frost-bite. Subsequently the toe became gangrenous. and the disease extended upwards, involving the foot and lower part of the leg. There was also gangrene of the integument over the patella. The general condition of the patient did not favour amputating, death occurring through asthenia. Dr. Woolverton also presented an aneurism of the abdominal aorta. The patient had been in the hospital for several months under the care of Dr. Geo. L. Mackelcan.

Dr. Malloch gave the history of a case occurring in his practice. Mrs. P., æt. 35, supposed to be three months pregnant, suffered from severe vomiting.

A similar illness had occurred in a previous pregnancy, which was controlled by rest and the usual remedies. In the present case the vomiting was persistent, and the patient's condition becoming alarming it was resolved to produce a miscarriage. In the early part of September, a sound was introduced, and sea tangle tents used. The uterine action however did not expel the contents, but as the irritation of the stomach ceased further interference was suspended. On a return of the symptoms in the early part of this month, the os was dilated with sea tangle tents, so that the finger could be introduced. The patient being chloroformed the uterus was emptied of a small lump of degenerated placenta, which was produced for inspection by members.

Dr. Mullin, gave an interesting account of his visit to Boston, at the celebration of the Centennial of Harvard Medical School. (See page 367.)

Dr. Malloch, spoke approvingly of the course of Medical study in Harvard, and pointed to the similarity to that pursued in the schools of Edinburgh and Glasgow.

Dr. Macdonald, stated that he regretted that the system of yearly examinations had not been continued by the Council of the College of Physicians and Surgeons Ontario, and referred to certain difficulties in the way. He thought it would be of great advantage to students if they gave special attention to Anatomy, Physiology, and Chemistry in the first two years of their studies, and afterwards devoted themselves to the more practical branches of Medical study. The Society then adjourned.

Book Notices.

Delayed and Non-Union of Fractures. By N. Senn, M.D., Milwaukee, Wis. (Reprint from *Weekly Medical Review.*)

Infusion of Jequirity or Licorice Bean in Inveterate Pannus. By Edward S. Peck, M.D. (Reprint from the *Medical Record.*)

Weekly Health Map and Meteorological Record. Issued by Provincial Board of Health, Ontario, P. H. Bryce, M.A., M.D., Secretary.

Report of Proceedings of the Illinois State Board of Health. Quarterly Meeting, Chicago, October 18, 19, 1883, John H. Rauch, M.D., Sec.

The Antipyretic Treatment of Typhoid Fever. By G. C. Smythe, A.M., M.D., Greencastle, Ind. (Reprint from *Cincinnati Lancet and Clinic.*)

Quarterly Retrospect of Surgery. By Francis J. Shepherd, M.D., C.M., M.R.C.S., Eng. (Reprint from *Canada Medical and Surgical Journal.*)

Weekly Bulletins of Health in Michigan, Meteorological Reports October and November, together with Monthly Mortuary Statis-

ties of City of Lansing, for October. H. B. Baker, M.D., Sec. State Board of Health.

A Case of Severe Purulent Inflammation of the Middle Ear with Restoration of the Drumhead. Consecutive Dentalgia without Caries. By Edward S. Peck, M.A., M.D. (Reprint from *The Independent Practitioner.*)

An Examination of Some Controverted Points of the Physiology of Voice, especially the Registers of the Singing Voice and the Falsetto. By T. Wesley Mills, A.M., M.D., L.R.C.P., London. (Read before the *American Association for Advancement of Science,* and reprinted from *Journal of Physiology,* Vol. IV., No. 2.)

Transactions of the Saint Louis Obstetrical and Gynæcological Society, 1882-83. (Reprint from the *St. Louis Courier of Medicine.*

The papers here presented are all of high merit. The interest excited by their perusal is excelled only by that afforded by the perusal of the discussions upon them. We know of no Society Reports in which the discussions display so great and so varied a fund of information, nor which bring the speakers in such close personal relation with the readers.

The Treatment of Wounds; Its Principles and Practice—General and Special. By Lewis S. Pilcher, A.M., M.D. New York: Wm. Wood & Co., 1883.

This constitutes the August number of Wood's Library of Standard Medical Authors. It will prove one of the most interesting, as it is one of the best of the Series. The name of the distinguished author gives a guarantee that the antiseptic treatment of wounds will be ably advocated, and that all the subjects of which he treats will be handled carefully, judiciously, and scientifically. We can heartily recommend the work to all who expect ever to meet with a wound, and who desire to treat it *secundum artem.*

The Roller Bandage. By Wm. Barton Hopkins, M.D., with Seventy-Three Illustrations. Philadelphia: J. B. Lippincott & Co.

