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THE
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CANADA MEDICAL RECORD

JANUARY, 1898.

THE SECTION OF OBSTETRICS AND GYNÆCOLOGY.

By W. JAPP SINCLAIR, M.D.,

Professor of Obstetrics and Gynæcology in Owen's College, Manchester.

When I received the flattering invitation of the Council of the British Medical Association to occupy this position to-day, which is to me one of distinguished and, I fear, unmerited honor, I began to debate with myself whether I ought to take advantage of the privilege granted to me to open the proceedings of this Section with an address. The occasion seemed at first too great ; no subject within my range of ideas appeared adequate. It did not seem fitting that I should take advantage of a meeting of such unique interest—a British Empire Meeting during the Queen's Commemoration Year, in this already historic centre of commercial and intellectual achievement in the greatest of the British Colonies, to give utterance to a formal discourse of mere academic interest, chosen without spontaneity, and laboriously compiled in the library. After much cogitation, however, the feeling grew upon me that there had been in my mind more or less continuously in recent years a subject sufficiently interesting to myself and sufficiently general for the occasion. The subject is so important in its far-reaching, practical bearings in obstetrics and gynæcology that I became convinced you would hold me justified in pressing it upon your attention, and would find in the interest of the subject matter some measure of excuse for the inevitable shortcomings in my method of handling it. The subject to which I refer is that of the *Injuries of Parturition, the Old and the New* ; and I may state at once at the outset that the reason why it has haunted my mind is the frequency with which, as a gynæcologist, I am called upon to deal with injuries produced by parturition, and the growing conviction that in many, if not in the majority of these injuries, their existence has not appeared to be

altogether satisfactorily explained as inevitable, and not a few have been proved by irrefragable evidence to be produced by operative proceedings altogether unwarranted by the circumstances.

A Comparison and a Contrast.—My position will be made more clear by one or two examples, and these lead me *in medias res*. Some time last year I was asked to see a young primipara who was very ill towards the end of the first week of the puerperium. When we met in consultation I was informed by the practitioner in charge that the case had been quite straightforward, from first to last, and in answer to my enquiries he could not in any way account for the patient's condition, which was as serious as it could be even in a case of the kind. It appeared, in fact, almost or altogether hopeless. On making a physical examination without moving the patient from the dorsal position, I discovered a deep and wide laceration of the vaginal vault, the examining finger passing easily into the tissues of the parametrium. No mention of forceps was made in the conversation we had before seeing the patient, and it was only after the examination and in reply to a question that my colleague explained why and when they had been applied. It seemed to me at the time that he thought the completion of labor by means of the forceps such an insignificant detail that he forgot to mention it. The child, in this case, was saved, but the mother died.

A few years ago I felt called upon to make several repairing operations on the injured pudenda of a young married woman who came under my care as a hospital patient. She had been by all accounts perfectly sound and active a year before, but meanwhile she had got married and she had become a mother. When I first examined her the uterus was found to be completely prolapsed, and it was so lacerated that the anterior and posterior halves of the cervix projecting from between the nates looked like two separate organs, and the perineum was torn completely through into the anus. This patient then suffered from dislocation of the uterus, transverse laceration of the cervix and complete rupture of the perineum. She was treated by Emmet's operation, restoration of the perineum and shortening of the round ligaments, and then she was fairly comfortable with a pessary. I learned afterwards that this case had been one of normal labor in a primipara, and that the delivery had been effected instrumentally by a *vacuum tenens* within six hours from the commencement of the pains.

Let us now compare this sort of practice, still possible at the present day, in spite of all our anesthetics, antiseptics and perfected scientific apparatus with what occurred in a former and different age.

