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THE AMERICAN ASSOCIATION OF
PHYSICIANS.

BY J. E. GRAHAM, M.D. TOR., L.R.C.P. LOND.

The fifth annual meeting of this association took place on May 13th, 14th and 15th, in the Surgeon-General's library, Washington. It might be of interest to your readers to have presented a brief sketch of the new building, and of the library and museum it contains.

Both museum and library owe their existence to the civil war. In order to promote military medicine and surgery, Surgeon-General Hammond, in 1862, ordered "all medical officers of the army to collect and to send to the office of the Surgeon-General all specimens of morbid anatomy, surgical or medical, which may be regarded as valuable, together with projectiles and foreign bodies, and such other matter as may prove of interest."

For the purchase of books to be used for reference in the compilation of the medical and surgical history of the War, Congress made an appropriation of \$5,000 yearly.

Thus began both the museum and the library. They were for many years located in Ford's old opera house, where Lincoln was assassinated, but are now placed in a magnificent new building, for the erection of which, Congress, in 1885, appropriated \$200,000. The structure is of plain red brick, four stories in height, and made up of a centre building and two wings.

The centre building is 112x53, while each of the wings is 60x131. The museum occupies one wing and the library the other.

There are twenty-four persons employed in the library, and twenty-two in the museum.

The capacity of the library is for 170,000 volumes. In July, '88, there were 95,000 bound volumes, and 135,000 pamphlets. The celebrated index catalogue was commenced in 1880, and the 11th volume is now in course of publication. \$2,500 are annually spent in purchasing periodicals. The following figures will give an idea of the size of the museum. In July, '88, there were specimens of comparative anatomy, 1,687; specimens of normal anatomy, 2,961; pathological specimens, 8,354; instruments, 814; microscopes, 141; medals, 384; miscellaneous, 835.

Dr. Billings, the medical director of this flourishing institution, deserves the thanks of the medical profession of this continent, as to his efforts its present position is due.

The following is a brief summary of parts of the discussion of the Physicians' Association, which may be of interest to the general practitioner.

The proceedings began by the reading of a paper, by Dr. Reeve, of Chatanooga, on "Some Points in the Natural History of Typhoid or Enteric Fever." In the discussion which followed, Dr. J. C. Wilson spoke of the advantage of the cold-water treatment of typhoid.

Dr. Loomis said he had never seen a case of perforation in typhoid recover; but had seen recoveries from peritonitis. He had seen

œdema of the feet from venous thrombosis. Patients generally recover from softening of the heart muscle, but care should be taken during convalescence to avoid heart strain. When a mitral murmur is heard at the apex, there is danger of either of two accidents, cardiac thrombosis, or dilatation. Subacute gastritis, an occasional sequel of typhoid, is often brought on by the ingestion of improper food.

Weir Mitchell stated that there is local elevation of temperature over the tender spots in many cases of "typhoid spine." He is of opinion that spondylitis is present in such cases.

Dr. Pepper had seen excellent results from the continuous administration of nitrate of silver in small doses, from the very commencement to the end of the disease.

Dr. Budge, of Chicago, read an interesting paper on "Inflammation of the Appendix and Cæcum, and the duty of the Physician regarding them." He came to the following conclusions with regard to surgical interference:

(a) In acute cases, with rather protracted high temperature, and with distinct induration that does not yield in forty-eight hours.

(b) In cases of undoubted severe inflammation, lasting several days, even though no particular induration can be made out (violent appendicitis), and in acute localized peritonitis having its origin at the appendix, and producing marked constitutional symptoms (threatened peritoneal abscess).

(c) In all acute cases where large induration develops rapidly with high fever. Here extensive deposit and abscess are almost certain, and the operation should be early.

(d) In all cases advanced to subacute or chronic stage, with distinct induration and dullness (regardless of the temperature), since in most such cases pus is present.

(e) In all cases of undoubted chronic appendicitis, with recurring exacerbations, even if no induration can be demonstrated. In all such cases the patient is in constant danger of perforation of the appendix, and mortal peritonitis, and laparotomy and extirpation of the organ (if done antiseptically) reduce the hazard.

Dr. Atkinson was of opinion that constant watchfulness on the part of the physician is necessary, and that an operation should be done immediately before or shortly after perforation.

Dr. Fitz, of Boston, spoke of a case in which recurring attacks of peritonitis occurred, and when an operation was made, there was no evidence of perforation of the appendix. Seventy-five per cent. of all cases of appendicitis recover. Mortality of cases treated medically, eleven per cent.; of those treated surgically, forty per cent. He spoke of the difficulty of operation in cases where there were frequent attacks, and of the danger of hernia after operation.

Dr. Jacobi was of opinion that every physician should be able to perform the following operations: Herniotomy, tracheotomy, intubation, and laparotomy for appendicitis.

Dr. Pepper strongly dissented from Dr. Jacobi's opinion, saying that he had not known of a more severe and difficult operation than laparotomy under these circumstances.

At the afternoon session, a very interesting paper was read by Dr. Lusk, on "Antisepsis during Labor." He spoke of the great diminution of mortality in lying-in-hospitals, and attributed it to greater cleanliness, and use of antiseptics. He advises the use of the vaginal douche previous to delivery in hospital, but does not think it necessary, as a general, rule in private practice. He also spoke of the great value of corrosive sublimate solution. He preferred, in hospital practice, the antiseptic diaper. He was of opinion that imperfect washing of diapers was a frequent cause of disease.

Dr. Pepper believed that the frequent and careless use of vaginal douches after confinement was a cause of puerperal septicæmia.

Professor Welsh referred to the fact that, according to recent researches, it is impossible to completely sterilise the vagina and the hands of the operator by corrosive sublimate solution. He thought, however, that the small amount of the corrosive sublimate adhering to the hands might be sufficient to hinder the propagation of the few germ cells remaining on the epidermis.

Dr. Weir Mitchell read a most interesting paper on the "Disorders of Sleep." He took up principally those of the pre-somnum and post-somnum stages. He spoke of the importance of noticing the presence of hallucinations in the pre-somnum as strong premonitory indications of insanity. It is, of course, possible in rare cases to have such hallucinations without

insanity supervening. Another disorder is the presence of fear or terror without known cause. The distinguished writer also spoke of waking and post-somnic paresis and paralysis.

He also spoke of night neuralgias, mentioning a case in which peculiar distressing pains attacked the limbs after he had gone asleep. He would wake up, walk about the room, and when the pains passed away, go to sleep, to be again disturbed in the same way. He also described peculiar sensory shocks, which some experienced upon going to sleep. One in whom a peculiar feeling would pass from the hands up the arms to the head, when he would hear a loud crashing noise, like the breaking of a number of panes of glass. This was accompanied by a flash of bright yellow light. By getting up, or by moving over on his right side, he could prevent the progress of the attack. If, however, the feeling passed up to the neck he could not check it. These sensory are different from epileptic attacks, as the latter take place in the waking stage.

Jerking movements on going to bed are common. There are cases in which the jerkings are so severe as to require treatment.

Dr. Folsom then read a paper on "Insomnia," giving its various causes, and their respective treatment. He advised trying all known methods of relief before resorting to sedatives. He preferred giving small doses of sedatives frequently repeated.

Dr. Mitchell stated that in some cases it was better to procure sleep at once by giving a large dose of a reliable sedative, such as sulfonal. In such cases the disordered functions of the body became more easily restored after a sleep was procured.

Dr. Wharton Sinkler read a paper on "Recent Observations in the Etiology and Treatment of Migraine." He spoke of some of the reflex causes of migraine, such as eye-strain, uterine disorders, nasal irritation, etc. He spoke also of its frequency in children, especially when the permanent teeth were coming through the gums. He spoke of the therapeutic agents, antipyrin, phenacetine, eucalyptus, and caffeine. He used phenacetine in preference to antipyrin, as it was safer and more reliable.

Dr. Ernst, of Harvard University, presented a specimen of a rabbit which had died of tu-

berculosis of the bowels. Six weeks before, eight drops of suspected tubercular milk had been subcutaneously injected in the abdominal region.

He also exhibited some results of Dr. Martin's work in his investigation of small-pox and vaccination. It would appear that the bacteria of the latter have been successfully isolated, cultivated, and re-inoculated. Further developments will be looked for with interest.

Dr. E. O. Shakespeare discussed the subject of the prevention of tuberculosis. He concluded his paper by stating the following general principles, which underlie an efficient system of prevention of tuberculosis.

1. From the standpoint of the already diseased, effective preventive measures should look to the rapid destruction of the tubercle bacilli in excretions and secretions of the affected, by little as possible prolonged close association of the well with the sick.

2. From the standpoint of those liable to become infected, nothing which may contain the living tubercle bacillus should be permitted to enter the digestive apparatus. Rigid inspection of meat and milk is a necessity.

3. Tuberculous subjects should not be admitted to hospital wards in which those with other diseases, especially of the lungs, are confined. In general hospitals, consumptives should be assigned to special consumptive wards.

4. Special hospitals for the treatment of consumption should be established.

In the morning session of Thursday, Dr. Kinnicutt read a very valuable paper on "Methods of Diagnosis in Diseases of the Stomach." He spoke of the importance of chemical examination of the contents of the stomach, as an adjunct to other means of diagnosis. In his opinion, the presence of free hydrochloric acid in the gastric juice was sufficient to exclude cancer. He then described the various tests for the presence of free hydrochloric and of lactic acids, and afterwards took up the differential diagnosis between cancer, ulcer, and hyperscretion.

In the discussion which followed, Dr. Forscheiner spoke of the great difficulty of making tests of the gastric juice in private practice.

Dr. Kinnicutt did not think these tests would present much greater difficulty than those of a qualitative and quantitative character of the urine.

Dr. Graham then read a paper entitled "Notes of Two Cases of Acromegaly," after which the session closed.

MITRAL STENOSIS.*

BY A. M'PHEDRAN, M.D.

Lizzie D., aet. 39, married. A small spare woman of most irascible temper. No reliable account could be obtained as to either her family or personal history. She gave no account of a decided attack of rheumatism, but said she had suffered from pains. There is no certainty of her having had measles, scarlatina, etc. She had been in the hospital many times during the last few years. During that time she had more or less cough, some shortness of breath, with a "wheezy" voice. She complained of pain in the præcordial region—it may have been feigned. Her complexion was clear with a pink hue to the cheeks and lips. The lungs, to examination, gave negative results.

The heart, two years ago, presented the following conditions:—On inspection there was nothing unusual to be seen. On palpation there was a marked systolic thrill over the apical region. The apex beat was felt in the normal position and slightly diffused to the right. To percussion the area of cardiac dullness was not altered. On auscultation there was a loud rough presystolic murmur heard over a circular space in the apical region, loudest in the centre of the space, which was a little to the right of the normal seat of the apex beat. The first sound of the heart was short, resembling the second sound in character; both were audible at the apex. There was accentuation of the pulmonic second sound heard to left of the sternum in the second interspace.

During the following winter (1888-9), she came under observation again. By this time the thrill was much less marked, and often absent. The murmur was not so harsh or loud, and was now followed by only one sound of the heart, so that, by some, the murmur was thought to be regurgitant now, followed by the second sound. But by carefully auscultating above the apical region over the fourth costal cartilage, the two heart sounds became distinct, and by moving the stethoscope a little downwards the

murmur became audible, and at the same time the second sound was lost; with care, however, a point could be found at which both the murmur and heart sounds could be heard. The pulmonic sound was still accentuated, while the aortic was weak; owing to weakness of the latter it could not be heard at the apex.

Her condition otherwise was but little altered.

Last winter she entered the hospital again. She had married and was pregnant about five months. She was weaker and the breath shorter, with more cough and expectoration, but no blood. There was some œdema of the feet and legs. Urine was normal.

There was no thrill at the apex. The murmur was much less harsh, but still terminated abruptly before the heart sound, that followed it. The two sounds of heart were audible over the middle and upper parts of the præcordial region, but only the murmur and one sound at the apex, and that sound was short and sharp-like second heart sound.

The pulmonic sound was less accentuated but still much sharper than the aortic sound, which was much weaker than normal.

