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CANADA  
MEDICAL & SURGICAL JOURNAL

MAY, 1878.

Original Communications.

REMARKS ON KERATOTOMY.

BY FRANK BULLER, M.D., M.R.C.S., ENG.

OCCULIST AND AURIST TO THE MONTREAL GENERAL HOSPITAL, LECTURER ON  
THE DISEASES OF THE EYE AND EAR, MCGILL UNIVERSITY.

(Read before the Medico-chirurgical Society, of Montreal, March 22, 1878.)

It has long been known to those who are familiar with the treatment of the diseases of the eye, that many ulcers of the cornea continue to enlarge until perforation of that membrane takes place, that the destructive process then comes to a standstill, and from this time forth nature proceeds to repair as far as possible the damage which the eye has sustained. Under such circumstances, however, it is not uncommon to find that the amount of destruction has been so great as to render anything like a *restitutio ad integrum* an impossibility, indeed many eyes are thereby rendered useless for visual purposes; others again can perhaps be restored to some degree of usefulness by subsequent operations, whilst the best of them are almost certain to remain more or less permanently blemished. The importance, therefore, of preventing such an issue by an early arrest of the disease, is one which cannot be too highly estimated, and it is with this that we shall have to deal this evening.

About the year 1870, Professor Sæmisch of Bonn, described

a certain form of ulceration of the cornea as "Ulcus serpens," and recommended the operation of Keratotomy as the best means of arresting it, if a fair trial of simpler means fail to do so.

The chief characteristics of the "Ulcus serpens" are, according to Sæmisch, as follows: Somewhere near the centre of the cornea, a round or oval loss of substance occurs, giving rise to a greyish opacity at this part. At some portion of the circumference of this defect the margin is more or less swollen and of a yellowish colour. This appearance will sometimes correspond to half the circumference of the ulcer which is moreover always deepest at this part. Beyond the ulcer, but in the immediate neighbourhood of its swollen edge, the cornea is for a short distance somewhat turbid, and traversed by opaque striæ running obliquely through its substance, beyond these again it is entirely normal in appearance. The ulcer tends to spread more or less rapidly in the direction of the opaque striæ, both in depth and circumference. From the posterior surface of the cornea a gelatinous-looking, turbid mass may be seen extending back towards the pupil and iris; often the anterior chamber will be found to contain a purulent deposit or hypopyon, just as in other forms of purulent keratitis. Iritis almost always occurs before the disease of the cornea has made much progress. The subjective symptoms, such as pain and intolerance of light, vary considerably in different individuals without any obvious reasons for such variation. The disease almost always attacks elderly people, especially those who are in a feeble state of health, and it may generally be traced to some slight injury which the cornea has sustained. One of the predisposing causes of this form of ulceration seems to be the existence of chronic catarrhal inflammation of the conjunctiva, such as obtains in old cases of dacryocystitic blenorrhœa.

The treatment recommended by Sæmisch for this form of keratitis depends upon the extent of the disease and the rapidity of its progress; and I may say here that my own experience has convinced me that his views are entirely correct.

At first when the ulcer is small, say not more than two or three millimeters in its longest diameter, even when there is

hypopyon, the use of atropine will sometimes suffice to check its progress and initiate the healing process. This treatment may be rendered still more effective by the use of fomentations continued for 15 or 20 minutes, several times daily, and a compressive bandage. The latter is contra-indicated by the existence of blenorrhœa of the lachrymal sac, or when there is much catarrhal secretion of the conjunctiva. If a fair trial of these remedies does not arrest the ulceration in the course of two or three days, or if the ulceration exceeds the limits mentioned when first seen, operative interference is generally called for.

Several different operations have been found to answer the purpose, and a comparison of their individual merits might be both interesting and instructive. I shall, however, only describe one of them, that is the operation of keratotomy.

Supposing we have to deal with an "Ulcus serpens," situated at or near the centre of the right cornea, and spreading towards the median line, or nasalwards. The operation would be performed in this way: The patient lies upon his back on a suitable couch or table, and, if necessary, chloroform may be administered, though an anæsthetic is not usually necessary. The lids are to be held apart by means of a stop speculum, and the eye-ball fixed by firmly grasping the conjunctiva and sub-conjunctival tissue with a fixing forceps held in the left hand and applied a short distance beyond the inner margin of the cornea. The surgeon now taking a narrow-bladed cataract knife in his right hand, causes it to penetrate the cornea a short distance to the temporal side of the ulcer; the puncture being made in a direction nearly perpendicular to the surface of the cornea. The handle of the knife is now to be depressed till the back of the blade is parallel with the plane of the iris, then the knife is pushed onwards till its point is seen to be beyond the inner edge of the ulcer; at this point the counter puncture is made, and the incision slowly completed.

Care is to be taken that both puncture and counter-puncture are made through healthy corneal tissue. The incision must as nearly as possible divide the swollen edge of the ulcer into two equal halves, hence its direction must be made to vary according to the direction in which the ulcer is extending, care must also be

taken not to wound the lens, and a sudden escape of the aqueous humour is to be avoided by gentleness of manipulation.

The contents of the anterior chamber soon after their escape coagulate in the conjunctival sac, and form a yellowish gelatinous, stringy mass. This is to be cleared away, and a drop of atropine solution instilled, and a light compress bandage applied, unless there be blenorrhoea of the lachrymal sac, in which case careful and repeated cleansing of the eye is all that is advisable. The effect of the operation is salutary from the very outset, often in a few minutes all pain will have ceased, and the patient will obtain a good night's sleep, the first perhaps that he has had for a long time. The next day the wound will generally have healed, or at least its edges will be sufficiently adherent to retain the aqueous humour, but in addition to the cessation of pain and lessened irritability of the eye, the ulcer itself will often already show changes for the better, the swollen edges will appear less swollen, and of a less yellow colour. The pupil will be more dilated by the atropine than before the operation. If, however, we allow matters to rest in this condition a relapse of the ulceration will almost certainly occur; to prevent this a very simple procedure is all that is necessary. The wound must be re-opened from time to time, say once or twice daily until the healing process is fairly established: that is, until the ulcer has lost all its yellowness and become smooth, the aqueous humour clear and no longer coagulable. The re-opening of the wound is devoid of danger, and causes little or no pain, it is best done with a probe-pointed, lachrymal knife, or a fine probe, in such a way as to separate the edges of the wound in its whole length, and thus permit the contents of the anterior chamber again to escape.

Atropine instillations and the compress bandage may be continued till healing is well advanced.

I have no hesitation in saying that keratotomy performed in this way is one of the most satisfactory operations in ophthalmic surgery, and hardly ever fails to arrest a disease which would otherwise terminate in destruction of the eye; and I am at a loss to understand why it has not met with greater favour in the writings of such men as Brudenel Carter, and Soelberg Wells.

The former gives the preference to the operation of iridectomy, and objects to keratotomy on grounds that are, I think, scarcely tenable. Amongst other objections he states that the cicatrix left by the healing of an incised ulcer, yields after a time and becomes a source of pain and irritation. Though I am not prepared to say that this statement is wholly incorrect, I can after a pretty large experience positively affirm that I have never met with any such results. Soelberg Wells also speaks of the operation of keratotomy, but he, too, prefers to rely on iridectomy.

Pridgen Teale, however, in the Ophthalmic Hospital Reports, Vol. VIII, part I, strongly advocates the operation of keratotomy (which he designates median incision of the cornea), and is disposed to give it a wider range than Sæmisch has done.

He says: "The following principles seem to be indicated by the cases in which I have tested the operation during the last year and a half."

"That the suppurative affections of the cornea and iris which do not rapidly yield to atropine and opiates, ought to be dealt with by direct incision through the median part of the cornea into the anterior chamber just as much as a matter of course, as one would incise a whitlow, or a thecal abscess."

(*b.*) "That such an incision be made crucial or T shaped, if it be thought desirable that the wound should not heal up rapidly, thereby avoiding the necessity of springing the wound once or twice daily for a week or more."

(*c.*) "That an incision near the centre of the cornea, in length about  $\frac{1}{3}$  of its diameter, passing vertically through its lamellæ into the anterior chamber, does not, as a rule, produce any serious damage to the cornea by way of opacity, nor to the iris by way of prolapse or anterior synechia."

(*d.*) "That in hypopyon a median incision of the cornea gives exit to pus and purulent lymph lodged in the anterior chamber more readily, certainly, and completely than a marginal incision."

(*e.*) "That an incision into the anterior chamber, through a suppurating cornea, can arrest destructive suppuration and

“sloughing where iridectomy has already been employed un-  
“successfully.”

The three last principles I am prepared to endorse on the strength of my own experience, but I would only accept the first two with a certain reservation.

The two following cases will illustrate the advantage to be derived from incision through the cornea according to the method advocated by Sæmisch, though they were neither of them typical examples of the creeping ulcer, or “*Ulcus serpens*.”

I might give a long list of equally successful cases, but to do so would be, I think, superfluous.

H. B., æt. 33, brass-finisher, a pale, sallow man, was admitted into the Montreal General Hospital, October 6th, 1876. He has been affected for many years with a chronic blepharitis, which has resulted in pretty complete loss of the eyelashes, eversion of the edges of the lids and the puncta lachrymalia, overflow of tears, and a chronic catarrhal inflammation of the conjunctiva. About ten days before admission the right eye became inflamed and has been growing worse ever since, he is suffering great pain in and about the eye, with intolerance of light, and there is a good deal of muco-purulent discharge from the conjunctiva. In the lower and inner quadrant of the cornea is a large, oval, purulent infiltration, with some loss of substance at its centre, and a good deal of purulent material in the anterior chamber. Atropine, frequent cleansing of the eye with warm water, and occasional instillations of dilute chlorine water constituted the local treatment.

*Oct. 8th.*—The affection of the cornea having increased in size I decided to cut through it in the manner recommended by Sæmisch. The incision was made through the centre of the infiltration, from the margin of the cornea obliquely upwards and outwards, the counter-puncture occurring at a point just above and to the outer side of the pupil. The aqueous humour and hypopyon escaped from the anterior chamber, and formed the usual yellowish coagulum in the conjunctival sac. The after treatment was conducted in the manner already indicated, with

strict attention to keeping the conjunctiva free of discharge. Improvement was manifested from the first day, pain ceased, and the cornea soon began to clear up. The anterior chamber was re-opened several times and then allowed to close permanently.

On the 17th, I commenced the use of astringent applications to the conjunctiva, which were continued daily till the date of his discharge November 10th.