This is a very good little book of 90 pages, designed to inculcate the art of bandaging by illustration rather than by precept, and evidently by an adept both in bandaging and teaching. The drawings are made from photographs of bandages applied to the living model. It is rather curious that the convenient method of rolling the bandage over the inclined thigh with the palm of the hand receives no notice. Comment on the publishers' work is quite unnecessary.

Physician's Visiting List (Lindsay & Blakiston) for 1884. Philadelphia: P. Blakiston, Son & Co., 1012 Walnut Street.

This well-known List is again to the fore. It is only necessary to say that this is its Thirty-third annual appearance; that it presents its old features of excellence, and in addition revised Posological Tables, a List of New Remedies, Sylvester's Method of Artificial Respiration, illustrated, and a Diagram of the Chest.

What to do First in Accidents and Emergencies. A Manual Explaining the Treatment of Surgical and Other Injuries in the Absence of the Physician. By Charles W. Dulles, M.D. Second Edition, Revised and Enlarged, with New Illustrations. Philadelphia: P. Blakiston, Son & Co., 1883.

This is an excellent little manual of domestic Medicine and Surgery, conveying within 100 pages and in clear and intelligent terms, brief directions for the management of cases in emergencies or until skilled services can be obtained. The work is calculated to be of great service to unfortunates in securing for them rational prompt attention, and saving them from ignorant meddlesome interference at the hands of bystanders.

A Manual of Pathology. By Joseph Coats, M.D., Lecturer on Pathology in the Western Infirmary, Glasgow, etc. Philadelphia: Henry C. Lea's, Son & Co.; Toronto: Hart & Co.

We are very much pleased with this book, which for General Practitioners and Students, comes nearer to our idea of perfection than any we know on this subject, within the same dimensions. The author includes both Pathological Anatomy and General Pathology, and the work is more comprehensive on that account. The style is exceedingly good, being plain, concise, and practical, without being like a dictionary. We regret that some of the plates are not what we would like to see, but otherwise the Publishers have done their work well. We have pleasure in recommending it to students, as we think it especially well adapted for their use.

Quiz Compends: Materia Medica and Therapeutics. By J. O. L. Potter, A.M., M.D., and *Surgery.* By Orville Howitz, B.S., M.D., with Fifty Illustrations, 1883. Philadelphia: P. Blakiston, Son & Co., 1012 Walnut Street.

These numbers, 6 and 9, of the Quiz Series, are excellent little compilations from the standard authorities on the subjects, and owing to their very convenient shape and size, constitute admirable *Vade Mecums* and Remembrancers for students. That on Materia Medica is issued in the form of Question and Answer.

Elements of Histology. By E. Klein, M.D., F.R.S., Joint Lecturer on Anatomy and Physiology, St. Bartholomew's Hospital, London. Philadelphia: Henry Lea's, Son & Co.

This little Manual of Histology is published especially for the use of Medical Students. To those who are anxious to have a great deal within a little space, it will be very acceptable.

Transactions of the Medical and Chirurgical Faculty of the State of Maryland. Eighty-fifth annual session 1883.

The Medical and Chirurgical Faculty of Maryland, in the present volume of their transactions preserve their reputation for learning and science as well as the practical application of these to the exigencies of our profession. Time and space will not allow us to make more than a passing mention of the contents of this volume. After the record of the minutes and the reports of the various committees, appears the address of Dr. W. M. Kemp, the President. Dr. John S. Billings, delivered the annual address choosing as his subject Medical Bibliography. Then came the reports of the various sections: Surgery, Dr. Coskery; Medicine, Dr. Thomas; Obstetrics and Gynæcology, an excellent paper by Dr. W. T. Howard; Materia Medica, etc. Amongst the invited papers special mention must be made of H. Newell Martin's, on "The Direct Action of Ethyl Alcohol upon the Heart." Amongst the volunteer papers an account of Liernur's Pneumatic System of Sewerage, by Dr. C. W. Chancellor, is of interest.

Types of Insanity an Illustrated Guide in the Physical Diagnosis of Mental Disease. By Allan McLane Hamilton, M.D., New York: Wm. Wood & Co.

The forcible and accurate description of the insane patient, is drawn with the facile pen and in the singularly lucid style of the well known author; and without the aid of the accompanying plates would be sufficient to cause the veriest tyro in psychological medicine to recognize the type indicated. The book made up in a very neat style, contains thirty-six large pages of letter press consisting of five chapters. Chap. I. Treating of the General Appearance of the Insane. Chap. II. Condition of Special Organs. Chap. III. Bodily Functions. Chap. IV. Examination of Patient. Chap. V. The Commitment of the Insane.