As pregnancy advanced, the dyspnoea, cough, dropsy, and weakness increased; the urine became highly albuminous. At times no murmur was audible, only the first sound being heard at the apex. By April 15th, being then about eight months pregnant, her condition became so critical that it was deemed necessary to induce labor, and she was transferred to the care of Dr. A. H. Wright for that purpose. Matter progressed favorably; she was in fair condition just before the head was delivered, the pulse being about as good as usual. Immediately after delivery of the child no pulse could be felt; she sank rapidly and died shortly afterwards.

At the post-mortem examination, which was performed by Dr. J. Caven, the lungs were found extremely œdematous, greatly fibrosed, and to contain many recent hæmorrhagic patches. The heart: the right auricle greatly dilated and filled with recent clot; the right auriculo-ventricular orifice narrower than normal, only admitting the ends of two fingers; the right ventricle somewhat dilated, with thickened walls; in its walls, near the pulmonary orifice, was found a large sinus extending to the left into the tissue of the left ventricular wall, and terminating in

*Read before the Pathological Society of Toronto.

two blind cul-de-sacs, the whole lined by smooth membrane.

The left auricle was much dilated and its walls thin. The mitral orifice was much contracted, the valves thickened and adherent, forming a funnel the apex of which formed a narrow oval slit about half an inch in length. The edges of the slit were approximated by slight pressure, and were doubtless closed with each systole of the ventricle. The cavity of the left ventricle was small and its walls thin. The thickening of the endocardium extended from the mitral sgment of the aortic valves, which were slightly affected also, but competent.

The liver was "nutmeg," and very fatty, but not enlarged. Kidneys showed little change. In the uterus the placenta was still adherent. There was a fairly large clot in the vagina.

The cause of death was probably due to the sudden emptying of the uterus and the slight uterine hemorrhage, both combining to deprive the general circulation of more blood than could in her condition be spared.

Remarks: This case is fairly typical of the general course of mitral stenosis. The clearest conception of the history of a case of mitral stenosis is obtained by following Broadbent's plan of dividing the history into three stages, as given in his Harveian lectures (*Brit. Med. Jour.*, vol. 1, 1884, page 449). "In the first stage there are the presystolic murmur and thrill with more or less accentuation of the pulmonic second sound; its distinguishing mark is the presence of the second sound at, and to the left of, the apex." An apex murmur preceding the cardiac impulse, followed by two heart sounds is almost pathognomic. At this stage there are few if any symptoms. "The second stage is marked by the disappearance of the second sound from the apex." At the same time, the first sound has gradually undergone a complete change in character and has become short, sharp, and loud, resembling an exaggerated second sound. Now, mistakes in diagnosis are easily made; the presystolic murmur, followed by a short, sharp, first sound is taken to be a systolic murmur followed by a loud second sound, and the disease is supposed to be mitral insufficiency."

This accurately describes the condition in the above case. Very few of the works refer to the

disappearance of the second sound at the apex, yet it is a point of great importance not only in diagnosis but also in prognosis, which is much more grave in stenosis than in insufficiency of the mitral valves.

Normally, the second sound is always to be heard at the apex and to the left of it, and its disappearance in mitral stenosis is owing, (1) to weakness of the aortic second sound on account of the insufficient distension of the aorta by each systole of the left ventricle, and (2) to the enlarged right ventricle overlapping the left and preventing its coming into contact with the chest wall, thus the aortic sound is not conducted through to the ear.

In Broadbent's third stage the murmur disappears, and only the short, sharp, first sound is heard at the apex. In the case detailed above this stage was not fully developed. The thrill disappeared, the murmur lost much of its harshness, and on one or two occasions was not to be heard but it did not disappear for long. This is probably due to the fact that the termination was hurried by the pregnancy, without which life would, probably have been prolonged, it may be, for a year or two at least.

This is to be noted also, that the murmur in this case, even when softest, always terminated abruptly, and never had the prolonged character that characterizes a regurgitant murmur.

Selections.

RUPTURE OF THE HEART.—The man had been found dead on the railway with several fractures of the limbs and a scalp wound, but no fracture of the skull. No external sign or trace of injury to the thorax in front. A large portion of the sternum was detached from the rest of the skeleton and thrust down on the underlying viscera, all the costal cartilages being broken as well from the 2nd to the 8th. The pericardium and the pleura were found full of blood. At the apex of the right ventricle there was a large rupture; another great rent into the right auricle. There was no laceration, neither was there any blood-clot in the heart, nor any rupture of the valves or of the chordæ tendineæ. In the auricular appendix and the muscoli pectinati there were a couple of small ruptures. In the back of the heart at the left auricle, in the

interval between the entrance of the pulmonary veins, there were two or three large lacerations. The left auricular appendix was ruptured; but the left ventricle was free of rupture, or of any lesion whatever. Clearly what happened was, that the heart being full of blood, pressure of the detached bone burst the whole of the three chambers.—*Beihnett in Med. Press and Circular.*

DIASTASE OF MALT IN EXPERIMENTAL DIABETES.—At a meeting of the National Society of Medicine, of Lyons, M. Lepine related an experiment proving that the injection of diastase of malt into the blood is capable of diminishing enormously the glycosuria produced experimentally by obliteration of the pancreas. A bitch in a state of inanition, whose pancreas had been removed, and which could be catheterized every half hour, had urine drawn off one hour after operation, and nearly 50 grammes of sugar per litre were found. Two hours after the operation there were 66 grammes per litre. Two grammes of diastase were now injected into the animal, the quantity of sugar was rapidly lessened; half an hour after less than twenty grammes were found; the quantity then began to increase again, and 2½ hours later the effect of the diastase had nearly passed off. This result is perfectly in keeping with the results obtained by M. Lepine in the case of a man in whom he had injected some diastatic ferment. Unfortunately the diminution of the glycosuria is but transitory, the injected ferment being soon eliminated.—*Lyon Medical, April 6th, 1890.*

SOME CASES OF EPILEPSY TREATED WITH SUCCESS BY COLD BATHS AND LARGE DOSES OF BROMIDES.—Dr. P. Glatz.—The author publishes four cases of epileptic attacks very much improved, and even apparently cured, by the simultaneous use of the bromides and the cold douche, which had been recommended by Charcot in one of the cases in which bromides and other remedies taken alone had failed. Knowing how frequently relapses occur, he insisted that the patient shall employ the treatment during at least three months of each year. The douches should be in form of shower-bath of very short duration, lasting not longer than half a minute to a minute, and should be taken morning and evening. The bromides were un-

der form of polybromides (? combination of bromides) of Charcot, from 60 to 120 grains daily, or simply the bromide of sodium, of which the dose did not exceed 135 grains daily.—*Gas. med. de Strasbourg, April 1890. Lyon Medical, April 27th, 1890.*

G. A. F.

EXTRAORDINARY EFFECTS OF NAPHTHALIN ON THE EYE.—A recent *Lancet* referring to some new observations by Dr. Kolinski points out that naphthalin, which has been coming much into use from the powerful effect on the micro-organisms which exist in the intestines in some kinds of diarrhoea, also possesses the property of producing changes in the nutritive power of the blood, thus being able to set up degeneration of the blood vessels. As the eye is one of the most vascular organs, it is one of the first to show any of the changes induced by interference with the nutritive property of the blood. Naphthalin, according to Dr. Kolinski, first causes small extravasations in the choroid, and in the ciliary body, then ecchymosis and white patches in the retina, and finally cloudiness in the lens and crystals in the vitreous humour. We may add to these remarks published by the *Lancet*, and in Van Grafe's *Archiven* (xxxv. 2), that it has long been known how much influence is exerted on the eye by disturbance of the digestive organs, and especially by affections of the liver, which may actually produce cataract, the latter disappearing when the liver symptoms are cured. We know also how strongly certain medicaments, such as santonine, morphine, hyoscyamine, etc., act upon the organ of sight. The Polish physician has done well to draw attention to the effects of naphthalin in this respect.—*Magazine of Pharmacy.*

PRIMARY CARCINOMA OF PANCREAS; EXTIRPATION, RECOVERY.—By Professor Rugge of Bologna (*Gioen, Internazionale delle Scienze Mediche*, 1890, February)—A very instructive case occurred recently in which the pancreas of a woman of Ravenna, 50 years of age, was completely extirpated. The patient came to the clinic of the author in Bologna, complaining of gastric uneasiness, want of appetite, anorexia, persistent constipation, and pains radiating from the epigastrium in all directions. On examina-

tion, a tumor was found in the region of the transverse colon, bounded by the navel and left hypochondrium. The tumor was somewhat uneven, hard and resistant to the touch. It measured $9\frac{3}{4}$ inches in the transverse, and 4 in the vertical diameter. Tumor was slightly movable. Diagnosis was somewhat difficult, and the author diagnosed a probable retroperitoneal sarcoma. The patient asked for the removal of the tumor. Operation was performed on September 4th. Much difficulty was experienced on account of the many adhesions, and of the unusual softness and brittleness of the tumor. Finally the growth, which was recognized as the pathologically altered pancreas, was removed piecemeal. Careful microscopical examination revealed primary cancer of pancreas. The wound ran an unusually favorable course, and healing was rapid. The general condition of the patient improved from day to day; the appetite increased, and in spite of fact that patient received a mixed diet at her own request, there were no digestive disorders, and all former troubles disappeared. Commenting on this rare case of total extirpation of the pancreas without any unfavorable after-effects on digestive process, the author expresses the belief that other glands must assume the functions ascribed to the pancreas, and that among these the principal are Brunner's and Lieberkühn's glands.—*Dr. Sterk of Wien-Marienbad in Med. Chir. Rundschau, April 15, 1890.*

G. A. F.

RESEARCHES ON THE USE OF LIPANIN AS A SUBSTITUTE FOR COD LIVER OIL.—By Dr. Demetrius Galatti (*Archiv. f. Kinderheilk. xi., Bd. i., Steft*). As a result of observations made in the polyclinic of Dr. Herz in Vienna, Galatti concludes that lipanin is superior to cod liver oil. Twenty-seven children between the ages of eight months and thirteen and a-half years were put under treatment. Working on the hypothesis that the therapeutic value of cod liver oil depended on the presence of free fatty acids Von Mering was led to substitute for cod liver oil, a mixture consisting of pure olive oil, holding in solution five to six per cent. of oleic acid. This is now prepared under the name of "Lipanin," by the wholesale firm of Kahlbaum in Berlin, and is well liked by children, on account

of the absence of the peculiar smell and taste of cod liver oil, and of the unpleasant after-effects of that drug.

Galatti has come to the following conclusions as the result of his observations:

1. Lipanin is well liked by children.
2. In none of the cases observed was there any discomfort, nausea, vomiting or diarrhoea, following its use.
3. The gain in weight even among the poor, badly-nourished patients attending the polyclinic was marked and even surprising.
4. The appetite was markedly improved, and a desire for food was manifested, even by those who had suffered from complete loss of appetite.
5. In patients suffering from tuberculosis the pulmonary lesions either remained stationary or progressed in spite of the improvement in the general condition. Lipanin may be taken even in summer, and young children should begin with two to three teaspoonfuls per day, gradually increasing to as many dessertspoonfuls, taken preferably afterwards. Older children might take as many tablespoonfuls. In rickets, Lipanin might be combined with phosphorus after the formula of Kassawitz, with cod liver oil. In the same way, if indicated, it could be combined with creasote or menthol.—*Dr. Heigenberger Budapest in Medicinisch Chirurgische Rundschau, April 1st, 1890.*

G.A.F.

DIABETES MELLITUS AND PANCREATIC AFFECTIONS.—In the *Med. Chirug. Rundschau* for April, 1890, attention is drawn to an article in the *Berliner Klinische Wochenschrift*, from the pen of Dr. Minkowski, of Strassburg, in which the author considers the relations existing between diabetes mellitus and affections of the pancreas. He shows that while in post mortem examinations of diabetic patients, affections of the liver are practically never found, and lesions of the medulla oblongata only in rare cases, serious disease of the pancreas is, on the other hand, often met with. The author thinks it is no longer open to doubt, that at least some cases of diabetes are due to a primary lesion of the pancreas, but he suggests that we should advance from this position, and ask whether all cases of diabetes do not depend on some affection of the pancreas.

