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## Original Communications.

## DIAGNOSIS OF CROUP.

BY A. HAMILTON, M.A., M.B., PORT HOPE, ONT.

The summons, oftenest at night, to see a child, previously healthy, who has an acute attack of what the mother calls, or dreads, as "croup," is of sufficiently frequent occurrence and significant import to be worthy our attention. Observe, at the outset, that the case supposes a child, in fair health, with an acute attack, in which the symptoms point to a throat lesion. This will exclude a number of diseases which, with others, are purposely passed by with brief mention.

Croup may be mistaken for (1) *tonsillitis*, but inspection excludes that. (2.) A *foreign body* in the larynx or trachea, but the absence of the peculiar cough, of fever, the paroxysms not completely intermitting and the history of the case sufficiently exclude this. (3.) In ordinary *bronchitis*, symptoms do not point to the throat, but in that form called capillary we have unremitting dyspnoea and fine râles in the lungs. In any lesion likely to be called croup, the dyspnoea at least remits, and râles, if present, are coarse, and only there because of a previously existing bronchitis. (4.) *Whooping cough* occurs in epidemics, and so, if no epidemic be prevalent, may fairly be left out. (5.) *Retro-pharyngeal abscess* is excluded by the child's being supposed in previous good health, the most common cause of such abscess being caries of vertebra, which implies a child in bad health. Furthermore, with it we would have difficulty of swallowing not present in croup, tumefaction and stiffness of the neck, while its access is seldom so sudden as that of croup. (6.) *Edema of the glottis* is a disease of adults nearly always, and when present in a

child is a sequel to a previously existing disorder, while the premises suppose a healthy child. (7.) *Hysteria* is excluded by our patient being a child, while hysteria generally occurs in adult women.

The way being now cleared of these seven already mentioned (they being left out of consideration for the future), the practitioner, summoned to our supposed case, may fairly ask himself what disease of several he is likely to meet. It will be almost certain to be one of three: 1. LARYNGISMUS STRIDULUS; 2. LARYNGITIS CATARRHALIS ACUTA; 3. LARYNGITIS CROUPOSA, called respectively spasmodic, false, and true or pseudo-membranous croup. These three diseases have one symptom common to them all, viz., dyspnoea, or attacks of dyspnoea, bordering on suffocation and depending on obstruction at or in the larynx. You may fairly ask me at the outset to define these diseases and give their pathology, as at the present stage of medical science their names are not so frequently at the ends of our tongues, nor their pathology as well settled as that of many other diseases.

LARYNGISMUS then consists in spasm of the larynx, due to irritation, the means of communication between the source of irritation and the larynx being the par vagum. The term laryngospasm is, perhaps, best reserved as a name for spasm of the larynx, considered as a symptom, while the name laryngismus is reserved when considered as a disease. It is doubtful if it be a disease at all, any more than dropsy is a disease, although the Royal College considers it such, and in so far, we are bound to accept it as such. I do not discuss its pathology, whether due to enlarged thymus gland or not, but content myself by stating it again and more fully: "It seems to be an independent affection of the par vagum, or of its recurrent branch, due either to pressure along some part of the course of one of these nerves or to centric irritation at the root of the vagus, or else we may be compelled to regard its exalted sensibility as a reflex phenomenon arising from excitement of some other nervous trunk. In most cases," continues Niemeyer, "its pathogeny is obscure."

In the second place, ACUTE LARYNGEAL CATARRH consists of inflammation of the mucous membrane of the larynx, so that the normal cylindrical epithelium, which forms the uppermost layer of the larynx, falls off largely. The mucous

membrane is loose, succulent, moist and reddened; the submucous tissue is sometimes swollen, sometimes not, while small superficial ulcerations are often found in cases quite recent. It is usually in the higher grades of this inflammatory action that we are summoned. The milder forms are not seen by us. They are commonly given over to quack treatment, instead of being left, as they should be, to nature unthwarted by senseless remedies.

In the third place, CROUPOUS LARYNGITIS consists of inflammatory action affecting the mucous and submucous tissues, the areolar, glandular and other structures within its range or adjacent, accompanied by an exudation, consisting of cells and interlocking and rapidly coagulating fibrin. If you object that this definition includes diphtheria, it cannot be denied. If a difference be admitted, it is that the inflammation called diphtheritic is of a higher grade than the croupous. Clinically there is some difference as to location, and therefore as to treatment, but pathologically separate them if you can.

Before proceeding to the bedside, let us stop to answer the following query: Do you admit no higher grade of inflammation than the catarrhal, and yet which is not croupous? In other words, may not the child you are going to see have acute laryngitis? In other mucous membranes, as the intestinal in dysentery, of the conjunctiva, of that of the tympanic cavity in suppurative otitis, of the urethra, we have such; but in the larynx it is of extremely rare occurrence as a disease *per se* and of idiopathic origin. If we leave out obviously exciting causes, it is a fair question whether we ever see acute laryngitis. The scald from hot steam and the occurrence of laryngitis from extension from adjacent regions, as from inflammation of the œsophagus, due to swallowing boiling or corrosive liquids, and as following some diseases, is not uncommon, notably variola, diphtheria, and scarlatina.

With these remarks, in regard to pathology, let us approach the bedside to carefully diagnose before we begin to treat. If we have ventured there without having laid the sound basis of accepted and regular pathology, we are rank empirics and likely to remain such.

Of these three diseases, laryngismus, catarrhal laryngitis and pseudo-membranous croup, it is to be observed that the latter two consist of inflam-

mation, the first in spasm. In laryngismus we have no cough, no aphonia, no fever; the temperature is within the normal range or below it. Our reliable and well-tried thermometer is the touchstone, and settles the question as to the presence or absence of the first. The skin is not hot, but rather cool, while the child presents a palor the opposite of flush, and this too when *a priori* we would expect the system to manifest irritation. Spasm of the glottis has so far interfered with aëration of the blood as to have produced this even abnormally cool condition.

Might not the skin, you ask, during the last days of a true croup, about or likely to be fatal, be just as cool, and how then are we to distinguish? In true croup we have a history with no intermission, barely a remission, of alarming symptoms, and especially a history of *fever*. There has been and is yet considerable *cough*. These are almost absent in laryngismus. If the latter has lasted several days already, it is because the exciting irritant is still present. In case contraction of the thumbs or feet, twitchings, squint, or general convulsions are, or have been present, they belong to the spastic affection, to the neuroses, and not to the inflammatory.

One of the journals, on which I cannot now lay hand, some time ago, recorded a striking case of laryngismus, well illustrating a point or two here brought out. A young child, and the great majority of cases of laryngismus are under a year, had been a sufferer for several days. The case was exceedingly well marked—as well marked as the treatment, often changed, was ineffectual. An enema seeming necessary, and that, judging by the record of the case, given more by routine than by rational indication, a body half-a-finger in length was brought away. On examination it proved to be fecal accumulation around half a head of rye or some other grain. The child was instantly better, as if by magic. I lost two of the first three cases I saw, by a too exclusive reliance on the empirical use of bromide of potassium. In America the source of irritation is in the alimentary canal nineteen times out of twenty, somewhere between mouth and anus, in the gums, stomach, duodenum, colon, or rectum. Laryngo-spasm is a frequent symptom of rickets. The worst and most persistent case I ever saw was cured by recognizing this fact and pushing the administration of iron

and cod liver oil, with valerian as an anti-spasmodic as long as needed. But rickets, common enough in the old world, is rare among the well-fed, shall I say over-fed, children of the new. Next, after the alimentary canal and such constitutional affection as rickets, head lesions may be suspected near the origin of the pneumogastric nerve.

Having, on the other hand, excluded laryngismus, one element in the problem is eliminated. It remains to distinguish the inflammatory affections. Is it false or true croup? Is it catarrhal or pseudo-membranous laryngitis? Here we have the semblance of spasm too. This, however, is only true in the sense that every cough is spasmodic action. It has been said that there is a constant spasmodic condition of the glottis with exacerbations at intervals. This is all wrong. There is the very opposite of spasm, namely, paralysis, producing the dyspnoea with coughing exacerbations. Animals whose pneumogastric nerves have been cut, and in whom by consequence there has been produced traumatic paralysis of the glottis, die with the exact dyspnoea of croup. This difference between the lumen of the glottis in the adult and child is to be borne in mind. In the child the glottis is a uniformly narrow slit bordered on each side by the true and false vocal cords. In the adult the arytenoid cartilages stretch forward turning their extremities inward in ram's-horn fashion, to the centre of which the posterior ends of the true vocal cords are attached with a triangular space between. Besides, the false vocal cords are withdrawn from the median line, giving a triangular cavity for respiration and the play of the cords. In the child, in any laryngitis, we have then an element of paralysis, for a very moderate inflammation of mucous membrane and subjacent tissue will interfere with the free action of the crico-arytenoid muscles which withdraw the cords and so open the glottis. When there is membranous obstruction of larynx we have greater obstruction from both the exudation itself and the greater attendant swelling, and hence both inspiration and expiration are impeded. When from simple paralysis only, such as is present even in catarrhal laryngitis, inspiration is more impeded than expiration. This we have drawn from pathologico-anatomical considerations. In the milder inflammatory affection, then, having a small amount of laryngeal secretion and the child more quiet, we are apt to have

prolonged sleep with accumulation and drying of the secretion in the larynx. This will occur most at night when the child has slept for some time. Hence the family alarm in the night, and our being summoned most commonly at night in false croup cases. Hence, too, with the dislodgement of the dried mass, relief has come before the doctor. The child has raised the mass to the entrance of the œsophagus and swallowed it. Children seldom expectorate. In cases of true croup there is less likely to have been such a remission as to have allowed much dry accumulation. The disease has been more continuous; while, in false croup, when the secretion is cleared away, the child seems almost well. When a child is reported to have had six, eight, or a dozen attacks, we are about safe in considering them false. These repeated attacks have left a chronic laryngeal catarrh, with predisposition to acute exacerbations, in one of which we are summoned. In a child then who has had several such attacks, they are probably of the catarrhal variety, and for the reason assigned. Hence the reputed efficacy of emetics, which by the acts of swallowing and vomiting in that neighborhood of the larynx, the œsophagus, and by the frequent and forcible opening and closing of the epiglottis, in the acts of emesis, have dislodged the dry and adherent secretion. Hence, too, our practical direction to have the child awakened every two hours, for two succeeding nights, and let it cough and drink. It is better to do this than to have more violent attacks of extreme dyspnoea, threatened asphyxia, and a doctor called out of bed.

When the child is old enough the laryngoscope should be used. This is advisable in distinguishing between the inflammatory affections. It is unnecessary in distinguishing between the simply and purely spastic and the inflammatory; in other words, in excluding the latter. Using the laryngoscope is seldom practicable, and so we proceed without it. If we have succeeded in its use we have found either (1) a catarrhal condition of the mucous membrane of the larynx, with or without catarrhal ulceration; or (2) a higher grade of inflammation with pseudo-membrane about to appear or actually present. Even in young children inspection of the fauces is to be employed. In the gagging of children caused by inspecting the throat I have several times seen the epiglottis. The chance of doing this depends upon the size

of the faucial cavity and is exceptional. Should a white exudation be observed in even small quantity any where in the fauces it is to be carefully examined. It is likely to be attended by more, and in a more dangerous locality, farther down. How are we to distinguish the croupous from the white exudation in other inflammations? Observe how adherent it is. This is the test, even *post mortem*, relied upon in our largest dead-houses, whether it is or is not croupous. The croupous exudation is attached firmly, and detached with great difficulty, being rooted into the follicles. Other exudations are detached readily. In case the exudation seen is not white, and especially if it be of a dirty dark color, the presumption is that it is croupous, this appearance being regular and expected if the exudations have been out a day or two. Other exudations are so easily detached by the motions of breathing and swallowing as not to remain long enough to be anything else than white. In case the dirty dark exudation is removed with difficulty, but more easily than when fresh, it is croupous. More recent exudation of curdy white color will probably be observed elsewhere, if it is looked for. It is in these cases in which there is exudation high up, and which may fairly be denominated diphtheritic, that we are apt to have most marked laryngeal paralysis, because the mucous membrane of the pharynx forms the covering of the posterior crico-arytenoid muscles which in normal inspiration when healthy enlarge the glottis and the mucous membrane is so swollen as to impede muscular action. If physical examination show enlarged glands, the inflammation is of higher type than the catarrhal.

Should physical examination be negative, or out of the question, we can then rely on a comparison of the rational signs only. This is here done in tabular form. The reasons for most of the signs will be apparent if the pathology is kept in view. Otherwise it is chiefly matter of memory—always treacherous when most wanted :

## IN FALSE CROUP.

1. The invasion is sudden.
2. No adherent pharyngeal exudation.
3. Little fever.
4. Symptoms alarming from the first.
5. Morning remissions and evening exacerbations always.
6. Dyspnoea intermits.
7. Aphonia is never complete.
8. May have alarming symptoms developed suddenly without any serious lesion in the lungs.
9. Voice between attacks is natural.
10. Night attacks, seldom in day.
11. No barking cough.
12. Always begins with a whispering cough.
13. No false membrane ejected.

## IN TRUE CROUP.

- Begins slowly.  
May be such.
- Considerable.  
Early symptoms mild, but become slowly and steadily more severe.  
Not so, but gradually and insidiously increasing.  
Dyspnoea remits only.  
May be complete.  
When alarming symptoms develop during its course we will find something to account for it in the lungs or throat.  
Voice is more or less changed.
- Progressive impediment to breathing.  
Begins with a barking cough  
Aphonia is developed after several days.  
False membrane coughed up or vomited.

CASE OF INTESTINAL OBSTRUCTION.—  
LEFT LUMBAR COLOTOMY—RECOVERY.

BY PETER MANSON, M.D., GOLD HILL, NEVADA.

James Cook, æt 41, a Scotchman; came into my office about eight o'clock on the evening of the 27th of Sept., 1878, having travelled during that day by stage coach from Bodie, California, a distance of 130 miles, over a rough mountain road nearly all the way.

He said that his present illness commenced about six weeks previous, and that he had been under the care of the doctors of Bodie for intestinal obstruction. When first taken ill he went about three weeks without an action of his bowels, and was treated during that time with large doses of castor oil and other purgatives. His bowels were greatly distended, tongue dry and cracked, and suffered intensely from wind colic. One of the doctors of Bodie diagnosed the case typho-malarial fever. After three weeks treatment his bowels began moving freely, and continued so for eight or ten days, thin watery discharges. As soon as the stools assumed a little more consistency, the evacuations again stopped, excepting an occasional small stool. The above was his own account of his case during his six weeks' illness in Bodie.

On examination I found the bowels moderately distended with gas; pulse normal, no fever, tongue moist, and slightly coated. He seemed to think that if he could only get rid of the wind he would feel all right. In the region of the cæcum there was a round distention of gas; on pressing over this it would suddenly start, and fly around the colon to the region of the sigmoid flexure, abruptly stopping there; on pressing over the sigmoid flexure, the gas would again fly back to the ileo-cæcal valve. This led me to suspect an obstruction in the region of the sigmoid flexure. The patient said that he had been troubled a great deal with flatus for some months before he was taken down. He thought that his stools had been more narrow and ribbon-shaped than normal. On introducing my finger into the rectum I found a small quantity of fæces. There had been no evacuation of the bowels for five days previous. High up in the rectum opposite the left sacro-iliac symphysis I could feel a slight ridge along one

side of the bowel. The wall of the intestine felt as though it was thickened and somewhat contracted. I then carefully introduced a rectal tube up alongside of my finger, guiding the end into the apparently contracted bowel, but this manipulation caused him so much pain that I discontinued further explorations for the present, and prescribed a pill containing podophyllin, gr. i, ext. colocynth comp., grs. iv., ext. hyoscyamus, grs. ij., to be taken that night, and to report himself next morning. This was the only purgative that was prescribed during my treatment of the case.