The plates accompanying the volume are drawn from instantaneous photographs by T. J. Manley, and are specimens of high artistic merit, They are ten in number as follows: Plate I. Idiocy. Plate II. Imbecility. Plate III. Melancholia Attonita. Plate IV. Chronic Melancholia. Plate V. Sub-acute Mania. Plate VI. Chronic Mania. Plates VII. and VIII. Dementia. Plate IX. General Paresis. Plate X. Affections of the Ear and Conditions of the Teeth in the Insane.

As is to be expected neither the camera nor the pencil can give a picture of certain forms of insanity that will be distinctive and recognisable. Such forms for instance as depend upon disorders of motility. Plate IX. pretends to represent a case of general paresis and we have no doubt the original suffered from that form of insanity, but his counterfeit presentment suggests to our mind no suspicion of insanity.

How to Draw a Simple Will with Special Information for Clergyman and Doctors and Instructions for Executors in Ordinary Cases. By D. A. O'Sullivan, M.A., LL.B., Toronto: Carswell & Co.

We entirely agree with the learned author of this *brochure* "that an unskilled person should invariably refuse" to draw up a will unless in case of necessity. It has happened to us on more than one occasion that this necessity has arisen, and our ignorance painfully impressing us, we determined in future to prevent the recurrence of such feelings by looking up the subject, and learning how to draw a will. Fortified by this laudable resolution we proceeded until a second occasion caught us in the same condition of unpardonable ignorance. Such a sense of humiliation will henceforward be impossible. Mr. O'Sullivan has prevented that. The

principle inculcated by the author in drawing up a will, and which in our attempts we carried out, is to express simply and informally the wishes of the testator. The *brochure* contains nine short chapters and two appendices pertaining to Medico-Legal matters and the Witness Box. The whole is as entirely free from "the unknown jargon of the Law" as is compatible with a due exposition of the requisite procedure. In a city like Toronto where the limbs of the law are as numerous as the lights of medicine, a case of necessity is not so likely to arise as in the country where hours may elapse before a lawyer could be obtained and a life may pass away leaving wealth and property to become the starting point of litigation and contention leading to heart burnings and the disruption of families. And all this for lack of a little knowledge of an important subject.

The Medical Student's Manual of Chemistry. By A. A. Witthaus, A.M., M.D. New York: Wm. Wood & Co., 1883.

This Manual of Chemistry is intended to meet the peculiar needs of the Medical student. The author proposes to accomplish this by suppressing, as much as possible, the merely technological portions, and giving prominence to the chemical relations of Physiology, Hygiene, Therapeutics and Toxicology. An arrangement of the matter has been adopted, which, however scientific and logical, has not been in general use, and we humbly submit that for a Medical student, with his peculiar needs, to be so suddenly plunged into the beautiful but confusing maze of the Carbon Compounds, will be calculated to dishearten if not totally to discourage him from the arduous task of attempting to comprehend the subject. Another departure from the ordinary text-book is in the Classification of the Elements. He abandons the classification instituted by Berzelius into Metals and Metalloids, from their physical properties, and substitutes a division into groups, formed upon the basis of similar chemical properties. He then forms three classes from the behaviour of the oxides of the Elements in the presence of water. A first class is formed of Oxygen and Hydrogen, which he calls *Typical Elements.* These classes are further sub-divided into groups. This classification, while ingenious and scientific, will, unless generally adopted, be apt to be confusing to the student, especially when he enters the Examination Hall.

The matter of the book is all that can be desired. Much is therein contained that will be of practical importance to the family physician in the investigation of the sanitary aspects of the surroundings of his patients, whose opportunities, and whose purse, do not permit a more thorough and close analysis. The book closes with a short sketch of Laboratory Technics, Tables, etc., and a copious index. The whole work is neat in appearance, and handy in size. The paper and typography are excellent, and the cuts possess an air of novelty.

The International Encyclopædia of Surgery. A Systematic Treatise on the Theory and Practice of Surgery by Authors of Various Nations: Edited by John Ashurst, Jr., M.D. In six volumes. Vol. III. New York: William Wood & Co.; Toronto: Willing & Williamson.