Some months later this patient presented himself for inspection. The eye had given him no further trouble since his discharge from Hospital. No trace of the incision was discoverable. A thin but rather large opacity occupied the lower and inner quadrant of the cornea, the curvature of which appeared normal; there was no synechia, vision, though somewhat impaired, was fairly good, and he could easily read ordinary print with the right eye.

CASE II.—J. R., æt. 21, labourer, admitted into Hospital June 7th, 1878. The left eye has been inflamed for two weeks. There is an ulcer with a large surrounding purulent infiltration at the centre of the cornea, occupying at least one half of its area. The peripheral portion of the cornea is quite clear, and through it a corresponding part of the iris is visible, the two being separated by a shallow anterior chamber, the lower fourth of which is filled with a purulent material. The pupil and a good deal of the surrounding portion of the iris, were of course hidden from view, and I inferred from the shallowness of the anterior chamber that perforation of the cornea had taken place, but that the aperture was not sufficiently free to permit the whole of aqueous humour, and the inflammatory products contained in the chamber to flow out. Having seen iridectomy fail to afford relief under similar circumstances, I determined to try the effect of keratotomy, and accordingly divided the cornea in the horizontal meridian to such an extent that both ends of the incision passed through healthy corneal tissue. The wound was kept open for about a week in the usual manner, by which time the infiltration had lost its yellow colour, and the anterior chamber was free from pus. Strict attention to cleanliness, atropine instillation, and a compressive bandage constituted the other local measures. Though the pain and intolerance of light



which up to the time of operation had been pretty severe, were thereby considerably diminished, the eye continued in an irritable condition, and it was evident when the ulcer had healed that a complete anterior synechia had formed, for the relief of which, on the 20th of June, I performed an iridectomy downwards and inwards. From this time the eye steadily improved and the patient was discharged July 3rd, at which date he could count fingers at three feet distance, and the eye, though disfigured by a large central opacity of the cornea, was perfectly comfortable. Four months later the corneal opacity had diminished very considerably in size, and vision was so far improved that with this eye he could count fingers at eight feet distance, the disfigurement resulting from the corneal opacity can at the proper time be almost entirely removed by tattooing with Indian ink.

Assuming, as I think we are justified in doing, that in this case operative procedure was essential in order to prevent a further extension of the corneal affection, it may be argued that an iridectomy performed at once would have fulfilled every indication, and thus have obviated the necessity for a second operation. I will not deny the possibility, but at the same time I am perfectly certain that no better result could have been attained than that which was afforded by the plan of treatment pursued.

Against the first case no such objection can be made, since the one operation sufficed to effect a perfect cure. Seeing, as I do, a considerable number of eyes which have been allowed to perish in consequence of purulent inflammation of the cornea, and being fully convinced that the operation of keratotomy, if done in good season, is almost a certain means of arresting the disease, whether it be in the form of a creeping ulcer, an abscess, or a spreading purulent infiltration with ulceration, I have been induced to make these remarks with the hope that an operation which does not seem to be generally known, but which is at once simple, easy of performance, and efficacious, may receive a fair trial at the hands of every medical man, who, though accustomed to treat diseases of the eye, has hitherto not ranked this operation amongst the most important therapeutic measures at his command in this class of cases.

CASE OF ELEPHANTIASIS ARABUM,  
OF THE RIGHT LEG,

TREATED BY LIGATION OF THE FEMORAL ARTERY.

BY D. C. MACCALLUM, M.D., M.R.C.S., ENG., &amp;c.

Some time ago my friend, Prof. G. W. Campbell, sent me a number of the *St. Louis Medical Journal*, at the same time calling my attention to an article which it contained on Elephantiasis Arabum, from the pen of Professor Bauer, a gentleman well known to the profession in Canada. In this communication a chronological table is given of the known cases in which the operation of ligation of the main artery of the limb was performed for the relief or cure of the intractable disease under consideration, and Professor Campbell noticed that no mention was made of a case that was so treated in the Montreal General Hospital in the month of April, 1859, and which was the first operation of the kind performed after those of Professor Carnochan of New York, the distinguished surgeon who first proposed and carried into effect this bold and original treatment of Elephantiasis.

The truth is, the case has never been placed on record. Shortly after the operation I transmitted a brief account of it to Professor Carnochan, promising him to publish the case later and send him a copy of the article. The notes of the case, however, were mislaid, and I recovered them unexpectedly a few months ago. As this treatment is exciting some attention at present in the medical world I have thought that it would be well to publish the notes. They are as follows:

J. W., æt. 20, was admitted into the Montreal General Hospital, January 24th, 1859, suffering from Elephantiasis Arabum of the right leg. He states that this limb has been enlarged as far back as he can remember. His parents told him that the swelling first appeared after the subsidence of an eruption on the skin of the lower extremities. The limb has of late years increased much in size, and become weightier and more unmanageable. He has never felt any pain in it; but

has observed that after exposure to wet and severe cold, the affected part becomes more tense, and this is accompanied by a feeling of general uneasiness, and a feverish state of the system.

The Elephantiasis is confined to the right leg, and principally to the part between the knee and the ankle joints, although there is considerable swelling above the knee. The surface is rough and nodulated, and intersected by fissures varying in depth. From these fissures, at times, a thin discharge distils, which, on drying, forms brownish-looking scales. The skin and subcutaneous cellular tissue, are much hypertrophied, and exceedingly dense and inelastic. For a period of fourteen years he has not been able to flex his foot, in consequence of the resistance offered by the hardened tissues at the ankle-joint, and he has had but a slight degree of motion in the joint during that time. The relative dimensions of the two limbs are as follows :

Healthy leg measures in circumference,		Affected leg measures in circumference.
At the malleoli, 9 inches. - - - - -		11 $\frac{3}{4}$ inches.
5 inches above do. 8 $\frac{1}{2}$ " - - - - -		12 $\frac{3}{4}$ "
8 " " " 10 " - - - - -		14 "
12 " " " 10 $\frac{1}{2}$ " - - - - -		13 $\frac{1}{2}$ "
At patella - - - 12 " - - - - -		14 "
Middle of thigh 13 $\frac{1}{2}$ " - - - - -		14 $\frac{1}{2}$ "
Upper part - - - 16 " - - - - -		16 $\frac{1}{2}$ "

From the date of his admission until the 30th April, a period of three months, the patient was placed under what had been the most approved forms of treatment, but without deriving the slightest benefit from them. In the month of February a very large abscess formed in the upper part of the thigh of the diseased leg, which, in due time was opened, giving exit to a large quantity of foetid pus of a greenish colour.

On the 30th of April, having called a consultation and obtained the consent of my colleagues, I ligated the femoral artery in Scarpa's triangle. The vessel was exposed without difficulty, and found to be perfectly healthy. The patient progressed favourably, and the ligature separated on the 21st day. Mea-

measurements were taken on May 3rd, three days after the operation, and again on June 6th, when he was walking about the ward. The differences are exhibited in the following table :

Measurements 3 days after operation, May 3rd.	Measurements 37 days after operation, June 6th.
At Malleoli, - - - 11 inches.	- - - - - 10½ inches.
5 inches above do. 11 “	- - - - - 10½ “
8 “ “ “ 13 “	- - - - - 11½ “
12 “ “ “ 12½ “	- - - - - 11½ “
At Patella, - - - 13 “	- - - - - 12 “
Middle of thigh. 14½ “	- - - - - 14¼ “

Some months after his discharge from the Hospital he was re-admitted for abscess of the thigh of the right side. I met him two years after the operation, and on examining the limb I found it enlarged from œdema. The skin and cellular tissue had lost, however, all the characteristics of Elephantiasis. He informed me that so long as he kept the limb bandaged, the œdematous swelling was absent. He had become very dissipated in his habits and was a frequent inmate of the Montreal General and Hôtel Dieu Hospitals. I am of opinion that had J. W. been a person of strictly sober habits, and had he given the limb proper support for some time, he would not have suffered from the œdema which frequently troubled him. It is quite possible, moreover, that the two large abscesses in the upper part of the thigh for which he was treated, had much more to do in causing the subsequent œdema than had ligation of the femoral artery,

INFLUENCE OF THE PIANO ON THE AFFECTIONS OF THE UTERUS.—Dr. Balastre terminates an article which he has published in the *Nice Médical* by saying that his meaning would be misunderstood if it were thought that he discountenanced music as a part of female education, or that he believed it to be the origin of uterine ailments. All he wishes to enforce is what observation has demonstrated to him—that in very nervous and impressionable women who are suffering from affection of the uterus, music may provoke and aggravate congestions of this organ, and that in advising the patient concerning her hygienic management this fact should be borne in mind. Moderation in the practice of music and interruptions in its pursuit must be insisted upon while pursuing the ordinary measures of treatment; and by this means various accidents occurring during uterine affections will be obviated.—*Rev. Méd.*, April 1.—*Med. Times and Gazette*.

## Hospital Reports.

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

*Dislocation upwards and backwards into the Ischiatic Notch.—  
Reduction successfully practised by the Rotatory Method,  
on the thirty-second day after the injury.—By GEO. E.  
FENWICK, M.D. Reported by Mr. J. B. LAW FORD.*

A case of this comparatively rare form of accident presented itself at the out-door department of the Montreal General Hospital, in a young man aged 21 years, and he was admitted into the house under the charge of Dr. Fenwick, on April 5th, 1878. The following details were obtained.

E. L., æt. 21, farm labourer, is of medium size, but strongly built. Has always enjoyed good health. No history of any constitutional diseases.

On the fourth of March last, as he was driving a sleigh load of bark along a country road, the sleigh upset falling against him and knocking him down on to his left side. He says that he fell on a large lump of hardened snow, which struck against the middle of his thigh, but he was under the impression that the dislocation was not due to the fall but was produced by his efforts to extricate himself from under the sleigh load. He was taken home and a doctor brought who attempted to reduce the dislocation by traction on the leg, but failed. The man was subsequently experimented on by two men and a woman, but their efforts were also ineffectual. He remained in bed for three weeks. During the first two weeks of which he appears to have suffered considerably, as by his own description "he was yelling all the time." At the end of the third week he began to hobble around, and in another week came to the Hospital.

On admission, his appearance was characteristic, there was great fixity of the limb, it being adducted and twisted over the other thigh. He hobbled along on one leg by the aid of a staff. The left leg was visably shortened and the foot inverted. On closer examination the toes of the left foot were seen to rest

on the instep of the right. The foot was also somewhat advanced and directed obliquely across the other. The left knee rested against the inner and anterior surface of the right knee, immediately above the patella. The axis of the left thigh was directed across the knee of the opposite leg. The knee-joint was kept in a semi-flexed position. The head of the femur could be felt by pressure on the lower part of the dorsum Ilii laying in the position of a line from the anterior superior spine of the ilium to the coccyx. The great trochanter was felt somewhat behind its natural position and nearer the anterior superior spinous process of the ilium.