Mauriceau,* for example, mentions a case "*Du laborieux accouchement d'une femme dont l'enfant étoit resté au passage, à cause de l'extrême grosseur de la tête.*" He was called in March, 1669, to a primipara, aged 35, who had been in labor eight days. The head was in the cavity of the pelvis, and the child had been dead four days. The patient had been visited and abandoned by three or four surgeons, one of whom had made an incision into the soft parts of the vulva. The obstruction arose from the large size of the child's head. Mauriceau perforated and extracted with the crochet, and the woman who appeared to be moribund when the accoucheur arrived, lived on for eleven days, ultimately dying of "*une grosse fièvre qu'elle avoit cinq ou six jours auparavant.*" From this circumstance Mauriceau concluded that the patient might have escaped if she had been delivered two or three days earlier, that is to say, if she had been in labor only five or six days.

He relates another case "*De l'accouchement d'une femme qui eut un très-laborieux travail.*" It was that of a primipara, aged 28, who had been in labor two entire days after the rupture of the membranes. There had been ten hours of very strong pains. The head was low down in the vagina and had rested there for twelve hours. The pains had now ceased. "*Quoique sa Sage-femme lui eût donné deux clystères assez forts, pour tâcher de lui exciter de nouvelles douleurs, et qu'elle l'eût fait aussi saigner du bras suivant mon conseil.*" . . . Mauriceau ordered a strong dose of senna to be administered, and two hours afterwards a powerful clyster. Pains then came on, and the patient was delivered without more ado, "*d'un gros enfant mâle, qui étoit encore vivant.*"

Here then, we have two extremes of practice contrasted, the helplessness of the seventeenth century, and our own resourcefulness at the end of the nineteenth, and yet it may be alleged, not without reason, that there is to be seen in the contrast only one more illustration of how "knowledge comes but wisdom lingers." Such results of our modern practice as I have given in illustration do not make it so perfectly obvious that in obstetrics we are much wiser than our sires.

The work of Mauriceau from which I have quoted, contains the famous case in which he met Chamberlen, who failed to deliver with his forceps a woman with a deformed pelvis, and immediately after fled from Paris.

Mauriceau's practice illustrates, then, that of the age imme-

* Observations sur la grossesse et l'accouchement, etc., Paris, 1715.

diately preceding the introduction of the obstetric forceps. We may divide the century and a half from the introduction of the forceps to the present time roughly speaking into three periods: First, from the introduction of the forceps to the discovery of anæsthetics, about a century; second, from the discovery of anæsthetics to the introduction of antiseptics, a quarter of a century; third, from the general introduction of antiseptics in midwifery practice to the present time, very nearly a quarter of a century.

Now, if we consider our present position, we have much to congratulate ourselves upon, and yet we may fairly ask if there is not much room for improvement in the use which we make of our resources. Is not one of the most remarkable things in the history of medical science, during the last quarter of a century, the extraordinary development of gynæcology in its surgical aspect? Gynæcology flourished and has become largely surgical; so largely surgical that Sir W. J. Priestly, my predecessor of two years ago in the position which I occupy to-day, addressed to the Obstetrical Section a warning and a remonstrance on the too free application of surgical methods to gynæcology. Midwifery has, during the same period, become also largely surgical—too surgical—and a thesis which I shall endeavour to maintain to-day is that gynæcology has become so largely surgical as the direct result of surgical interference in midwifery practice; the accoucheurs are the providers of material for the gynæcologists. I fully appreciate the admirable work done during that time by gynæcological surgeons in dealing with the new growths of the sexual organs, and I do not decry it, but for the material of his ordinary daily labour the gynæcologist has to look to the accoucheur. Last year Dr. Cullingworth did a good service to the medical profession by addressing the Obstetrical Society of London, on the subject of the undiminished childbed mortality in England in spite of our advantages and improved methods of practice. But in addition to the avoidable childbed mortality, there is the very serious question of childbed morbidity, which I maintain and repeat is largely owing to the prevalence of surgical methods in the practice of midwifery. The term "surgical" is employed here with almost exclusive reference to the use of midwifery forceps. It was said by Baudelocque that the midwifery forceps was the most useful surgical instrument ever invented, and with that strong and unqualified opinion we are all more or less in agreement. But like all our powerful remedies, the forceps must be used with circumspection, else disastrous consequences must ensue.