I did not hear from him until the next night, when I received a call to see him at a friend's house near the north end of Virginia City. I found him suffering very much from distention of the bowels, colic and vomiting. The pill had not operated; he had passed no gas from his bowels, although belching up considerable quantities from his stomach. I ordered an injection of warm water, but was unable to inject any more than than would fill the rectum, which gave him no relief. I then gave him a hypodermic injection of morphia sulph., gr.  $\frac{1}{4}$ , atropia sulph., gr.  $\frac{1}{16}$ ; prescribed one grain of opium to be taken every two or three hours if in pain; and ordered hot fomentations to be applied over the abdomen. Saw him next morning, found him no better; abdomen more distended, still vomiting, pain somewhat relieved by the opium. Tried injections of warm water again, with the addition of asafoetida, but obtained no relief, not being able to inject any more at a time than would fill the rectum. During the afternoon I called Dr. Hall, of Gold Hill, in consultation. The doctor recommended ext. belladonna in addition to the opium. During the next five or six days we invited Drs. Conn, Aiken, and J. Manson, of Virginia City, to see the case with us at different times, and everything that was likely to benefit the patient was diligently tried, but without relief; the patient getting worse all the time. It was quite evident the obstruction was in the region of the sigmoid flexure. We could never succeed in introducing the rectal tube further than the left ileo-sacral symphysis; nor inject more liquid at a time than would fill the rectum.

On the seventh day of our treatment, we chloroformed the patient, and Dr. Aiken tried to introduce his hand into the rectum to explore the sigmoid flexure more thoroughly, but was unable to

do so. We then introduced a trocar and canula into the large intestine in the region of the cæcum, and let escape a large quantity of gas, which greatly relieved the distention, and enabled us to arrive at a more correct diagnosis of the case. We could feel a hard ridge about two inches long along the sigmoid flexure, and there seemed little doubt but that the cause of the obstruction was a stricture of the bowel in that region, and the only alternative was an artificial anus. To this the patient reluctantly consented, after telling him that the false opening might be closed up at some future time, if he survived the operation, and the natural passage ever got well so as to justify the artificial one being closed. There were no bad effects from introducing the trocar into the cæcum. The bowels were again greatly distended, tongue dry and cracked, with a brown coating over it; temperature not higher than  $102\frac{1}{2}$ ; pulse 120, and the patient's strength failing fast. It was very evident that we would soon lose our patient if nothing more was done, so we decided to operate at once. Drs. Conn, Weber, Bronson, and J. Manson, of Virginia City, were present by invitation. After the patient was thoroughly chloroformed, Dr. Bronson, who has a small hand, succeeded in introducing it into the rectum, but could not introduce it high enough to make any further discoveries. I was ably assisted in the operation by Drs. Hall and Conn, Dr. J. Manson attending to the chloroform. In Bryant's "Practice of Surgery," page 367, he says, "that in irremediable stricture, or mechanical obstruction of the rectum from any cause, Callisen's operation of opening the colon in the left loin should always be followed; and when the seat of obstruction is higher than the rectum, and it is a point of doubt whether it be in the sigmoid flexure or transverse colon, Amussat's operation in the right loin should be performed." In this case the stricture or obstruction was in the lower end of the sigmoid flexure, so that there was little or no danger of not getting above the obstruction by operating in the left loin.

There are three methods of operation, that of Callisen, by longitudinal incision, Bawden's, by oblique incision, and Amussat's, by transverse incision. These different methods of operation are fully described in nearly all recent works on practical surgery, so that it is unnecessary to repeat them here. I chose Amussat's, it being the oper-

ation chiefly recommended at the present day in case of adults. Bryant prefers the oblique incision.

I commenced the operation by making a transverse incision in the left lumbar region, three inches in length about midway between the ilium and last rib; the centre of the incision corresponding to a point half an inch behind the mid-point between the anterior and posterior superior spines of the ilium, according to the rules laid down by Allingham in his work on diseases of the rectum. The fascia and muscles were carefully divided on a director, layer by layer, keeping the bottom of the wound the same length as the incision through the skin. When the incision was made through the lumbar and transversalis fascia, the adipose tissue was unravelled, exposing the colon, which bulged up into the opening, and was easily recognised by its greenish color, distended appearance, &c. The bowel was then caught up from behind by a tenaculum, and pulled forwards and outwards to the surface of the wound, keeping clear of the peritoneum. A curved needle armed with a strong silk thread was then passed through the edge of the wound into the bowel, diagonally across, and out at the opposite side, then another at right angles to the first. The bowel was then opened between the two sutures, the loops drawn out, cut and tied, thus making four sutures, and securing the bowel to the edge of the wound. The balance of the edge of the bowel was then fastened to the edge of the wound by silver wire sutures. The anterior and posterior parts of the wound were drawn together by deep wire sutures, and the operation completed. Works on surgery recommend that the posterior part of the wound be not drawn together by sutures, but left to heal by granulation. I think that it would have been better if I had not closed the posterior part of this wound, as the sutures gave way, and the wound had to heal by granulation. During the operation not more than an ounce of blood was lost; no vessels were cut requiring a ligature. There was only slight hemorrhage from the deep lumbar muscles which was easily controlled by a styptic application, doing no more harm than causing a slight delay in the operation. Shortly after the operation was completed, the bowels commenced moving, and discharged enormous quantities of soft feces through the artificial anus for several days.

It is not necessary to give a history of the patient's condition from day to day. I think that it will embrace all that is required in this case, by stating that the next morning after the operation, the temperature and pulse were normal, tongue moist; and from that time the patient never showed an unfavorable symptom from the effects of the operation. The upper edge of the bowel adhered to the edge of the wound by first intention; but the sutures in the lower side cut through, and allowed the edge of the bowel to drop down into the wound. This gave me considerable anxiety for several days, in case some foreign matter might work its way into the peritoneum, but the constant pressure of feces kept the edge of the bowel pressed out against the wound, which soon formed adhesions, and gave no trouble whatever. In looking over the statistics of these operations, I do not find that the edge of the bowel is very apt to drop away from the wound in case the sutures should give way. Parts of the wound that did not heal by first intention, healed very nicely by granulation, and the patient was soon able to be up, and around. On the seventh and eighth days after the operation, his bowels moved per natural anus; then after that they would only move per natural anus every third or fourth day until the patient was up and around on the streets, when he put a leaden plug into the artificial anus. He had then a natural operation every day; but it caused him so much pain through the pelvis, that he took out the plug, and allowed the bowels to evacuate themselves through the artificial anus. I think that in all probability when the bowels became obstructed, the pressure and distention from above may either have caused the stricture to become inflamed and swollen so as to occlude the narrow opening altogether; or the bowels loaded with feces may have pressed down on the stricture in such a manner as to prevent anything from passing through. After the operation the pressure was taken away from above so as to relieve the stricture, and allow the stools to pass through. This case may have been similar to a case mentioned by Hilton in his twelfth lecture on rest and pain. He says "that upon making a *post mortem* it was found that there was no cancer. There had been contraction of the intestine where the sigmoid flexure of the colon joins the rectum. This had produced an obstruction, and, consequently a distention of the colon.

The weight of the fæces had caused the colon to descend considerably below its normal position, like an inverted syphon; the fæces, therefore, had to ascend, and then could not pass over the fixed point where the constriction had taken place, the weight of the colon making this part an acute angle, and so producing insuperable constipation. When the opening was made into the upper portion of the colon, the weight of the fæces was taken off; the accumulation in the lower part was then forced upwards and made to pass through the rectum."

After the wound was healed, and the patient able to be around, he complained of a great deal of pain through the pelvis, radiating down the right thigh. He would have an evacuation of mucus per natural anus five or six times a day; and the disease in the upper part of the rectum seemed to be steadily progressing. Two and a-half months after the operation, the small hard ridge that I detected during my first examination, widened out into a thickened mass surrounding nearly the half of the upper part of the rectum. I was unable to decide whether the growth is malignant or not, but I am of the opinion that it is. If the disease should ever get well so as to leave no danger from future obstruction, could the opening in the loin be closed up, as I encouraged the patient to believe? There are cases on record where the artificial anus has contracted, and closed by nature. In the *Am. Jour. of Med. Sciences*, Oct. 1873, Dr. Erskine Mason, in an able article on lumbar colotomy, expresses the opinion that the artificial anus could be closed up; but he says in the same article that Mr. Allingham states in his work on diseases of the rectum, that he has made attempts to close this opening, but as yet without success, and this also, Mr. Allingham states, has been the experience of Mr. Bryant. In the *Boston Med. and Surg. Jour.*, Oct. 3rd, 1878, Drs. Cullen and Homans, report a case in which they tried to close the opening, but did not succeed. They had decided to wait several months, and if the contraction of the wound which was then going on rapidly had ceased to take place, to operate again.

In regard to morphia causing constipation in these cases, Sir Jas. Paget remarks in connection with a case that he operated on for cancer of the rectum; that since the fæces had been no longer

subjected to the influence of the rectum, morphia had completely lost its power of constipating, so that the patient could enjoy this drug without becoming constipated. Mason says that he has never seen this statement confirmed by other operators, nor has his experience verified it. In this case we tried morphia and other opiates, but they constipated him so that he preferred to suffer the pain in the pelvis rather than the inconvenience from constipation. On the 19th of December, three months after the operation, our patient started for his home in Glasgow, Scotland, arrived there safely, stood the voyage well and attended to his own wants all the way.

I report this case more for the purpose of recommending general practitioners to try this operation for the relief of their patients requiring it. It would seem to me that a great many general practitioners with a limited experience in surgery think that these operations are only to be made a success in the hands of more eminent surgeons in the large hospitals. I think that nearly all eminent surgeons within the last twenty years speak favorably of this operation. In E. Mason's article in the *Am. Jour. Med. Sciences*, he says that the diseases for the relief of which it has been done, and for which we advocate its adoption, are these: cancer, intricate stricture of the rectum or colon no matter from what cause, obstruction from the pressure of tumors, ulceration of the rectum or colon in some of its phases, and for the relief of vesico-intestinal fistula, especially in the male. He also says in the same article, among the names of those who have probably done most to cause this operation to be favorably received and now so generally done throughout the United Kingdom, though it may be chiefly in London, he would mention the names of Curling, Hawkins, Holmes, Bryant and Allingham, though we are by no means unmindful of the other hospital surgeons of London who have done much in this direction, so that at the present it might be difficult to find one who has not both performed and publicly advocated the operation. Mason also says that in the majority of cases the operation will be found easy, and as far as the life of the patient is concerned, safe.

Mr. Maunder in a clinical lecture published in the *London Lancet*, Jan. 1878, says that he has operated thirteen times, eleven in the left, and two in the right loin. He also says, that in more



than one instance he regretted very much that the operation had not been performed sooner, although it afforded an easy death. This in itself is sufficient justification for an operation which can be done with comparative facility and rapidity, as easily and as quickly as the majority of cases for strangulated hernia. The operation in this case of ours proved to be a very easy one; any competent surgeon could readily have performed it. There was no trouble from hemorrhage, no vessel of any importance was cut. The incision was only three inches in length, still it gave plenty of room to pull out the bowel. The bowel being greatly distended made the operation less difficult. When the colon is empty and likely to give some trouble in finding it, it would be an advantage to make the incision longer.

If the disease causing the stricture in this case should prove to be malignant, it will probably cause other complications and carry the patient off in a short time; but the operation has prolonged his life, and relieved his sufferings to a very great extent. It enabled him to get home to his relations in Scotland, and enabled us to feel that we had done our duty to our patient.

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### TRANSFUSION AND PLETHORA.

TRANSLATED BY DR. J. WORKMAN, TORONTO.

The above interesting *brochure* of 125 pages, in the German language, by J. N. Müller, Prof. of Physiology, Christiania; though published in Norway, exhibits an instructive report of a series of very careful experiments, made by the author on some of the inferior vertebrate animals, chiefly dogs and rabbits, with the view of ascertaining the physiological effects of blood transfusion.

It would be incompatible with the scope of the *Journal*, or the limits of our space, to reproduce the numerous details given by Prof. Müller; we therefore limit our quotations to transference to our columns of the ultimate conclusions of the author on the effects of blood transfusion, based on his own observation and that of other eminent authorities.

"Has transfusion of Lamb's blood ever any beneficial effect?" Both old and recent researches show that by the aid of lamb's and calf's blood, dogs that lay in death agony, from loss of

blood, could be revived; but only for a short time. The transfused blood corpuscles may, for a short time, (most likely only a few hours, as they speedily vanish, and their colouring matter is thrown out), introduce a certain quantity of oxygen, and the mechanical circulatory relations may, as Landois observes, apparently be improved; but this is about all. Whether this foreign blood can bring to the organism any nutrient material, is very doubtful. The harmful influence, (hæmorrhage, kidney disorder, &c.) exceeds the benefit. In the lamb's blood infusion in man, the quantity transfused has been comparatively small, apparently scarcely  $\frac{1}{8}$ , never  $\frac{1}{6}$  of the normal human blood-mass. How far, by means of so small an infusion any profitable result to the nutrient relations may be attained, and how far in this case it may succeed, that either albumen or blood colouring matter may be discharged in the urine, I cannot, from my own observations give answer. I have never made either direct or indirect transfusion of lamb's blood, in small quantity in the dog; they hardly merit experimenting; the shadings before and after the transfusion would certainly be so trivial, that a very detailed and methodical research would be requisite, in order to arrive at any definite conclusion. Speaking, however, from what I have observed, I feel in any case justified in expressing the opinion, that the favourable influence, when any such is perceptible, will scarcely counter-balance the disturbance which is caused by the operation.

If we make a retrospection of the results of lamb's blood transfusion in man, we shall soon discover that they correspond with the phenomena of physiological experiments. As far back as 1667 the French physician Denis, had made very significant observations. In one experiment the individual, within two hours after transfusion of lamb's blood, lost some drops of blood from the nose; in another experiment with calf's blood, the individual was taken with fever—and pains in the region of the kidneys, and voided bloody urine. Next day he passed a large glassful of urine, as black as if mixed with soot. On the third day he passed an equal quantity, nearly as dark as that of the preceding day, and he bled very freely from the nose; on the fourth day the urine became lighter coloured, and by degrees it came back to

the natural color. The Bachelor of Theology, Arthur Coga, to whom the often quoted King, likewise administered lamb's blood by transfusion, had after a second transfusion, transient fever.

Of the resumed transfusions of lamb's blood in late years, the following have been the observed results:—1st, That not seldom strong fever has ensued; such occurred in one experiment, (by Hasse), in which death took place shortly after the transfusion; the temperature rising to  $42.8^{\circ}$  C ( $109^{\circ}$  Fah.) 2nd, That the urine holds largely blood coloring; it seems almost always to be of dark color on the first day. That often the urine has a large quantity of blood coloring, was observed by Czsony, who found in the bladder a quantity of hæmatine corresponding to that of the transfused blood. That infarctions also, after lamb's blood infusions in man, may occur has been shown by a transfusion made by Masing in St. Petersburg, from which death resulted. On dissection, globular infarctions were found in the substance of both kidneys. Icterus has been observed to follow in some cases. In a puerperal woman, who died in 20 minutes after a transfusion of lamb's blood, Herr Ponfick showed by microscopic examination, made almost immediately after death, that in the human vascular system the transfused lamb's blood corpuscles are destroyed. The phenomena are alike, whether lamb's blood be injected in the dog or in man. The reason why a comparatively smaller number of dangerous symptoms are observed in man, lies certainly almost solely in the fact, that the quantity of transfused blood has usually been only  $\frac{1}{2}$ , or  $\frac{1}{3}$ , and at most  $\frac{1}{2}$  of the normal blood mass. In the well known experiments of Hasse, the quantity transfused was in maximum 200 cubic centimetres, and in the average 150 C. C. M. (cubic centimetres). If, however, we put the question, whether the quantity named by the physician was actually introduced into the vascular system, the reply must be in the highest degree doubtful. Hasse, Gesellius, and some others, have estimated the quantity of blood introduced, in a most incorrect manner,—namely: by noting the rate of the outcoming current. I have myself twice discovered that great error is thus fallen into; the transfusion in these instances terminated in  $1\frac{1}{2}$  minutes, and there was no apparent hindrance. After the transfusion the carotid of the sheep was perfectly permeable, and

the blood flowed in a copious stream. I found by weighing the animal before and after the transfusion, that the blood introduced was only 10 or 12 C. C. M., so that the operation had to be repeated. The only correct and reliable manner of estimating the quantity transfused, is by weighing the animal experimented on before and after the transfusion, and as direct transfusion lasts only 1 or  $1\frac{1}{2}$  minutes, the loss by respiration and perspiration is too insignificant to be taken into account.