The third volume of this excellent work has just been issued. It contains contributions from two London surgeons; Mr. Edward Bellamy, of King's College, who writes the article on "Injuries and Surgical Diseases of the Lymphatics," and Mr. Richard Barwell, of Charing Cross, who writes on "Aneurism;" one Paris surgeon, Dr. Nicaise, who writes on "Injuries and Diseases of Nerves": four American physicians, Drs. Liddell, Andrews, Conner, and Wyeth, who write on "Injuries of Blood-vessels," "Injuries of Joints," "Injuries of the Muscles, Tendons, and Fascia," and "Surgical Diseases of the Vascular System," respectively.

The article on "Injuries of Blood-vessels" is the largest in the volume. The author, who had a large experience in the American Civil War, considers hæmorrhage as the most serious complication of wounds, and gives very minute instructions as to its prevention and treatment. He also gives a very large number of illustrative examples, which increases materially the value of the article. Mr. Barwell's article on "Aneurism" is a very able one as might be expected. In treatment he favours Valsalva's method, but depends mostly on compression and deligation. He considers Iodide of Potassium as worse than useless in the majority of cases. The papers on "Injuries of Joints" is not so complete as one would expect to see in such a work, but is very

good. Prominence is given to Prof. Bigelow's contributions on the mechanism of luxations of the hip and his methods of treatment. Kelly's methods of treating dislocations of the shoulder, elbow, and hip, are not mentioned. Other items such as various hints on diagnosis are omitted, though we should have them. Great importance is attached to an old fashioned contrivance called Jarvis' Adjustor, but the author adds the rather discouraging information that it cannot now be procured.

The remaining articles, which are named above, are quite up to the mark, and the volume as a whole is very creditable to its authors.

Excision of the Knee-joint, With Report of Twenty-eight Cases. Illustrated by Thirteen Photographs and Wood Engravings. By G. E. Fenwick, M.D., C.M., Prof. of Surgery, McGill University. Montreal: Dawson Bros., 1883. Price, $2.25.

We welcome this little *brochure* not only as a meritorious contribution to the subject of which it treats, but especially as the work of a Canadian Surgeon. Our countrymen are very diffident about appearing in print; and we are glad that one of Dr. Fenwick's undoubted competence and ability should present this encouraging and successful example. The seventy pages of which the book is composed, are divided into two sections; the former embracing a discussion and description of the operation, the latter, a record of cases. Dr. Fenwick's special method of dealing with the bone, and which has certainly proved eminently successful in his hands, is to apply the saw to the femur from before backwards in such a way as to produce a smooth and uniformly convex surface, destined to be received into a concavity in the head of the tibia, analogously made, but the sections being carried from behind forwards.

A table of twenty-eight cases of ex-section of knee, performed in the Montreal General Hospital in the last eighteen years, is appended. This shows twenty-four cases, one death from pyæmia, two subsequently submitted to amputation, and one doubtful case. Shortening varied from half to four and a half inches. Patients' stay in bed varied from 28 to 212 days.

Chemistry: General, Medical, and Pharmaceutical, including the Chemistry of the U. S. Pharmacopœia. A Manual on the General principles of the Science and their Applications in Medicine and Pharmacy. By John Attfield, F. R. S., etc. Tenth Edition specially revised by the author for America. 1883: Henry C. Lea's Son & Co., Philadelphia.

The rapidity with which the numerous editions of this excellent manual have succeeded each other is a proof that the work has met the wants it was expected to fill. To this, the latest edition, we can add nothing to the remarks made on the last occasion on which we had the pleasure of looking over its contents. It is the Book for Medical Students of Chemistry. No other manual in our opinion, approaches it in clearness of diction, lucidity of statement and comprehensive grasp of the subject matter. It cannot fail to be a source of sincere gratification to the author to feel that he has so successfully catered to the needs of that limited public which are generally so difficult to meet satisfactorily.

Miscellaneous.

VASELINE.—Vaseline is very largely used both by the profession and the public. It is generally considered very bland and unirritating. It is well however to know that it has been frequently found very irritating, producing an eczematous eruption in some cases very obstinate in its character. At a meeting of the Cincinnati Medical Society recently held, this occasional unpleasant effect of the remedy was referred to by many of the members and Dr. Wilfert said the Vaseline used at present is not the same preparation that was formerly employed. It is frequently found to be acid. When there is any tendency to eczema caution should be observed in its use.