Measurement showed the sound leg to be  $34\frac{3}{4}$  inches from the anterior superior spine of the ilium to the internal malleolus; the same measurement on the injured limb was  $34\frac{1}{4}$  inches. The distance from the anterior superior spine, to the great trochanter was  $5\frac{1}{2}$  inches on the sound side, and  $5\frac{1}{4}$  inches on the injured side. There was no pain except on movement. The patient felt very well otherwise, but complained of weakness from remaining so long in bed.

Dr. Fenwick having examined the patient diagnosed dislocation "backward into the ischiatic notch." The dorsal dislocation below the tendon of the obturator internus of Bigelow.

On April 6th, the patient was placed under the influence of chloroform, Dr. F. proceeded to reduce the dislocation by the rotation method. On the first attempt the head of the bone slipped round the border of the acetabulum and entered the thyroid foramen. The characteristic features of that displacement were at once developed; by reversing the movements the head of the bone was returned to the position it formerly occupied. A second attempt was made, and the same result followed, and again was the bone restored to its abnormal position in the ischiatic notch. In bringing the head of the bone round a third time, the operator placed his hand firmly on the ascending ramus of the ischium when the bone slipped with ease into the acetabulum. The patient's legs were then bandaged together after being carefully padded at the knees and ankles, and he was placed in bed.

An hour after the Reduction he complained of great pain about the hip-joint, and kept up a low moaning. There was slight redness on the inner and upper part of the thigh just below the articulation, and tenderness on pressure everywhere in the vicinity of the joint. Temperature normal. Pulse 100. Was given Morph. Mur. gr.  $\frac{1}{2}$  hypodermically.

*April 7th.*—Patient complained of weakness. Slept very little, although he was given a draught of liq. mor.  $\bar{3}$ i. at midnight. Pain about the hip much less; redness has all disappeared. Skin dry. Tongue dry and slightly coated white. Complained of much thirst. Temperature  $99\frac{3}{4}^{\circ}$  in axilla. Pulse 120.

*8th.*—Much easier this morning. Slept well from a draught similar to that of the night before. There is still considerable pain on pressure about the joint, but especially half way down the anterior surface of the thigh. Thirst less. Temperature normal, and continued so from this time. Pulse 100.

*9th.*—Patient improving every day. Pain is still present on pressure, but is much less than formerly.

*12th.*—Bandages were removed to-day, for which the man was truly thankful.

*15th.*—Patient tried to walk a few steps to-day with the aid of crutches, getting along very well, and though, of course, stiff, experienced no pain.

The next day he left the Hospital, a very different-looking man from what he was when he entered it, and able to use both his legs, instead of hobbling along with one leg and a stick.

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*Case of Stone in the Bladder, with a very tight and firm Stricture of the Urethra. — Internal Urethrotomy. — Lithotomy. — Recovery.*—Under the care of Dr. RODDICK. Reported by JAMES BELL, M.D., Assistant House Surgeon, Montreal General Hospital.

C. C., a young Englishman, 27 years of age, of haggard and anxious appearance, presented himself at the Montreal

General Hospital, on the 21st of June, 1877, suffering from retention of urine. His bladder was greatly distended and he was suffering excruciating pain. On attempting to relieve him with a catheter, it was discovered that he had a very tight stricture in the usual situation, about the juncture of the spongy and membranous portions of the urethra. After a prolonged and ineffectual attempt to pass a catheter into the bladder, he was admitted as an in-door patient. He was ordered a hot bath and a Dover's powder, and an hour later a second attempt was made, when after much difficulty a No. 1 catheter was passed, and a large quantity of purulent urine withdrawn. This gave him great relief, and for some days he did not require to be catheterized, though in the act of micturating the urine came away drop by drop, or at best, in a very weak and tiny stream.

On inquiring into his case more thoroughly, his family history was found to be bad, his mother and two sisters having died of phthisis. He was of medium size, good muscular development, and well nourished, and gave the following account of himself: That he had suffered from bladder irritation from childhood—from five or six years of age, and that on several occasions he had passed *per urethram* small stones, varying in size from a mustard seed to a small pea. He ran away from home and went to sea, at the age of 14 years, since which time he has led a very hard life. At 16 years of age he contracted gonorrhœa in China, and soon after syphilis, from which he recovered in about seven months. In June, 1876, he began to have difficulty in passing his urine and had to be catheterized then for the first time. About the same time he began to suffer from pain in the bladder and loins, which was aggravated by exertion, and several times he passed bloody urine after violently exerting himself. In the Autumn of that year (1876,) he was discharged from his ship in this city. During the winter months he did a little work but spent a good part of his time in the House of Refuge. He suffered a good deal, and was frequently catheterized in the out-door patient department of this Hospital, until as already mentioned, he was admitted on the 21st of June. A few days after admission his bladder was explored with a sound, and a



stone was discovered. His heart and lungs were found to be healthy but he had a cachectic appearance, and suffered from frequent chills which were followed by high fever, and he had to be catheterized from time to time. He was at this time under Dr. Fenwick's care. A consultation was called about the 10th of July, when, owing to his bad health and his troublesome stricture, it was not considered advisable to operate. He was accordingly kept in Hospital, and given generous diet and tonics, but did not improve. He had frequent chills followed by fever, and began to complain of pain and tenderness over his right kidney, while his urine contained from day to day a varying quantity of pus. From these symptoms organic disease of the kidneys, either of calculous or tubercular origin was suspected. About the end of September he came under Dr. Roddick's care. He, after having him under observation for a couple of weeks, decided that it was useless to wait for the symptoms to improve before operating, and determined to cure his stricture by internal division, and afterwards to perform lithotomy.

On the 4th of October, he divided the stricture internally with Teevan's urethrotome, a new instrument which he had just brought from London. A No. 10 catheter was then tied in for twenty-four hours. This caused a great deal of irritation by coming into contact with the stone whenever he moved in the bed. Next day it was removed and a No. 9 passed, and immediately withdrawn. On the 12th, a No. 11 was introduced, and withdrawn immediately. The catheter was passed daily until the 17th, when all irritation from the previous operation having subsided, the lateral operation of lithotomy was performed and the stone removed. No bad symptoms followed the operation, and from this time he rapidly improved. The wound closed rapidly and completely, the urine became clear, he had no more chills nor fever, and in a few days he was perfectly well. On the 7th of November he left Hospital to sail for England, declaring that he had not felt so well for years. The calculus was phosphatic, and about the size of a pigeon's egg.

## Reviews and Notices of Books.

*Cyclopædia of the Practice of Medicine.*—Edited by Dr. H. VON ZIEMSEN. Vol. XIV. *Diseases of the Nervous System and Disturbances of Speech.*—By Professor A. EULENBURG; Professor H. NOTHÄGEL, Professor H. VON ZIEMSEN, Prof. F. JOLLY, Prof. A. KUSSMAUL, and Dr. J. BAUER. ALBERT H. BUCK, M.D., New York, Editor American Edition, 8vo. pp. xviii. 893. New York: WILLIAM WOOD & COMPANY, 27 Great Jones Street, 1877.

This is one of the most interesting and important volumes of the series. The opening article is by Prof. A. Eulenburg, on vaso-motor and trophic neurosis. Hemicrania, angina pectoris, unilateral, atrophy of the face, Graves' or Basedow's disease, progressive muscular atrophy, pseudo hypertrophy, and true hypertrophy of the muscles are the subjects touched upon in this paper. The various theories as to the cause of Basedow's disease are discussed and the author concludes in speaking of treatment that much is to be done in these cases by the persistent use of galvanism, applied to the sympathetic cervical ganglia, the constant current to be used, at the same time careful regulations should be enjoined as to habits of life, avoidance of all excitement and much physical exertion, a complete abstinence from all stimulating drinks, as coffee, tea and alcohol, in whatever shape, a mild, nutritious diet, composed largely of milk and vegetables, and a residence in the country, more especially mountain health resorts, with much open air exposure. According to the author the employment of iodine or its preparations in this disease is not only useless, but unscientific, and may be the source of mischief. The use of quinine and iron is alluded to, and they are of decided benefit when persevered in for some time, for they improve the general tone of the system. as there is usually much anæmia present. Nevertheless, the anæmia must not be regarded as the cause of the disease.

Professor Nothnagel gives a paper on epilepsy, and eclampsia, After some general introductory remarks on the subject, the author passes on to experimental researches, mentioning very fully those of Brown-Séquard, including his more recent publications, which are to be found only scattered through various periodicals ; also those of Schiff, Westphal, Hertzig, and others

This paper is followed by one from the pen of Dr. J. Bauer. of Munich, on tetanus. The subject of increased temperature in this disease is gone into, and the conclusions arrived at are that no marked increase in temperature occurs, or only a very slight increase, and this especially in the evening. It has been noticed, however, that the temperature rises sometimes to an excessive degree, shortly before death, and continues to rise after cessation of life. This increase in temperature is supposed to be due to tonic spasm, but not wholly to this cause ; indeed it is remarked that after death has taken place, and that all muscular contraction has ceased, the temperature still continues to rise, from this we are led to look for some other cause, and the author concludes that the excessive increase in temperature is due to irritation of the centres of innervation. Post mortem, increase in temperature is noticed in other diseases besides tetanus, but in tetanus only is it occasionally very great. This fact the author accounts for, after Fick and Dyblosky, by the setting free of heat during the stiffening of the muscles, or the coagulation of the myosin.

Catalepsy is the next subject discussed in this volume, Eulenburg being the author of the article ; this is followed by the same writer's views on tremor, paralysis agitans, with an appendix on what Hammond has described under the name of athetosis. von Ziemssen gives us the next article on chorea. This is followed by one from Prof. Jolly of Strassbourg, on hysteria, and the last article, by far the most exhaustive in this volume, is from Prof. Kussmaul, and consists of some thirty-five chapters, the subject being the disturbances of speech ; but not only does the author discuss the disturbances of speech as a result of some pathological change, he goes into the origin of speech, and accounts for it on physiological

grounds. It is a most learned article, original and practical in its conclusions, although at first the reader might be somewhat staggered at its abstruseness.