Now the avoidable evils which I maintain are so prevalent at

the present time have developed insidiously and largely in consequence of the resources which have come to us in the evolution of medical science. If we sin, it is against the clearest light. If we trace the history of Obstetrics during the last century and a half, and consult the old and many of the new masters on the subject, we find their opinions are almost unanimous on the limitations and conditions under which the practitioner should resort to his most powerful remedy. There have been from the beginning fluctuations and fashions in practice, but none in theory.

First Period.—In addressing a meeting of English speaking obstetricians one cannot illustrate the theory and practice of the first period to which I refer without quoting Smellie.* In Smellie's time, the men who practised obstetrics were no longer helpless in dealing with the most frequently occurring cases of difficulty, namely, in tedious labour from inertia, or from disproportion between the foetal head and the maternal passages. In reading Smellie's collection "of laborious cases when the head of the child is low in the pelvis and delivered with forceps," no one could fail to be impressed with the caution exercised in the use of the forceps in obviously suitable cases. Take, for example, the first case, in which he makes his visit, gives his instructions for the night, and then proceeds: "When I called in the morning, I found the child's head advanced lower in the pelvis." He gives in detail his reasons for expecting further progress. He says, "Being called in the evening, and understanding that the pains were still weak and the gossips uneasy, I examined in time of a pain, and found the head was lower." He then describes in minute detail how he applied the forceps and extracted the first child in a twin pregnancy, and concludes: "I used the forceps in this case as a pair of artificial hands to assist the delivery, because the pains were too weak to expel the child." This case very well illustrates Smellie's practice, particularly the patient waiting for the natural efforts of delivery before interference. In another case he says, "The patient, though much recruited, being still weak and the pains languid, I directed the midwife to proceed in supporting her with the broth, and prescribed a cordial mixture without any opiate, to amuse the woman and her friends." In another case he was called to a patient who had been in labour for three days under the care of a midwife. "As soon as I was disengaged," he says, "I accompanied my pupil to the place where I found this loquacious midwife extremely ignorant, without the least tincture of knowledge in her possession. When called to the patient, whose pains were just beginning in this her first labour, she had

* Collection of Cases and Observations in Midwifery. 3 vols. London. 1764.

walked her about and fatigued her so much that she was quite exhausted and the pains had entirely ceased. The midwife complained that her fingers were swelled and painful with stretching the birth, but she did not know how long the waters had been discharged." Smellie gave directions with the object of obtaining some rest for the patient, and early the next morning delivered her with the forceps, "without lacerating her parts or even marking the child's head."

By way of illustration of the theory of the next generation in this period, I may quote from the "Practical Essays on the Management of Pregnancy and Labour," by Dr. John Clarke, published in London in 1793: "Violence offered by the improper use of instruments may also become a cause of fever; therefore they ought never to be employed in any case except where they are absolutely and indispensably necessary. He who uses them unnecessarily, and solely with the intention of saving his own time, has much to answer for, both to society and to his conscience."

If instead of accepting an opinion, we prefer to turn to a record of facts in order to draw our own conclusions, let us look into the "Practical Treatise on Midwifery," by Dr. Robert Collins, published in 1835. The author gives an account of 16,414 cases of labour in the Dublin Lying-in Hospital during his Mastership. The rules laid down by Collins for the use of the forceps sound very much like some contained in the most recent German literature on the same subject. He says, "In tedious labours, where the mouth of the womb is fully dilated, the soft parts relaxed, and the head so low in the pelvis as to bring the ear within reach of the finger, if there be a necessity for interference, the forceps may be used with advantage; but ample experience has most fully proved to me, that under those circumstances, uterine action fails but seldom in expelling the child, and that it is only in cases as above described, where the *safety* of the patient *requires assistance*, that we are justified in using this instrument."

In 16,414 deliveries in the Hospital, he met with but fourteen cases answering this description; in eleven of which the forceps were used, and in three, the lever. In the other instances where the forceps was applied the labours were complex.