The writer maintains as specially worthy of consideration in this connection the fact that, in cases of extirpation of the pancreas, all the sugar taken in with the food is excreted in the urine. This fact, he observes, points to a specific function of the pancreas possessed by no other organ; that it renders probable the theory that every interference with the destruction of sugar in the organism answers to a disturbance of this specific function of the pancreas. He is inclined to give the more weight to this view, as all other views, according to which the cause of the disease would depend on lesions in other organs, have much less foundation than that which makes it depend on a disease of the pancreas. He admits that, in some lesions of the nervous system, sugar is present in the urine, but he suggests that in these cases the action may be an indirect one, as the sugar molecule is certainly not destroyed in the nervous system, although the nervous system may influence those organs by which sugar is utilized in the organism.

The organs on which attention has been nearly exclusively directed in this connection are the liver and the muscles. Dr. Minkowski says there is only one fact in favor of the hepatic origin of diabetes, namely, the presence of glycogen in the liver. Beyond this, he says, neither clinical nor pathological observations, nor the results of experiments are in favor of this theory. As regards the muscles, we know that when active they produce carbonic acid; we know also that muscular exercise can lessen the quantity of sugar in the urine of diabetic patients; but the writer insists that never in the most diffused diseases, the most widespread atrophy, or the worst forms of paralysis of the muscles, is sugar to be observed in the urine. He compares the facts just mentioned with those that tell in favor of the pancreatic theory: the numerous pathological changes found in the pancreas of diabetic patients; the occurrence of true diabetes mellitus after the removal of the pancreas, the only method by which true diabetes has as yet been experimentally produced.

Two objections remain to be answered:

1. Excretion of sugar in the urine has not been observed in all cases of disease of the pancreas.

2. Changes in the pancreas are not observed in all cases of diabetes.

As regards the first objection, the writer observes, that partial removal of the pancreas is not followed by diabetes. If a small portion of pancreatic tissue is left, even though it be not in connection with the excretory duct, it is sufficient to prevent the onset of diabetes. In one case the author, by removing about nine-tenths of the pancreas, succeeded in producing a mild form of diabetes. The dog experimented on had no sugar in the urine as long as he was kept on a meat and milk diet; after a meal rich in carbo-hydrates, however, a considerable quantity of sugar appeared in the urine. In answer to the second objection, the writer says that it is not possible at present to form an opinion on the frequency of pathological changes in the pancreas in cases of diabetes mellitus, seeing that only in a small number of cases has sufficient attention been paid to changes in the pancreas in post-mortems on diabetic patients. He points out that an accurate microscopical examination is necessary, in addition to the macroscopical. He admits that, even when this has been done some cases will probably be met with in which no pathological changes will be found sufficient to account for the disturbance of function, and that lesions of the nervous system, toxic influences, disturbances of circulation, may bring on diabetes just as well by disturbing the function of the pancreas as by disturbing that of the liver. In order not to be misunderstood, the author states that he is far from holding as proved the pancreatic origin of diabetes. At present it is a possibility to which he points, but one which is supported by important facts. It is even possible that the function of the pancreas forms but a link in the chain of tissue-changes by which sugar is destroyed in the organism; and that as the chain may be broken by the removal of the one link, so it could be broken in many other places. It is by no means out of the range of possibility that by further researches a decisive conclusion may be arrived at, that glycosuria is the expression of a disturbance of the function of the pancreas, just as albumuria is the expression of a disturbance of the function of the kidneys.

The writer shows that the present dietetic method of treating diabetes could then be explained as an attempt to spare a diseased organ by making fewer demands on its disturbed functions.

Minkowski and Von Mering have tried to treat diabetes by mixing fresh pancreas with the food of the patients, but without any marked influence on the excretion of sugar. This, as the writer remarks, need cause no surprise, as it is not a question of the action of the pancreatic juice in the intestine, but as to the action of the pancreas as a factor in producing tissue changes.

G. A. F.

THE

Canadian Practitioner

A SEMI-MONTHLY REVIEW OF THE PROGRESS
OF THE MEDICAL SCIENCES.

Contributions of various descriptions are invited. We shall be glad to receive from our friends everywhere current medical news of general interest.

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TORONTO, JUNE 2, 1890.

TRINITY MEDICAL COLLEGE AND THE UNIVERSITY OF TORONTO.

We had hoped that the time had come in the history of medical colleges in this Province when they could work side by side in friendly rivalry, without any of the disagreeable features which characterized their relations in times past. The perusal of an open letter from the Dean of Trinity Medical College to the Minister of Education, in March last, would tend to dispel any such pleasant illusions. We have not space for this extraordinary production, which uses such terms as "traps," "utter meanness and gross unfairness," "sly and underhand character," "tortuous policy," etc., with reference to the new Faculty, its methods of formation, and its present position; but will simply say the main object of the letter is to show that Trinity has been badly treated. In connection therewith we desire to give a plain statement of facts, and leave the profession of Ontario to form their own conclusions.

Under the Federation Act, passed by the Provincial Legislature, power was given to the Senate of the University of Toronto to re-establish and conduct a Medical Faculty. A committee of the Senate was appointed to consider the

matter, composed as follows: The Vice-Chancellor, Sir Daniel Wilson, Sir Matthew Cameron, Hon. Justice Patterson, Hon. Justice Falconbridge, Rev. Principal Caven, Rev. Father Vincent, Hon. John Macdonald, Professor Galbraith, Dr. O'Sullivan, Mr. W. A. Foster, Q.C., Mr. C. Moss, Q.C., Mr. Wm. Houston, M.A., Drs. Fulton, Oldright, McFarlane, and A. H. Wright. The committee decided that it was desirable to re-establish a Medical Faculty in the University, and showed a strong desire to obtain the sympathies of the profession as a whole, and especially the assistance of the two schools of Toronto in such establishment. In their report, presented to the Senate March 21st, 1887, we find the following sentences: "If the Faculty or Faculties of the Toronto School of Medicine or Trinity Medical School, Toronto, decide to suspend their charter or charters, and accept the proposed scheme, the members of such Faculty or Faculties shall hold, as far as possible, the same positions in the new college as they held as professors or lecturers in their present schools." "The present salaries of professors shall be maintained *pro rata*; and for the purpose of defining what is understood by salaries, the scale at present existing at Trinity Medical School shall be taken as a basis; and a practical scheme for retiring allowances for the professors shall be arranged." This latter clause was inserted for the purpose of overcoming certain objections raised by Dr. Fulton in the interests of the school he represented. Every effort was made to enlist Trinity's active co-operation in the organization of a combined Faculty, whose aim would be, not simply to attract large numbers into our already over-crowded profession, but chiefly to raise the standard of medical education in the Province.

This report was formally submitted to the Trinity Faculty for approval. The official reply stated that the report had been "very carefully gone over section by section, and after mature deliberation" it was decided that the "Corporation of Trinity Medical School is not willing to suspend its charter, and enter into the scheme proposed." Many reasons were given to show the causes for refusal to co-operate. In one of the Dean's letters, we find the following concluding sentences: "I think it will be ample time to give the subject full consideration when

we learn that the Government of Ontario, with the cordial co-operation of our Provincial Legislature, has fully decided to create, equip, and endow liberally a new medical teaching body, and to provide for it a staff of the best teachers the country can furnish, each of whom shall have a salary secured to him of not less than \$2,000 a year for each of the principal chairs, and a suitable retiring allowance when, from age or ill health, he is no longer able to discharge his duties. Till this is done, the project is a mere 'castle in the air.' When it has assumed this tangible form, I feel quite sure Trinity Medical School will accord to it a most careful and respectful consideration."

Thus we find that, according to Trinity's views, after carefully considering the report, the principles involved in the formation of the new Faculty were entirely wrong; but, at the same time, its professors were willing to sacrifice their principles for the small sum of \$2,000 a year each.

Trinity's Dean, in his open letter, says: "Indeed, for reasons which need not be detailed here, not a few members of the Faculty, who knew all about the *proposal* and its *origin*, considered it a mere trap, falling into which would have destroyed the identity of Trinity Medical College." A charge so serious as this must be simply astounding to those who have any intimate knowledge of the various stages of the negotiations. We hope that a careful review of the names given will furnish a sufficient guarantee that this committee could scarcely condescend to such a procedure as laying a "trap" for the purpose of deceiving Trinity. Some of its members, whose memories were, have died; and we consider it singularly unfortunate that their fair names should be subjected to such slanderous accusations.

We would like to know by what authority the Dean presumes to speak of the "independent Medical Colleges" outside of Trinity as hostile to the University of Toronto, and struggling against a "grievance," an "evil," "a great wrong, and all the greater because of its sly, underhand character," etc.? Who is he that now poses as the champion of medical colleges in distress? It singularly happens to be the man who, acting on behalf of the Trinity Faculty, attempted to destroy the Kingston Medical School when

its students were in open rebellion against the authorities, during the session of 1882-3, by offering to take those students and give them full standing on their own declarations. McGill had previously refused to do so dishonorable an act. So grateful did the Kingston Faculty feel towards McGill that two of its professors went to Montreal (as the Hon. Dr. Sullivan publicly stated) "mainly to show their appreciation of the honorable and upright manner in which the Medical Faculty of McGill University had acted." How they felt towards Trinity may be inferred from Dr. Lavell's statements as they appeared in public print, to the effect that they "were left to the unpleasant consciousness of feeling that they had been betrayed, and their confidence in the honor of a sister institution was shaken."

In view of this unfortunate episode, unparalleled in the annals of medical education in Ontario, it would certainly be a strange spectacle to see Queen's yoked with Trinity in a crusade against higher medical education. But, apart from this particular incident, we believe there are in Queen's a solid respectability, a sturdy honesty, and an unselfish desire for the general good, which will ever prevent her from engaging in the petty methods of warfare inaugurated by Trinity. Of that vigorous and worthy young medical college in the west we have nothing to say in this connection excepting that she will probably leave the Dean very severely alone, and that nothing is likely to destroy the good feeling and kindly friendship that has ever existed between London and Toronto.

After all, so far as we know, apart from this peculiar and rather hysterical attack on the part of Trinity, there is a general disposition to give the University a fair and impartial support. It is unfortunate that any opposition to it should arise from a sister so near her doors. The University of Toronto appreciated Trinity's high standing, and the good work she had done, and paid her the highest compliment possible in offering her a place second to none. There were many things for the Toronto and Trinity Schools to consider. The disadvantages from their point of view were numerous, and have been referred to before. One of the advantages which the Dean attaches much importance to is the fact that the fees from students for chem-

istry and biology go into the Medical Faculty fund. We presume the Senate can place them where it likes; but supposing the statement to be correct, as we hope it is, what is the remedy? Two alternatives are proposed: 1st, the students in medicine should not be charged for these subjects. In such a case the Medical Faculty would have a decided advantage over other schools which would hardly satisfy even Trinity; 2nd, such fees should be placed in the general funds to be expended for the benefit of the Arts Department. As it is now the Arts Department is supported by the country, while the Medical Faculty has cost the Government nothing. Is it just that the Medical Faculty, the only portion of the University which is self-supporting, should be asked to subsidize the Arts Faculty? The idea that medical students should pay certain fees merely for the purpose of assisting in the education of the arts men is rather a brilliant one, and possibly worthy of careful thought and consideration; but, for that purpose, time fails us at present.

Trinity thought that the disadvantages predominated. Her answer was eminently business-like: we will not accept, but just try us with an offer of \$2,000 each, and we "will accord to it a most careful and respectful consideration." They had a perfect right to refuse, but why should they prevent others from accepting? Surely they were too dignified to pursue a dog-in-the-manger policy! Well, at first they were, and treated the Faculty with a proud and haughty disdain. Then they fired their shafts of wit. The course was "too scientific." There was too much "frogology." The Faculty was an "unwieldy invertebrate thing—principally composed of tail." At this stage the Dean was really almost too funny for anything. Finally, after passing through various phases, wit gave place to fear. The third session after the re-establishment showed a degree of success which was as unpleasant as it was unexpected. Trinity appears to be displeased with the results, and, as a consequence, has made, probably, the most remarkable and ill-judged attack on the University of Toronto that that institution has ever experienced. Fear was accompanied by a well marked hyperæsthesia and general hysteria, and finally we find Trinity's Dean standing, almost alone, in the valley of despair, gazing excitedly

on the wave of progress which threatens to swallow him, while he frantically calls upon it to stop—but it won't stop.