FROM *New Remedies* we learn that knowing manufacturers of pepsine heartlessly take advantage of the well-known sympathy between the mouth and stomach, and by placing before the doomed hog a trough of mush covered with wire netting, make his mouth water, and thus excite a sympathetic flow of gastric juice in his stomach. While thus engaged in pleasurable but fruitless anticipation, the fatal blow is struck, and it is said that the yield of pepsine from the stomach is not only greater in quantity but superior in quality to that obtained under ordinary circumstances.—*Can. Phar. Jnl.*

THE EXPERIMENT AND THE PRINCIPLE.—Dr. Holmes in his recent Harvard address relates the following anecdote about the first Professor of Chemistry. "This experiment, gentlemen," he is represented as saying, "is one of remarkable brilliancy. As I touch the powder you see before me with a drop of this fluid, it bursts into a sudden and brilliant flame," which it most emphatically does *not* do as he makes the contact. "Gentlemen," he says with a serene smile, "the experiment has failed; but the principle, gentlemen, the principle remains firm as the everlasting hills."

Personal.

CHAS. WM. SIEMENS, died in London, æt. 63, on the 20th of November.

H. BENCE JONES, M. D., was accidentally shot in the ankle. The leg had to be amputated, and death resulted.

DR. FRANK KRAUSS has been appointed Examiner in German and French at the University of Trinity College.

PARKDALE Board of Health have appointed Major Gray Chairman, C. F. Mansell, Sec., and G. G. Rowe, M.D., Health Officer.

Dr. McGill, of Oshawa, died Nov. 9th. He was one of the best known and highly respected among our Canadian Physicians. He was prominent in Political as well as Medical matters.

JAMES SHUTER, Assistant Surgeon to St. Bartholomew's, died suddenly on November 1st. Death was supposed to be due to an overdose of morphine, hypodermically administered by himself to relieve the pain of an attack of sciatica, accompanied with an acute nephritis.

THE following gentlemen were admitted Licentiates of the Royal College of Physicians, London, on October 25th:—J. C. Bowser, M. D., McGill; Geo. Carruthers, M. D., McGill; F. J. Dolsen, M.B., E. M. Hoople, M.B., J. E. Jenner, M.B., and L. Backus, M.B., all of Toronto.

J. M. DEPAUL, the pupil and successor of Paul Dubois, died October 22nd at the age of 72. He was one of the founders of the Biological Society. He took a lively interest in politics. He published a number of works. His perseverance is evidenced by the numerous *concours* he passed in order to become a Hospital Surgeon at the age of 42, although he had never directed as titular a large surgical service.

THE friends of Dr. L. M. Sweetnam, of this city, will be pained to hear of the accident which befel him. While driving on College street the wheel of his buggy broke, and the horse ran away. Dr. Sweetnam threw himself from the vehicle, and dislocated his right shoulder. We are glad to be able to state that his injuries, though painful, are not of a serious nature. He is progressing favourably.

J. MARION SIMS, M.D., was born in 1813, in South Carolina. He graduated in medicine at the South Carolina Medical College in 1832, and Jefferson College in 1835. He settled in Montgomery, Alabama. It was there that he began that course of study, in which in after years he achieved such brilliant triumphs. With a private hospital of sixteen beds, maintained at his personal expense, and occupied chiefly by slave girls, he pursued the study of vesico-vaginal fistulæ, with "energy, endurance and enthusiasm." In 1853 he removed to New York, where he founded the Woman's Hospital. In 1861 he visited Europe, and introduced his methods of operation. He was well received, and formed numerous and powerful friends. He was invested with many honourable decorations, and was enrolled amongst the members of many of the prominent medical societies. He was President of the American Medical Association in 1875. In 1880 he suffered from a severe attack of pneumonia, from the effects of which he never entirely recovered. On the morning of the 13th of November, his death took place suddenly and unexpectedly, as the autopsy shewed from obstruction of the circulation from degeneration of the muscular fibres of the coronary arteries.

Married.

BURNHAM—SMITH—On Wednesday, 14th ult., at "Hamilton House," Cobourg, the residence of the bride's father, by Rev. Canon Stennett, M.A., Dr. George Herbert Burnham, Toronto, son of the late Dr. Burnham, Peterboro', to Frances Sarah, only daughter of the Hon. Sidney Smith, Q.C., formerly Postmaster-General of Canada.

Deaths.

MAINWARING—On the 18th inst., N. E. Mainwaring, M.D., St. George. aged 70 years.

ROGERS—At Mount Forest, on November 6th, Dr. S. R. Rogers, in the 26th year of his age.

McGILL—In Oshawa, on November 9th, Dr. William McGill, Ex-M.P., in the 77th year of his age.

DELAHAYE—At Winnipeg, on the 20th of November, Dr. DeLaHaye, late of Toronto, aged 40 years.