It may now be hoped that even the most enthusiastic admirers of lamb's blood infusion, after the researches of Landois, Ponfick, and myself, and the unfortunate cases of Hasse, Masing, and Schmidt, as well as the negative results of the transfusion experiments of Fiedler and Birch Hirschfeld in Phthisis, will at last admit, that in this relation the enquiry has been conducted too superficially and thoughtlessly, and that Hasse, without a just consideration of lamb's blood infusion, has rejected that of defibrinated man's blood, of which his own single experience afforded a fortunate result. The grounds on which Hasse gave up transfusion of defibrinated man's blood, were, 1st, that lamb's blood is more active, and its effect of longer duration, and 2nd, that we may thus benefit the sick, without injury to the healthy. As regards these reasons, the first is now fully disproved; and as to the second, it is incontestible; but the injury to the sound person is, as a rule, hardly worth consideration.

Happily the occasions for transfusion in man, are so limited, that the cases in which it is necessary to abstract blood from one person to save the life of another, are of but rare occurrence. We must ever keep in mind, that the transfused blood in itself serves not for nutrition, but that chiefly, and probably exclusively, it benefits the organism by the red corpuscles.

Only after copious hemorrhages, or after certain poisonings,—for example, by carbonic acid gas, and further, in some chronic anemias, in some cases of chronic anemia after blood loss, and of chlorosis and leucæmia, can transfusion be indicated. The indications must be sharply and reflectively defined, if medicine is to draw any valuable conclusions from the observed phenomena. Random transfusion, in all possible infectious diseases,—as the puerperal, typhus, or *en bloc*, in the most varied forms of diseases with

defective nutrition,—for example, phthisis,—any such experimentation represents a far backlying standpoint of medicine; not the loud trumpeting of solitary cases, but the quiet, and the faithfully recorded experiments of physiological and pathological investigators, will, most probably, extend the field of the employment of transfusion by the side of the sick bed.

### Correspondence.

#### WHAT HAS THE ONTARIO MEDICAL BOARD DONE FOR THE PROFESSION?

To the Editor of the CANADA LANCET.

SIR,—Permit me through your valuable space to call attention to certain facts, which are a source of grievance to the medical fraternity, and ask what has the Ontario Board done for the Profession, especially as far as the Eastern counties of this Province are concerned? I believe it has been organized to elevate the standard of medical education, to promote the welfare of the profession in general, and protect it against the aggressions of charlatanism and quackery. Such being its mission, it has, to a certain extent, succeeded in the former, *i.e.*, in elevating the standpoint of requirements for qualification of the honest practitioner, at the same time, almost doubling his expenses; but in the latter it has signally failed. The fees in all the medical schools are higher than they were a few years ago, to meet the higher standard exacted by this Board; and when the student graduates in any University, by which perchance he is drained of the last cent of his hard earning, he has of necessity to make the raise of one hundred or one hundred and fifty dollars more to enable him to pass the Ontario Board before he can do anything for himself. Then he has to submit to an annual tax, to support this Board and a public prosecutor, whilst, at the same time, the growth and spread of quackery seem to be more luxurious and rampant than ever, and the young practitioner, with all his dearly acquired qualifications, makes his exit into the world to battle his way through life entrammelled by professional etiquette, and thereby placed under many disadvantages, to compete with a host of empirics for whom public sympathy has been enlisted by the feigned persecutions of the Boards.

I happen to be one of the unfortunate ones who had to pass the aforesaid ordeal, and began practicing a few years ago in one of the Eastern counties of this Province, where I found to my great surprise and disgust on an average two unqualified persons for every one qualified in the practice of medicine, surgery and midwifery; especially the latter, as you will find one, two, or perhaps three midwives in every section giving their services at the modest rate of one dollar for each accouchement, thus taking the bread out of the mouths of those who have given their time and money to qualify themselves for the practice of the profession, and in many instances jeopardizing the health and prospects, and not unfrequently sacrificing in the lives of their dupes.

I have already incidentally alluded to the public prosecutor. Sometime ago he paid a flying visit to this part of the country, and brought to the bar of justice an offender—an empiric will I say?—No, but a clever young man, a graduate of one of the principal Universities of the Dominion, who had worked his own way through his collegiate course, and graduated with honors, after which he went to practice with the intention of presenting himself before the Board as soon as he could earn sufficient funds to defray his expenses. Now I ask why should this individual be selected whilst the whole country is bespread with those vampires, who fatten upon the credulity of the public, or why not scour the country of all pretenders, if there is any way of putting a stop to this evil, which is degrading the profession to such an enormous extent? I fear ere long the initials M.D., affixed to a man's name will be construed to mean humbug, as every Tom, Dick, and Harry, and every ignoramus in the country is at liberty with impunity to style himself Doctor. It may be said that the remedy is in our own hands, and that we should personally prosecute those offenders, but I feel satisfied that any man trying the experiment and then facing public indignation, will never try the same again.

I was notified sometime ago by the medical Registrar that my subscription towards the common funds was due, and threatened with prosecution unless the same was remitted in due time; but I here publicly declare that unless this section of the country at least, is purged of charlatanism I shall not pay one cent more towards the main-

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tainance of the Board, and if prosecuted will test the legality of such procedure. I am, however, willing to contribute double, or even fourtimes the amount of annual fee at present demanded, if necessary, provided that a proper prosecutor be appointed, and paid to ransack the province, from North to South and from East to West, and free the public and profession from the annoyance of such nuisances. I am credibly informed that the present prosecutor has been invited time and again to this Eastern district, but never filed an appearance save one, the occasion already referred to. Thanking you for inserting this in your valuable space.

I am, yours truly,  
JUSTICE.

March 17th, 1879.

To the Editor of the Canada Lancet.

SIR,—Your correspondent of last month (Student) endeavours to bring the contempt of the profession upon "a regularly qualified medical practitioner in this village, who attends cases of midwifery five miles distant from his office for a fee of two dollars and fifty cents, this, he presumes, including the fee for the usual visit after confinement." The charge is not true—I have no such case on my books, the others deny the charge. If he had said, attended a case, I could easily suppose he was innocent of intentional deceit, but when by the expression—attends cases—he makes out a practice, I greatly fear the sin is a wilful one. He appears anxious to obtain a copy of the Code of Ethics. I trust you will, if possible, supply him; in the meantime he can be assured that bearing false witness against his neighbor is not recommended, neither will he find any intimation that he is at liberty, when he wishes to bring contempt upon another to offer "presumption" for facts. Whether an M.D., is guilty of contemptible conduct by attending cases of midwifery, five miles (or five rods) from home for \$2.50 with or without the extra visit, I will leave for others to decide, as the practice is not in vogue here.

I think, Mr. Editor, you would be justified in demanding some explanation, or in default, in publishing the name of the student who is so anxious to maintain the dignity of his expected associates. Thanking you for the manly stand you have always taken in maintaining the true dignity of the profession.

I remain yours truly.

Odessa, March 29, '79.

W. W. MEACHAM.

To the Editor of the CANADA LANCET.

SIR,—The Registrar-General in his report, speaking of the excessive death-rate amongst children, says: "This reflects but little credit upon the manner in which the resources of medical science are applied in the nineteenth century, and the method in which sanitary regulations are enforced." If he intends this to apply to the *people*, he is right; if he intends it to apply to the medical profession, he is *wrong*. So far as my experience of more than twenty years goes, medical men are faithful in urging attention to sanitary regulations; but as to "applying the resources of medical science," let me tell the Registrar-General that many parents are so sordid that they would rather part with their children than their dollars; and I venture to say there is not in Canada a medical man of extensive experience who has not heard, over and over again, the blood-curdling expression "It is only a child." A vast number of children die without medical attendance; and in a great many instances the doctor is called merely to save appearances. I have been called time and again to see moribund children, and when I pronounced the case hopeless, the parents have, with the utmost coolness, said:—"We didn't expect that you could do anything; but we didn't like to have it die without a doctor having seen it." It is also true that, in the case of children, medical advice is not sought as early as it should be—*not* until the disease has made considerable progress—and the consequence is an increased number of fatal cases. To use a common phrase: "The Doctor had'n't a fair chance."

In reference to the *indefiniteness* of the reports as to the cause of death. Medical men, in country practice, are often called upon, in the case of children, and frequently in the case of adults, to make a post-mortem diagnosis, from a report of the symptoms of the deceased person, taken from the lips of parent or friend, and to fill up a death report. I have invariably refused to fill such reports. It is possible that others have been more accommodating. Either let medical men make a post-mortem examination, in such cases, and charge for it, before filling a death report; or let the case be reported: "Died without the benefit of the Doctor." Such a rule would, I believe, do away with a great deal of indefiniteness.

Yours truly,

Winnipeg, April 8, 1879.

N. AGNEW.

## Selected Articles.

## ANTISEPTIC MIDWIFERY

Dr. J. Milner Fothergill communicates the following to the *Med. Times*, Philadelphia.

"Perhaps the most interesting communication made to any of our societies lately is that of Dr. Matthews Duncan to the Medical Society, on *Antiseptic Midwifery*. So important was it, and listened to with every attention by a distinguished audience, that an abstract of it may be acceptable to your readers. Being a great personal friend of Prof. Lister, having left the northern metropolis at nearly the exact time Prof. Lister turned his steps southward, it might *a priori* be surmised that Dr. Duncan would be an advocate of the antiseptic plan of treatment. Consequently a large number of practitioners came to hear, and also to learn how antiseptics are applied to every-day midwifery. Dr. Duncan commenced by saying that there is no subject which excites more professional interest or more interest among the general public than that of puerperal deaths. A wife, the mistress of a household, the solace of her husband, the proud mother of a number of happy children, is suddenly snatched away after an auspicious event. There is something so sad about such deaths that all would welcome with heartfelt joy any plan which promises to lessen such disastrous events. Puerperal deaths own various causes, but by far the most frequent and prevalent causes are septicaemia and pyaemia. Both these diseases involve or imply inflammatory processes, and both are essentially septic. It is against them that antiseptic midwifery wages war, and in which, he said, it had already achieved great success. The object of the paper was to spread and diffuse further knowledge on this important matter, and to stimulate further inquiry into it, with a view to the more general adoption of the beneficent antiseptic methods. Already, said Dr. Duncan, more pain is prevented, more life saved by antiseptic methods than by all the recent improvements of modern midwifery combined; and there is no prospect half so bright and encouraging as that held out by the general adoption of the antiseptic treatment of the parturient condition. And, it is certain, all fervently wish that these high hopes may be realized. He would not, he said, proceed to discuss that division of the subject, the treatment of the blood by which the fermentation or sepsis is carried throughout the organism, as by the use of hyposulphites, introduced by Polli, of Milan. He would confine himself to the consideration of the local use of antiseptics. He pointed out that the healthy lochial discharge of some women approached in smell and odor putrefactive discharges, so that it was not always possible to discriminate them; but

in all doubtful cases it was well to treat them as if putrefactive. The putrefying lochial discharge may find its way directly into the blood by the uterine sinuses, or be taken up by the lymphatics; in either case a state of blood-poisoning, or septicaemia, is set up. The removal of all putrefying material is essential to the arrest of this blood-condition. The antiseptic measures to be adopted consist of the removal of the offending material by the obstetrician's finger, or a pair of forceps, previously covered with an antiseptic. In some cases it becomes necessary to introduce the hand, which should previously be carbolized, by being smeared with the ordinary carbolic acid and oil mixture. By such treatment of the hand preparatory to its introduction into the female passages, two ends are attained. If there be no great amount of putrefaction present, the hand thus treated carries with it no danger of leaving putrefying matters, or germs, on the bared surface; while on the other hand it is a means of applying an antiseptic to a surface on which a putrefactive process may be actively progressing. Then as to injections into the uterus, he advocated carbolized water and the gentlest possible force sufficient to throw the fluid into the uterine cavity. Neglect of these precautions might lead to the introduction of air or fluid into the uterine sinuses, and produce baneful results. To secure gentleness of pressure, it was of the first importance to have free and sufficient exit for the fluid injected, and often it became necessary to use a double canula. The running out should be carefully watched, and the moment the outflow ceases the injection should be stopped. He did not agree with those who advocated the leaving of the intra-uterine tube *in utero* to act as a drainage tube. If antiseptically plugged, it no longer acted as a drainage-tube, and not so plugged it was a source of danger in itself. To secure gentle pressure it was well to have a long tube, so that the fluid could be held above the patient; but it should not be raised to an undue height. A warm carbolic lotion of the strength of one in fifty was useful. About half a pint or a pint should be injected at once, and the uterine cavity should be washed until the fluid returns clean. It is not desirable to have too frequent daily injections. Such irrigation might be desirable in some cases even when no putrefaction was present. I am not now engaged in midwifery practice, and never lost a patient in the parturient or post-parturient state, but I can remember a number of cases where the lochia became offensive, where such irrigation would probably have given much comfort to the patient and those in attendance upon her. There was a certain risk of the carbolic acid producing poisoning of its own in certain cases, but Dr. Duncan said that the production of dark-colored urine merely, was quite unimportant. At times more serious symptoms were

produced, as shivering, cyanosis, and a weak and fast pulse. So far as he knew, no fatal case had yet occurred.

The great modern improvement in antiseptic midwifery was the prophylaxis of puerperal septicaemia. This subject could be divided into the prevention of danger from within and of danger from without. In addition to the most scrupulous carefulness as to perfect cleanliness about the parturient woman, in different Continental schools, they had adopted the plan of using carbolized ointment for smearing the finger previous to its introduction into the vagina, and systematic carbolized irrigation of the uterus after parturition, with most excellent results. As to the use of the spray in labor, at the moment of the birth of the child, it had been attempted, but was found to be very troublesome. The spray had been tried in the performance of Caesarean section, as it had in the operation of ovariectomy, with good results. It certainly seemed very desirable that the spray should be used for the treatment of the abdominal as well as the uterine incision; but the drawback here was that, in spite of all care on the part of the operator, septic material might find its way into the uterus through the natural passages. Returning to the subject of antiseptic midwifery, he said that now it was comparatively easy for physicians and nurses to keep themselves medically clean, and that the danger of puerperal septicaemia being carried by medical men, and nurse, from one patient to another was much diminished,—an expression of opinion which elicited some adverse comment from Professor Playfair, who advocated the old plan of refraining from midwifery for a time, when it was found that one case of puerperal fever followed after another. Dr. Duncan pointed out that if this principle was carried out to its logical conclusion the general practitioner would have to abandon all his other practice if he, by any oversight, saw a case of scarlatina.