THE REGISTRARSHIP OF THE ONTARIO MEDICAL COUNCIL.

The work connected with the registrarship of the Ontario Medical Council has been enormously increased during recent years. The able and popular incumbent, Dr. Pyne, has always proved equal to the occasion even under the most trying circumstances. His honesty, zeal, tact, and perfect impartiality, are universally recognized. It is quite within the mark to say that the success of the Council is largely due to his patient and untiring efforts. Is it not time that his labors should receive something like a decent recognition? We understand he is now receiving the beggarly salary of \$1200 per annum. It ought to be \$3000. A good officer should be, at least, fairly well paid. We feel certain the profession would support the Council in giving an increase something like the one suggested. Let justice be done as soon as possible.

NOTES.

BRITISH COLUMBIA MEDICAL COUNCIL.—The annual meeting of the British Columbia Medical Council was concluded May 8th. The following officers were elected for the ensuing year: Dr. Hannington, of Victoria, President; Dr. W. A. DeWolf Smith, of New Westminster, Vice-President; Dr. Lefevre, of Vancouver, Treasurer; Dr. G. N. Milne, of Victoria, Registrar and Secretary. The Council decided to prosecute all unqualified practitioners. The following gentlemen have been appointed examiners: Materia medica and chemistry, Dr. Milne; physiology and clinical medicine, Dr. McGuigan; surgery, Dr. Davie; diseases of women and children, Dr. Lefevre; practice of medicine, Dr. Hannington; anatomy and clinical surgery, Dr. Tunstall; Medical jurisprudence, Dr. Smith.

Dr. W. Belfield, 612 Opera House Building, Chicago, Ill., U.S.A., respectfully solicits information concerning unpublished cases of operations upon the prostate, especially for the relief of the so-called hypertrophy of the organ.

Meeting of Medical Societies.

HAMILTON MEDICAL AND SURGICAL SOCIETY.

Stated meeting, May 26th, '90.

Dr. Gaviller in the chair.

Dr. A. B. Osborne read a paper entitled,

SPECTACLES AS THERAPEUTIC AGENTS.

If "the proof of the pudding is in the eating," then the value of any therapeutic measure consists in its successful application.

The results—remote and direct—of strain upon certain portions of the ocular mechanism are being rapidly ascertained, and are becoming recognized by the profession. So far-reaching are the effects of ocular strain, that an examination of the eye is considered incomplete unless the state of the refraction and motor apparatus is fully noted, and many chronic inflammatory affections of the eyes become much more amenable to treatment when the ciliary strain is removed by glasses.

The constant occurrence of certain symptoms in cases of hypermetropia and astigmatism, as well as the equally constant relief to these symptoms afforded by wearing glasses, point at once to a strain of the ciliary muscle as the prime factor in their production.

Headache is one of the commonest manifestations of ciliary strain, in fact refractive errors are so productive of this disorder that every case of chronic or recurring headache should be tested for glasses. The headache may occur in almost any form but is most frequently frontal, accompanied by a sensation of weariness and a desire to close the eyes. It is rarely present upon first awakening in the morning, but commences during the day, or in the evening after the eyes have been in use for some time. Among school children who are compelled to study at night these headaches are specially frequent; a good night's rest usually removes the trouble completely, but only to return at the end of another day's work. The sufferer may be quite unaware of any defect of the eyes, as there are frequently no symptoms pointing directly to them and the vision may be excellent, in fact it is the proud boast of many such cases that their sight is perfect, yet a careful examination reveals an amount of hypermetropia, which

when corrected affords a measure of perfect relief. It is not infrequent to be consulted by patients about headaches which are referred to a slight or purely imaginary catarrh, but are in reality due to the eyes and are cured by wearing appropriate glasses. The causal relation between ciliary strain and headache is proved by the disappearance of the latter when the former is relieved, but the direct chain by which such an effect is produced is difficult to trace.

Neuralgia, especially of the frontal nerve, but also of the facial and occipital nerves is not unusually the result of ocular strain, indeed such association is sufficiently frequent to call for an examination of the eyes in obstinate and recurring cases. This form of neuralgia is particularly prone to occur when the patient is somewhat run down, owing to the fact that the eyes are required to do their customary work, notwithstanding the fact that they are in the same weakened condition as the rest of the system. In these reflex neuroses, which are influenced, if not actually caused, by strain of the ocular mechanism, the neurotic condition, unless early relieved, may become a confirmed habit, making it much more difficult to eradicate. This is one of the strongest arguments in favor of an early optical correction. It is hardly necessary to remark that the symptoms so far enumerated are most apt to occur when the system is debilitated, so that invigorating treatment is indicated, as well as relief to the ocular strain.

The local effects of ciliary strain are numerous, fully two-thirds of an oculist's cases presenting themselves on account of, or as a result of, such strain.

The causation of cataract is probably one of the most direct results of ciliary strain. It has long been known that the majority of cases of cataract were hypermetropic, but it has been reserved for recent observers to begin at the other end of the scale and demonstrate incipient cataracts in a large proportion of cases of hypermetropia and astigmatism. The probabilities have long been in favor of such a theory, and recent observations appear to have established it as a fact.

A large percentage of squints are the outcome of ciliary strain, and many oculists can cite cases where—having seen the patient before the squint had become a confirmed habit—it disap-

peared completely under the use of atropine and correcting glasses. Similarly, a simple surgical correction without the assistance of spectacles is too frequently a complete failure. So well known has this fact become that surgeons do not operate upon squints without first testing the vision and ordering the requisite glasses.

Chronic affections of the lids, as blepharitis and recurring styes, may be kept up by ciliary strain; these cases recover rapidly when glasses are worn. This is also true of a chronic form of conjunctivitis, affecting principally the palpebral conjunctiva. The writer has found a considerable proportion of his cases of chalazion associated with hypermetropia and astigmatism, and the correction of these defects has materially lessened the irritation. Photophobia, lachrymation, and an apparent hyperaesthesia of the retina, may all be produced by strain of the refractive mechanism.

The hypertrophy of the ciliary muscle, resulting from the continuous strain necessary in hypermetropia and astigmatism, is an important factor in the production of glaucoma.

Lastly, the asthenopia produced by some forms of ocular strain is familiar to all; it disappears rapidly after proper glasses are worn.

The large number of children wearing spectacles in the present day is frequently adduced as evidence of the deterioration of the species. It would be more correct to call this an index of the advance of science, inasmuch as we are now able to relieve diseases by means of glasses, which our predecessors were barely able to diagnose, much less treat.

From what has been said it will be seen that spectacles occupy a prominent place among our therapeutic agents, not only in relieving visual defects and in the treatment of some painful reflex symptoms, but also in diminishing the danger to eyes later in life from such serious diseases as cataract and glaucoma.

Dr. Lafferty read notes of following case:—

J. M., a laborer, aged 51, married; has served in the British army for 11 years. Has, with the exception of small-pox 32 years ago, had no sickness of any kind. Drank very hard until about 12 years ago. During this latter period he has been a total abstainer. Family history good; parents both lived to 80.

Never contracted any venereal disease; in

fact never required any medical attention until about four years ago, when he experienced a difficulty in micturating. The urine contained considerable quantity of white substance, milky in appearance. Had retention; was delivered by means of a catheter. This deposit has gradually increased in quantity ever since, being almost constantly present. About this time pains began to be felt in the sacral and gluteal regions, darting and shooting down both legs to the heels. Little notice was taken of it; was considered to be sciatica until in May, 1887 (3 years ago), there was a decided weakness in his lower extremities. The pain was more frequent and severe, and shortly after, while walking with a friend at night, fell down on the sidewalk and had to be assisted home by his companion. In August of this same year (1887), I was summoned to attend him; found the patient in bed, complaining of pain in both limbs, especially in the calves. While lying on his back with his legs crossed, when endeavoring to change their position by lifting the top one, there would be a disposition for the lower one to move first. Has considerable difficulty in walking, in the dark stumbles from side to side. If walking during the day, cannot look back without first stopping, that is, he cannot look back over his shoulder and still keep moving forward. His tendency under these circumstances is to fall. Eyesight, good; pupils equal, no arcus senilis, conjunctivæ normal. No evidence of paralysis; has good power of muscles. Can stand steadily when eyes are open, but when asked to close them begins to sway back and forward and is quite unsteady. With closed eyes can place right index finger on tip of nose without any hesitation. The left is slower in movement, and does not find the nose so conveniently. Walks with a staggered gait, bringing the heel down with the toes.

Diminished sensation in both extremities.

Tendon reflex nil; bowels very constipated; appetite diminished and variable.

Describes a feeling of numbness most noticeable in right leg and foot, a sense of constriction about the body as if a rope was tied around him above the hips.

Urine somewhat increased in quantity, very slight trace of albumen, no sugar, sp. gr. 1022, turbid and alkaline. After micturating a light

creamy deposit was frequently passed. Sexual powers normal. Pulse 65; weights 160.

Diagnosis: tabes dorsalis - non-syphilitic. Ordered rest in bed, liberal dose of castor oil, as bowels had not been moved for 4 days. Fl. ex. calabar bean 2 gr., four times a day.

Aug. 21st. Bowels moved thoroughly, feels much more comfortable.

Sept. 2. Allowed up. Pains slight, appetite good, sleeps well. Takes pulv. glycyrrhizae co., every alternate day.

Oct. 15th. Retention, relieved by catheter. Complains of a fatigued feeling generally, marked numbness in both legs. Pain increased. Has to use a cane to steady himself when walking at night. Ordered pill argentum nitrate $\frac{1}{4}$ gr. 3 times a day, in addition to previous prescription.

Nov. 20th. No improvement. Thinking that owing to his military career and previous intemperate habits there might possibly be a specific cause, pot. iodide was given (in gradually increased doses). This drug produced gastric disturbance and was intolerable at times, and hence discontinued it after a trial of a few weeks, and substituted fl. ex. calabar bean M; with 4 minims of ac. phos. dil. 4. i. d.

Aug. 30th, 1888. Galvanism has been systematically used for last two months. The pains are somewhat relieved by its use. Walks very slowly, assisted by a cane, dare not venture out at night alone. Occasional doses of morphia have to be administered to relieve pain. Greater loss of sensation in lower extremities; numbness extends higher up the waist. Complains of tightness from the ribs down. Slight numbness in right arm. Sensation in soles of feet when walking, as though stepping on a spongy material. On pinching the neck the pupils do not respond by dilating as is seen in normal subjects. Power of co-ordination much lessened; in fact the conditions present a year ago are now greatly exaggerated. Prescribed syr. trip. phos. 3 ter in die.

May 1889. Is so much disabled as to be unable to get out. Goes around the house with a crutch under each arm. Pains in the lumbar region and down both legs very troublesome. Says stiffness and tightness has become worse. Sensation leaving right arm and shoulder. Can remove the hair from his arms without feeling it. Left arm normal.

Is now given Sayre's apparatus, which is attached to the ceiling. By means of this he is to be raised off his feet once a day and allowed to hang five minutes each time. When raised, he described the sensation as if being pulled apart. Could feel the spine, as if it were separating. Found almost immediate benefit, pain and stiffness being relieved. Bowels began to move without purgatives, and four weeks after walked from the street car into my office, the only assistance being a heavy cane.

Aug. 1889. Went to Toronto on a visit for a month, using Sayre continually, taking syr. trip. phos., and still improving.

Dec. 1889. The pain, stiffness, etc., has again returned, although he has persevered with the treatment recommended. Is forced to use the crutches once more. Has lost all sexual desire and power. Urine is now clear and normal. Muscles do not respond to a very strong faradic current. Sensation in legs almost entirely gone. Can strike them with a heavy stick without feeling it, as he puts it, "they are just like a board." Loss of sensation extends over upper right half of body, limited by clavicle and scapula above, and the median line before and behind.

April, 1890. General condition much the same as in December last. Sayre's apparatus is of no benefit to him now, further than some temporary relief for an hour or so. Has taken nothing in the way of drugs for the last three months, except an occasional half grain of morphia as may be found necessary.

NEW YORK ACADEMY OF MEDICINE. SECTION ON ORTHOPÆDIC SURGERY.

Stated meeting, April 18th, 1890.

V. P. Gibney, M.D., Chairman.

HÆMATOMA OF THE STERNO-CLEIDO MASTOID MUSCLE.