There are several other situations in which the forceps may be applied with much benefit, as in convulsions, hæmorrhages, etc., where the case is in other respects suited to their application; these are pointed out in the remarks on the treatment of such labours.

"The forceps was used during my mastership 24 times, and

the lever 3 times, total 27; making the average about 1 in 608 deliveries. According to this calculation, most physicians in private practice would require to use them but seldom, as, supposing an individual to attend 4,000 cases in the course of his life, which is a greater number than falls to the lot of most men, the forceps or lever would be necessary in little more than *six* cases. I consider the forceps, when used with prudence, a most valuable instrument; but its utility is greatly lessened by the injury so frequently inflicted on the patient, by having recourse to it where *no* instrument is *necessary*: but *much more so* by using it where, in my mind, it is not only inapplicable, but highly dangerous to the patient's safety."

But it may be objected to the frank acceptance of Collins' rules for our guidance at the present time, that the childbed mortality under such rules must have been very high. It was far otherwise. After giving an account of the measures adopted to banish or guard against puerperal fever, he says: "Of 10,785 patients delivered in the Hospital subsequent to this period only 58 died, which is nearly in the proportion of 1 in every 186; the lowest mortality, perhaps, on record in an equal number of a similar class of females." Another objection which naturally arises to what some might call procrastination in the management of labour is the high death rate among the children born under such circumstances; but Collins supplies us with full and exact information on this subject, and the infant mortality is surprisingly small. He says: "The total number of children born was 16,654, of these 284 died previous to the mother leaving the hospital. This is nearly in the proportion of 1 in 58½, which must be considered a moderate mortality under any circumstances; however, when it is considered that this included not only all the deaths that occurred in children born prematurely, and in twins, but also every instance where the heart even acted or where respiration ceased in a few seconds after birth, the proportion of deaths becomes *trifling* indeed. Of the 284 deaths, 100 were premature deliveries."

The Influence of the Introduction of Anæsthetics.—The introduction of anæsthetics into midwifery practice marks the opening of such an era that every modification of the obstetric art within the first period sinks into insignificance. Time permits me only to indicate, not to fully detail, the modifications of practice during that time. We find, for example, that Smellie was rather attracted by the use of the forceps, and then he and his pupils initiated a mode of practice which came dangerously near to abuse. The work of William Hunter, who published his "Anatomy of the Gravid Ute-

rus" in 1774, and founded physiological midwifery, produced some modification in the opposite direction, and the opinion brought about through his influence may be indicated by a quotation from his disciple Denman. "It has long been established, in this country, that the use of instruments of any kind ought not to be allowed in the practice of midwifery, from any motives of *eligibility*. . . . Whoever will give himself time to consider the possible mistakes and want of skill in younger practitioners, which I fear many of us recollect; the instances of presumption in those who, by experience, have acquired dexterity, and the accidents which under certain circumstances seem scarcely to be avoided, will be strongly impressed with a sense of the propriety of this rule."

This is also the position taken up by Collins, from whose work I have already quoted. There can be little doubt, however, that under these rules the interests of the mothers were not conserved. The practice was to delay too long during the second stage of labour, and this brought about those terrible injuries from sloughing, leading to the formation of fistulæ between the vagina and the bladder, and between the vagina and rectum, which produced such a frightful amount of suffering among women at the most vigorous and useful period of their lives. Collins speaks of using the midwifery forceps only once in 608 cases, but he gives concisely the facts of many cases of cruelly prolonged childbirth, of which the following are fairly typical examples :

No. 504. Was brought to hospital from the country; reported to have been five days in labour; it was her first child; it was dead and the head firmly fixed in the pelvis. She was much exhausted; pulse 110; tongue parched. "The head was immediately lessened," and delivery effected with the crotchet. She sank on the ninth day from admission.

No. 555. Was sixty hours in labour of her first child. The pelvis was defective, and there had been no advance for the last twelve hours, the child's death having been ascertained by the stethoscope some hours previous; the head was lessened and delivery thus completed.