If a piece of membrane or placenta was retained in the uterus, it was well to use a three per cent. solution of carbolic acid for at least twelve days after the accouchement, as a prophylaxis against danger arising from within. Others advocated a solution of the subsulphate of iron with glycerine under these circumstances. But poisoning from within was not so common a cause of septicaemia as poisoning from without; and care on the part of the obstetrician would be found the great means of obviating puerperal septicaemia. It was by avoidance that puerperal mortality was to be reduced in amount. When septicaemia had once been started, then the treatment was no longer that of prevention, but that of cure. Dr. Duncan, as he announced at the commencement of his lecture, did not go into the treatment of the blood in puerperal septicaemia, but perhaps your readers will not feel aggrieved if his remarks are supple-

mented by some others on the management of the general condition. When symptoms of septicaemia set in, not only should the irrigation of the uterus several times a day be carried out, but antiseptics should be administered internally. Chlorate of potash and the sulphites and hyposulphite of soda, together or singly, should be given freely by the mouth. In one case in my by-past general practice, a delicate woman was confined of a dead putrid child; on vaginal examination the head felt like a leather bag with a lot of pieces of broken pot in it, the cranial bones being all loose and out of place, and the foetus discolored and far advanced in putrefaction. In this case the lochia became very putrid and stank, and there were evidences of blood-poisoning on the part of the mother. By means of vaginal injections of a solution of the sulphites and the internal administration of chlorate of potash and sulphite of soda, the ominous symptoms passed away, and the woman made an excellent recovery. Such was a successful case treated antiseptically, but in a very primitive way. Now the management of the case would be considerably more advanced and scientific. In addition to the injections and the internal administration of the various antiseptics, it would be well to influence the air respired by the patient, and to place in the sick room some disinfectant; the drawback to this being the objectionable smell of most of these potent agents. Sanitas is odorless, and solutions of thymol are not offensive certainly, if they do not form a very agreeable scent, and such should be used freely, being sprinkled over the floor, and, better still, being well sprayed about the room at frequent intervals. This should be continued as long as any signs or symptoms of septicaemia remain. That such should be the line of treatment to be pursued in all cases, either of established septicaemia or where it is threatening, there can be no doubt remaining. The question then arises "Shall antiseptic precautions be taken in all cases of parturition?" As regards my personal opinion, it is affirmative of this proposition. Antiseptic precautions in the first place, are not expensive. They would form a species of cheap insurance. In the next place, they are free from danger if used carefully. Dr. Duncan pointed out that careless irrigation of the uterus might lead to serious consequences; air or fluid might be forced into the uterine sinuses; but against this may be set the presumption that the man who is careful enough to adopt antiseptic obstetric precautions would be careful enough to see the antiseptic method carried out properly in the one single source of possible danger, the irrigation of the uterus. As to the argument which might be raised that this involves unnecessary fuss and trouble, the answer must be returned that after certain unpleasant incidents it is commonly found that a very little care and foresight would have

prevented the disasters. All preventive medicine has for its *raison d'être*, and many, if not most, practitioners will probably soon adopt antiseptic midwifery; and as to those who do not, it is probable that when they do have cases of puerperal septicæmia they will find their conduct and management of cases sharply criticised. The obstetrician should carry with him, as part of his armamentarium, a bottle of carbolized oil with which to anoint the finger at each vaginal examination and to anoint the dorsal surface of the hand and arm in turning. Also the instrument might be smeared with this antiseptic before being applied, in the cases which require them. This would involve their being thoroughly cleaned; and then it is to be hoped we will hear no more of such sad cases as that reported in a recent number of the "Confessional" commenced in the *British Medical Journal* quite lately, where a medical man owned that after delivering a woman with his forceps he forgot to clean them, and the next woman delivered with the forceps died of septicæmia. This matter cropped up in the discussion on Dr. Duncan's paper, and Dr. John Brunton pointed out how the wood of the handles of midwifery forceps often shrank from the metal, thus leaving a crevice in which putrefactive material might lodge. He exhibited his own forceps which he had for years in constant use; they consisted entirely of metal, nickel-plated, and their condition was admirable. In addition to the above, a little carbolic acid might be carried, in case it turned out that the child was dead, and it might be well to irrigate the uterus in a few hours, so as to prevent any putrefactive change with its consequent dangers. An irrigation of the uterus once a day, in all cases, with carbolized water, would be a cleanly practice, as well as a sanitary precaution, in midwifery practice, and might be adopted generally with advantage.

How far the use of carbolized oil on the obstetrician's finger would tend to prevent that sad accident, syphilitic poisoning, it is difficult to say. An answer only could be given after a considerable experience by many and numerous individuals. But antiseptic midwifery must not be looked at from the point of view of the safety of the accoucheur, but from that of the safety of the patient. Where operative measures are anticipated, I venture to think that antiseptic precautions will always be taken, after the evidence we have already before us.

And, lastly, comes the cause of all this, the thing born,—the infant itself. Dr. Duncan said that young organisms are readily poisoned septicæmically. It appears that ulceration of the stump of the umbilical cord has been followed by blood-poisoning in some cases, and that pus has found its way into the umbilical vessels. It is well then to dress the stump antiseptically, by enclosing it in a

piece of lint treated previously to an application of carbolic acid and oil. An animated discussion followed Dr. Duncan's paper.

A case of *opium-poisoning* treated successfully by the subcutaneous injection of atropine recently occurred in the practice of an ex-house-surgeon of the West London Hospital.

#### PELVIC PERITONITIS AND CELLULITIS.

The following clinical lecture by Wm. Goodell, M.D., of Philadelphia, is reported in *THE HOSPITAL GAZETTE*. This is a subject which concerns all-gynæcologists very deeply, because the conditions which it includes may follow almost any gynæcological operation:—

Dr. Thomas, of New York, and some others of like high repute are in the habit of dividing this disease into two distinct diseases and of treating of each separately—pelvic peritonitis and pelvic cellulitis—but I prefer to consider them together, first, because it is usually impossible to draw a sharp line of division between the two, and, secondly, because cases occur but rarely where the conditions exist apart from each other. To show how closely connective tissue and peritoneum are associated in the parts adjacent to the womb, I have only to point to the broad ligament where there is a double layer of peritoneum bound together by connective tissue. (Pelvic peritonitis is an inflammation of the parts of the peritoneum adjacent to the womb, while pelvic cellulitis is an inflammation of the underlying cellular tissue.) I shall not speak in this connection of all the adjacent pelvic cellular tissue—but only of that around the Fallopian tubes, ovaries, broad ligament and neck of the womb and of that connecting the womb with the bladder.

Pelvic peritonitis and cellulitis occur sometimes as a result of labor. You find a woman on the third day after labor suffering from a painful inflammation of the broad ligament which you will be very liable to mistake for puerperal peritonitis, but which you can distinguish from that condition, by discovering how promptly it yields to morphia.

Again this condition may arise after a miscarriage and is especially frequent after criminal abortion. Occasionally it is brought on by direct violence applied to the parts, or by septicæmia, or as a symptom of the absorption of putrescent discharges. As I have just told you, it *may* follow almost any operation upon the female genital organs, even the slightest. A patient, for instance, comes to your office with a constant flow of blood from the womb, you diagnose the presence of fungous granulations of the lining membrane of the uterus and, introducing a curette, scrape them

out. There is some little local soreness felt after the operation, and on the day following the patient has a slight attack of peritonitis, and is confined to bed for two or three days with a bounding pulse and high temperature.

Again you are led, perhaps, to put a sponge tent in the womb, and are surprised the next day to find your patient in the midst of a violent chill and suffering from a great deal of pain in the region of one or other of the broad ligaments.

The disease usually begins with a rapid rise in temperature, chills, and agonizing pelvic pain. Generally the attack is slight and easily subdued, but in the more serious cases there will be marked night-sweats, meteorism, dysuria, etc. What do these symptoms mean? The pain is due, of course, to the inflammation and plasma thrown out. The chill is the result of the shock to the nervous system, while the dysuria is caused by an exudation in the neighborhood of the neck of the bladder which presses upon it.

So much for the general run of cases. The attack, however, may not always begin with a chill. The first symptom may be the local pain. Indeed in some cases—cases of insidious peritonitis—there is no chill, nor pain, nor fever.

I have no doubt that just as the dissecting table leads us to suppose that there are but few lungs which are entirely free from adhesions of one sort or another, so there are many cases in which adhesions and inflammations have occurred in the region of the broad ligament and have passed off entirely unsuspected.

The names usually given to this disease—pelvic peritonitis and pelvic cellulitis—are too generic. Virchow styles the two factors *parametritis* (referring to cellular tissue), and *perimetritis* (referring to the peritoneum.)

But to return. We will suppose that some uterine operation has been performed, that a lady comes to your office with menorrhagia, for instance, that you very properly put a sponge tent into the mouth of the womb for the purpose of enlarging the cervical canal, (the use of a dilator is less hazardous,) that on the second day you introduce a curette and gently scrape out the granulations, that on the third day you are summoned in haste to see your patient who has been seized with a smart chill, with pain in the left iliac fossa, and find her with a pulse of 120, and a temperature of 103°. I can recall just such an instance as this to mind in my own experience. When I first saw the patient I found her with a temperature of 102¼°, with her knees drawn up and with a constant frown on her face caused by the agonizing pain. Whenever I touched the left iliac region the woman shrank, and to make the examination of the parts necessary I had to keep my finger on the part and maintain pressure. I discovered finally a hard tumor to the left of the womb.

The womb in its natural position floats like a ship at anchor, and just as the ship is frozen in during winter, so pelvic peritonitis and cellulitis bind down the womb, plasma is thrown out all around, changing the broad ligament into a board-like consistency, and securely fixing the womb. Sometimes, as in the present case, a hard body will be felt in the neighborhood of the womb. This is generally an agglutination of the intestines. Nature, you see, is always alive to an emergency, and prepared to protect herself. She sees an inflammation beginning near the womb, and all the tissues giving way before it. Immediately she sets to work to form a barrier to its progress. She sets up a process of agglutination between the intestines, causes them to become adherent to the margin of the pelvic peritoneum, and so prevents the inflammation from spreading.

How is the inflammation carried on from the womb to the adjacent tissues, you will ask me. It is not known whether the inflammation is phlegmonous or septicæmic. It may be either. If it be septic the inflammatory materials are absorbed and so transplanted. If the inflammation be frank the process of transplantation is by extension.

Passing the finger into the vagina, in cases of this disease, its walls are found to be hot and dry, while the cervix of the womb is immovable and tender to the touch. The roof of the vagina is hard and not flaccid; feels in fact as if plaster-of-Paris had been allowed to harden round the womb. When one is not expert in such matters it is very easy to be deceived into believing that the hard body felt above the vagina is a uterine fibroid, but more careful examination will show that the hardness is thin and not like that of a thick, large tumor.

Always make it a point to find out whether the womb is fixed or movable. If it is fixed, you may with propriety suspect the existence of pelvic peritonitis and cellulitis.

If you cannot abort the attack you must take up the treatment regularly, and the first two and most important indications are: (1), To stop the pain, and (2) to prevent the formation of pus. The medicines demanded are full doses of opium and bromide of potassium, together with from thirty to forty grains of quinia daily. In addition to this you should paint the abdomen with iodine and put on a poultice. Now some persons use as many as half a dozen poultices daily. The reason of this is that the poultices, being uncovered, dry up rapidly. If the poultice is covered with oiled silk, or greased brown paper, one poultice will remain soft for twenty-four hours. All this time you must be keeping your patient under the influence of large doses of quinia and morphia. Quinia contracts the capillaries, lessens the flow of blood to the womb, and also inhibits the migration and transformation of white corpuscles into pus cor-



puscles. If the woman be plethoric the morphia may be given by the mouth with neutral mixtures and wine of ipecac, or in some other fever mixture. In some cases tonics are demanded. Occasionally the application of belladonna and blue ointment locally is of benefit.

The disease ends either by resolution, or in the secretion of pus. When pus is formed the tumor usually becomes a little softer, and this condition of things is accompanied by chills, night-sweats, and hectic fever, although these symptoms cannot be regarded as in any way pathognomonic. In nine out of ten cases the end is by resolution. When pus is formed the condition immediately becomes troublesome.

If the sickness, therefore, lasts for more than a week, and the local tenderness increases, apply the hot water douche to the tender cervix. Then you will very often find that after a few days the pain and inflammation subside, but that there is still some fever in the afternoon. Now is the time to apply flying blisters. Begin with a good-sized one applied over the sore iliac region. In some cases this will be all that is required. When the pelvic tumor still remains, however, put another blister on over the womb and then another over the other side of the abdomen and then begin over again, so going the rounds and keeping the skin raw in spots until you have gained the resolution of the exudation. In some rebellious cases of pelvic peritonitis a hard tumor like mass may exist for some time in the abdomen. I say pelvic peritonitis, because cellular tissue would not harden in this way, but would degenerate and fall into pus. When the cellulitis preponderates you are more likely to have pus formed, and instead of the chronic local hardness you have a chill and high pulse.

Very often the pulse will have fallen below 100 and the temperature will have almost reached the normal, when a sudden chill will supervene and the patient will complain of pain in the opposite iliac region. This is quite common as a sequel of abortion and in the puerperal state, but is rare after operations. When this metastasis occurs the only thing to do is to begin all over again with large doses of quinia and of morphia, give ten grains of quinia at a time, and, if necessary, from  $\frac{1}{4}$  to  $\frac{1}{2}$  of a grain of morphia hypodermically. This second attack will generally be found to be more manageable than the first.

When pus is formed, tonics are demanded, and among them iron. Never give iron, however, in the early stages of the disease, as it is only too liable to send the blood to the womb and so increase the already inflamed condition of that organ. Never keep the poultices on after the formation of pus has begun. Some authorities hold that poultices tend to the formation of pus.

It is in these later stages of the disease that

muriate of ammonia is a very excellent remedy; so, too, is aconite. I usually prescribe the following:

R. Mist. glychrrhizæ comp., f ʒ vj.  
Ammonii chlorid., ʒ ij.  
Hydrarg. chloridi corrosivi. gr. j.  
M. Tinct. aconiti radiceis., gtt. xxiv.

S.—A tablespoonful in water every six hours.

Suppose that you are convinced that pus has formed and that you are unable to secure its absorption by medicinal means. What do you do now? Examine the vagina and see if you can detect any soft point which fluctuates, or pits upon pressure. The most common site for the pointing of pus formed, as a result of pelvic cellulitis and peritonitis, is the vagina, the next most common site is the rectum. Of these two the vagina is the more desirable. Occasionally the pus empties into the bladder.

When the spot has been found where the abscess is beginning to point make an incision large enough to admit of a free drain of pus. Be as sure as you can be, however, before you cut an opening, that all the small abscesses, if such there be, have melted down to form one large one. If the abscess is very slow in pointing you will have a perfect right to search for the best point at which to introduce the aspirating needle. In this way you may empty as many separate collections of pus as you can find. After aspirating inject the cavities with dilute iodine—one part of iodine to nine parts of water; or you may use, instead, a five per cent. solution of carbolic acid. In some cases it is well to begin at first with a two per cent. solution.

When you find it necessary to aspirate the abscess through the vaginal walls, it is well to make but a small opening with the knife into the tissues, and then to pass a grooved director or a uterine dilator into the opening and enlarge it. In this way you will avoid the blood-vessels. After aspirating its contents keep the abscess open by inserting a drainage tube, or by making daily injections into it of disinfectant solutions, otherwise you will find that there is a tendency on the part of these abscesses to become chronic. Abscesses form in only about one case out of ten of pelvic peritonitis and cellulitis. Indeed, I myself have not had even so large a percentage as this.

On the other hand, if the result of the active inflammation be a hard tumor instead of an abscess, the inflammatory process may be relighted at every menstrual period, and I have seen several women waste away to mere shadows from this very cause. Therefore always endeavor to bring about resolution as soon as possible in these cases. Otherwise, and if the case become one of a chronic nature, the woman is likely to become sterile, a

false membrane being thrown out over the entrance of the oviducts.

(When speaking of the causes of pelvic peritonitis and cellulitis, I overlooked one very important cause of the condition, viz., gonorrhœa in the female. This disease is more likely to produce perimetritis than parametritis and sterility is very often brought on by it, and, as a consequence, of the changes occurring around the womb.)

When pus forms, the destruction of tissue is usually very great.

I remember being present at a *post mortem* examination made at Bellevue Hospital some twelve years ago, and I never saw such destruction of tissue as had been produced by the disease in that instance. It was utterly impossible to discover an ovary, or broad ligament, and we had to pass a sound up the vagina to discover the womb.