Dr. A. B. Judson presented a patient, four and a half weeks old, who had been referred to him as a case of congenital torticollis. There was a long fusiform tumor in the course of the muscle, the hardness of which suggested a short and fibrous sterno-cleido mastoid. There was, however, but little shortening, and no wry-neck. The condition was supposed

to be the result of injury to the muscle in parturition. Dr. B. E. Hadra, of Texas, had reported two cases which had been relieved by tenotomy, and Dr. F. D. Brooks, of New Hampshire, had followed with a report of three cases, which had recovered by expectant treatment, or the use of friction and local applications. In the present case, a favorable prognosis had been given without special treatment.

A NEW BED FOR USE IN HIP DISEASE.

Dr. A. M. Phelps presented a little girl with hip disease, who had been treated on an improved surgical bed, which was also exhibited to the section. When she came under his care, there was flexion nearly to a right angle, adduction, sinuses, and an abscess, and the liver was already enlarged. His improved bed consisted of the ordinary iron bedstead found in hospitals, to which was added a convenient arrangement for the application of traction. The iron bed-posts at the foot of the bed were continued upwards much higher than those at the head. An iron cross-bar slid up and down on these foot-posts, and could be fastened at any height, so as to make traction at any angle desired. This cross-bar carried a pulley, which could be adjusted laterally so as to make traction directly in the line of deformity. The side-bar of the bedstead was also fitted with an adjustable pulley for the purpose of making lateral traction. This apparatus cost about five dollars, and could be supplied by Reynders, either with or without the bedstead.

The patient whom he exhibited had been treated by traction in this bed; but this was not sufficient to overcome the deformity. Under chloroform, the tensor vaginæ femoris and fascia lata, the adductors longus and magnus, and the contracted anterior border of the glutei muscles and the rectus femoris, were divided. Traction with a weight of eight pounds was then applied in the line of the deformity, and a force of two pounds at right angles to this. After two months, the deformity had been for the most part reduced, and his splint, with crutches and a high shoe, were then applied to prevent relapse, and they would be continued until the case was cured.

Dr. R. H. Sayre presented

A CASE OF CONGENITAL LOCK-JAW.

No definite history could be obtained con-

cerning this boy, except that he was five years of age, and that nothing unusual had been noticed about the jaw until a short time ago. The boy was quite intelligent, and no other joints were affected. The jaw appeared to be subluxated backwards, and the deformity was presumably congenital. The recession of the jaw, and the apparent atrophy on both sides, added to the interest of the case. Dr. Sayre said that before adopting any operative measures, he would attempt to relieve the case by stretching; and for this purpose would employ a wedge-shaped instrument, devised by Dr. L. W. Hubbard, and presented last year before the society of the Alumni of Bellevue Hospital. It consisted of two plates of steel, fastened together by a separable hinge, and capable of being separated at the other end by turning a screw. Having partly separated the jaws of the instrument, a cork could be inserted between the plates near the hinge, and the action of the screw reversed, when the instrument would exert considerable pressure on the molar teeth.

Dr. W. R. Townsen^d presented two cases of RACHITIC POSTERIOR CURVATURE OF TIBIÆ.

He said that the dispensary records showed that about two years ago there was a well marked knock-knee and rachitis in one case, who returned last week with the present peculiar condition of the tibia. Since then, the other case, with a similar deformity had come under observation. The latter case presented an increased growth of one portion of the tibia, amounting almost to an exostosis. It also showed a well marked "rachitic rosary." Macewen had called especial attention to these secondary bone formations on the inner side of the knee in cases of knock-knee. The posterior curves of the tibia were rarely seen, these being the only cases met with during the past two years at the Hospital for Ruptured and Crippled.

Dr. S. Ketch reported a case of

RHEUMATIC (?) ARTHRITIS OF KNEE.

On July 3rd, 1888, he was asked to see the following case in consultation with Drs. Lawrence Johnson and N. J. Hepburn:

E. S., single, 22 years of age, having a good family history, had been perfectly well up to the present illness, and denied having had any venereal disease; an examination of the urethra failed to show the presence of a urethritis.

Early in May, 1888, he had a slight attack of what was considered to be rheumatism, in the left elbow and the right thumb, which left these joints in a few days, and lodged in the right knee. No other joints became involved; but he grew steadily worse under treatment for rheumatism, and emaciated rapidly after the involvement of the knee. When first seen by Dr. Ketch he presented the facies of extreme suffering; the knee joint was flexed beyond 90° , and was very much swollen, and excessively tender; there was manifest atrophy of the thigh and calf; pulse, 120; temperature, 103.5° F. He had had no chill. Anodynes were constantly required, and his general health was failing rapidly. The urine was abundant, and was free from albumen. Urates were in excess. The acute symptoms continuing unabated after the constant application of ice, and the administration of morphine and the salicylate of soda for several days, the patient was etherized on July 12th, and the knee straightened with as little force as possible. Adhesive plasters were applied from below the knee to above the malleoli, and plaster of Paris over this with reinforcements with steel bars, the joint being left exposed. The limb was elevated, the ice-bags applied to the knee, and traction made in a straight line by a weight of ten pounds. This was followed by speedy relief, and a reduction of the temperature to 100° F. On the following day the swelling had greatly increased, but the limb could be handled quite freely. The joint was firmly bandaged, and the ice continued. On July 16th, Dr. Gibney saw the patient, and advised a continuance of the treatment regardless of the swelling. The patient did not then require anodynes; appetite was improving, and the temperature had fallen to 99° F. Ice-bags were continued during the month of August, and the local tenderness diminished more rapidly than the pain on motion. When the splint was removed early in October, there was scarcely any motion at the articulation, and the joint could be freely handled without complaint. A retention splint was applied, and the patient allowed to go about on crutches. In April, 1889, the ankylosis was complete, and he was enabled to return to work. He could at present walk long distances without fatigue, and his general condition was good. The chief points

of interest in the case were regarding the etiology and the treatment. He believed that there were cases of rheumatism like this one in which the rheumatic process was modified or entirely changed in character. The presence of a poison in the system was undoubted; but it was remarkable that it should have been so mild at the time the elbow and thumb were attacked, and then have become so concentrated in the knee joint as to practically destroy it. Rheumatoid arthritis was usually a chronic process involving numerous joints, and eventually crippling them; but such a process was not found in the present instance. The subject of treatment was important as bearing on the treatment of joints, affected with rheumatism; and he was positive that his case would have resulted in a bad deformity, if he had not in the beginning of his treatment, secured a good position of the limb.

DISCUSSION.

Dr. Gibney had seen a great many cases of hæmatoma of the sterno-cleido mastoid muscle, and they invariably got well. He had often wondered whether in some cases of congenital torticollis, actual shortening of the muscle had not been caused by long continued holding of the head in one position, necessitated by the presence originally of a large hæmatoma. In these cases of hæmatoma, there was probably laceration of some of the muscular fibres, with escape of the blood into the sheath, or into the muscular tissue itself.

Dr. N. M. Shaffer said that he had made measurements of the length of the sterno-mastoid muscle in these cases, as well as in normal cases, and his observation showed that there was an arrest of development in the affected muscle, which suggested a possible central lesion, involving the spinal accessory nerve. These cases might arise from traumatism; but unless the destruction of muscular tissue was very great, it would not account for the total arrest of growth.

Dr. Ketch thought that the existence of some deformity in Dr. Phelps' case, after such extensive division of the muscles, showed the fallacy of depending altogether upon dividing muscles for the rectification of the deformity of hip disease. As long as the bone disease was active, and muscular spasm was present, deformity would return from this spasm, even after division of the muscles.

Dr. Shaffer also thought that division of the muscles offered only a temporary relief. He had frequently seen recurrence of the deformity after such a procedure in disease of various joints, and especially in cases of tetanoid paraplegia. An examination under ether would determine the amount of muscular resistance, and the breaking up of the intracapsular and extracapsular adhesions, together with subsequent maintenance of the straight position, were all that could be expected in the way of preventing ultimate deformity.

Dr. R. H. Sayre said that much less traumatism was inflicted by dividing the muscles first, rather than by trying to reduce the deformity with the muscles in a state of tension. Dr. Ketch's remarks simply emphasized the importance of proper mechanical treatment after division of the muscles.

Dr. Ketch said that if the reduction of the deformity could be accomplished effectually by mechanical treatment alone, he did not see the advantage of the operation. In answer to a question from Dr. Phelps, as to what he would do with a deformity which had not yielded after one year's treatment by traction, he said that such a deformity was probably due to intra-articular changes, and was independent of the muscles, and he would therefore prefer exsection or other bone operation.

Dr. John Ridlo wished to join the ranks of those who believed in rapid reduction of the deformity—slow reduction caused needless traumatism. In some cases the deformity could be rapidly reduced by mechanical means and without anæsthesia; others required anæsthesia; and still others were not reducible even then. In this latter class the first indication was a division of the soft parts, and the second was to maintain the good position until a cure was effected. The average case of flexion through an arc of forty-five degrees, required from twelve to eighteen weeks of treatment with the traction splint, for its reduction; and the advocates of the traction splint had just confessed that the deformity would recur after such treatment. The deformity should be overcome in at least a fortnight. Thomas' hip splint would keep the leg straight, and prevent flexion, adduction, and abduction.

Dr. A. B. Judson had not found that the muscles seriously interfered in the acute stage

of the disease, with the reduction of the deformity, and he considered that the reduction could be effected by slow and painless methods, without any harm to the patient. The difficulty in overcoming the deformity was a purely mechanical one, arising from insufficient leverage—only the short distance from the acetabulum to the crest of the ilium.

Dr. Phelps, in closing the discussion on his case, said that the muscles were not divided to overcome reflex muscular spasm, but to overcome deformity; and in obstinate cases of long standing, like the one just presented, this was a safe procedure; while excision of the hip joint was a serious one. He had not wished to cut the muscles more deeply, and the deformity, although not completely reduced at the time of the operation, in October, was being constantly diminished by the treatment employed. Statistics showed that a very small percentage of cases, treated solely by mechanical means, recovered without deformity; and, therefore, a resort to operative methods in a certain class of cases, and subsequent mechanical treatment, offered better hopes of success. He would be sorry to cut a tendon, and have the case relapse—it would indicate improper treatment. He did not believe in trying to overcome the deformity by Thomas' splint, or any other. During the treatment, in order to get proper leverage, and hold the patient quiet, a long splint was applied to the well leg, extending to the axilla, and the body, limb, and splint enveloped in plaster of Paris. No splint could overcome the deformity, or possibly prevent it, which did not pass up on to the thorax. The idea of allowing the patient to walk upon a splint, or upon the diseased limb, was a heresy which we would eventually renounce. The patient, in his opinion, should use crutches, and he thought that Thomas struck in the right direction; but the splint should be fitted to the patient, and not the patient to the splint. Extension in a line with the axis of the neck of the femur was also necessary to relieve intra-articular pressure by overcoming the contraction of the adductor and abductor muscles.

Dr. Judson thought the physiognomy of the case of partial ankylosis of the jaw was one of arthritis, and the deformity was directly due to the inability to use the jaw, and was not the re-

sult of the peculiar shape of the bone. Operation seemed much more successful than the stretching process.

Dr. Phelps concurred in this opinion, and added that in his experience, good results had followed resection of one of the temporo-maxillary articulations, as ankylosis was usually found only in one articulation. An incision, one and a quarter inches long, was made along the zygoma, and the articulation exposed, Chiseling away the articular surface, was all that was necessary to cure the case. His cases had presented evidences of arthritis. The ankylosed joint was also on the side of non-development.

Dr. Shaffer remarked that if he had not heard the history of the case, he would have supposed that the patient had Pott's disease and had been treated with an apparatus in which the chin-piece had been forced too far backward. He thought there was much rigidity on both sides of the jaw. If the parts relaxed under ether, the evidence would be in favor of arthritis; but if not, it would indicate a permanent contracture, and would demand operation.

Dr. Gibney said with reference to the case of posterior deformity of the tibia, that nothing but an osteotomy would correct the deformity. While under ether, the operator should endeavor to bring the fragments nearly into line, and then apply retentive apparatus. Subsequently, a supra-condyloid osteotomy would be needed. By doing a Macewen's or a Macormac's operation, the subsequent dressings would, in great measure, correct the antero-lateral curvature. He had frequently seen this occur, sometimes to a marked extent. It was possible that the long rest in bed might have made the bone more yielding.