No. 608. The labour pains were very tardy and feeble, producing irritation without causing any dilatation of the mouth of the womb. In this state she remained for thirty hours, after which opiates were given three times at considerable intervals, each time with benefit, and at the expiration of fifty-three hours she was delivered naturally of a still-born child.

We need not go abroad to seek the advice of the masters of the obstetric art during this period, and I need not further multiply

quotations. We shall find the great teachers always sound and clear in their utterances. I shall only refer to our own Ramsbottom who comes in with Sir James Y. Simpson at the end of the first period. His great work* made its appearance in 1841. He considers the application of the forceps such an important operation that he strongly recommends consultation, "even though a neighbouring, probably a rival, and perhaps not very friendly practitioner" may have to be called in. And he frequently exclaims: "Cautiously and tenderly must this iron instrument be used! . . . We must remember that one injudicious thrust, one forcible attempt at introduction, one violent effort in extraction, may bruise, may lacerate, may destroy."

The typical injury of parturition during this period was vesico-vaginal fistula, but there can be no doubt that the not infrequent use of perforating instruments and the crotchet produced bruises and lacerations which, in pre-antiseptic days, must have conduced considerably to the maternal mortality. The mistaken practice, also, of "stretching the birth," which I am afraid is by no means a thing of the past, was so prevalent that it must have done infinite injury. By causing minute necroses or lowering the vitality of the tissues it must have opened up the way to bacterial invasion with all its consequences.

Laceration of the perineum must have been occasionally inevitable in former generations as in our time. But special attention appears to have been given to its prevention. Denman indeed refers to its prevention as "the principal object of our attention in natural labours."

With the *second period* commencing with the discovery of anæsthetics, and ending with the general introduction of antiseptics, I have at present comparatively little concern. The obstetrician of that quarter of the century, of whom we may take as a type the late Dr. Mathews Duncan, was much concerned with the mechanism of labour, and this is the only period, if any exists, in the history of obstetrics when the warnings against meddling midwifery by the teachers ceased to be as clear and emphatic as they had been in former times. With the beginning of this period, we have the work of Marion Sims marking an epoch in the history of gynæcology. He and his contemporary imitators and his successors were long busy repairing the characteristic ancient injury of vesico-vaginal fistula, for they had the accumulated misery of a whole generation of women to cure or ameliorate. With the end of the period comes

* Principles and Practice of Obstetric Medicine and Surgery.

the introduction of Emmet's operation, which, according to Jenks, marks "one of the greatest advances in modern gynæcology," an opinion not even yet so generally held in England as it ought to be.

The introduction of anæsthesia did not lead to any great improvement in the practice of obstetrics; the medical practitioner could now relieve the patient from the worst pangs of parturition, and therefore could well afford to wait in normal labour for completion by the natural process. But it was soon found that the production of anæsthesia was not all gain. It was found that the prolonged administration of chloroform brought on inertia of the uterus, tedious labour and post-partum hæmorrhage. The tediousness of the labour made the "gossips uneasy," and the most conservative of practitioners was too often driven by the appeals and reproaches of the patient and her friends to the application of the forceps. In fact, the consciousness that the final pangs of labour and the acute suffering which would otherwise be produced by the application of the forceps could be entirely relieved by the administration of an anæsthetic had for its practical effect a great extension of operative midwifery. Lacerations of the perineum became much more frequent than under the old practice of delay, and as it was quite unusual to suture these lacerations as is now the universal practice, incontinence of urine, owing to vaginal sloughing, was replaced by incontinence of fæces resulting from complete laceration of the perineum. The lacerations of the cervix and vagina and their relation to parametritis were either unobserved or not understood until Emmet taught the medical world their importance. Just as the practice of the first period made material for the special beneficent work of Marion Sims, so the abuses of the second period provided the opportunities which Emmet had the genius to recognize and to use. He was the first to observe and describe the injury that had been inflicted, and to teach the gynæcologist the method by which it could be repaired.