Sometimes abscesses are formed without the knowledge of the physician. If an abscess opens into the rectum, the result will be a collapse with sudden stools. If an abscess bursts into the bladder, the results are very serious, since the urine finds its way into the pus-containing cavity. The prognosis is also grave when an abscess opens into the small intestines. In some cases I have known the pus from an abscess to dissect its way into the tissues above the pubis and open in the groin.

#### GASTROTOMY FOR MALIGNANT STRICTURE OF THE ŒSOPHAGUS.

The following case is reported in the *British Medical Journal*:

A cachetic emaciated man, aged 55, had presented himself for relief at the out-patient department of St. Bartholomew's Hospital a month before the consultation. Mr. Langton then detected a dense obstruction just behind the cricoid cartilage, and a probang passed beyond the pharynx returned stained with blood. There was severe dysphagia; but the patient could swallow fluids with tolerable ease. At the date of the consultation, his condition had become much aggravated. It was with the greatest difficulty that he could swallow fluids, and any beet-tea, that he managed after painful efforts to get down his throat, soon returned. This indicated that dilatation probably existed above the seat of stricture. An induration could be detected to the right of the cricoid-cartilage, pushing outwards the sterno-mastoid muscle. The patient was rapidly losing flesh, and suffered from the constant pain in the epigastrium observed in cases of starvation.—Mr. Langton remarked that one of three methods of treatment might be reasonably proposed. The patient might be fed by a narrow tube passed beyond the stricture into the stomach.

Then, too, he might be fed by the rectum. Or gastrotomy might be performed under antiseptic spray, the peritoneum first being laid open, the stomach stitched on the abdominal wall, and opened a few days later. This appeared to be the only satisfactory way of averting the pangs of hunger for the rest of the patient's life.—Mr. Holden believed that the disease was situated lower down than the cricoid cartilage. He would first feed the patient by a narrow tube, and, when that became dangerous, he would perform gastrotomy in the manner recommended by Mr. Langton.—Mr. Savory considered the disease to be epithelioma at the junction of the pharynx with the œsophagus. He objected strongly to the passage of a tube through the diseased part, and feeding *per anum*, always unsatisfactory, would be necessary; but it would be best to perform gastrotomy.—Mr. Willett considered that gastrotomy was in this case quite justifiable; though it was but palliative, it would promote euthanasia. At present, the patient was in misery, and considerable risk might be incurred to relieve him from hunger.—Mr. Baker was in favor of feeding by a tube until much pain was produced; then the stomach might be opened.—Mr. Marsh thought that, although gastrotomy was one of the most fatal operations in surgery, this was a case where it was really necessary.—Mr. Langton, in conclusion, stated that he was very loth to feed by a tube or by enemata, and intended to recommend the unfortunate patient to submit to the operation of gastrotomy.

*Result:* On Monday, February 10th, Mr. Langton performed the first steps of the operation of gastrotomy. A vertical incision about two inches in length was made through the abdominal walls, corresponding to the segment of the left linea semi-lunaris immediately overlying the stomach. That organ was fixed to the edges of the wound by wire sutures, the wires on the right side passing through the substance of the edge of the rectus. Mr. Langton considered that there would be less inversion of the margin of the wound than if he had not included muscular tissue in the suture; nor did he fear that the transfixion of the muscle would produce any ill effects. The operation was performed under carbolic spray. The patient was fed with essence of beef, brandy, etc., *per anum* till Wednesday, February 19th, when Mr. Langton opened the stomach and introduced a vulcanite tube, through which greenish bile immediately escaped. The patient's temperature, which was 94 deg. before the operation, rose to 96 deg. in the evening. On the next day, the patient retained most of the nourishment introduced through the tube under the superintendence of the house-surgeon, Mr. Bruce Clarke. Though greatly emaciated, the poor sufferer appeared to be somewhat the better for the operation; but he gradually

became more and more feeble, and expired at 3 A.M., on February 22nd. On *post mortem* examination, the primary disease was found to be cancer of the mediastinal glands, compressing the œsophagus. There were secondary deposits in the lungs, and slight constriction of the œsophagus close to the stomach, which was held in apposition to the wound by the sutures alone, no plastic lymph having been effused.

[Another case is reported in the LANCET, April 5th, under the care of Mr. McCarthy, at the London Hospital, for impermeable stricture of the œsophagus. The operation was performed with great care and under antiseptic precautions. The patient seemed for the first few days after the operation to be doing very well, but died suddenly on the 5th day. At the *post mortem* basal pleurisy was discovered on both sides; the œsophagus was completely closed by malignant disease, and the lesser curvature of the stomach was infiltrated with carcinoma.—ED. LANCET.]

#### NOTE ON THE TREATMENT OF DIPHTHERIA.

Dr. Joyce (*British Med. Journal*) says:—I have treated my last eight cases successfully by the local application of sulphurous acid spray. Of course, I cannot say I cured them; but I have not had a previous series of eight cases without a death. I teach the nurse how to work the spray-producer, and direct it to be used every three or four hours, and I apply it thoroughly myself at least twice a day. Internally, I have given heroic doses of the liquor ferri perchloridi, and a supporting diet. I am induced to send this note by the perusal of Dr. A. Carpenter's paper "On the Possibility of an undue quantity of Carbonic Dioxide being a predisposing Cause," and by his suggesting sulphurous acid as an appropriate remedy; also, because, in the leader of the journal on "The Treatment of Diphtheria," it is omitted from the list of spray medicaments. There is also another agent, I think, which should be tried, with the view of limiting the outpouring of the albuminous exudation on the tonsils and fauces, viz., electricity applied to the back of the neck. It has seemed to me that the stress of the poison, whatever may be its nature, falls on the great cervical ganglia of the sympathetic; certainly the local manifestation, *i. e.*, the exudation, chiefly forms in the parts in nervous relation with them, and it is possible their stimulation might control it. As bearing on this point, I remember a paper "On a Case of Diphtheria" being read at one of the Branch meetings, I think by Dr. Kirby, in which

consecutive paralysis and albuminuria existed, and in which it was found that the amount of albumen in the urine was distinctly controlled by electricity applied to the back of the neck. There must surely be some agent, capable of being locally applied, either by spray or inhalation, that would prevent the exudation from solidifying. Then one rock at least, on which life is frequently wrecked, would be eliminated from the case.

#### THE PHILOSOPHY OF POULTICES.

Dr. Lauder Brunton, in the *Popular Science Monthly* for March, speaking of the philosophy of poultices, says:—

"The effect of poultices is probably different from that of blisters, although ultimately productive of similar relief; for, if we again take the simple instance of a finger inflamed in consequence of a thorn having run into it, we find that we can relieve the pain in two ways, either by putting the hand into cold water or by plunging the finger into a warm poultice. Both of these measures, apparently so dissimilar, will produce a like result in regard to the inflamed point; that is, both will lessen the pressure of blood in the vessels where stasis has already taken place. The cold, applied to the whole of the hand, will cause the arteries leading to the finger to contract, and will thus diminish the supply of blood to the inflamed part, and lessen the pressure in the blocked capillaries. The warm poultice will also lessen the pressure, not by diminishing the flow of blood to the part, but by dilating the vessels around the point of stasis, and affording the blood a ready exit into the veins. In the case of internal organs, the blister applied to the skin probably acts like the cold applied to the finger, while the warm poultice placed upon the surface of the thorax or abdomen affects the deeper lying organs in the same way as it does the superficial ones, the warmth penetrating through the thin thoracic or abdominal parietes. On this account, when we wish to relieve pain in the chest or abdomen, we ought to make our poultices in a particular way. The common practice of mixing the linseed meal with hot water, and applying it directly to the skin, is quite wrong, because if we do not wish to burn the patient we must wait until a great portion of the heat has been lost. The proper method is to take a flannel bag (the size of the poultice required), to fill this with the linseed poultice as hot as it can possibly be made, and to put between this and the skin a second piece of flannel, so that there shall be at least two thicknesses of flannel between the skin and the poultice itself. Above the poultice should be placed more flannel, or a piece of cotton-wool, to prevent it from getting cold. By this method, we are able to apply

the linseed-meal boiling hot without burning the patient, and the heat, gradually diffusing through the flannel, affords a grateful sense of relief which can not be obtained by other means. There are few ways in which such marked relief is given to abdominal pain as by the application of a poultice in this manner."

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#### ABORTION: HÆMORRHAGE: INJECTION OF PERCHLORIDE OF IRON.

Dr. Angus reports the following case in the *British Med. Journal*, March 22, 1879: On New Year's afternoon last, I received a hasty summons to attend a lady, residing within three minutes' walk of my house. She had been carried from the dinner table (where a large party were assembled) to her bedroom, and upon my arrival, I found her reclining on two chairs in a very nervous condition. I ascertained that she was forty years old, the mother of eight children, all living, the youngest five years of age; she had had no miscarriage prior to my attendance. She had seen nothing for about three months, till a slight discharge began, which had been going on for a week. Not being aware she was pregnant, it was attributed to "change of life"; but, as sharp pain came on suddenly, and she felt something passing from the vagina, removal to her bedroom became necessary. I had her placed in bed and her clothes taken off. On examining the petticoats, I found a considerable quantity of clotty blood, in the midst of which was a fœtus about the twelfth week, and a placenta. A firm compress and binder were immediately applied, and a drachm of liquid extract of ergot, with half a drachm of aromatic spirits of ammonia, given, and ordered to be repeated every two hours if the discharge continued at all profuse. Within an hour of leaving her, I received a message that the loss appeared very great. I immediately returned, when my patient was in a most unsatisfactory state: throwing her arms about, sighing, almost pulseless at the wrist; there was great hæmorrhage, with complete inertia of uterus. I plugged the vagina immediately with five soft linen handkerchiefs, wet in equal parts of vinegar and ice-cold water, and administered another dose of ergot and ammonia. A practical nurse was at once obtained; and brandy, beef-tea, milk, and white of egg beat up in it, were frequently given. On leaving at 11 P. M., she had rallied considerably, the vaginal plug having entirely prevented external loss. About half-past 2 A. M., I was again summoned, and was informed that vomiting had commenced an hour before, which expelled the plug; that the bleeding was very profuse; and that they thought her dying. I certainly was startled at her condition; she was completely pulseless

at the wrist, and the action of the heart was barely perceptible on placing the ear over it. A solution was at once made of one part of strong solution of perchloride of iron, with four parts of cold water, and, after carefully filling a Higginson's syringe, all air being excluded, I passed the vaginal-tube well up into the uterus, slowly injecting about six ounces. Immediate contraction took place and all discharge ceased. For several hours, it was doubtful whether she could rally; but the assiduous attention of the nurse in carrying out everything as ordered, and her admirable method of getting frequent small doses of nutrition administered, was rewarded with success; for slowly but surely improvement took place. Eighteen hours after the iron injection, I gently washed the uterus out with a pint of tepid water, to which was added one tablespoonful of Condy's fluid, and repeated it night and morning for fourteen days. Some amount of febrile disturbance commenced on the third day, the highest degree of temperature being on the fifth day, when it rose to 103.6 deg. Fahr.; after which it steadily fell. Between the third and fourth week, considerable tenderness of the left femoral vein began, and threatened an attack of phlegmasia dolens; but, raising the leg to the horizontal position, frequent hot applications, wrapping the whole limb in cotton-wool, doses of calomel and Dover's powder at bedtime, with a purge next morning, had the effect of beating back what would otherwise have been a troublesome complication. Menstruation commenced on Jan. 27th, and a thin scanty discharge went on for three days. She is now (February 15th) going about again.

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#### PRESENT YOUR BILLS.

The *Louisville Medical Journal* says: "The doctors are almost alone in the custom of giving long credits, and they should get out of it, in justice to themselves and to their patients. Many a bill is lost because it was not presented promptly. It is painful for any one to pay for a thing which is well-nigh forgotten; and besides, when an account runs a long time it may have grown to such an extent as to put it beyond the ability of the debtor to discharge it, while in broken doses it might have been easily managed. There has been no better time than the present to make a change in these matters. The necessities of the times have educated the people to expect frequent settlements of their indebtedness, and the general shrinkage of professional incomes makes it desirable for even the greater practitioners to get quick returns for their work; so concert of action can be confidently expected. Cash payments for services rendered would be the pleasantest of all plans, but it is not always practicable. Monthly statements, however,

should be rendered; and certainly the demand should be made for money on quarter-day. We trust that with the beginning of April there will be a grand presentation of professional bills for work done since January (and we fear in too many instances for work done before that time), and the people be made to understand that settlement is expected. It is all nonsense to be "mealy-mouthed" about matters of this sort. No patient whose patronage is worth having can take offence at the doctor for taking care of himself and family. When tailors and milliners and butchers and bakers and candlestick-makers (or, in more modern English, the "gas companies") and landlords and carriage makers and horse-feeders, in fact all the gentry who supply the doctor with his inexpensive living, adopt the plan of mentioning their little affairs against him semi-occasionally, then can the doctor afford to do likewise with his clientele. In the meanwhile we advise him to follow the fashion of the times, and collect his dues promptly; and when he does, may we mildly request that as printers and publishers are among those who expect to be paid now and then, he will assist us in this matter to the extent of any little amount he may owe upon the subscription to this journal.

#### SURGICAL TREATMENT OF ANASARCA.

Dr. Wickers, (*London Lancet*) says: the treatment of anasarca, whether cardiac or renal in its origin, after ordinary therapeutic measures, such as diuretics, purgatives, &c., have failed, is, in many instances, very unsatisfactory. If the patient be let alone he rapidly gets waterlogged and dies; incisions or punctures nearly always lead to sloughing, while other plans of treatment have proved less unsuccessful.

The following method has been in use at Charing-cross Hospital for some months; it has been found to increase the patient's comfort considerably, while in no instance has it been followed by ulceration, sloughing, or cutaneous inflammation; it appears, indeed, to substitute a perfectly safe means of getting rid of the fluid for those which have hitherto been attended by much risk.

The legs having been well oiled, and a Macintosh sheet placed under them, about twenty or thirty punctures are rapidly made in their sides with a stout straight needle or hare-lip pin, care being taken that the needle is passed deeply into the subcutaneous cellular tissue. Some sponges which have been well wrung out in a solution of salicylic acid are now placed against the punctures, so as to absorb the dropsical fluid as it transudes, these sponges as they become saturated are squeezed out, and again passed through a solution of salicylic acid before being replaced against the patient's skin. In this manner renewals may be required every two or

three hours, and several pints of fluid may be drained away during the first twenty-four hours, the whole process being possibly completed in four or five days, at the end of which time the punctures are usually healed.

By the use of salicylic acid in the manner described, decomposition of the transuded fluid is obviated, the sponges are kept free from odor, the skin is not irritated, and cutaneous inflammations of a low type, with their attendant evils, are entirely prevented.

#### REGISTRATION OF COLONIAL AND FOREIGN DIPLOMAS.

Dr. Quain proposed the following memorandum on the registration of colonial subjects or foreigners:—

"That, with the consent and approval of the General Medical Council, any of the medical authorities may confer, without examination, on a colonial subject or on a foreigner, a degree, diploma, or license entitling him to be registered, provided that the medical authority has received such evidence as to character, professional education, and examination as would be deemed sufficient as a qualification for the like degree, diploma, or license in the case of a person not a colonial subject or a foreigner. There shall be a right of appeal to the Medical Council if no medical authority consent to admit such colonial subject or foreigner."

His suggestion was, that foreigners or colonial subjects wishing to practice in this country should apply to one of the institutions, which would investigate their character, education, and examination, in such a way as to justify them in giving a diploma and that it should not be open to an institution to do that carelessly or indifferently, but each case should be submitted to the approval of the Medical Council, and, therefore, the admission of foreigners as practitioners in this country would be subjected to the double ordeal of the authorities admitting them and of the Medical Council.

Dr. Pettigrew seconded the resolution.

Mr. Turner said, in the table of amendments to be moved in Committee by the Lord President, there were evidently important amendments on these very clauses referred to by Dr. Quain—Clauses 6 and 7; and, as the Council had not yet had time to consider the full import of those amendments, it might be as well if time were allowed for such consideration.