Dr. Shaffer thought that the case of arthritis, presented by Dr. Ketch, answered very well the complete description given by Niemeyer, of arthritis deformans. He considered this nothing more than chronic articular rheumatism, and he had seen it both with and without high fever. It closely resembled gonorrhoeal rheumatism, even in cases where gonorrhoea could be absolutely eliminated.

Dr. H. W. Berg said that he had seen a case of gonorrhoeal rheumatism of the ankle joint, which was quite thoroughly ankylosed, and did not recover its function for nearly two years.

In such cases the lesion affected chiefly the soft parts, the inflammatory products binding down the tissues so firmly that the joint was virtually ankylosed.

Dr. R. H. Sayre had seen a severe case of arthritis similar to the one presented. After confinement to bed for eight months, suffering from severe pain and high fever, the knee joint seemed to be absolutely ankylosed, and the patella immovable; but vigorous and persistent massage had secured, after about one year, pretty fair movement. The fact that the joint, in the case presented, was a little tender, was in favor of the ankylosis not being complete; for the tenderness arose from the pain caused by an almost imperceptible motion of the joint. Persistent and careful efforts at moving the knee joint, not sufficient to cause pain many hours, would probably give the patient a movable joint.

Dr. Judson called attention to the admirable position of the limb, remarking that a perfectly straight limb was much more stable than one bent at ever so slight an angle. These cases of stiff knee should wear a "lift" on the shoe of the well side, to enable the stiff knee to readily swing past the other, and so avoid awkward tilting of the pelvis at each step.

Dr. Phelps thought that in Dr. Ketch's case there was a fibrous ankylosis, and that, by breaking this up, motion could be secured. In one such case, while forcibly reducing the deformity, the femur was fractured without the exercise of much force; and he called attention to this, because after prolonged rest in one position, the bone frequently underwent fatty degeneration, sometimes only a shell of bone remaining. Union of the fracture in his case took place normally. He did not think there was much danger of exciting inflammation by forcible manipulation in these cases, unless the joint had previously been purulent.

Dr. Shaffer's experience had led him to believe that there was considerable danger of exciting inflammation by such treatment; and he would prefer a stiff joint in good position to incurring such risks.

Dr. Ketch in closing the discussion, said that he believed his case belonged to a class which had never been accurately described. In ordinary cases of arthritis deformans, there was involvement of other joints. This was not true of his

case, and the sudden onset of such acute symptoms, and the speedy occurrence of ankylosis, were certainly unique. His patient had far too useful a limb to make him desire to incur any risks by employing forcible manipulation.

Hospital Reports.

SUPRA-PUBIC LITHOTOMY IN A PATIENT WHO HAD PREVIOUSLY BEEN SUCCESSFULLY OPERATED UPON FOR PERINEAL FISTULA,

UNDER THE CARE OF LACHLAN M'FARLANE, M.D. IN THE TORONTO GENERAL HOSPITAL.

J. S., æt. 49, admitted April 8th, 1890, complaining of frequency of micturition and great pain in passing water. Seven years ago patient for the first time observed that there was something wrong with his water; whenever he took "a drop of drink" he suffered subsequently from frequency of micturition. Five years ago he consulted a doctor for a lump in the perineum. A week after the scrotum became distended and discoloured and he had extensive extravasation of urine; free incisions were made and the patient recovered. A fistulous opening existed for a week or two in the perineum, through which urine trickled during the act of micturition; this subsequently closed up. Two years and a half ago patient states that he experienced a sensation as if "something burst" in the perineum, and a lump formed; a doctor was called in and a free incision made, and a perineal fistula again established which, however, closed up after five weeks. The fistula reopened three months subsequently.

In May, 1888, he came to the Toronto General Hospital and was admitted under Dr. McFarlane's care; complaining of inability to pass water freely and great pain during the act. Dr. McFarlane discovered a pretty tight stricture anterior to the triangular ligament. When he made water a small stream came through the meatus urinarius, and another through a fistulous opening in the perineum. An operation was performed, and a catheter retained in the urethra for 9 days; the fistula closed entirely. He left the hospital very considerably relieved, but still complaining of slight pain during micturition; this pain got worse, occasionally the

stream would stop suddenly; he had frequency of micturition which latterly amounted almost to incontinence, the water constantly dribbling away.

The patient had been strong and healthy until 8 years ago. No history of syphilis; he had gonorrhœa 26 years ago, and a "second attack" six years subsequently.

On admission: suffering considerable pain and a constant desire to pass water. The urine dribbles away from him all the time, but occasionally he makes a special effort and passes about a tablespoonful, followed by a thick sediment, the passage of which causes him great pain. The pain is referred to the neck of the bladder, perineum, and just above the pubes. It is increased when he walks about, particularly if he takes a false step, and when he goes to stool. He has a hard lump in the perineum at the site of the former fistula. A sound was passed and a stone detected in the bladder.

On April 16th, Dr. McFarlane performed an operation. The pubes had been previously shaved and the parts thoroughly cleansed. Four ounces of warm boracic lotion were injected into bladder, and the catheter having been removed a tape was tied tightly around the penis to prevent the lotion escaping by the urethra. Petersen's bag was then introduced into the rectum, and twelve ounces of warm water injected. An incision two inches long was made immediately above the pubes, and the various structures divided so as to expose the distended bladder. A stout silk suture was now passed through the bladder wall transversely, the viscus was incised across the line of the suture, this having been done, the loop of the suture lying within the bladder was drawn out at the incision, and this loop divided, leaving two sutures attached, one on either side of the bladder wound. The opening in the bladder was kept in apposition with the opening in the abdominal parietes by traction on the sutures. The forefinger was passed into the bladder and the stone detected. A forceps was now introduced and the stone extracted. The bladder was thoroughly irrigated with weak boracic lotion, and a drain tube passed through the wound down to the neck of the bladder; a few points of suture were introduced in the upper part of the abdominal inci-

sion. An absorbent dressing was applied and the patient sent back to bed.

The patient made an uninterrupted recovery, and left hospital on the 22nd of May. The wound above the pubes had long since healed and distressing symptoms had disappeared entirely.

Remarks: The stone extracted was of large size, ovoid in shape, measuring 2 inches in its long diameter and $1\frac{1}{2}$ inches transversely; weight 825 grains; it was coated with phosphates. The supra-pubic operation was chosen in preference to lateral lithotomy for several reasons; the stone was judged to be of large size before operating; the hard lump in the perineum indicated the presence of inflammatory or cicatritial tissue through which the incision would have to be carried. This would probably yield very little and extraction of a large calculus would be difficult, and it is doubtful if the wound would heal rapidly. From these considerations and from the success which has of recent years attended the operation, it was deemed advisable to open the bladder above the pubes. The prevesical fold of peritoneum was not even brought into view during the operation. A plexus of veins lying on the anterior face of the bladder occasioned some difficulty when the bladder wall was reached, a ligature had to be passed around a section of these, and others were held aside while the incision in the bladder was made.

Books and Pamphlets Received.

Special Hospitals for the Treatment of Tuberculosis. By L. W. Flick, M.D.

Etudes de Clinique Infantile, par le Dr. Sevestre, Paris. Bureaux du Progres Medical.

Transactions of the College of Physicians of Philadelphia, 3rd series, vol. xi., edited by Dr. J. P. Crozer Griffith.

De la Grippe et son Traitement, par le sulfate de quinine, par le Dr. P. Gellie. Bordeaux: G. Gounouilhou, Imprimeur de la faculté de médecine.

Treatment of Torticollis. A Rational Brace for the Treatment of Caries of the Vertebrae, a Practical Splint for Inflammatory Conditions of Joints. By C. F. Stillman, M.D., Chicago.

Lymphatiques des organes genitaux de la femme.
Par le Dr. Paul Poirier, Paris.

Book Notices.

Révue Internationale de Bibliographie Médicale, Pharmaceutique et vétérinaire. Par le Dr. J. Rouvier. 10 francs. Paris and Beyouth.

This is an effort to establish a French equivalent to the Index Medicus. Each volume includes the bibliography of the preceding three months. The subjects are taken up in alphabetical order, and the titles of the articles translated into French. This is, to a Frenchman, a certain advantage, but it must tend to limit the circulation of the publication.

Chronic Urethritis, and other affections of the Genito-Urinary organs. By Matthew Berkeley Hill, M.B. Lond., F.R.C.S. Professor of Clinical Surgery in University College, London, etc. H. K. Lewis, 136 Gower St., London, W.C., 1890.

This is a revised publication of three lectures delivered at the Royal College of Surgeons in June, 1889. A series of colored plates, illustrating the appearances presented by the urethra in health and disease, as indicated by endoscopic examination, form an important feature of the work. The writer is well known as an authority on this subject, and it would be superfluous for us to make any comments on the practical usefulness or interest of lectures from such a well known source.

Etude anthropométrique sur les prostituées et les voleuses. Par P. Tamowsky.—*Bureaux du Progrès Médical, 1889.*

An interesting anthropometrical study on prostitutes and female thieves conducted in some of the Russian Hospitals and prisons. The authoress seeks to establish the fact that many prostitutes and thieves are such, not from misfortune or mere chance, but because these occupations are most pleasing to them. In summing up, she says: "They are incomplete beings, whose development has been arrested, and who show signs of physical and mental degeneration."

The influence of alcoholism and phthisis in the parents, as manifested in debauched and thievish children, is strikingly portrayed.

A Retrospect of Surgery: January, 1886—January, 1890. Prepared by Francis J. Shepherd, M.D., C.M., Surgeon to the Montreal General Hospital; Professor of Anatomy and Lecturer on Operative Surgery, McGill University. Published by The Gazette Printing Company, Montreal, 1890.

The author of the retrospect has made a most happy selection in the matter he has chosen for publication from the vast amount of literature which has appeared since January, 1886. In a book of 261 pages it would be impossible to review in detail all the important work done in four years, yet one is surprised with the large amount of interesting and useful matter which is presented. A most useful feature of the book is the method which has been adopted of referring the reader to original papers, indicating the date of publication and the journal in which any paper referred to may be found.

A New Medical Dictionary: Including all the words and phrases used in medicine, with their proper pronunciation and definitions. By George M. Gould, B.A., M.D. Published by P. Blackiston, Son & Co., Philadelphia, 1890.

This is a book containing 519 pages, and, while it is thus of small size, it is marvellously complete. We can cordially recommend it to all who read medical literature, and who wish a work of reference to aid them in discovering the meaning and derivation of words and phrases, more particularly those of recent introduction. This work will supply a want long felt by the medical student. It is of small size and cheap, and contains all the information the student would expect to find in such a work. It far surpasses any of the smaller dictionaries we have examined, and we are therefore glad to have the opportunity of recommending it.

Wood's Medical and Surgical Monographs. Volume 6, Number 1. Including: The Human Foot: Its Form and Structure, Functions and Clothing. By Thomas S. Ellis, M.R.C.S. Modern Cremation: Its History and Practice. By Sir H. Thompson, F.R.C.S. Aphasia: A Contribution to the subject of the Dissolution of Speech from cerebral disease. By James Ross, M.D., LL.D. William Wood & Co., New York.

These monographs, published monthly, are now widely and favorably known amongst the

profession. We must compliment the publishers on the matter which is from time to time selected for these periodicals.

The paper on Modern Cremation will be appreciated from the pen of Sir Henry Thompson, whose name has been associated so much with the development of the practice of cremation in England. Dr. Ross, as an authority on diseases of the nervous system, is too well known to require an extended notice of his interesting and exhaustive paper. Few of our readers have heard much of Dr. Ellis, nevertheless all who have the good fortune to read his paper will find in it a thoroughly original and suggestive treatise, full of interest, and containing many practical hints concerning the normal form and structure of the foot, with special application of ascertained facts to its proper functions and clothing.

The Doctor in Canada: His Whereabouts and the Laws which Govern Him.—A ready book of reference. By Robert Wynyard Powell, M.D., Ottawa.