Anæsthetics plus Antiseptics—The advent of the *third period*, that of anæsthetics combined with antiseptics, dates from 1870 to 1873, or somewhat later. About that time began those triumphs of abdominal and pelvic surgery applied to the diseases of women of which men of our special branches of medicine are so justly proud. The operations in general surgery also took on a new phase, and our students, accustomed to witness in the hospital the audacity with which the modern surgeon, depending upon anæsthetics and antiseptics, could deal with new growths and surgical injuries, were influenced, perhaps almost unconsciously, by what they

had seen of operative surgery towards applying its methods to midwifery practice. There has been little of precept and example to counteract this tendency. Our students in the medical schools are not taught obstetrics and gynæcology in a reasonably practical way—while on the other hand they apply themselves to surgery, theory and practice, from the time they pass the entrance examination until they graduate. They learn surgery which they will never practice, and they will practice midwifery which they have never learned.

But the mischief is not merely negative. If the young practitioner turns to some of our English manuals of midwifery, or to contributions to our medical journals, he is liable to be misled into practice which is actively harmful. It would be a long and invidious task to support this statement by references, but it may be as well to take one or two illustrations. A friend of mine has published a "Practice of Midwifery" as a guide for practitioners and students. The edition from which I quote is dated 1896. He says: "The perverted old adage that 'meddlesome midwifery is bad' has long stood in the way of an early application of the forceps in uterine inertia Rash and inconsiderate measures I would not be thought to encourage. . . . but we must not let our caution warp our judgment and so delay a comparatively simple and harmless operation until it becomes one that is difficult and dangerous." On the rest of his chapter on the forceps I have no relevant criticism to make, except that it is too much like the summing up of a judge to a jury to afford a clear, definite and helpful guidance to the student; but in this respect it is by no means an exception among the manuals.

I have already quoted a master of the Rotunda Hospital of Dublin, and I should like to refer for a moment to a phase of midwifery practice initiated, or largely influenced in its development, by another. Dr. Johnston* published an account of the use of the forceps at the Rotunda Hospital in Dublin during the year 1875. He says: "There were 113 cases where we considered it advisable to deliver with the forceps, and 83 of these were primiparæ, 75 mothers recovered, 8 died, 6 being cases of seduction, fretting; 2 cases of peritonitis. Thirty were pluriparæ; 26 mothers recovered, 2 died." There were 1,025 cases, and the forceps were used in 11 per cent. The maternal mortality is 10 per cent. in the forceps cases. Death in child-bed from "fretting" appears to be a speciality of the Dublin medical school. They have not anything

* "Medical Press and Circular," January, 1876.

of the kind in Germany, and Fritsch, in his book on puerperal fever, in referring to the Dublin peculiarity, calls it "dummheit." Dr. Johnston goes on to meet the objection that the forceps is a dangerous instrument, and he says: "As a proof to the contrary I may mention that of the 752 cases that have been delivered within the last seven years, in no one instance was injury inflicted by the instruments on the soft parts of the mother." We shall see again how the best practice in the German lying-in hospitals contrasts with this wonderful result. There they have not three times as many deaths from fretting as from peritonitis, but they confess to inflicting much injury on the soft parts by the use of the forceps. After the usual formal caution against rash interference, Dr. Johnston goes on to say: "The more we see of early interference and the benefits arising from it the more we are induced to persevere in it." He says little about his mortality, which was about double that of ovariectomy in experienced hands. His argument that this operation should not be undertaken by an "unskillful person," introducing a comparison between applying the forceps and tying the subclavian artery or lithotomy, amounts to a plea for leaving operative midwifery entirely in the hands of a special class.

Facilis descensus averni. We soon find even such an experienced and cautious obstetrician as Dr. Swayne,* of Bristol, referring to Dr. Johnston's hospital reports, and expressing approval of the practice of using the forceps during the first stage of labour. Dr. Swayne quotes Denman's aphorism, "The first stage of labour must be perfectly finished before we think of applying forceps," and he declares with evident satisfaction that in no branch of obstetrics have we departed from the precepts and practice of our forefathers as in this.