At the request of the President, Mr. Turner read Clause 7 as it was proposed to be amended.

Dr. Quain: Do I understand that by this clause the holder of a foreign diploma placed on the separate *Register* has all the privileges of an English registered practitioner?

Mr. Turner: Yes

Sir William Gull said all this had been gone into by the Council last year.

Dr. Andrew Wood said he had always been struck with the too great facility given to foreign and colonial practitioners for being introduced into this country on so much easier terms than their own people; and even since the last meeting of the Council, this foreign affair had become more complicated. They might have people coming from France, Germany, or from some of the other great schools, and it could be no great hardship for a foreigner, on coming here, to get a stamp put upon him. He ought not to be made to pay any considerable fee—that would be a hardship; but there could be no possible objection to his being obliged to submit himself to the consideration of one of the medical authorities, who would not necessarily be required to examine him, and should not be entitled to take any great fee, but still who could make sure that they were not admitting upon the *Register* on easy terms men who had no title to be put on it.

Mr. Simon said this proposal was foreign to the business of the Committee as a matter of form, though he had no wish to hamper the proceedings with such a technical objection. What he wished to insist upon was this, that the Council had already delivered their opinion upon the point. In 1877, the question of these qualifications was referred to a committee; that committee had reported, and their report was accepted by the Council. That report laid down a particular policy with regard to foreign and colonial diplomas, and the report was communicated to the Government. Last year, the whole subject was reconsidered, some of the members of the Council, as he suspected, forgetting what had passed in the previous year. The result of that discussion was the following recommendation (clause 7):

"That where a person who had been *bona fide* resident in the British possessions showed that he had a good character, and had a recognised diploma, or diplomas granted in British possessions, he should, upon payment of the registration fee, be entitled without examination to be registered as a colonial practitioner on the *Medical Register*."

On that recommendation the Government had proceeded, and now, when the case came back to them, were they to upset the whole thing, and to go into an entirely new line of advice—a line of advice that was to base this jurisdiction in the medical authorities instead of in the Medical Council, making the Medical Council the court of appeal instead of making, as the last resort, the Privy Council the court of appeal? Apart from all other objections, the Government would not for a moment entertain the notion of making the

Council a final court of appeal in a matter of that kind. At the time of Lord Ripon's Bill, there was a difference of opinion; the Council then was not as liberal as the Council was now, and the Government refused to pass clauses that did not give an appeal against anything like factious exclusion to the central government. He hoped Dr. Quain would withdraw his proposal.

Dr. Aquilla Smith did not take the view that, because this matter had been discussed by the Council, they were not to discuss it again. He believed that the proposed amendments were quite sufficient to warrant them in reopening the question. One of the most important points connected with the admission of foreign and colonial degrees was, that the Council should take care that reciprocity should be granted with regard to English diplomas in the countries and colonies with regard to which they proposed to take this step. They should be very careful to see that means were taken to establish such reciprocity with the corporations whose diplomas were to be accepted.

Sir William Gull did not wish to see the Council stultifying itself by going back upon its former conclusions. His friend Dr. Wood seemed very much affected at the idea that a man might come from a bogus university or corporation abroad. The ninth clause of the Act stated—"The medical diploma or diplomas granted in a British possession or in a foreign country, which are to be deemed such recognised medical diploma or diplomas as are required for the purposes of this Act, shall be such medical diploma or diplomas as may be recognised for the time being by the General Medical Council." That fully provided for the emergency.

Mr. Turner thought that Dr. Quain's motion had met with a little more severe criticism than it deserved. They were not advising the Government not to register foreign and colonial practitioners; they were not in the least degree departing from the liberal policy laid down by the Council in the previous years. They were simply suggesting to the Government that there might be another way of getting these people on the *Register*, and of associating them in one of the existing medical authorities of the country.

The resolution was put and carried, by a majority of 12 to 7. The Council however subsequently rescinded it when the report was brought up, so that the clause stands as passed in 1877.—*British Med. Jour.*, March 22, '79.

A letter was read from Mr. E. H. Baldwin of Toronto calling attention to a Bill introduced to amend the Ontario Medical Act, in which it was proposed that in cases where it was proposed that in cases where British practitioners sought registration in Ontario a fee of 400 dollars should be charged. It was moved by Mr. Simon seconded by Dr. Rolleston, and agreed to.

"That the President be requested to bring Mr.

Baldwin's letter under notice of the Colonial officer as alleging an endeavour to introduce into the Colony a system of differential registration fees to the disadvantage of legally qualified practitioners from the mother country."

#### LATERAL SCLEROSIS OF THE SPINAL CORD.—

Dr. J. Althaus (*Brit. Med. Jour.*, Nov. 9, '78) gives an excellent account of this affection, from which we extract the following:—The affection begins in the posterior portion of the lateral columns, called the crossed pyramidal column, composed of fibres derived from the opposite cerebral hemisphere. In this disease this column is found studded with wedge-shaped grey patches reaching anteriorly as far as the lateral column proper, exteriorly as far as the lateral column proper, and interiorly as far as the posterior cornua. True paralysis with muscular spasms and rigidity are characteristic symptoms of this disease. These are directly referable to the fact that all voluntary movements must pass through the diseased columns in their passage from the brain to the muscles. At first the loss of power is slight. The patient feels weak in the legs and has a difficulty in going up and down stairs; after walking a short distance he is greatly fatigued. There is great difficulty in lifting the feet from the ground; they are apt to shuffle along it, and thus to wear out the soles of the shoes first at the toes. Soon the patient takes to sticks or crutches. Coincident with this loss of power we have motor irritation, shown by twitches, cramps and convulsions, which are apt to occur after fatigue, but often come on without any apparent exciting cause and with considerable regularity. After a time the muscles assume a degree of rigidity which renders voluntary movements more difficult and offers resistance to passive movements. The legs resist flexion, extension and abduction; they ultimately become fixed in extension and abduction, and the foot assumes the position of varo-equinus. In walking the patient seems, as it were, fixed in a vice. He has no difficulty in standing, but the legs seem so stiff that he is almost unable to get the feet from the ground; he walks on tiptoe; the whole body seems to join in the spasmodic effort and is thrown forward in order to aid the action of the legs. The tendon reflex symptom of Erb is greatly increased. Thus if the patient affected by lateral sclerosis stamp upon the floor with his foot the whole limb is thrown into a state of tremor which may last for hours. This increase of tendinous reflexion is due to the cessation of arrival of inhibitory influence from the brain in the muscles from interrupted connection. The mode of development of this disease is, as a rule, extremely chronic, extending over years or decades. It usually begins in the lumbar enlargement of the

cord. Its progress is by fits and starts. In a variable time it extends upwards to the cervical enlargement. Generally before the medulla is reached the patient dies of some other disease. The chief cause of this disease is taking cold. It occurs between the ages of thirty-five and fifty. The prognosis is in a general way unfavorable. Generally we must be satisfied to arrest the disease. The prognosis will vary with the ability or disposition of the patient to adopt the mode of life most conducive to recovery. In treatment we must have rest and use ergot and nitrate of silver, and other remedies as the general state of the patient calls for them.

SPINAL IRRITATION.—Dr. Beard, in the *Virginia Medical Monthly* says:—Of the many affections allied to hysteria, spinal irritation is one of the most prominent, and is often associated with it. When it is simply a lesser symptom of hysteria or nervous exhaustion, it cannot claim a distinct nomenclature, and does not call for special consideration in treatment. When, however, the spinal tenderness and the symptoms that directly flow from it overshadow other accompanying conditions, it claims a place as a distinct disease, and should be treated accordingly. Spinal galvanization, with labile currents in a descending direction, rarely fails to effect a cure. Indeed, there is hardly a disease in which there is so little doubt as to the treatment indicated, and the probable benefit to be derived.

Case V.—Miss—was sent to me by Drs. A. E. M. Purdy and F. P. Kinnicutt, of New York, and also by Dr. P. C. Barker, of Morristown, N. J. This young lady was of an exceedingly delicate and sensitive organization, and for a number of years had suffered from spinal irritation, with various accompanying symptoms. The tenderness along the spine was almost continuous, and firm pressure in several special areas caused great pain. The patient complained of palpitation and *breathlessness*, weakness with low spirits and other distressing symptoms which she described as "sinking" feelings—an expression which is sufficiently suggestive to those who have had much experience in this class of cases. There was occasional nausea, with flatulence and loss of appetite, together with sharp neuralgic pains. Very slight exertion caused utter exhaustion. Treatment by the method mentioned above was immediately begun, and with some variation continued for three months. This variation consisted in alternating, just so soon as there began to be a decided diminution of the spinal tenderness, general faradization with spinal galvanization. Improvement steadily continued, and she is now enjoying as vigorous a degree of health as at any previous time of her life.

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# THE CANADA LANCET.

A Monthly Journal of Medical and Surgical Science

Issued Promptly on the First of each Month.

Communications collected on all Medical and Scientific subjects, and also Reports of Cases occurring in practice. Advertisements inserted on the most liberal terms. All Letters and Communications to be addressed to the "Editor Canada Lancet," Toronto.

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TORONTO, MAY 1, 1879.

## EQUALIZED REPRESENTATION IN THE ONTARIO MEDICAL COUNCIL.

Now that the representation of the Eclectic members of the Medical Council has lapsed by the efflux of time, viz., five years from the passing of the Consolidated Medical Act, assented to March 24th, 1874, it is in order once more to discuss the propriety of increased representation of the general profession on the Council Board. As matters stand at present there are 8 representatives of colleges on the Council, 5 homœopathists, and 12 members of the general profession. About one-third of the members of the Council are representatives of Colleges, one-fifth represent about 50 homœopathic practitioners, and the remaining 12 represent about 1700 general practitioners. Surely no one looking at those figures, but will admit that the representation is very unequally divided.

We will not allude to what has been done on more than one occasion, by the combination of the school-men with the homœopaths and eclectics. Our object is simply to deal with the question of increased representation on its own merits. We are anxious to have the general medical profession more in sympathy with the Council, and we see no better way than to give it a larger share of representation. The territorial divisions, which are the same as the old electoral divisions for representatives on the Senate, are in some instances excessively large, embracing two or three counties, and it is impossible for representatives to represent satisfactorily such large constituencies. There should at least be two members for each division, elected conjointly, or each elected to represent one half of the constituency. The period of time for which each member is elected should also be shortened

from five to three years. This would bring candidates more frequently before their constituents, and be the means of infusing more life and activity into the council and create a deeper interest in its proceedings. The action of the representatives should be more closely watched, and the interest of the profession more carefully looked after.

The only objection that can be successfully urged against increased representation is the increased expense, which would be incurred. The same parties however who urge this objection most strongly are themselves spending hundreds of dollars every year in lawyer's fees, sundry meetings of the executive committee, trips to Ottawa and such like, which might be saved by the exercise of a little more caution and economy on the part of the council board. The question of increased expense, however, is not so great an objection as at first sight might appear. The five representatives of the eclectic body having ceased, there would in reality be only seven new members added to the number lately constituting the board. Even this number is small when compared with the Board of Governors, consisting of forty members, of the sister institution in Quebec which has a much smaller medical population. The mere matter of a trifling additional expense, however, should not be allowed to prevent the carrying out of a policy which is certain to be for the best interests of both the profession and the council. It must also be remembered that the profession contributes, either directly or indirectly the greater portion of the funds of the council and should on that account have a larger voice in its expenditure. We have no doubt the proposition to increase the territorial representation will be strenuously opposed in some quarters, but that is no reason why, if the principle be correct, it should not ultimately prevail. The equalization of the representation of the different bodies on the medical council may be accomplished in either of two ways, viz. by increasing the number of territorial representatives as we have proposed, or by diminishing the number of University and homœopathic representatives on the present board. The number of homœopathic representatives is out of all proportion to the number of practitioners of that school in the province, and the representatives of those Universities having no medical department might be left off altogether. Three members would be quite sufficient to re-

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present the homœopathic body, one member from each of the three teaching bodies and 12 territorial representatives would place the representation on a much more equitable basis than at present; but we have grave doubts whether this plan will after all commend itself to those who object to increased territorial representation on the score of increased expense. We are prepared to open our columns to a discussion of the subject.

#### MORTALITY FROM SMALL-POX.

The following statistics of mortality from small pox, which we have derived from an interesting and elaborate article, in the *Revista Médico-Quirúrgica* of Buenos Aires, by the editor, Dr. E. Coni, may be worthy of perusal by all who appreciate this sort of information.

In Vienna, with a population of 670,183, there were 7,821 deaths in 10 years (65 to 74), or an annual average of 782; Prague, with a population of 165,526, there were 1489 deaths in 10 years (65 to 74), or an annual average of 150; Trieste, with a population of 123,498, there were 1203 deaths in 10 years, (65 to 74), or an annual average of 909; Munich, with a population of 195,326, there were 290 deaths in 7 years (68 to 74); Turin, with a population of 212,644, there were 631 deaths in 10 years (66 to 75); Venice, with a population of 129,676, there were 783 deaths in 10 years (66 to 75); New Orleans, with a population of 203,439, there were 2184 deaths in 9 years (67 to 75); Boston, with a population of 250,526 there were 1088 deaths in 9 years (64 to 71); Saint Louis, with a population of 450,900, there were 4141 deaths in 9 years (67 to 75); Stockholm, with a population of 150,446, there were 904 deaths in 10 years (64 to 73); Christiana, with a population of 75,042, there were 23 deaths in 10 years (64 to 73), Berlin, with a population of 968,634, there were 6915 deaths in 5 years (69 to 73); Breslau, with a population of 234,396, there were 1717 deaths in 10 years (66 to 75); Paris, with a population of 1,851,792, there were 3844 deaths in 6 years (69 to 75); London, with a population of 3,489,428, there were 10,784 deaths in 4 years (70 to 73), or an annual average of 2696.

It is, perhaps, unnecessary to apprise our readers that in judging of the proportional

mortality from small pox in the above named places, comparison of the annual number of deaths with that of the entire population is to be made. The following figures show the proportion of deaths, (not, be it observed, of cases), to the whole population in 8 of the principal cities,

Paris, 1 death to every 2892 of the population. Boston, 1 death to every 2087; Breslau, 1 death to every 1351; London, 1 death to every 1294. St. Louis, 1 death to every 980; Vienna, 1 death to every 851; New Orleans, 1 death to every 840; Berlin, 1 death to every 700.

If the statistics are correct, it would appear that Paris has suffered a less proportional mortality than any of the other seven towns above given, whilst London shows a rate considerably more than double of that of Paris.

Were the small pox mortality of the City of Montréal before us, we are pretty sure that it would not fall short of the worst in the catalogue, if indeed it would not be much in excess.

#### THE RESTORATIVE POWER OF MUSIC.

"Through every pulse the music stole  
And held sublime communion with the soul;  
Wrung from the coyest breast the imprisoned sigh,  
And kindled rapture in the coldest eye."

It has been tersely said that one half the ills of the race are closely allied to, or in reality are disorders of the mind. Until very recently the intimate relation between, and the powerful influence exerted by the mind over the body was but dimly realized. Modern medicine, however, gives to the mind its due share of credit in estimating the causation of disease. In this fast age the overstrained mind is apt to give way in some degree, if not altogether, and impaired mental or physical phenomena are the result. In dealing with such derangements, the physician is often obliged to forego medicines, and adopt other agents that will soothe and tranquilize the nervous system, favor rest and repose, and aid nature in restoring her disturbed forces to their equilibrium. Beside medicine, there is none so successful as pleasing associations, and among these none more potent than the mysterious influence of good music. But as music can exercise every kind of influence, mirthful, melancholic, martial, exciting, or soothing, fascinating, subduing, tranquilizing; therefore it is

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needed that discretion should be used in the kind of musical influence to be brought into action.