The book gives a great deal of useful and interesting information about our profession and the members composing it. In the first place we find the various Acts which govern us in the different Provinces of the Dominion, and the full text of the British Medical Act of 1886. Following these are the Public Health Acts passed by the various local Legislatures. Part III gives much information regarding medical education in connection with the Provincial Licensing Bodies, and the Medical Colleges. Parts IV and V contain descriptions of the Hospitals, Asylums, Quarantine Stations, and Medical Journals. Part VI gives very complete lists of the licensed practitioners of all the provinces with their addresses. Finally we find the names of Physicians in Parliament, Medical Military Officers, Coroners, Health Officers, and Medical Examiners for all the Life Insurance Companies.

The book makes no pretence of originality, but certainly contains a vast fund of information which should be highly appreciated by the Profession of the Dominion. It is in short a sort of dictionary of Canadian things and persons medical. It is a kind of book which every physician should have, and is likely to prove about

as useful to the doctor as the Canadian almanac is to the general citizen. Dr. Powell must have expended an immense amount of work on his book, and we hope that he will receive the encouragement he deserves.

Spinal Concussion. By S. V. Clevenger, M.D., with thirty wood engravings. Philadelphia and London: F. A. Davis, 1889.

In this book of three hundred and sixty pages, spinal concussion is considered as a form of traumatic neurosis, for which the designation of Erichsen's disease is suggested. The book is largely made up of excerpts from the writings of many others on this subject, notably, besides Erichsen himself, of Page, Appenheim, Erb, Spitzka, Bramwell, and Seguin; to these the author has added much of his own, including a large number of very interesting cases. The chapter on Electro-Diagnosis will be found useful. As the author points out, but few of the profession are competent to undertake a thorough electrical examination; and if this book leads some to study electro-therapeutics and electro-diagnosis, it will have done much good. To those who may be called upon to give evidence in cases of so-called "railway spine" and other injuries, the work will prove most helpful. The tone generally is rather controversial, and the style at times anything but elegant; this later editions may correct. There are a number of excellent plates, and the publisher's work is all that could be desired.

COLLEGE OF PHYSICIANS AND SURGEONS.

MAY EXAMINATIONS.

The passes in the primary are as follows:

H. B. Anderson, Apsley, Ont.; P. M. Brown, Sarnia; A. S. Bueglass, Bright; W. E. Brown, Roseneath; E. B. Blain, Hamilton; W. F. Brown, Medina; D. B. Bentley, Forest; T. Beath, Columbus; W. W. Baldwin, Toronto; D. A. Beattie, Blair; H. A. Bruce, Port Perry; B. Bayley, London; E. J. Bowes, Ottawa; C. H. Burrill, Mitchell; T. H. Balte, Smith's Falls; A. M. Clark, Elcho; F. S. Comfort, Campden; W. Chambers, Toronto; Annie Chambers, Port Elgin; A. P. Chalmers, Poole; D. A. Clark, Agincourt; J. W. Cunningham, Hespeler; J. A. Cowper, Welland; J. W. Campbell, Kingston; A. H. Coleman, Belleville; D. A. Coon, Elgin; J. Delahant, Moorefield; Bertha Dymond, Brantford; J. A. C. Evans, Bradford; W. M. Earl, Winchester; T. H. Ellis, Ottawa; E. B. Echlin, Copetown; W. A. Empey, Winchester; F. Fenton, Toronto; W. S. Ferguson, Avonbank; R. F. Forrest, Mount Albert; Mattie J. Foster, Welland; A. E. Fraleigh, Arva; P. A. Gillopie, Cannington; R. H. Green, Ayr; Jennie Gray, Rebecca Gray, H. H. Gray, Toronto; T. J. Gowen, Greenore; A. S. Gorrell, Brockville; S. D. Green, Amvion; J. C. Gibson, Milverton; E. H. Henning, Toronto; J. F. Hanly, Waubesaene; K. H. Hagerman, Parkhill; J. A. Hershey, Garrison Road; D. Herald, Medicine Hat, N.W.T.; A. Haig, Menie; W. E. Inksetter, Copetown; J. T. Ken-

ney, H. M. Lloyd, Toronto; J. W. Leiniger, Hopetown; A. J. Murray, Embro; J. A. Mitchell, Caistorville; T. H. Middleborough, Owen Sound; W. E. Matthew, Beeton; H. Millard, Newmarket; W. H. Miller, Cottam; M. W. Murray, Beechwood; D. S. McLennan, Port Hope; G. P. Meclun, Edinburgh; J. S. McCulloch, H. B. McConnell, Toronto; H. A. McPherson, Crief; D. McEachren, Harriston; O. McCulloch, Everton; J. McAsh, Varua; H. F. McDonald, Rodney; J. A. McEwan, London; E. H. S. McLean, Kingston; A. E. McColl, Canpbollford; F. J. McCammon, Kingston; A. W. Nixon, Esquesing; W. Northup, Forest; R. J. Nidric, Hampton; J. H. Oldham, Kingston; H. H. Oldright, Toronto; F. J. Old, Caledonia; H. C. Parsons, R. B. Potts, Toronto; L. Phelan, North Gower; A. Quackenbush, Morpeth; C. C. Richardson, Vaudarf; J. F. Ross, Argyle; W. Robertson, Chesterfield; W. W. Sautler, Toronto; F. L. Switzer, Curleton Place; M. Sharp, Alberton; L. W. Shaw, Lucean; L. G. Sinclair, Tilsonburg; W. A. Thompson, Roseville; A. S. Tilly, Julia Thomas, Bowmanville; J. J. Thomson, Avonton; J. Watson, Sherwood; J. A. Wilson, Lakelet; D. F. Webster, Glencoe; A. S. Wade, Perth; Isaac Wood, Kingston; J. W. White, Branchton; J. H. Yorrell, Aylmer.

The following candidates passed the final examination for the license of the college:—

A. G. Aldridge, Port Hope; J. C. Auld, Forest; D. Archer, Burketon; Mary L. Agar, Chatham; E. H. Adams, Toronto; H. T. Arnold, A. P. Ardagh, Barrie; W. W. Baldwin, Toronto; B. Cayley, London; E. J. Bowes, Ottawa; Minnie Brown, Strathroy; J. D. Berry, Warkworth; G. T. Bigelow, Port Perry; R. V. Bray, Chatham; E. T. Boyes, Binbrook; W. F. Bryans, Susannah P. Boyle, Toronto; W. L. Bond, Newmarket; W. A. Baker, Stouffville; M. C. Black, Gilmuis; J. H. Burger, Toronto; L. P. Barker, Ingersoll; E. J. Boyes, Toronto; J. H. Bell, Colborne; F. S. Comfort, Campden; A. H. Coleman, Belleville; T. S. Cullen, Sarnia; H. J. Crystal, Arthur; F. B. Clarke, Colborne; C. B. Coughlin, Hastings; C. B. Carveth, Port Hope; E. M. Copeland, Balguy; B. Cunningham, Kingston; J. Delahant, Moorefield; S. Douglas, Marsh Hill; F. A. Drake, South Cayuga; J. A. Dinwoody, Cler Hill; F. J. Dolan, Belleville; Clara Demarest, Naponee; Thomas H. Ellis, Ottawa; W. S. Ferguson, Avonbank; R. Ferguson, London; J. E. Forfar, W. J. Fletcher, Toronto; C. E. Flatt, Millgrove; C. A. D. Fairwell, St. Catharines; A. Fraeuland, Ottawa; Mrs. Rosina Feinell, Kingston; A. S. Gorrell, Brockville; J. H. Ghent, Toronto; J. H. Ginty, Owen Sound; A. J. Gould, Mt. Pleasant; J. A. Gibson, London; A. R. Gordon, Toronto; W. A. Gray, Perth; W. C. Herriman, Lindsay; D. J. Hutchinson, Ingersoll; A. N. Hayes, Parkhill; A. T. Hobbs, London; R. M. Hillary, Aurora; G. Harrison, Selkirk; Mary Hutton, Forest; C. A. Hodgetts, Toronto; R. Hill, Aylmer; R. G. Howell, Jarvis; W. T. Holdcroft, Tweed; W. E. Inksetter, Copetown; H. Irwin, Penbrooke; A. F. Irwin, Chatham; F. H. Kalbfleisch, Paisley; T. E. Kaiser, Edgley; Miss Ida E. Lynd, Boud Head; G. D. Lockhart, Mount Brydges; M. W. Murray, Beechwood; J. A. Macdonald, V. A. Michell, Toronto; M. T. MacFarlane, Ridgetown; C. S. Morrison, Elnwood; E. R. Morton, Barrie; W. C. B. Murray, Harrington West; A. C. Mavety, Odessa; James A. McEwen, London; H. A. McColl, Georgetown; W. McGillivray, Whitby; J. D. McNaughton, North Kappel; J. H. McFaul, Seaforth; O. E. McCarty, Belleville; C. F. McGillivray, Whitby; D. McLeod, Cannington; D. K. McQueen, Ripley; J. A. McGregor, Longwood; J. W. J. McCollough, Dundalk; W. A. A. McPherson, Prescott; A. McDonald, Yanleek Hill; Maggie McKellar, Ingersoll; Jas. McKenty, Kingston; R. J. Maddie, Hampton; John Noble, Arthur; C. T. Noble, Sutton West; C. B. Oliver, Motherwell; L. Phelan, North Gower; S. G. Parker, Toronto; W. M. Pugh, Milverton; W. H. Philp, Waldemar; W. Robertson, Chesterfield; T. Russell, Alton; L. E. Rice, Embro; T. B. Richardson, Goderich; C. Sheppard, Toronto; W. D. Springer, Nelson; J. M. Sifton, Thurstonsford; D. Smith, Belmont; G. L. Starr, Brooklyn; R. Schell, Plattsville; D. K. Stenton, Port Lambton; T. L. Stringer, Stoney Point; J. E. Shannon, Kingston; W. Thistle, Toronto; J. F. Uren, Medina; F. Walsh, Guelph; G. Wright, Wheatley; Mrs. Hattie Walker, Pitts' Ferry; F. Zwick, Belleville.

Personal.

DR. E. B. O'REILLY has resigned his position as superintendent of the Winnipeg General Hospital, and will be acting superintendent of the General Hospital in Toronto during the absence of his brother, Dr. Charles O'Reilly, who will spend three months in Great Britain and the Continent.

The following have been appointed assistants in the Toronto General Hospital for the ensuing year: Drs. C. F. McGillivray, L. F. Barker, T. S. Cullen.

DR. McFARLANE, of Toronto, sailed for Europe, from New York, May 24th. He will spend most of the summer on the continent, and expects to attend the meeting of the International Medical Congress.

DR. NEIL L. MCPHATTER, formerly of Guelph, who settled in Cleveland after his return from Birmingham, where he worked six months with Mr. Lawson Tait, has gone to Denver, Colorado, where he is engaged in a large and lucrative practice. He has the chair of Gynæcology in the university of that city.

Births, Marriages, and Deaths.

BIRTHS.

HEARN—On May 18th, the wife of Dr. R. Hearn of a son.

DEATHS.

ELLIOTT—On Saturday, the 24th inst., Jeanie Elliott, beloved wife of Dr. J. Ephriam Elliott, and eldest daughter of Warring Kennedy, Esq., of this city.

Miscellaneous.

A Provincial Medical Association has been formed in Manitoba, with the following officers: President, Dr. Macklin, Portage la Prairie; first vice-president, Dr. Donnell, Winnipeg; second vice-president, Dr. McDonald, Brandon; secretary-treasurer, Dr. Jones, Winnipeg.

A BEAUTIFUL CANADIAN STORY.—*The Graphic*, Chicago's popular illustrated weekly, is publishing a beautiful story of Canadian life, by Mrs. Mary Hartwell Catherwood, author of the famous "Romance of Dollard," the "Story of Tonty," and other charming chapters of Canadian history and tradition. *The Graphic* story is entitled the "Children of Ha-Ha Bay," the scene being laid successively near St. Alexis, Chicoutimi, and Tadoussac.

MEDICAL LIBRARY.—These new books have been received at the Ontario Medical Library: Seven reprints on "Intubation," by Dr. O'Dwyer; "Transactions of the American Orthopædic Association," Vol. 1, 1889; "A Retrospect of Surgery," Shephard; "Manual of Life Insurance Examinations," Dr. James Thorburn; "A Treatise on Bright's disease of the Kidneys," Millard; "Surgical Bacteriology," Senn; "Insomnia and its Therapeutics," MacFarlane; "Hypnotism: Its History and Present Development," Bjornstrom; "Guy's Hospital Report, 1889."