His observations on the localization of speech, are worthy of attentive perusal, and his chapter on Deaf Mutism and the education of deaf-mutes, shows the superiority of the German over other methods. This volume is fully as interesting as those which have preceded it. Throughout the interest is maintained, and it is in every respect a valuable addition to the series.

*Clinical Lectures on Stricture of the Urethra and other Disorders of the Urinary Organs.* — By REGINALD HARRISON, F.R.C.S., Surgeon to the Liverpool Royal Infirmary; and to the Liverpool Northern Hospital. Svo. pp. 193. London: J. & A. Churchill, New Burlington Street: Liverpool, Adam Holden, Church Street, 1878.

Many of the lectures here collected into book form, have already appeared in the *Lancet* and other periodicals, and some of the cases reported have before been published. The author has collected them into book form with a view of expressing his own opinions upon certain points in practice, as well as to criticise the opinions of others.

In the opening lecture a few preliminary remarks are made on the ample opportunities enjoyed by the author, as surgeon to two large Hospitals, in a large sea-port town like Liverpool, for studying the surgery of the Genito-Urinary System. He limits the use of the term stricture to those cases in which there occurs an obstruction consequent on a change in the calibre of the canal from organic disease, spasm, and inflammatory œdema of the mucous lining do not constitute stricture in the true acceptation of the term. In referring to the causes of stricture, the author mentions a case, unique of its kind, which came under his observation, wherein during the operation for circumcision *the surgeon* removed a portion of the glans penis, together with the prepuce, and, as might be expected, a very tight stricture of the meatus resulted. On page five it is

remarked, in speaking of gleet, "it requires careful and well-considered treatment, and if it does not receive this—that is to say, if it is clumsily dealt with, or not dealt with at all—it most probably ends in the formation of stricture." This may be so, but we incline to the belief that in the majority of cases where gleet exists, it is kept up by the presence of stricture, that the canal has lost its resiliency, and that in consequence the last drop of urine is not expelled, this acts as a local irritant and keeps up the discharge which is thin and semi-purulent, but after all, to decide this point, we must first ascertain what we mean by the term gleet.

In the second lecture the author gives the surgical anatomy of the urethra, embodying the views and measurements of Dr. F. N. Otis of New York. Specific directions are given for the passage of instruments into the bladder, and the value of tracing the course of the urethra with the finger in the rectum is alluded to. The author remarks "Fewer false passages would be made in difficult cases of catheterism, if we bear in mind that we have the means of testing, in the deep portion of the urethra the course the instrument is taking, and of rendering assistance to the passage of the instrument through the stricture, by the introduction of the finger into the rectum."

The symptoms of stricture, and the consequences which follow to the genito-urinary organs, are next considered. The treatment of stricture occupies three lectures, and the author points out the danger of forcing a stricture; he remarks: "If you cannot pass a catheter by a legitimate amount of firmness and tact, you are pretty sure to do harm by such hap-hazard manipulations." Syme's operation for external division of stricture is discussed, as is also that by Wheelhouse, more recently proposed for impermeable stricture. There is an excellent description of the consequences of stricture, urethral abscess, fistula in perinæo, extravasation of urine, &c.

The various proposals for internal urethrotomy is next touched upon, and there are figured the instruments of Maisonneuve, Teevan, and Watson. The author also figures an instrument suggested and used by himself, which is a modification of

Teevan's urethrotome, having the advantage, however, of a double cutting blade, whereby the danger of hæmorrhage is lessened; the urethra is incised to a more limited extent at two points of its circumference, instead of deeply at one place, as must result in the employing any of the other urethrotomes in use.

There is an interesting lecture on foreign bodies in the urethra and bladder, with the report of some illustrative cases, these are very instructive. The author remarks on the value of the lithotrite in removing foreign bodies from the bladder, and he mentions an instance in which he seized a pencil case at first transversely, but by gradually rotating the lithotrite towards one side, while the pencil was kept within the blades of the instrument, he succeeded in reaching one end, when the pencil was removed point foremost, without any injury to the bladder or urethra. After discussing hypertrophy of the prostate, retention of urine, incontinence of urine, and the formation of calculi, he passes on in the fourteenth lecture to the consideration of cystitis, its various causes, washing out of the bladder, and topical applications to the bladder. In this chapter the author figures an instrument which he calls the pessary catheter, and which he has designed for the purpose of introducing into the bladder soluble pessaries of cocoa-nut butter, containing various medicinal reagents. This is a most ingenious instrument, and is so arranged, that the bladder by its use may be thoroughly emptied before depositing the pessary.

There is a chapter on calculous disorders, and with many others there is figured in plate H. Fig. 1, a calculus, which was removed, post mortem, from a patient admitted into the Royal Infirmary in a dying state. This presents a remarkable similarity in shape to a specimen which is in the collection at McGill University, and which was removed by the lateral operation from an aged man of 79 years.

In the last two lectures will be found a clinical account of tumours of the bladder and prostate, malignant, and non-malignant, villous growths, ulceration of the bladder, perforation and sloughing of the bladder.

The book is illustrated by 12 lithographic plates and some twenty-five wood engravings.

We commend this work to our readers ; the teaching is sound, the style colloquial, and very readable. There is no one chapter from which the reader may not derive much instruction as being the plain enunciations of a thoroughly practical man, based on a large and varied experience.

*The Action of Medicines.* — By ISAAC OTT, A.M., M.D.,  
Formerly Demonstrator of Experimental Physiology,  
University of Pennsylvania ; with twenty-two illustrations.  
S vo. pp. 168. Philadelphia : Lindsay & Blakiston, 1878.

We are told, somewhat obscurely, in the preface to this work, that the first volume on the physiological action of medicines was by Professor Nothnagel. If by this we are to infer that Nothnagel was the first man to write on the physiological action of medicines on animals, we must enter a protest against any such assumption, and on reference it will be found, that in Pereira's classic work on *Materia Medica and Therapeutics*, the subject of the physiological action of medicines on man and animals was very fully discussed ; furthermore it will be found that Pereira published the first edition of his work, in 1839, some two years before Nothnagel was born. To Bernard, perhaps is due the merit of first applying the principal of the action of drugs in elucidation of physiological facts.

The work before us is divided into four chapters. In the first will be found some practical hints on the method of studying the physiological action of medicines, including a description of apparatus to be used in carrying out experiments on animals. The author mentions the animals chiefly used for experimentation, and also the method of feeding and preserving them for future use. He then passes on to the method of securing animals for the purpose of conducting experiments, various apparatus are figured and their use explained. The subject of anæsthesia, artificial respiration, measurement of temperature, time measuring apparatus, electrical apparatus, method of ad-

ministration of medicines, and the antagonism of drugs are touched upon.

In the second chapter is to be found a short description of the action of drugs on the nervous system, on the motor nerves, effects on the spinal cord, on reflex action. The action on the medulla, cerebellum, cerebrum, on respiration, glandular action, and intestinal movements.

In the third chapter the effects on the circulatory apparatus is dwelt upon. Effects on the nerves of the heart, and on those of the blood vessels, blood pressure, rapidity of circulation and the measurement of arterial tension, &c., and subsequently the effect of drugs on the vessels of organs after their removal from the living body.

In chapter four the action of certain drugs on the lower animals and on man is discussed. The work is intended as an aid to the student of practical physiology, and will be found of much use. It is concise, but sufficiently explicit, and supplies a want which has been long felt.

*A Guide to Therapeutics and Materia Medica.*—By ROBERT FARQUARSON, M.D., Edin., F.R.C.P., Lond. Lecturer on Materia Medica, at St. Mary's Hospital Medical School. Enlarged and adapted to the U. S. Pharmacopœia. By FRANK WOODBURY, M.D., &c. 8vo. pp. 410. Philadelphia: HENRY C. LEA, 1877

It would seem unnecessary in the face of so many elaborate works on therapeutics already before the profession, to publish one more; nevertheless, the desire for knowledge is such that room exists for a work of this character. It gives in moderate compass all that is required, and to the student and busy practitioner will be of special use. In the preparation and arrangement of the work, the author does not desire to supercede or rival the more voluminous volumes of Ringer, Wood and others, but aims solely at presenting the subject under discussion in a brief form, seeking at the same time to avoid the encumbrance of botanical or pharmaceutical detail. After some preliminary



remarks, the author gives a few broad rules as a guide in the construction of prescriptions, and he correctly remarks, "that much professional credit may be derived from a good prescription, and as much damage done to the practitioner who orders for his patients mixtures, which are neither agreeable to the eye nor palatable to the taste." These rules consist in studying out the combination of drugs, their form of administration, the proper time for giving them, the dose, the intervals between doses, individual peculiarities, habits or idiosyncrasy, the constitutional or toxic effect from small doses; chemical and physiological incompatibles; prescribing for children, prescription writing, weights and measures, observations upon, and general rules for doses.

In the first section there are remarks on certain classes of remedies, as, for instance, antidotes, acids, anthelmintics, antipyretics, antiseptics, counter irritants, diaphoretics, diuretics, emetics, ecbolics, expectorants, and purgatives. In this section are compared, side by side the physiological and therapeutical action of the class of remedies indicated. This same scheme is carried out in the second section, in which individual remedies are taken up and discussed in alphabetical order.

In section three we have a number of remedies which are in frequent use, but which are not in the primary list of the *materia medica*. Many of these remedies are not always to be found in works on the subject. The account of them therapeutically and physiologically is derived from the writings of those who introduced them to the notice of the profession. This section is followed by a series of questions, which the student of medicine is encouraged to answer, and which are on the border line between practical medicine and therapeutics. There is an index of diseases, and also a very full general index. We regard this little work most favourably, being impressed with the value of the method adopted in its arrangement. It is fully up to the most recent researches and observations of the experimentalist and clinical teacher. It is a work which will be of great service to the general practitioner, and the student of medicine will find it a short but valuable compendium.

*Practical Gynæcology*.—A hand-book of the diseases of women.

By HEYWOOD SMITH, M.A., Oxon. Physician to the Hospital for Women, &c., with illustrations. Svo. pp. 205. Philadelphia: LINDSAY & BLAKISTON, 1878.

The author tells us in his preface that he offers this present work to the busy practitioner as one systematically arranged, and not burthened with vexed questions of pathology. He likewise informs us that "of big books on Diseases of Women there is no end." But while the author has avoided giving us a big book, we fear he has erred slightly on the other side. It appears so boiled down as to present more the appearance of a list of women's diseases than a dissertation on them. Still, however, it is a useful little work, and we may hope to see it enlarge its borders in the next edition. In the appendix will be found a number of prescriptions for the preparation of pessaries, injections and applications to the cervix and os. It certainly will be found of use by the practical man, as it is more suited to the practitioner who possess adequate knowledge of the subject and who desires to have his memory jogged.