That music exerts a magic influence over human beings, all history attests. The power of music to sway with varying emotion the human soul, was recognized among the ancients. The servants of Saul recommended music to their master, to cure his mental malady or evil spirit which it was supposed had come upon him. David took a harp and played with his hand, so Saul was refreshed, and was well, and the evil spirit departed from him. And Shakespeare seems to have anticipated the wonderful skill of the Indian Jugglers in their snake charming feats, and the wild beast and horsetamers in their application of music as an aid to their endeavours, when he writes thus :

" . . . Orpheus' lute was strung with poets' sinews ;  
Whose golden touch could soften steel and stones,  
Make tigers tame, and huge leviathans  
Forsake unsounded deeps, to dance on sands "

Music can rouse the love of country, and stir the patriot to wondrous deeds of valour ; it can awaken the softest emotions of the soul ; inspire love, or lift it in fondest aspirations after the Divinity, up from the sordid and the earthly and bring its fancy to flights which stay not until they reach beyond sublimity to the Divine. It can hide the sorrowing hope, and chase away the melancholy that sits brooding over the spirits of disappointed men. It can arrest the ravings of the madman, and by its magic power awaken memories of bygone days ; recall reason, and seat her for a brief space upon her long deserted throne. The restorative powers of music upon the invalid are so well known, that special proof in this enlightened age is quite unnecessary ; no argument in its behalf is needed ; it is its own vindicator. Its power to cheer the spirit, revive the soul, and rouse the mind from its depressing passions, and to put it into a cheerful mood have been demonstrated times without number.

It is a medicine for the soul, and possesses a therapeutic power that no drug has ever had claimed for it. It awakens new hope, and, owing to the close intimacy of mind and body, acting and reacting as they do upon each other, imparts a wonderfully exhilarating and restorative influence to the flagging powers of nature ; while in every disease accompanied with or characterised by

disturbance of the nervous system, its soothing influence and recuperating power is little less than marvellous. Music should be in every house, should be indulged in by every family, by every individual ; especially is it a boon to the sick, the aged, and the infirm, for

—" Music exalts each joy, allays each grief,  
Expels disease, softens every pain ;  
Subdues the rage of poison, and the plague,  
And hence the wise of ancient days adored,  
One power of physic,—melody and song."

Some people seem to be afraid of music in a sick room, but if it be of the gentle, melodious strain it can do only good. Thanks to the enlightened spirit which in these days prevails over our Insane Asylums, music is regularly furnished one a week (an innovation, which to his infinite credit be it said, owes its origin to the benevolent hearted Jos. Workman. M. D., ex-superintendent of our Provincial Asylum), for the benefit of the inmates and with salutary effect—for what can minister to a mind diseased like music? We know of nothing. While thankful for this boon, we wish, however, to plead for the sick, who we would be glad to see enjoying its benefits, by having it introduced into our Hospitals. The kind of patients to submit to its influence and the frequency of its ministrations, should be matters of detail to be judged of by the surgeon in charge.

It has been said of Beethoven that on one occasion when dangerously ill, and all hope seeming to have fled, a friend suggested music, and at first employed a person to sing soft strains in an adjoining room. The beneficial effect upon the patient being quite appreciable, instruments were provided, and finally, as he grew better an orchestra was employed to discourse some of his own magic compositions. The result was a complete success, and music accomplished what medicine had utterly failed to do.

The meaning of song goes deep, and there are few that can in logical phrase express the effect it has upon them. Let music be generally introduced into our Hospitals and sick chambers, and instead of pianos being carefully closed, if used judiciously physicians would be much aided in their work, and relieved of a great deal of anxiety by this cheerful assistant, while the very atmosphere of Hospitals would become stripped of much of that dreary melancholy sadness, which, do what

you will with flowers and papers, seems to hang like a chilling pall around them.

We close with Dryden's beautiful stanza, expressive of the power of music—trusting that a word fitly spoken may prove, "like apples of gold in pictures of silver."

We have, most of us listened—as the gods are here described as doing—at some period or other of our existence to the enchanting strain of music with like rapture and agreeable astonishment.

"When Jubal struck the chorded shell,  
His listening brethren thronged around,  
And, wondering, on their faces fell,  
To worship that celestial sound.  
Less than a god, they thought, there could not dwell,  
Within the hollow of that shell,  
That sung so sweetly and so well!"

### TORONTO UNIVERSITY ELECTIONS.

Our contemporary in this city, the Toronto School of Medicine "organ," in an article in the May issue, and intended as a leader, says in regard to the elections to the Senate of Toronto University which take place on the 8th inst. :—"We shall be glad to see Prof. Loudon and Dr. Thorburn re-elected, and we hope that Dr. Graham may be successful;" in other words, the "organ" desires the election of the two medical men of its own school. "There needs no ghost to tell us this." It is quite characteristic and perfectly in keeping with the various stratagems and devices of the members of this school. They cannot brook fair competition, but are continually endeavoring to form rings and obtain monopolies. The question with the graduates, however, should be, and no doubt will be, which of the candidates seeking election will best serve the interests of the University? Neither the graduates nor the University can have any interest in giving to the Toronto School of Medicine a *sixth* representative on the Senate. The faculty of this school has completely repudiated its former advocacy of single affiliations by taking the earliest opportunity of *affiliating with Victoria College*. It has therefore less claim than ever to increased representation. Should the nominees of this school be successful in their candidature, there will be the very unusual and somewhat anomalous spectacle of six members of a body in close affiliation with a rival University, sitting and voting in the Senate

of Toronto University. We ask in all sincerity is this desirable? Is it becoming?

The "organ" is very much exercised about a circular which was issued, dated April 16th, 1879, a copy of which we also received, recommending the candidature of Prof. Loudon, Wm. Houston, and Dr. Jas. H. Burns, and signed "Graduates of Toronto University." This circular placed the issue fairly before the graduates, and the authors are to be congratulated upon the fact that there was not a single statement in it which could be refuted. Not even the "organ" with its green-eyed goggles could discover a solitary flaw, and so it sets to work to abuse the authors (plaintiff's attorneys) in the following choice language: "Their only claim to be heard is that they are such (graduates);" "their names are unworthy to be associated with the title;" "the old animus is again apparent;" "discreditable to its authors;" "undutiful sons of *alma mater*;" "they will appear supremely ridiculous;" "unscrupulous partizans;" &c., &c.

It is a great pity that there should be any squabbles over these elections. It all arises, however, from the insatiable greed of office, of members of the above mentioned school, and their persistent attempts to get control, if possible, of the national University and the sooner some remedy is applied to this unsatisfactory state of affairs the better.

### RECIPROCITY IN MEDICAL REGISTRATION.

In another column will be found extracts from the minutes and proceedings of the British Medical Council, in regard to the matter of reciprocal registration between Great Britain and the Colonies. An additional amendment was proposed by Dr. Quain to be introduced into the bill now before the House of Commons, but which, for obvious reasons, was subsequently rescinded. It proposed that any of the medical authorities might confer, *without examination*, on a colonial subject, a degree, diploma or license, on payment of a nominal fee, entitling him to be registered in Great Britain, provided that the medical authority had received satisfactory evidence of character, education, and examination in a recognized colonial university or licensing board, and should any medical corporation refuse to give him a diploma, he still had the right of appeal to the Medical Council.

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This liberal, dignified and professional-like action on the part of the British Medical Council is in striking contrast with the course pursued by certain members of the Ontario Medical Council, whose actions we have had occasion to criticise so severely of late. We think it might well be considered an honor to have the diploma of the college of Physicians and Surgeons of Ontario recognized by the medical authorities and Medical Council of Great Britain. But a few of the very wise and learned members of the council seem to think otherwise, and are bent upon pursuing a course which they will find sooner or later very much to their detriment. At present their is an evident (and proper) intention on the part of the British Medical Council not to admit any colonial practitioners to registration who are not licensed to practice in their own country. If, however, our Ontario Council arrogates to itself, as certain of its members seem disposed, an air of superiority, and refuses to reciprocate, it will then be in order for the British Medical Council to receive the diplomas of recognized universities, such as Toronto University or the University of Trinity College, whose educational requirements are at least equal to those of any other university or licensing board, either at home or abroad.

#### COUNCIL ORAL EXAMINATIONS.

The oral examinations of the Ontario Medical Council which commenced on the 29th ult. are not concluded as we go to press. We delayed publication for a day or two in the hope that we might be able to announce the names of the successful candidates. The examiners were obliged on the second day to adjourn in consequence of the threatening attitude of a few of the more reckless students. They broke some of the windows, tore down the banister of the stairway, and kept up such a commotion that it was impossible to get along with the examination. The conduct of some of them was simply shameful, and an example should be made of certain of the ringleaders with a view to prevent similar occurrences in future.

This difficulty with the students is becoming chronic, and requires to be dealt with in some way. It is a matter for serious consideration, whether it

is necessary or expedient to continue the oral examinations. This style of examination is after all only a relic of antiquity, and the sooner it is dispensed with the better. All the best universities both at home and abroad, conduct their examinations entirely by means of written papers. Let the examination, by all means be a rigid one, and let the standing of the candidates be determined solely upon the character of their written papers. It may be urged that the oral examination is the best test of a man's fitness and that he has no chance for cribbing; but it has always been the custom to pass without an oral all who have answered *fifty* per cent of the questions, so that it is only the inferior men who are supposed to receive an oral, and this examination is given, to help them to make up if they can, wherein they were deficient in the written examination. It is quite evident that this act of clemency on the part of the council board is not appreciated by the students.

#### ONTARIO MEDICAL COUNCIL EXAMINATION—

The following gentlemen have passed the final examination of the Board and are entitled to the license of the college—D. C. Brooke, B. F. Butler, J. L. Browne, R. Clapp, J. W. Caughlin, A. B. Chisholm, A. Cattanach, J. Dryden, C. Hamilton, W. Henderson, R. N. Horton, F. Hanna, H. Hunt, D. Kilborn, T. Kidd, R. Leonard, J. M. Lefevre, A. McDiarmid, R. P. Mills, J. McIlhargy, G. McCullough, D. O'Brien, E. Prouse, G. G. Rowe, E. Sullivan, R. W. B. Smith, E. M. Thuresson, J. A. Todd,—passed without an oral T. W. Beeman, W. Bremner, J. B. Baldwin, F. Black, W. F. Chappell, T. Chisholm, R. A. Davis, J. T. Dowling, J. S. Edwards, A. J. Geikie, D. H. Gould, A. C. Graham, T. R. Hossie, H. W. Lloyd, G. W. McNamara, J. McArthur, D. D. Nelles, G. O'Reilly, C. O'Gorman, and G. C. Ward.

There were 12 or 13 candidates besides these who passed the final examination, but as they did not matriculate till 1876, the licenses cannot be granted until 1889 unless by the authority of the Council.

MEDICINAL AND SURGICAL PLASTERS.—We have been favored with a sample of plasters from the well-known manufacturers, Messrs. Seabury & Johnson, of London and New York. Their me-

thod of manufacturing adhesive plasters with rubber has given the utmost satisfaction. The adhesive properties of the surgeon's salicylated adhesive plaster, its strength and durability, render it invaluable in the treatment of wounds, fractures and the like, and its antiseptic properties are a great desideratum, as it can be kept on without irritating or in any way inducing septic conditions. It is readily applied, requiring neither heat nor moisture, conforms quickly to the parts, and adheres more firmly than any other form of plaster. Salicylic acid has also been incorporated in their isin-glass plaster, by which it has been much improved. The Belladonna plaster, in rubber combination, manufactured by Seabury & Johnson, cannot be surpassed. In addition to its greater medicinal strength, it is freed from all stimulating and irritating properties, and its sedative qualities are thereby promoted. They also manufacture cantharidal plaster, mustard plaster, etc., all of the first quality.

TRINITY MEDICAL SCHOOL.—The annual examinations in this institution took place at the close of the winter session, and the following successfully passed.

*First Year's Examination.*—W. F. Peters, 1st First Year's Scholarship, value \$50; Ferrier, 2nd First Year's Scholarship, value \$30; M. L. Cameron, Urquhart and Wolverton.

*Primary Examination.*—Mearns, Second Year's Scholarship, value \$50; Hatton, M. A. Martin and R. Wilson, certificates of honor; Chappell, Ellis, R. McWilliam, J. McWilliam, Patterson and J. E. Shaw. Mr. McNaughton passed in Anatomy, Physiology and Botany, and Mr. Lundy in Anatomy and Physiology.

*Followship Degree.*—Mr. Chappell, Trinity gold medal; McDiarmid, Faculty gold medal; Thur-esson, Faculty silver medal; Duck, certificate of honor; Anderson, Geikie, O'Gorman and Parke.

The annual Commencement for the conferring of prizes, scholarships and diplomas was held on the 24th ult., and was largely attended. The successful students were well received and warmly applauded by their class-mates.

MCGILL UNIVERSITY, MONTREAL.—There were 166 medical students registered in McGill Medical School during the past winter. The following gentlemen have received the degree of M.D., C.M.:

J. L. Brown, H. J. Burwash, B. F. Butler, P. E. Carman, J. B. Carman, M. Chisholm, W. Case, T. Gray, J. H. Groves, D. F. Gurd, G. C. Hart, F. Hanna, A. J. Henwood, A. W. Imrie, J. L. Irwin, J. A. Jackson, C. J. Jamieson, J. B. Lawford, J. M. Lefebvre, H. W. Lloyd, C. C. Lyford, J. A. McArthur, O. J. McCully, M.A.; G. McCullough, W. J. McGuigan, S. McNee, J. B. Menzies, O. H. Riley, M. C. Rutherford, J. G. Scott, M. M. Seymour, W. F. Shaw, J. Smith, R. Spencer, W. R. Sutherland, C. A. Weagant, H. V. Williston, M.A. Prizemen—Holmes gold medallist, J. B. Lawford; best final examination, A. W. Imrie; best primary examination, J. A. McDonald; Sutherland gold medallist, W. L. Gray. Honorable Mention in final examination, Messrs. Shaw, Gray, Sutherland, and Williston; in primary, Messrs. Josephs, W. L. Gray, J. W. Ross, Beer, Rogers, Henderson, R. B. Struthers, and Heyd. Practical Anatomy prize, C. N. Beer; Practical Chemistry prize, W. Moore; Junior Class prize, J. Ross.

ROYAL COLLEGE OF PHYSICIANS AND SURGEONS, KINGSTON.—The following gentlemen have successfully passed their professional examination and obtained the Diploma of the College. They are placed in order of merit.

*Final.*—W. H. Henderson, J. C. Cleaver, G. G. T. Ward, P. C. Donovan, W. A. Lafferty, R. A. Leonard, R. N. Horton, G. Judson, G. Newlands, T. Hassie, R. K. Kilborn, R. N. Abbott, W. Cleaver and J. McCammon. All the above passed without an oral examination.

*Primary.*—J. E. Galbraith, H. H. Chown, J. Odlum, C. Empey, W. A. Lavell, L. Day, T. Wilson, W. Waddell, J. Knight, H. H. Reeve, C. G. Clark, W. D. Reid, C. H. Dickson and M. McPhadden. The first five passed without an oral

Dr. Clark, a graduate of an American college, also passed on a written examination.

COLLEGE OF PHYSICIANS AND SURGEONS, QUEBEC.—The semi-annual meeting of the College of Physicians and Surgeons, of Quebec, will take place in the Normal School, Montreal, on the 14th inst. Candidates for examination or license should remit their papers, accompanied with the fee (\$20), to D. Belleau, Quebec, or to Dr. Dagenais, Montreal, at least ten days previously. The preliminary examination or matriculation will be held at the same place on the 8th inst

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**THE PLAGUE IN BRAZIL.**—Bad as was the plague in Russia, a still worse scourge has existed in Brazil. Thousands of persons have fallen victims to its ravages. It first commenced after the drought in 1877, which occasioned a partial famine. It continued through 1878, first in the form of small-pox, then followed cholera, yellow fever and a peculiar disease known there as beriberi, and finally a disease resembling the Russian plague. The death rate at one time amounted to 1,000 per day in a population of 75,000, the largest death rate probably on record.