Further examples might be quoted by the score. The deterioration went on rapidly, until many teachers and writers of manuals seemed to have hardly the courage to speak with clearness and precision, and they talked and wrote as if they had no decided opinion of their own. Their formal cautions and restrictions, more or less explicitly stated to be applicable to the practice of the experienced and skillful, are a mere sham as applied to the untaught young practitioner, and they become a delusion and a snare.

It is only about twenty years since Dr. Swayne referred to the use of forceps in the first stage of labour as a "startling innovation" in obstetric practice; and the midwifery practice of to-day, especially among the working-classes in England, is something to wonder at and deplore. The young practitioner sees a woman suffering

* "British Medical Journal," April, 1877.

under the pangs of labour ; he can relieve these by anæsthetics ; normal labour is a process which requires time ; the practitioner does not like waiting, and he has appliances by which he can abridge the process of normal labour ; he knows he may produce injuries, but these are in his eyes trifling compared with the injuries he has been accustomed to see treated successfully by the surgeon with the aid of antiseptic appliances, and a laceration can always be sutured if it appears to be of sufficient importance. Why, therefore, should he permit suffering to his patient and waste his own time ? He does not know enough of gynæcological practice to be impressed with the importance of a laceration of the cervix or vagina or a dislocation of the uterus ; that is to say, of the remoter consequences of his well-meant interference. More than that, although he may have attended the statutory number of labours required by his college or university, he has enjoyed few advantages of direct practical instruction and example ; he may be unable to diagnose the presentation, so he must trust to force alone ; he has seen little or nothing of the puerperal state, so he is hardly in a position to appreciate the risk to his patient or to recognize some of even the immediate effects of operative midwifery.

Meddlesome Midwifery.—I have endeavoured to trace the course of change in obstetric practice in England, and to indicate the causes. That practice is now, in my estimation, vastly too meddlesome and mischievous, and some reform is urgently required. Probably few men even in the medical profession who do not actually see midwifery practice among the working classes of our large towns, or have their attention constantly drawn to the injuries resulting from their practice, are aware of the actual state of affairs. In Manchester, and the manufacturing towns of Lancashire, the proportion of cases in which the forceps are applied, with or without indications, amounts to five and twenty or thirty per cent. and even more. One of my friends who has a large general practice within the area covered by our Maternity Hospital has been good enough to give me a statement of his midwifery practice for the last ten years, and the proportion comes as nearly as possible to twenty-five per cent. From 1885 to 1889, five years, he attended 839 cases, and applied the forceps in 142, that is, in 17 per cent. From 1890 to 1896, seven years, he attended 900 cases and used the forceps in 246, that is a percentage of 27.3. His rate of forceps delivery is highest in 1896, when he used the instrument 50 times in 150 cases. Another friend, whose practice mostly lies within the same area, tells me that his proportion is at least thirty per cent. The highest figure mentioned to me has been 75 per cent. A busy

practitioner whose field of operations lies in one of the largest manufacturing towns in Lancashire, told me, in answer to the question which I so frequently put, "What is the percentage of forceps cases in your practice?" that his was "At least seventy-five per cent." "But," I replied, "you must be joking." "Not at all," he said, "between high and low applications of the forceps, at least seventy-five per cent." "But," I said, "surely you have no appreciable number of cases of application of the forceps at the brim?" "I had three cases only last week, but it is a good while since I had such a case before," and, to prove to me that his seventy-five per centage was a fact and within the mark, he promised to give me the exact figures from the record of his cases.

I have been frequently told by practitioners in similar communities that in the case of a multipara they allow half an hour to an hour for the second stage of labour, and, if the case does not show signs of immediate spontaneous completion, they apply the forceps. Among the gynæcological cases at the Manchester Southern Hospital it is by no means a rare thing to find a young woman suffering from dislocation of the uterus and lacerations of the cervix and of the perineum, whose first labour was terminated by forceps within four to six hours of the onset of regular pains.