### Extracts from British and Foreign Journals.

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

**Treatment of Acne Rosacea.**—(By Professor HEBRA, of Vienna.)—Hebra divides Acne Rosacea into three grades.

(1.) Where there are pustules, distended vessels and redness.

(2.) Where, in addition to the above, there is a general enlargement of the nose with alteration of shape caused by the growth of fleshy excrescences (Rhinophyma). The treatment that Professor Hebra now adopts in intractable cases is, to obliterate and destroy the distended vessels, and to relieve the follicles of their pustular contents, to make uneven parts smooth, and to remove the new growth of epidermis and connective tissue. He says: "The destruction of the superficial vessels, which are apparent to the naked eye as fine red stripes, or tortuous lines, is affected by puncturing them deeply with a double-edged lancet-shaped needle. To prevent this needle going

too far into the skin, it has a shoulder, two millimetres from its point. In performing this operation the patient should recline on a couch with the head on the raised end, the operator, standing behind the head of the patient, should at one time stretch the skin with his left hand while the punctures are being made, at another pinch it up to prevent too free bleeding, or put his finger in the nostrils when puncturing the alæ. The needle should be held between the thumb, index and middle finger, (like a pen), and the punctures, made as rapidly as possible, should be as deep as the distance between the point and shoulder of needle (3 mm.) To prevent the blood interfering with the operation the punctures must be commenced at the lowest part of the eruption and made in horizontal rows. The hæmorrhage is easily controlled by pressing on lint or wadding. This may then be changed, sticking plaster applied and the part left at rest 24 hours. The after treatment is simple; there is nothing to do but to take off daily the lint, wadding or plaster, and examine the punctures, and if, as is usually the case, they are not suppurating to apply dry lint again and bind up. If there are pustules apply ung. plumbi or ung. simplex. The repetition of the operation after the healing of the punctures is not necessary unless the destruction of the injected vessels has not been complete."

Prof. Hebra uses another method (Volkman's) of treatment, which is more applicable to the severer forms of acne rosacea. This is shaving or rather scraping off the inflammatory products, hypertrophied and newly formed masses by means of an instrument shaped like an ear spoon, having sharp edges. The spoon is sometimes set at right angles to the handle when deep shaving is necessary. He says: "This operation, so simple, so easily understood, so successful in its action and so harmless in its results, so little painful in its comparison to the once necessary cauterization, is welcomed by dermatologists with joy and employed by them in numbers of cases with a beneficial result." The position of the patient during operation should be the same as when puncturing is performed. The new growth must be scraped, not cut off, and Prof. Hebra uses this method to remove the

new growths, in lupus, epithelioma, &c., and the infiltration of sycosis, acne, &c., and says we must not stop scraping till all the products of disease are removed. This method may also be employed to remove nævi, port-wine marks and superficial teleangiectasis. The epidermis only should be removed, and he says by the obliteration of the small vessels of the skin the redness disappears as well in acne rosacea as in superficial nævi. In severe cases of the third grade, where there are large fleshy excrescences, Prof. Hebra either cuts wedge-shaped pieces out of the skin of the nose and unites the edges or he removes the growths singly by an elastic ligature. One case is related in which he removed the end of a nose, which had grown to an enormous length, by the elastic ligature, with the best result.—(Condensed from the Wiener Medizinische Wochenschrift, No. 1, 1878.)

**On Hydrobromic Acid.**—In an article on this new remedy, by Dr. Edward Squibb, in the *Transactions* of the New York State Medical Society, he writes about it as follows :

The acid is a sedative neurotic, and its principal use, as developed up to this time, are as an occasional substitute or alternate for the bromide of potassium, sodium and ammonium.

It is well established that the bromine is the active medicinal agent whose influence is sought in the use of these salts, and it is also well known that the alkaline bases, and especially potassium, when given for a long time, are liable to enfeeble the muscular tissues, and produce other changes not desirable, through undue alkalinity of the blood and the secretions; and through the secretions to enfeeble the digestive and assimilative processes. It is true that the proportion of cases in which such effect comes into undue prominence is small, but to correct them when they do occur, and to forestall them when likely to occur, without suspending the bromine, whose continuous sedative action is often very important, this acid now comes into use.

It is, however, certainly not well adapted to very prolonged use, for like other so-called mineral acids, it would be very liable to interfere more with the normal processes of the economy than the bromine salts with alkaline bases. Therefore, for the present

at least, it must be regarded simply as an alternate for the bromides, for occasional and exceptional, rather than for general use. Such uses are, however, very important in the treatment of chronic affections of the nervous system, even when neither functional nor organic mischief is observed or apprehended, for several reasons, among which the disgust which patients often acquire for salines when long continued is not the least. In hospitals for the insane, especially in the epileptic wards, it should be very useful, both in effect and in facility of administration, because it can be given in the form of lemonade, if moderate small doses should prove effective.

It has been highly spoken of as a corrective and preventive remedy for the headache, ringing of the ears, and general cerebral distress, which often follows upon the use of salts of quinia, which should be called quinism, and not cinchonism. When given with or after the salts of quinia, the disagreeable head symptoms are said to be prevented. It should be remembered, however, that as a general rule, some degree of this quinism is necessary to indicate the full power of the quinia salts, and that irrespective of the quantity given, the full influence as an antiperiodic is never assured without some degree of the head symptoms, and that the dose required to produce the full antiperiodic effect varies very much in different individuals, and even in the same individual at different times. In those cases where small quantities of any of the salts of quinia produce head symptoms of disproportionate severity, so that the desired benefit of the antiperiodic cannot be attained because the sufficient dose cannot be borne, this acid is said to be very useful, either given with the quinia salt, or later, when the head symptoms begin. It is also said to be useful in nervous headaches and tinnitus from other causes than the administration of quinia salts, and to be effective when given at any stage of the affection.

Other uses to which the acid has been applied with alleged advantage are not yet confirmed.

The acid is not very easily administered in full doses, in consequence of the large dilution necessary, and the disagreeable effect of "setting the teeth on edge." A dose of fifty grains,

equal to 41.66 minims, and to twenty-grains of potassium bromide, requires not less than eight fluid ounces of dilution. And the dilution must contain not less than an ounce of sugar or two ounces of syrup, to make it easily drinkable. This will be found to be the principal drawback to the use of the acid, unless it shall be proved to be effective in smaller quantities than its equivalence to the bromides indicates. And this effectiveness in smaller doses is not only probable, but almost certain, if the experience of Fothergill and others may be trusted, since they give it in doses of one-eighth to one-fourth of those here indicated as being the bromine equivalent of potassium bromide. That is to say, the doses advised by those who appear to have used it with the best effects are equivalent to about six to eight grains of potassium bromide. This published experience would make the average dose of the acid here described, say about twelve to sixteen grains, or the bromide equivalent of only six to eight grains of potassium bromide. In the very limited experience of physicians around the writer these doses are too small, and twenty to thirty grains, equal to ten to fifteen grains of potassium bromide, are needed for a prompt sedative effect, while forty to fifty grain doses are not uncommon. And such doses have to be repeated, at times in controlling the headache, etc., of quinism. Even such doses require a dilution of two to four fluid ounces of water, for easy administration.—*Medical and Surgical Reporter*.

**Ophthalmoplegia Interna.**—The following is an abstract of Mr. Jonathan Hutchinson's paper "On a Group of Symptoms indicative of Disease of the Lenticular Ganglion." After briefly alluding to the anatomy of the lenticular ganglion, the author stated that its destruction by disease might be expected to be followed by paralysis of three distinct muscular structures, the dilator of the pupil, the constrictor of the pupil, and the ciliary muscle. Under such circumstances the pupil would become motionless, and the patient losing the power of accommodation, would be unable to read with spectacles. For this condition involving paralysis of all the muscular struc-

tures within the eyeball, the term ophthalmoplegia interna was suggested, while that of ophthalmoplegia externa was proposed in contra-distinction for cases in which all or most of the muscles moving the eye-ball were involved. The author expressed his belief that examples of both these conditions were met with occasionally in practice, and that the features of each were peculiar and of great interest to neuro-pathologists. His conjecture was, that when ophthalmoplegia interna existed alone—that is, unattended by paralysis or defect of any of the external muscles of the eye-ball,—the disease was in all probability, in the lenticular ganglion itself. In venturing upon this diagnosis, as great importance was to be attached to the absence of some symptoms as to the presence of others. If disease existed implicating the nucleus, or any part of the trunk of the third nerve, and thus paralysing the constrictor of the pupil, there must necessarily be defect of some of the external muscles of the eye-ball. The paper next proceed to narrate the details of eight cases in which the condition referred to was present. None had afforded an opportunity for dissection, and the diagnosis for the present must be held to be conjectured only. It was observed, however, that the cases bore a very strong resemblance to each other. In none of them was the patient seriously ill, and in but two were there definite indications of implication of other parts of the nervous system. In none did the disease of the nervous system whilst the patient was under observation extend, a fact which might, it was suggested, be in part accounted for by the fact that specifics were used in all. Of the eight cases, in five both eyes were affected. It appeared highly probable that syphilis was in most the remote cause. In three out of the eight there was no history of syphilis, but in none of these were the facts conclusive as to the negative. All the patients were of an age at which syphilitic affections of the nervous system are common. The eldest was forty four, the youngest twenty-seven. In one case the author had himself attended the patient for severe syphilis four years before the eye symptoms began. Attention was especially asked to the fact that in many cases the paralysis of the iris, preceded that of the ciliary muscle,

and was almost always in excess of it; and further, that under treatment the ciliary muscle might regain its power, whilst the iridoplegia persisted. In no single case was the failure of accommodation the first symptom. A suggestion was made as to the possible association of this group of symptoms with the early stage of locomotor ataxy, especially with that form of it which appears to be connected with Syphilis.—*The Lancet*.