SIR WILLIAM GULL.—The *London World* says:—The fact that the will of the late Sir William Gull has been proved, showing property to the amount of nearly three hundred and fifty thousand pounds, has created much talk during the past week. It is beyond a doubt that for the last few years, since physicians have doubled their fees, and since both branches of the profession are constantly in receipt of very large sums for expeditions by rail, the earnings of members of the healing art have very largely increased. There are possibly a dozen medical men in London who, at their death, will be found to have amassed a hundred thousand pounds; but there is probably not one who has put by anything like the fortune left by Sir William Gull. "Put by" is scarcely the term. Sir William was a very careful, not to say parsimonious, man, his expenses were comparatively small, he entertained very little, his practice was extensive, and from time to time he received from grateful patients, special presents of large amounts. But it was in the dealings with and the investing of those large amounts that the fortune was made, and in this it is understood that Sir William had the advantage of excellent advice.

By-the-bye, here is a good Gull story, which, though a "chestnut" to some, to the thousands who have never heard it, is worth telling. Sir William's butler was a great character; a small, dark man, always white-chokered, and dressed in black, with a calm solemn manner. His income from tips must have been large, as the waiting-room was always crammed, and the order of audience was settled by him. One day summoned to the street door by a more than ordin-

ary fierce knock, he found an excited individual just alighted from a cab. "Sir William Gull in?" "Yes, sir." "I want to see him." "Have you an appointment, sir?" "Appointment?—no! I'm very ill. I want to see Sir William." "Impossible, sir, without an appointment." Naughty word emitted by visitor; then: "When can I see him?" "Well, sir," after consulting paper, "At eleven on Tuesday next." "Tuesday next be——! I'm very ill! I tell you I must see some one! Do you know anyone near who could see me?" Servant, after cogitation: "Well, sir, there's a gentleman over the way—a very respectable practitioner named Jenner—he might be able to see you!"

Extra Selections.

QUESTIONS CONCERNING THE CÆSAREAN SECTION.—No one has a right to speak with greater authority upon this subject than Sanger. An article which he has contributed to a recent number of the *Centralblatt für Gynakologie* gives a brief history of the operation since the publication of his paper of eight years ago, in which he advocated improvements and modifications of the old, classical, and in many ways faulty, operation. With candor he admits that some of his propositions at that time have properly been superseded by others. He considers the fundamental elements to success in this operation to be asepsis, and the proper suturing of the uterine wound. The five necessary steps are incision of the abdomen, incision of the uterus, extraction of the uterine contents, suture of the uterine wound, and suture of the abdominal wound. He thinks the danger of hemorrhage has been overestimated. If the uterine wound is properly closed, there can be no hemorrhage except from the interior of the organ, and if the organ is in a state of atony, that will occur even when delivery has been accomplished through the natural channels. This leads him to lay down the absolute rule that the operation should not be performed until labor has begun, and the most auspicious time is toward the close of its first stage. Those who have performed it before the conclusion of the usual term of pregnancy have usually had occasion to regret it. He favors Duhrssen's method of tamponing the uterine cavity with iodoform

gauze, should atony with hemorrhage occur. He also has positive opinions respecting the use of the elastic ligature for the constriction of the uterus during the operation, believing that, unless the constriction is moderate and of short duration, atony and hemorrhage will be encouraged. Schauta's method of constricting the uterus with the hands is recommended as a good one, though not always easy of accomplishment. A better method would consist in throwing a broad bandage of some antiseptic material around the organ, and constricting it with the hands to the necessary degree. He is decidedly in favor of the longitudinal incision in the anterior wall of the uterus, rather than the transverse incision of Kehrer or the longitudinal incision in the posterior wall of Cohnstein, even though the placenta is implanted upon the anterior uterine wall. Washing out the uterus with antiseptic solutions is deemed unnecessary and in some cases injurious, and even the toilette of the peritoneum need not be very elaborate, as it is now believed by competent observers that a moderate quantity of blood, serum, or cystic fluid in the abdominal cavity does no harm.—*N. Y. Med. Jour.*

ARSENIC AND BICHLORIDE OF MERCURY IN THE TREATMENT OF ANÆMIA.—Although it is perfectly true that we have almost no knowledge of the manner in which alteratives act in instances of disease where, through morbid functional activity, enlarged glands or growths appear, it is evident that they must act upon the trophic nerves or directly upon the nourishment of the affected parts. If they are used in large quantities they act as depressants to the normal nutrition of the body, producing primarily a decrease in the vitality of morbid growths, so that they melt down and disappear, and they may finally so reduce the condition of the healthy tissues as to cause sloughs and ulcerations. Whether these changes are due to the over-stimulation of nutrition—that is, to an excessive trophic change—or whether they depend upon actual lowering of the tone of the parts we know not. One thing we do know, however, and that is that small doses of most of the so called alterative drugs act as very distinct stimulants to the development of normal structures, and in no instance do we find this more

typically represented than the effect which they exert on the blood. Quite a number of years ago Keyes, of New York, emphasized the value of minute doses of mercury bichloride in syphilitic and other anæmias, and abundant clinical observation has certainly confirmed his views. The dose of bichloride of mercury in anæmia should be about one-fortieth of a grain. Not only will minute doses of the bichloride of mercury act in this way, but small amounts of calomel or mercury itself will have such an effect.

Inunctions of very small amounts of mercurial ointment, once a day, or every other day, in adults and children, will increase the fulness and redness of the cheeks and lips, and the number of the corpuscles, the piece of ointment used being no larger than the half of a very small pea. This treatment will be found of service in cases not dependent upon specific taint or scrofula. The marked increase in the nutrition of children of syphilitic taint, who are suffering from marasmus, under the use of gray powder and inunctions, gives further evidence of this fact.

Arsenic also is of value in anæmic conditions, and may be employed in comparatively larger doses than mercury; but, nevertheless, smaller amounts than are usually given in chorea and similar states. Osler has shown the value of the drug in anæmia, and so has Barton, of University College, in England. Any one of the preparations may be employed, but not more than one-sixtieth of a grain of arsenious acid should be taken in a day, although more has been used with no less benefit to the patient. Most of the drug under these circumstances is in excess and is cast off in the urine and feces unused and wasted, and strains and irritates the emunctories of the body during its passage through them.—*Med. News.*

MEDICAL TREATMENT OF DYSMENORRHOEA.
—Dr. E. W. Mitchell writes as follows on the medical treatment of dysmenorrhœa: Remedial measures naturally divide themselves into those of relief and those of cure. Of the former, opiates occupy the first place in their power to relieve and in their power for ultimate evil; but once used, the danger of the opium habit is great. The bromides, chloral, tincture of cannabis indica, hyoscyamus, belladonna, are all

valuable. In plethoric women with scanty flow he has often found the bromides, combined with belladonna or hyoscyamus, promptly effective in affording relief. Sometimes the pain may be arrested by beginning their administration a day or two preceding the flow. Cannabis indica is useful in certain spasmodic cases, and in cases with a free flow. Antipyrine is a valuable addition to our means of allaying pain, and will give temporary relief in a large majority of cases, whatever the diseased condition, but the author has not been able to observe any curative effect. Caution should be exercised in its administration, since in too large doses dangerous symptoms may arise, especially in anæmic women. Dr. Palmer speaks highly of concentrated tincture of cimicifuga and of tincture of pulsatilla. Dr. Mundé also recommends pulsatilla in the neuralgic form. The physician may very wisely give his patients (and especially the anxious mothers) a warning against overdosing and over-soaking. Rest in bed, the application of dry or moist heat, an occasional hot sitz bath, the moderate drinking of hot fluids, are domestic measures which will afford a certain amount of relief. The dosing with gin or whisky, with tansy tea, etc., should be discouraged. With cannabis indica in cases in which the flow is free; belladonna or hyoscyamus in spasmodic cases; antipyrine, possibly oxalate of cerium, pulsatilla, etc., we have a list of remedies for relief which are safe and usually effective for the time. Bromides in congestive cases, used occasionally or for short periods of time, may be valuable, but their prolonged administration disorders the stomach and favors anæmia. Chloral should be used with circumspection, on account of the liability to the establishment of the chloral habit.—*American Journal of Obstetrics.*

THE USE OF FLUORESCIN AS A MEANS OF DIAGNOSING LESIONS OF THE CORNEA.—Dr. Straub, a Netherland army surgeon, first discovered that a solution of fluorescein, when dropped upon a portion of the cornea which was deprived of its epithelium, would color this spot a deep green and leave the rest of the cornea unchanged.

For the past two months, in the eye clinics of the Johns Hopkins Hospital and the Presby-

terian Eye and Ear Charity Hospital, I have been testing the value of this method of diagnosing corneal lesions. The experiments number over a hundred, and have led me to positive conclusions.

Fluorescein is a red powder, soluble in water, a product of coal tar distillation. I employ a solution of 10 grains of the powder to the ounce of water, to which is added 15 grains of the bicarbonate of soda.

I have never known the solution to have an irritating effect, and I have used it in the most intense forms of corneal inflammation. The portions of the cornea stained retain the color from half an hour to several hours. The solution produces not the slightest impression upon the healthy cornea. I have always found that when positive defects in the corneal epithelium existed, in other words where there was actual loss of substance, the coloration was more apparent. So long, then, as it is possible to color any portion of the cornea, we may be certain that some lesion still exists. In excoriations of the cornea positive results were the rule. One case I remember particularly, where the cornea had been scratched by a blow from a twig, and where the extent of the excoriation was scarcely visible to even oblique illumination. Every detail of the wound, and every minute point, where the epithelium had been removed was clearly brought out by a drop of the fluorescein solution. In ulcers of the cornea positive results were always obtained. In simple superficial keratitis the coloration was much less distinct than when this disease was associated with an ulcer. In parenchymatous keratitis the results were invariably negative. In three cases of iritis, uncomplicated with corneal trouble, I failed to obtain any coloration. In two other cases of iritis of syphilitic origin where the cornea was involved, superficially as well as interstitially, marked coloration was observed. In two cases of acute glaucoma the result was absolutely negative.

In foreign bodies in the cornea, no matter how small the foreign substance was, its position and size were located to a nicety. Here the coloration was immediate and distinct, showing itself by a green ring just around the foreign body. In phlyctens of the conjunctiva the color was rather yellow than green. Only in those

cases where the phlycten was located on the limbus of the cornea, and the latter had been involved to some extent, was there any positive green coloration to be seen. Pterygia and pinguiculae gave negative results. With the exception, then, of phlyctenular conjunctivitis, the solution is inapplicable to any of the other forms of conjunctival inflammation.

When one understands that where the coloration is produced the anterior epithelium is involved, the agent is of value in detecting, with accuracy, lesions of this part of the cornea. Ulcers so small that it is impossible to see them by diffuse daylight, are brought out with perfect distinctness, quite as clearly, indeed, as under oblique illumination; and I can readily believe that small points, which it is possible to overlook even with the oblique illumination, would invariably be revealed by a drop of the solution, and, moreover, in half the time that it takes us to subject a patient to the former method. In minute ulcers of the cornea in very young children, where the blepharospasm and photophobia are frequently so intense that the lids have to be forced apart in order to get a view of the eye-ball, and then the latter is rolled about so continuously, and the cornea flits so rapidly before our eyes, that we are obliged to simply infer, from the attendant symptoms, the nature of the trouble without actually seeing the lesion itself, a drop of the solution will locate the disease and its extent, and bring it out distinctly so that it can be seen, no matter how fast the eye-ball moves about. In such cases I am inclined to think that the fluorescein solution will be a help in establishing a diagnosis. I am using the solution every day, and find it useful in bringing to light lesions of the cornea so small as to be readily overlooked in the hurry of a crowded clinic. Clinical experiments seem to show that positive results are only to be seen when there is some lesion or break in the anterior epithelium of the cornea. Troubles beneath the corneal surface give vague, and hence unreliable, results. Two of my colleagues on the staff of the Presbyterian Eye and Ear Hospital, Drs. Harlan and Woods, have been cooperating with me in trying the solution, and their views coincide entirely with mine.—*R. L. Randolph, M.D., in Johns Hopkins Hospital Bulletin.*