**PROHIBITORY REGISTRATION.**—To show the feeling of the profession in Ontario in regard to the recent action of the Executive Committee of the Council, we publish the following as a sample of the letters we are receiving on this subject:

SIR:—I am glad to see by the April number of the *LANCET* that you uphold the view I have always held on the registration question, and oppose this foolish, undignified and unprofessional trades-union-like action on the part of the council in seeking to impose a prohibitory registration for our British graduates. I can only compare it in my own mind with the attempt made last session of the Canadian Parliament by the British Columbia people to exclude Chinamen from that province, and I sincerely hope it will be equally unsuccessful.

**ERGOT AND SODIUM BROMIDE IN EPILEPSY.**—Prof. Bauduy reports (*Cin. Luncet and Clinic*) a case of epilepsy of 16 years standing, which was cured by giving twenty grains of bromide of sodium, with half a drachm of fluid extract of ergot three times a day. This treatment was continued a year and a half, and four years have elapsed without the recurrence of a fit.

**LADY PEDESTRIANISM.**—The Medical Society of Philadelphia has entered its protest against the barbarities inflicted on women in the name of physical culture and pedestrianism, and has called on the Mayor to put a stop to it. The "Society for the Prevention of Cruelty to Animals" should interpose if nothing else will arrest this stupid and insane folly.

**TORONTO SCHOOL OF MEDICINE.**—The following are the names of the prizemen at the recent school examinations: First year, J. T. Duncan; second year, J. H. Duncan; third year, Cross; fourth year, Clapp.

**MALTINE.**—This new preparation is rapidly growing in favor among those who have tested it in their practice. In England it has received the attention of some of the most eminent physicians. It is a highly concentrated extract of malted barley, wheat and oats, and contains all the medicinal and nutritious qualities of these cereals. It is prepared with great care, so as to preserve intact the various principles which it contains. Maltine has been used with great success in the treatment of nervous debility, indigestion, pulmonary affections, wasting diseases of children, and during convalescence generally. The manufacturers have combined it with iron, quinine, pepsine, pancreatine, extract of beef, wine etc., in preparations which are elegant in appearance, palatable to the taste, easily administered, and which fully meet the requirements of medical practitioners.

**TWIN BIRTHS WITH AN INTERVAL OF THREE DAYS.**—Dr. Post, of Beirut, Syria, (*Med. Record*), reports a case of twin births with an interval of three days between the birth of the first child which was living, and the second which was still-born. The woman was attended by a midwife. The labor pains ceased immediately after the birth of the first child and the liquor amnii continued to escape for thirty hours. At this time the doctor was called in, but the woman refused to permit an examination, except by palpation over the abdomen. The feeling was that of a gravid uterus at full term. He left her, declining to give ergot unless allowed a satisfactory examination, and was informed that she was delivered of the second child on the third day.

**OPENINGS FOR MEDICAL MEN.**—There is an opening for a medical in Heathcote, Ont. Also, one wanted, to whom a bonus would in all probability be given, at Amherst Island.

The death of Dr. Geo. B. Wood, of Philadelphia, author of "Wood's Practice of Medicine," etc., is announced in our American exchanges.

**ROYAL COLLEGE OF PHYSICIANS, LONDON.**—The following is the official list of officers. President, J. R. Bennett; Treasurer, E. J. Farre; Secretary, H. A. Pitman; Examiners, Drs. Beale, Pavy, Priestley, Harley, Dickinson, Braxton Hicks, Moxon, Bastian, Liveing, Bernays, Thos. Smith and Croft.

**DEATH FROM CHLORAL HYDRATE.**—A death from an overdose of chloral hydrate occurred lately at Georgetown, Ont. An inquest was held by Dr. W. Freeman, and it was decided that the drug was taken by deceased to procure sleep.

**UREA FORMED IN THE LIVER.**—From some experiments lately performed by Prof. Gangee, of Manchester, he has arrived at the conclusion that the liver is the principal, if not the only organ, concerned in the formation of urea.

**ELECTION.**—Dr. Husband, of Hamilton, has been elected Homœopathic representative on the Ontario Medical Council in lieu of Dr. Campbell, deceased.

**NEW WORK ON GYNÆCOLOGY.**—Dr. J. Marion Sims is expected to return from Paris to New York in September next. His work on Gynæcology is nearly completed and will be issued shortly after his return.

**QUARANTINE.**—Dr. Montizambert, Superintendent of Quarantine, has returned to his duties at Groise Isle, Que.

**CORONERS.**—N. A. Powell, M.D., of Edgar, has been appointed Associate Coroner for the County of Simcoe. E. E. McNichol, M.D., of Cobourg, to be an Associate Coroner for the United Counties of Northumberland and Durham.

John Byers, M.D., of Lloydtown, to be an Associate Coroner for the counties of York and Simcoe.

**APPOINTMENTS.**—Dr. C. O'Reilly, Medical Superintendent of the Toronto General Hospital, was appointed to conduct the oral examinations in Physiology at the Ontario Medical Council examining board, in the absence of Dr. Pickup, a duty which he discharged most efficiently and satisfactorily, considering the short notice given him.

Dr. Almon, of Halifax, has been appointed Senator in the room of Senator Northrup, deceased.

Dr. Millman, of Woodstock, has been appointed assistant physician to the Asylum for Insane, London, Ont.

Dr. A. Davidson, of Trinity College, has been appointed assistant house surgeon to the Leith Hospital, Scotland.

Dr. Neish, formerly of Kingston, has been appointed Senior President Medical Officer of the Public Hospital, Jamaica.

**REMOVALS.**—Dr. A. M. Rosebrugh has removed his consulting rooms from 117 Church street to 85 Gerrard street east.

Dr. P. E. Kidd, of Manotick, has removed to Midland City, where he intends to practice. On the eve of his departure he was tendered a farewell supper by his friends and acquaintances in Manotick. The evening was spent very pleasantly. Dr. Kidd leaves much to the regret of many warm friends. He is succeeded by Dr. E. Kidd, formerly of Carleton Co.

Dr. Dumble, formerly of Belleville, has removed to Demorestville, where his success is already secured.

Dr. Wm. McKay, of Drumbo, has removed to St. Mary's, Ont.

**QUEEN'S COLLEGE CONVOCATION.**—The following gentlemen have received the degree of M. D. of this University; named in order of merit:—Wm. H. Henderson, J. C. C. Cleaver, Geo. C. T. Ward, P. C. Donovan, W. A. Lafferty, R. A. Leonard, R. N. Horton, Geo. Judson, Wm. F. Cleaver, Geo. Newlands, jr., Thos. R. Hossie, R. K. Kilborn, R. H. Abbott, Jas. A. McCammon, and W. Clark.

**TYPHOID FEVER IN AN INFANT.**—A case of enteric fever in a child fifteen months old is published by Dr. Walker in the *British Medical Journal* of March 8, 1879, and another case is published by Dr. Wiltshire in the number for March 22nd, as having occurred in an infant six months of age. The child manifested the ordinary symptoms, and the eruption was abundant and pathognomonic. The disease had been contracted through the food, which was almost wholly artificial.

**MEETING OF THE ONTARIO MEDICAL COUNCIL.**—The regular annual meeting of the Council of the College of Physicians and Surgeons of Ontario will be held in this city on the 13th inst.

**DINNER TO PROF. GROSS.**—A complimentary dinner was given to Prof. Gross, of Philadelphia, on the 10th ult., in commemoration of his 51st year in the medical profession. The banquet was largely attended by representative men from all parts of the United States. He was also presented with a gold medal with the letters "S. D. G." set in diamonds on one side, and on the reverse, the following inscription: "Presented to Dr. S. D. Gross by his Medical Friends in Commemoration of his 51st Year in the Profession."

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The death of Dr. Isaac Hays, editor of the *American Journal of Medical Sciences*, on the 12th ult., at the age of 83, is recorded in our exchanges. He was at the time of his death the oldest living American editor.

Dr. John M. Woodworth, supervising Surgeon-General of the United States Marine Hospital service, died in Washington on the 14th of March.

### Reports of Societies.

#### NEWCASTLE AND TRENT MEDICAL ASSOCIATION.

A meeting for the purpose of re-organizing the above association was held in Peterborough, on the 2nd ult. Members were present from Peterborough, Port Hope, Cobourg, Millbrook, Cold Springs and Mt. Pleasant.

The following officers were elected, viz. :— President, Dr. Herriman, Port Hope; General Secretary and Treasurer, Dr. Waters, Cobourg; Local Vice-Presidents, Drs. Boucher, Peterborough; Hamilton, Port Hope; Willoughby, Colborne; Local Secretaries, Drs. Bell, Peterborough; Burnet, Cobourg; Halliday, Grafton. Committee on By-Laws, &c., Drs. Boucher, Bell and Fraser, Peterborough.

Dr. Hamilton read a very interesting paper on the "Diagnosis of Croup," which elicited considerable discussion. On motion he was requested to furnish it to the "Lancet" for publication.

Drs. Fraser and Hunter promised to bring interesting cases before the next meeting, to be held in Cobourg on the first Wednesday in June. It is to be hoped all the medical men in the Division will endeavour to be then present and encourage the continuance of a flourishing association.

#### OXFORD MEDICAL ASSOCIATION.

The second regular meeting of the Medical Association of the County of Oxford for the year 1879 took place at Ingersoll, April 10th, the President, Dr. Williams, in the chair.

After the usual routine business, the subject of Locomotor Ataxia was introduced by Dr. Smith, of Mount Elgin, who cited cases in practice, Drs. Scott, Williams, and Hoyt taking part in the discussion.

Dr. Turquand, of Woodstock, gave a description of the varieties and complications of Diphtheria, which elicited a good deal of discussion from the members present, Drs. H. M. McKay, Smith, and Williams taking part.

Dr. A. McKay was appointed Secretary, owing to the appointment of Dr. Millman to the Asylum for the Insane, London. The Association adjourned to meet in Woodstock on the second Thursday in July.

### Books and Pamphlets.

PHYSICS OF THE INFECTIOUS DISEASES," by C. A. Logan, A.M., M.D. Chicago: Janson McClurg & Co. Toronto: Willing & Williamson. Price \$1.50.

The above is the title of a little book in which some interesting matter is found, associated with a rather liberal sandwiching of dissertations on subjects, the adequate disposal of which must be very imperfectly accomplished in a few by-chapters, embraced between the boards of a diminutive octavo of 212 pages. We certainly, with all sincerity, could have wished that Dr. Logan had expanded his observations on the second and third parts of his production,—“The Physical Aspects of the Pacific Coast of South America,” and the “Medical Aspects of the Pacific Coast of South America,” to the exclusion of his wandering speculations on “the Theory of Specific Causation,” the “Therapeutics of the Infectious Diseases,” and various other matters, the ventilation of which, doubtless, pressed heavily on his long suffering conscience. In truth, we are strongly tempted to conjecture, that the author's experiences of the Pacific Coast, valuable and instructive though they certainly are, would never have seen the light, had they not afforded promise of favourable opportunity for associate exhibition of his views on a goodly number of other subjects, which are at present, and long have been, and we imagine will long yet continue to be, questions of keen controversy.

It needs but a glance over the headings of the second half of the book, to throw the reader into the prodrome of an ague shake, in contemplation of the *omnium gatherum* of ponderous and portentous subjects threatened to be discussed, the very enumeration of which is an enterprise before which our courage pales.

Among these it would be wonderful that we should not find the “*Living Germ*” theory conspicuously figuring. But of this *hete noire*, Dr. Logan makes a pretty summary disposal, in less than 5 short pages, consigning it to the “tombs of all the Capulets” with little less than magic celerity.

We are by no means assured that had Dr. Logan read the latest experiments reported by Pasteur, Joubert, and Chamberland, on “the theory of germs,” (of which a translation was given in our columns, in the numbers for December, January, and February, last), he would have so precipitately pronounced



sentence on its demerits. We remember having once read a very harsh review of a work which to-day stands high in the estimation of profound scholars, rushed into type before ever the book had reached the critic; but what of that? he had seen transatlantic condemnations of the work, and he felt pretty sure that his own contribution to the fund would be graciously accepted.

Dr. Logan repudiates the germ theory of disease, but he seems not to hesitate over the alternative one of *fermentation*. This is very nearly a distinction without a solid difference. It is merely the substitution of a vegetative, for an animate process of propagation, and so far as preventive means are concerned, we cannot see that it at all lightens the anxiety or the labour of the surgeon or physician.

Should Dr. Logan find the appreciation of his book by the profession, such as to entice him to a second edition, we would entreat him to enlarge his observations on the valuable concrete matter, relating to the climate and diseases of the South American Pacific Coast. What he has written in this relation is truly valuable, and we cannot pardon him for his penurious curtailment of so instructive and interesting a subject. In the event, however, of re-appearance, we would venture to suggest that the book will lose nothing in merit, or discreet prestige, should the author make free use of the pruning knife in cutting out a few rather tall metaphoric phrases, which are scarcely consistent with classic medical literature. This is perhaps an American national frailty, or a sort of bacterial germ,—(we beg pardon,—a quasi-fermentative), impermeation,—the parental source of which is most probably in the same region with the zymotic inspirations of 4th of July eloquence.

After all, we must say, Dr. Logan's book is well worth the labour of perusal, and if all who read it appreciate it as we have done, they will wish it had not been so short where it is not long enough, and pardon the length where it might have been shortened.

#### THE POPULAR SCIENCE MONTHLY for May 1879.

This is the first number of the fifteenth volume of this interesting and popular monthly. It opens with an article from the pen of the late Prof. Daniel Vaughan on "The Origin of Worlds," which is a masterly presentation of the view that the planets like the living beings which inhabit them have their periods of growth, maturity and decay, to be followed by the birth of new ones. This is the third of a series on astronomical subjects, now unfortunately cut short by the death of the author, under circumstances of suffering and privation rarely paralleled in a civilized community. Then follows an article on "The Growth of the Will" by Prof. Alexander Bain, in reply to an

attack by Prof. Payton Spence; one on "New Guinea and its Inhabitants," by A. R. Wallver, Clews on Natural History by Andrew Wilson; Sensation and Sensiferous Organs by Prof. Huxley.

PHYSIOLOGICAL THERAPEUTICS.—In our notice of Dr. Poole's work in the last issue, the following paragraph, just preceding the last, was accidentally omitted. "In regard to the difficulties urged against the present theory, the author gives the action of alcohol as an instance: a glass or two of spirits usually causes a degree of vascular dilatation as seen in flushing of the face. On the accepted theory, arterial dilatation as seen in flushing, blushing, etc., is the effect of vaso-motor paralysis. Therefore alcohol, to produce flushing, must act as a paralyzer of the vascular nerves. But alcohol in such quantity is universally and properly regarded as a stimulant, which temporarily increases nerve force and certainly does not paralyze it. The accepted vaso-motor theory, the author maintains, is quite inconsistent with the facts of this simple case. He gives many illustrations of similar purport. The author is to be congratulated on the able manner in which he has advocated his theory, and placed it before the profession. It is not only very ingenious, but also well sustained by argumentative and cogent reasoning. The work also embodies several very important points, other than the vaso-motor theory. The opinions of the author are not wholly gratuitous and unsupported. He quotes extracts in support of his theory from many leading and recent authorities.

CATALOGUE OF MAMMALS, BIRDS, REPTILES AND FISHES OF CANADA. Collected and classified by A. M. Ross, M.D., Montreal, Que.

A catalogue of the Flora of Canada by the same author also nearly ready.

### Births, Marriages & Deaths.

In Toronto on the 17th of April, the wife of Dr. R. B. Nevitt, of a son.

At Londonderry, N. S., March 31st, the wife of Dr. James Kerr, surgeon, of a daughter.

At Shediac, on the 10th ult., Dr. R. Botsford, son of Hon. Judge Botsford, to Queen, eldest daughter of Lewis Carvell, Esq.

On the 4th ult., Martha J. Douglas wife of Dr. Thos. T. S. Harrison, of Selkirk aged 35 years.