**Early Diagnosis of Stone in the Bladder.**—Mr. TEEVAN read a paper on this subject. On the arrival of a stone in the bladder, it usually soon gave notice its advent. The larger the stone was permitted to grow, the more trouble it gave in its removal. If treated when small it could be dealt with satisfactorily. As to the amount of pain produced, a small oxalate of lime calculus would give rise to much pain while a large smooth stone behind the prostate caused but little suffering. When the stone was small, there was often difficulty in micturition, from the stone plugging the urethral orifice. This was more apt to happen with boys than with men. The amount of pain produced by stone varied with the habits of life. Hunting often elicited early evidence of the presence of stone, and so had saved many a life. The blood passed with stone was by drops at the end of the act of micturition. Changes in the urine itself were of little value diagnostically. In children, incontinence of urine was often present with calculus; here the stone passed into the prostatic portion of the urethra, and the urine trickled past its sides. Some incontinence was of great diagnostic importance. The family history and the patient's history were often of much service. Rarely more than four of the above symptoms were found together in any one case. In stone-cases, there was little complaint at night, while in prostatic cases the trouble at night was usually great. Motion aggravated the symptoms and the pain in stone cases, but did not affect stricture-cases. A stiff bolster under the patient's buttocks was useful, at the time of sounding. The finger in the rectum, and a short beaked sound, were of service. It was well to stand straight before the patient, and not on one side. By so doing,



it was easier to bear in mind the three long prominences of the pelvis, viz., the sacrum and the tuberosities of the ischia.—The President referred to the late Mr. Liston's diagnosis by asking the patient to jump down from a chair. The patient emphatically refused.—Mr. Giles, Dr. Stewart, Mr. Caird, and Dr. Wiltshire took part in the discussion which followed; after which Mr. Teevan replied, and the meeting adjourned.—*British Medical Journal*.

**Oculo-motor Paralysis of the Optic Disc.**—(Probably due to sympathetic growth.—Under the care of Dr. LEARED).

H. T., admitted on December 5, 1857, aged twenty-eight; married five years; has one child four years old, quite healthy; had two miscarriages. She states that she was in fairly good health until ten days ago (November 25th,) when she was seized with lancinating pains in the left eye, and around the left orbit and in the temporal fossa. For two or three days the pain greatly increased, and was referred especially to the eyeball. During this time she noticed that the upper lid began to drop. The pain then ceased, but with this cessation complete ptosis set in, and sudden attacks of dimness of vision every now and then supervened. There is a history of syphilis followed by secondary symptoms, but none of a specific character have appeared for about two years. She has, however, suffered at intervals during this period with difficulty of opening the mouth; this has always yielded to medicine. In connection with the above attacks she has had fulness in the left temporal fossa with some pain. Present Condition: Fairly well nourished; chest sounds normal; urine not albuminous; complete ptosis of the left side and fixation of eyeball, a slight tremulous action being the only result of any attempt to move it; left pupil responds to light very feebly; same size as other. Mr. Lowne, Ophthalmic Surgeon to the Hospital, examined the patient's eyes, and found that the left disc was atrophic and pearly white, the veins and arteries reduced in calibre, details of lamina cribrosa and that the right disc was congested at its edges, too

white at its centre. The patient was placed on the biniodide of mercury, and iodide of potassium, which treatment, considering the urgency of the symptoms, Dr. Leared determined to push as rapidly as possible. The levator palpebræ in a few days regained partial power, but the eyeball remained more or less fixed, and sight was worse. The medicine had at times to be decreased, and even discontinued, owing to the specific action of the mercury. Movement of the eyeball gradually returned, commencing with contractility of external rectus, and on January 5th, one month after admission, the levator had regained normal power, and also the several muscles attached to the eyeball. She could, however, discern no object whatever with the left eye. The note of January 12th, says: "The levator and muscles of the eye act well, as also the pupil, but vision is almost entirely gone. Left disc perfectly atrophic, quite white; right disc somewhat too red. No exophthalmos." The patient was discharged on January 25th; the action of the muscles was then normal, but vision was completely lost. The pathological view taken by Dr. Leared of the case was that a syphilitic growth, probably of a gummatous nature, had been rapidly formed in such a position as to involve the optic nerve as well as the third, fourth, and sixth nerves. Iodide of potassium and the biniodide of mercury were given every four hours in increasing doses until twelve grains of the former and one-eighth of a grain of the latter had been reached. The treatment seemed to confirm the diagnosis. Dr. Leared remarked that while the motor power of the eye was restored, it was interesting to observe that the presumably higher nerve function of vision seemed irreparably destroyed, either by pressure, that had probably been removed, or else by the action of the syphilitic poison.—*Medical Times and Gazette*.

**Polyuria Successfully treated by Ergot of Rye.**—The polyuria in a case reported by Dr. Rendu (*France Médicale*, Feb. 27th, 1878), was accompanied by supraorbital neuralgia, vertigo, with loss of consciousness, excessive thirst and hunger, with emaciation and loss of

strength, although the patient consumed a considerable quantity of food. The urine contained no trace of sugar; the quantity was about ten quarts a day. The urea eliminated by this means in the twenty-four hours amounted to from about 1,250 to 1,400 grains. Before having recourse to ergot of rye, tincture of valerian was first tried for this patient, in the dose first of 15 minims, and soon afterwards of half a drachm. Under the influence of this treatment, the urine diminished by nearly a quart. Sulphate of atropine, in the dose of one *milligramme* (.015 grain), at first, then two, daily, produced a similar improvement; but no advantage was found in persevering in this course, since the appetite diminished with the valerian, and the thirst increased with atropine. Ergot of rye was then tried. The success with this agent was remarkable. In eight days the urine fell to 1,600 *gram.* and the urea to 15 *gram.* in the twenty-four hours; the emaciation was stopped; the strength returned; whilst the thirst and the excessive desire for food also disappeared. Dr. A. Costa, (*New York Hospital Gazette*, Feb. 15th,) reports also a case of a diabetes insipidus, with the excretion of ten pints of urine daily, without sugar or albumen, marked by great emaciation; and states that he treated the patient with fluid extract of ergot, which treatment had been followed by striking success; *i. e.*, complete cure in two cases in private practice. Dr. A. Costa put the patient upon an initial dose of half a drachm of the fluid extract, thrice daily, the dose to be increased gradually, first to one drachm, and then to two drachms. There was at once apparent great reduction in the quantity of urine passed daily. From ten pints it fell to six pints daily; then to three, where it remained. Even before reaching the present limit, he ordered the dose to be gradually reduced, first to one drachm, and then to half a drachm. Then it was stopped altogether, mint water substituted in its place. For the past two weeks he had no ergot, and might be considered permanently cured. The amount of urine daily passed varied between two and three pints.—*British Medical Journal*.

**Administration of Dialysed Iron.**—In the *Medical and Surgical Reporter* for April 6th, appears a letter from M. Diehl, M.D., of Jeddo, Pa., in which that gentleman proposes the following novel method of administering dialyzed iron. The case reported was one of anæmia, with strongly marked hysterical symptoms, and such an irritable condition of her stomach as to preclude the internal use of iron :

In the early part of October, 1877, I procured some dialysed iron, from Wyeth & Bro., Philadelphia, with the purpose of giving it hypodermically, as the patient's stomach was then too irritable to bear large or frequently-repeated doses of the medicine. I commenced by giving eight minims, combined with an equal quantity of water, one, two, three and four times a week, as my time and the patient's inclination permitted, the injections being usually given in the fleshy part of the arm. The iron, in most cases, produced very little irritation beneath the skin, and in no case did inflammation or abscess supervene. The dose of the medicine was laterly increased to 16 minims, with water in the same proportion, and given with the former frequency, or rather infrequency, and at the end of four months I saw a marked change in the appearance of my patient; her stomach was less irritable, and she can at present eat an ordinary meal of mild, nutritious food, very seldom vomiting; her menses have returned more regularly and more natural in appearance; she has had no return of the convulsions for nearly two months, though she says that she has felt them slightly on several occasions. Sewing, and light house work she can now do without much fatigue, and is free to a great extent, from those severe pelvic pains which formerly caused so much annoyance and suffering. I feel very much gratified with the result obtained by the use of this preparation of iron, and should not hesitate to administer it in the same manner in other cases, should the opportunity offer.

Another means of which I have availed myself to introduce this iron into the system is to saturate a small pledget of cotton with about thirty minims of it, and introduce it into the vagina, where the mucous membrane offers a large surface for its absorption. I think I have seen a few people benefited by this procedure

**Treatment of Exophthalmic Goitre by Galvanization.**—In the *Gazette Medica Italiana*, Dr. D'Ancona relates the case of a woman aged nineteen, suffering for two years from exophthalmic goitre, the usual train of symptoms being well-marked.

In spite of all kinds of treatment she had arrived at such a stage of cachexia that her life was despaired of. At length galvanization with ten elements of Stöhrer's portable battery was tried, and on finding that it was followed by rapid signs of amelioration, it was persevered in for five months. During this time one hundred sances, lasting from three to five minutes each, were given to the patient. She gained thirty pounds in weight; her face lost its paleness, and regained its natural colour; the exophthalmia disappeared almost completely, as well as the enlargement of the thyroid body, and the pulse fell from 130 to 90. Menstruation was restored, and in every respect the health of the patient was entirely re-established.—*Medical and Surgical Reporter*.

**Gelsemium Sempervirens in Neuralgia.**—The action of this drug in affections of a neuralgic character, says the *Medical Examiner*, has recently been studied by Dr. Emery-Heroguelle, who made it the subject of his inaugural thesis. A summary of his observations appeared in a recent number of the *Paris Médical*. Taken in a large dose gelsemium produces frontal headache, stunning, visual troubles, diplopia, contraction of the pupil, and dropping of the upper eyelid. There is also weakness of the legs. The author reports six cases of intoxication from the drug, taken in mistake. Gelsemium is administered in powder or in pills, in the dose of three-fourths of a grain to three grains of the powder of the roots. It may also be given in the form of tincture, made with 100 parts of alcohol at 60° to 5 parts of the powdered roots. The dose is from 40 to 80 drops. A syrup may be also made by adding 50 parts of the tincture to 1000 of the simple syrup. M. Dujardin-Beaumetz has also had prepared an aqueous extract and an alcoholic extract. M. Emery-Heroguelle reports

thirty-one observations collected in the service of M. Dujardin-Beaumetz, and from foreign journals, all of which refer to the action of the drug on neuralgia. From an analysis of the results, it appears that gelseminum may be especially looked upon as an anti-neuralgic; that it acts favorably in cases of dental neuralgia of the 5th pair, of the frontal, temporal, supra-, and infra-orbital nerves, the brachial plexus, the intercostal and ilio-lumbar nerves. Sciatic neuralgia appears to resist, rather more than other neuralgias, the calming effects of this tincture. Dr. Ortille, of Lille, however, succeeded in curing with this remedy a patient who had suffered for a long time from sciatica which resisted all sorts of therapeutic means. The author considers gelseminum to be a powerful sedative in neuralgia, especially in those varieties which are not accompanied by that local fluxion in the effected point. Favourable results have also been seen in hemicrania.—*Medical and Surgical Reporter.*

### **Poisoning by Digitaline. — Recovery.**

In *La France Médicale* for 13th April, M. G. Béringer reports a case of poisoning with digitaline, which was admitted into the Hôpital Saint Louis under the charge of Dr. Hillairet. The particulars are as follows:

C., a female aged 28 years, was admitted into the hospital on the 26th February, 1878, suffering from symptoms of poison. Some time before she had been in the hospital under treatment for some cardiac affection. On her return home she became so depressed in spirits that she determined to destroy herself, and for this purpose procured 74 granules of d'Homolle and Qui-venne, each containing a milligramme of digitaline. She swallowed 14 of the granules on the 25th of February and the remaining 60 the day following. Shortly after swallowing the last dose she lost consciousness, and within one hour she was brought to the hospital. On admission the symptoms observed were, face pale and bathed in perspiration, apparently unconscious and unable to stand, two persons had to assist her to her bed. There was pain in the head and stomach and after getting to bed violent vomiting, chiefly of bilious matter, set in.

These efforts at vomiting were accompanied with pain in the stomach, dizziness, buzzing in the ears, loss of sight, dilated pupils, pulse weak but regular and about 40 in the minute. There was a harsh systolic murmur at the apex of the heart. An emetic was prescribed and strong coffee given *ad libitum*. The vomiting continued throughout the night at intervals, she did not sleep and in the morning the extremities appeared much congested, and she complained of a pricking sensation in her hands and feet, which was augmented on pressure—had passed no urine.

*Feb. 27.* She appeared much weaker, was unable to raise her head, vomiting continued, pain complained of along the vertebral column, the arms and legs were cold to the touch and the sense of pricking more extensive, Before taking the granules the catamenia had set in, but since, the flow had been quite arrested. The vertigo, ringing in the ears, loss of vision and pain in the head were of the same intensity. The pulse was still weak, slow, 40 in a minute but very regular. Temperature in the mouth,  $36^{\circ} 8'$ ; in the axilla,  $37^{\circ}$ . During the day from 150 to 200 grammes of urine was passed, which gave a heavy deposit of urates but there was neither sugar nor albumen in it. During the night there was a marked improvement in her condition. Vomiting continued but at longer intervals, she had some sleep, the extremities were less cold, the pain in the head was less intense but the vertigo much the same, pulse 44 in a minute, of the same character and the temperature was the same as in the morning.

*28th.* The report is much the same. There is still great prostration, her movements are sluggish and painful, vomiting persists less often, and there is diarrhœa, pulse 50, weak but regular, temperature in the mouth,  $36^{\circ} 4'$ , in the axilla,  $36^{\circ} 2'$ . The coffee was continued and an injection containing morphia was ordered as she had passed three liquid stools. At night she was quieter, inclined to sleep, vomiting at longer intervals, sight improved, ringing in the ears gone, less pain in the head, but still marked, in the precordial region urine scanty. Temperature the same as in the morning.

*March 1st.* Is much improved, feels stronger. The pain in the head is less, vision no longer impaired, vomiting has stopped, sleep calm, and she complains only of diarrhœa, which is not distressing. Her pulse remains slow and weak, 44 in a minute, but very regular. Catamenia returned to-day.

From this time she progressed favourably, and she was discharged from the hospital on the 6th of March, at which time her pulse was regular, somewhat stronger, and 60 in a minute.

**Cæsarian Section And removal of the Uterus.**—Prof. Späth related the following case to the Vienna Medical Society (*Allg. Wien. Med. Zeit.*, January 22.): A woman, aged 40, was admitted into his clinic pregnant with her tenth child. She had borne five living children, had aborted three times, and in her last labour the child's head was perforated. For the last five years she had suffered from osteomalacia. She was pale and considerably emaciated, suffered from a considerable bronchial catarrh, and there was much albuminuria, together with œdema of the lower extremities. On examination it was found that so great a degree of contraction of the pelvis existed that the Cæsarean section was absolutely indicated. Endeavours were made, without much success, to increase her strength while she was kept in a separate room awaiting the occurrence of pains.

After mature reflection, guided by former experience, Prof. Späth resolved that he would perform the Cæsarean operation under Lister's method; and in the case of the uterus not contracting completely, and thus endangering the occurrence of subsequent hæmorrhage, he would proceed to its entire removal. Although every case of Cæsarean section performed in the Vienna Lying-in Hospital during the last century had terminated fatally either from septicæmia, peritonitis, or hæmorrhage, yet, encouraged by the success of Péan and Porro in their cases of removal of the uterus, he hoped by the aid of Lister's method, and the prompt extirpation of the uterus if necessary, to secure a better issue in this case. Accordingly, on June 2, 1876, labour pains having become active, he performed



the Cæsarean operation, and removed a living child without any difficulty. An injection of ergotin had been previously made in order to secure energetic uterine contraction ; but, as this did not take place, and as considerable hæmorrhage occurred, which iced water failed to arrest, the extirpation of the uterus was resolved on. The uterus having been secured in the neighbourhood of its neck by the chain of the écraseur, and raised up from the wound, Prof. Späth separated its body from the neck by some strokes with the scalpel. The cavity of the abdomen was carefully cleansed, and the wound was united, securing the pedicle at its lower angle. The whole operation scarcely occupied an hour. The patient soon came to, and complained of but little pain. The subsequent course of the case was most favourable, the highest temperature being  $38.6^{\circ}$  C. The albuminuria and *œdema* disappeared. The patient's strength was kept up by champagne, and the catarrh, which had been very troublesome, diminished. On the tenth day the end of the pedicle fell off; and on the thirty-eighth day after the operation the patient was able to stand, and eleven days afterwards to walk in the garden. On September 18 she was discharged cured. In October the small fistula which remained after the union of the rest of the wound had completely healed, and the patient was rid of all her suffering.

Prof. Späth exhibited the patient to the Society, then some eighteen months after the operation, in the enjoyment of complete health, the pains caused heretofore by the osteomalacia having disappeared. On examination the freely moveable cervix could be felt high up, but no exudation was perceptible beyond. Prof. Späth believes that this procedure will be found to deserve adoption in preference to simple Cæsarean section. The wound in the uterus is definitively smaller, and can be submitted to external treatment, and uterine hæmorrhage and endometritis become impossible (nor can the woman, we may add, become again pregnant, as sometimes happens notwithstanding the danger that has been run in Cæsarean section).—*Medical Times and Gazette.*

**The Actual Cautery in Chronic Joint Disease.**—C. Jaffé refers to the excellent results recently obtained in chronic diseases of the joints by Richet, Julliard, and Kocher from the employment of the actual cautery. The most convenient form of applying it, he considers to be the thermo-cautery of Paquelin, a strictly antiseptic method of treatment being subsequently adopted. He observes that with the aid of percussion of the bones it becomes in many instances possible to determine the precise seat of the most intense processes of inflammation, and that in cases of primary or secondary central osteitis, the seat of the disease may be attacked with the thermo-cautery, either with or without previous incision and removal of the affected part, and that thus further mischief may be averted and all danger of secondary implication of the joint avoided. He gives a series of cases in which this plan of treatment was adopted with the best results.—(*Inaug. Diss. Strassburg, 1877, and Centrablatt f. d. Chirurgie, 4, 1878.*)—*Practitioner.*

**Treatment of Transverse Fracture of the Patella.**—At a late meeting of the Clinical Society, the President, Mr. George W. Callender, brought a patient fitted with an apparatus which he had employed for some time past, at St. Bartholomew's Hospital. It consisted essentially of a sheet of plaster fitting to the thigh, and extending to the upper margin of the patella, with loops on either side of that bone, and a canvas slipper between which, acting from the sole of the foot and the loops in the plaster, such extension was made by means of pulleys as suffices to draw the upper fragment down to the lower portion of the broken bone. It was easy to regulate the tension, and when it was thought well for the patient to get up, the apparatus was left on, as it acted just as well when the man was walking about as it did whilst he was recumbent in bed. Practically the appliance had been found to insure very good results.—(*Medical Times and Gazette, March, 2, 1878.*)—*Practitioner.*

CANADA

# Medical and Surgical Journal.

MONTREAL, MAY, 1878.

## THE BRITISH MEDICAL ACT AMENDMENT BILL.

There appears to be an earnest desire to establish in Great Britain conjoint examining boards, one for each division of the United Kingdom, and it is quite possible that the measure may carry during the present session of the Imperial Parliament. The Bill was introduced into the House of Lords by the Lord President of the Privy Council, His Grace the Duke of Richmond and Gordon. The bill was read a second time on Monday, 15th April. On this occasion His Grace made the following remarks which we take from the *British Medical Journal* of April 20th :

“The history of the Bill was this. In the month of May of last year, he received from the General Medical Council through its President—of whom one could hardly say too much either from a professional point of view or in reference to the manner in which he discharged his duties as President of that body—a memorial in which he was asked to deal with five points : first, the foreign and colonial degrees ; second, the registration of the medical qualifications of women ; third, the appropriation of penalties under the Act ; fourth, midwives ; fifth, the lunacy laws. It is a remarkable fact that the conjoint scheme was not included in that memorial of the Medical Council. He did not say that council was not alive to it ; but certainly the question was not brought under the notice of the Medical Council. He was quite willing to admit that if there were an uniform and satisfactory test, more especially with this Bill, it would be possible to deal with unqualified practitioners in a more stringent manner than they could now be dealt with, and he thought it possible that the best mode for having such a test was for a conjoint scheme. His noble friend when filling the office which he had the honor to occupy had endeavoured to legislate on the subject, and his experience in 1870, had led him to very candidly acknowledge that the task was no easy one. There were a number of interests which required considerable attention in order that a means of reconciling them one with the other might be found. And it was by no means clear that success in that direction was attainable. In England the difficulty in respect of a conjoint scheme was not so great. The Universities of Oxford and Cambridge

did not object to such a scheme. In Ireland, again, as all the medical bodies were more or less centered in Dublin, he did not imagine there would be any great difficulty. In Scotland, however, the case was otherwise. There were the College of Surgeons, the College of Physicians, and Faculty of Physicians in Edinburgh; the Universities of Edinburgh, Glasgow, Aberdeen, and St. Andrew's—all of which would be very much affected by a conjoint scheme. The fact was—so desirous had he been of, if possible, coming to a conclusion which would enable him to legislate on the difficult subject—that he had adopted the alternative his noble friend condemned very severely, and made the provision as to a conjoint scheme permissive for the three parts of the United Kingdom; and in order to meet the objection to the provision being only permissive, he had raised the qualification of medical practitioners by providing that no person could be placed on the Register of the Medical Council who did not possess two qualifications—one in surgery, and the other in medicine. He was quite ready to admit that this was not the best solution of the difficulty, but it was a step in the right direction supposing that it was not possible to insert in the Bill a compulsory clause, for the three parts of the United Kingdom. He was aware of the objection taken to the Bill by the medical bodies to which his noble friend had referred, and he was far from saying that there ought not to be a conjoint board. He thought it would be dishonest of him to say that it would not be an advantage to the country: but it was not always easy to carry out by Act of Parliament what one thought desirable. The clause in the Act referring to the medical examination of women was inserted to cure a technical defect in Mr. Russell Garney's Act, and would not render it more difficult for women to enter the medical profession, except inasmuch as it raised the standard of qualification for registration by requiring a double qualification from all persons who sought to be put on the Register;

The Bill was then read a second time.

At the session of the General Council of Medical Education and Registration, the bill as introduced before the House of Lords, was discussed clause by clause, and adopted. In reference to the conjoint examining boards the following motion by Dr. Humphrey, seconded by Sir James Paget, was carried by a large majority of the Council:

“Whereas, in 1870, this Council passed the following resolution by a large majority, and after much deliberation: ‘That this Council is of opinion that a joint examining board should be formed in each of the three divisions of the kingdom, and that every person who desires to be registered under any of the qualifications recognized in schedule (A) to the Medical Act shall be required, previously to such registration, to appear before one of these boards and be examined in all the subjects which may be deemed advisable by the Medical Council; the rights and privileges of the universities and corporations being in all other respects the same as at present;’ and whereas the council has subsequently sanctioned a scheme for an examining board for

England made in conformity with that resolution; the Council adheres to the principle of that resolution, that it is of opinion that no medical legislation relating to examinations will be satisfactory which does not provide for the formation of an examining board in each of the three divisions of the kingdom, and direct that every person who desires to be registered under the Medical Act shall be required to appear before one of these boards and be examined in the subjects which may be deemed necessary by the Medical Council."

The discussion, as reported which followed on this motion, is remarkably interesting. The Scotch and Irish representatives opposed the adoption of the conjoint scheme, as degrading their university privileges, and it would appear that some of the English colleges seem unwilling to surrender privileges which they have held for centuries. To soften the agony of severance of those privileges, the provisions of the bill as introduced, are permissive and not compulsory. Turning again to the report of Medical Council, we observe what more especially affects our own graduates. The motion, as adopted, reads as follows:

"That when a person who has been a bona-fide resident in a British possession outside the United Kingdom, shows that he is of good character, and holds a recognized diploma or diplomas (as hereinafter defined) granted in British possessions, such person shall, upon payment of the registration fee, be entitled, without examination in the United Kingdom, to be registered as a colonial practitioner in the Medical Register."

This is satisfactory as far as it goes, but we are unable to give our readers the desired information of what constitutes a "recognized diploma." In Canada we have no uniformity in this respect, a diploma or degree does not give any right to practice, it is merely an evidence of proficiency, but the holder must possess a license to practice before he can do so legally. Again, the method of granting that license *ad practicandum* is not uniform throughout the Dominion. In Ontario the candidate must pass an examination before a central examining board. This is the only condition required, provided he (the candidate) can give evidence of regular study at a recognised college or university. In our own province he is required to present his diploma and pay fees, and satisfy the board that he has obtained his diploma after a regular stated term of study, but no examination is exacted, provided the diploma gives evidence of his holding the double qualification.

## MCGILL MEDICAL SOCIETY.

The first meeting of this Society for the Summer Session took place on Saturday, April 20th, at 8 P.M., Mr. Sutherland, Vice-President, in the chair, in the absence of Dr. Osler.

After the reading and confirmation of the minutes of the last meeting, the following gentlemen were proposed for membership: Messrs. B. W. Burland, McCully, T. L. Brown, Spencer, R. C. MacDonald, Burwash, McCullough, Lloyd, J. J. McCaffrey, Williston, and J. Smith.

The Librarian reported that the Society now took seven medical journals for circulation among the members.

The election of officers for the ensuing session then took place, resulting as follows:

President, Dr. James Bell; 1st Vice-President, Mr. W. R. Sutherland; 2nd Vice-President, Mr. Thomas Gray; Secretary, Mr. Hans Stevenson; Treasurer, Mr. Gurd; Librarian, Mr. Mignault. Councillors: Messrs. Lawford, Imrie, and Small.

Mr. Gray then described a heart met with in a subject dissected by him during the winter, and which presented extensive disease of the aortic valves, these structures being converted into irregular granular masses. The walls of the heart were flabby; those of left ventricle did not appear much hypertrophied. No dilatation. Other valves normal. Liver and spleen enlarged and firm.

A short discussion took place on Phthisis consequent upon Pneumonia, after which the meeting adjourned.

APRIL 27th, 1878.

The regular meeting was held this evening, the President, Dr. James Bell, in the chair.

The minutes of the last meeting were read and confirmed.

Mr. C. A. Weagant was proposed for membership, and the gentlemen proposed at the last meeting were then balloted for, and unanimously elected.

Mr. Sutherland read a paper on Lithotomy, giving a sketch of the history of the operation from the earliest times, and a description of the instruments employed by the older surgeons; concluding with the notes of a case in the Montreal General

Hospital of stricture, with stone in the bladder, in which Dr. Roddick successfully performed the operation of urethrotomy and lithotomy. In the discussion which followed, Dr. Osler referred to a paper by an Indian Army Surgeon in the *Dublin Journal*, 1871, descriptive of the native stone cutters of India, who operated with remarkable dexterity and with a measure of success quite unknown to the surgeons in Europe, the mortality being only about  $\frac{1}{4}$  per cent. Certain districts in India were notorious for the prevalence of stone, and Surgeon-Major Harvey of the Indian Army, while passing through here a few years ago, had mentioned that some of the army surgeons reckoned these cases by hundreds, and he himself brought a cabinet of 79 stones obtained during two years sojourn in a stone district. Of these cases eight only were lost.

Mr. Small asked whether the residents of any district in Canada were more subject to stone than those of others.

Dr. Ross said he did not think so, and remarked that stone in the bladder was not a very common disease here.

Dr. Osler exhibited sections of the anterior tibial artery, occluded by arteritis obliterans. The specimen was from a woman aged 73, the subject of dry gangrene of the foot, for which Dr. Fenwick had amputated the leg just below the knee. On carefully dissecting the arteries it was found that the ant. tibial was pervious as far as the middle of the leg, while here in an extent of  $\frac{1}{2}$  of an inch its lumen was almost completely closed by a chronic arteritis. Above and below this point the artery was empty, the walls rigid and thickened. The dorsalis pedis and dorsalis hallucis were also empty, the latter being closed by a small thrombus at the limit of the gangrenous portion. Sections of the artery at the obliterated region show the disease to be chiefly in the intima, which is enormously thickened and converted into a low variety of connective tissue, having a translucent aspect and with only a few nuclei scattered through it. The media was also affected, annular calcification having taken place in bundles of the muscle fibres.

Dr. Osler also exhibited the uterus and ovaries of a woman, aged 23, who had died of pneumonia exactly fourteen days

after the beginning of the menses, which had been cut short by the illness. The woman had been a prostitute and the pelvic peritoneum presented, as is so common in this class of patients, signs of old inflammation, numerous bridges passing across in Douglas's fossa between the uterus and rectum; and the ovaries retracted almost to the uterus by shortening of the broad ligament. The Fallopian tubes were twisted and dilated, and the external tissue of the ovaries thickened and of a very opaque, white colour. The mucous membrane of the uterus was about  $1\frac{1}{2}$  lines in thickness, of a reddish colour, and, as the sections exhibited showed, tolerably normal. The Fallopian tubes were distended with material composed of blood corpuscles and desquamated epithelium. In the left ovary was a fresh corpus luteum  $\frac{1}{2}$ " long, the lining wall yellow, not folded; the interior was filled with coagulated blood. Dr. Osler stated that he had brought forward the specimen to enable him to refer to a recent valuable paper by Dr. Leopold in the *Archiv für Gynæcologie*, on the structure of the uterine mucous membrane during menstruation, a subject which has been brought prominently before the profession in the past few years by Kundrat, Engelmann, Williams and others. In the present case no reliable deductions could be drawn as the woman had died of an acute disease, the onset of which had interrupted the menses. Leopold had examined the uterine mucous membrane on the 1st, 2nd, 3rd, 4th, 8th, 9th, 21st, 24th, 25th, and 26th days during and after menstruation in healthy women who had died of various accidents. Two or three days before the menses appear the membrane is swollen, having reached its greatest development, not presenting at this time any signs of fatty degeneration nor is it congested. The hæmorrhage proceeds from the capillaries of the superficial part of the mucosa, the epithelium of which and the upper part of the glands alone being thrown off in the process, and not, as Williams supposes, the entire membrane. He has not found marked fatty degeneration of the membrane a constant feature. One very remarkable case was referred to at length; that of a girl 23



years old who was killed on the 26th day after menstruation, *i. e.*, two days before the next period. The uterine mucous membrane was swollen, 4 to 5 m.m. in diameter, and neither congested nor fatty. In the right ovary a ruptured and collapsed Graafian follicle was found, into which extravasation had not yet taken place. Dr. Leopold inclines to the belief that the ovum is always discharged 2 to 3 days before the onset of the menses, and that impregnation is much more likely to occur at this time than at any other. Moreover, the uterine mucous membrane is in a suitable condition for the reception of the germ, being in its highest condition of development, whereas, during and after the menstrual discharge it is undergoing changes, the superficial portion being cast off. If the ovum happens to be fecundated, the menstrual flow, which would have supervened in a few days, is interrupted, or else appears in a modified form. The beautiful coloured plates accompanying the paper were then handed round.

Mr. Lyford detailed some abnormalities met with in a subject dissected during the winter.

1st. The left styloid process was three inches long, and articulated with the lesser cornu of the hyoid bone. The process was in two parts, the lower  $2\frac{1}{2}$  inches, and the upper half an inch, and they were joined together by a capsular ligament. This is rare, and is considered to be an ossification of the stylohyoid ligament. This corresponds to the epiphyoid bone of the lower animals.

2nd. The jugular process of the occipital bone on left side was prolonged downwards, and articulated with the transverse process of the atlas. This is the normal arrangement in graminivorous animals, and takes the place of the mastoid process. This is a very rare abnormality indeed.

### Personal.

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