Now, before passing judgment on this kind of practice as to whether it is reasonable or unavoidable, or praiseworthy, or the reverse of all that, we must find a criterion of good practice. What means have we of forming an opinion as to the proportion of cases in which we may have to interfere *under proper indications*; that is to say, when symptoms indicate some danger to the mother, to the child, or to both. We must obviously compare the methods of treatment adopted and the results obtained over large numbers of recorded cases. For my present purpose I naturally put before you in the first place facts with which I am conversant and can establish beyond dispute. I have here figures showing the details of two years of the practice of the Manchester Maternity Hospital. The hospital contains only twelve beds for in-patients. The home-patients who form the great majority are attended by more or less trained and experienced midwives. The midwives have instructions in case of difficulty to send for the assistance of a district obstetric physician, who lives within the area for which she is responsible.

MANCHESTER MATERNITY HOSPITAL.

From October 1st, 1894, to September 30th, 1895.

In-Patients—

Total number confined in hospital.....	183
“ “ delivered with forceps.....	12

Out-Patients—

Total number attended.....	1102
District obstetric physicians sent for by midwives, forceps cases.	15

Doctor called in by midwife on account of—

Adherent, or retained placenta.....	4 cas es.
Breech presentation.....	1 “
Transverse presentation.....	1 “
Placenta prævia.....	1 “

From October 1st, 1895, to September 30th, 1896.

In-Patients—

Total number confined in hospital.....	177
“ “ delivered with forceps.....	21

Out-Patients—

Total number attended to.....	947
“ “ forceps cases.....	14

In the home-patient department, in addition to the fourteen forceps cases, the doctor was called in three times to twin cases (second twin transverse). Abortion 1. Retained placenta 2. Post-partum hæmorrhage 1, and shoulder presentation 1. Placenta prævia 1.

Only simple forceps cases are set down in this statement; the few in which forceps were applied after version are not included.

It will be seen from these figures that the forceps deliveries among in-patients are in a comparatively high proportion, but it must be explained that the hospital beds are understood to be retained for cases of difficulty and danger; hence a large proportion of the women admitted have a history of difficult or operative labour in the past. The proportion of forceps deliveries among these in-patients is almost exactly nine per cent., and no woman died after the use of the forceps. The proportion of forceps deliveries among the home-patients in the charge of the midwives may be considered the normal requirements in such a community as ours. The midwives are under strict supervision. Their credit is at stake if they lose their heads and send too frequently for medical assistance, and their position is in danger if harm comes to the mother or child by want of knowledge and judgment in failing to send when necessity arises. Now, in 2049 home-patient deliveries, the forceps had to be applied by the obstetric physicians 29 times; that is, as nearly as possible, 1.4 per cent. I have already called your attention to the fact that within the same area of population, but among the class of people who can afford to pay for private medical attendance, the proportion of forceps deliveries is from five and twenty to thirty per cent. Such a striking contrast surely supplies food for reflection and calls for explanation. Another point, which I mention with some diffidence because I have only my own figures to offer by way of illustration, is the remarkable difference in the proportion of forceps deliveries among the poor

as compared with those in a better position in life. I have for a long time made cautious inquiries with regard to the history of the confinements in taking notes of my private gynæcological cases, and my conclusion is that the hospital patients are delivered with forceps more than ten times as often as the class of women who consult the gynæcologist privately, and may therefore be assumed to be in a position to pay higher fees to the accoucheur. If this result should be found on extended enquiry to coincide with the experiences of others in a similar position, it is a not unimportant fact in guiding our judgment to a conclusion as to how far we may have drifted astray from right and reasonable midwifery practice at the present time, and as to one cause at least of the aberration.

My attention was first attracted to this subject about twelve years ago, and I have given it some attention ever since. I was then assisting an experienced accoucheur in a case of normal labour in a primipara. As far I could judge, nothing could be more typically normal than the labour up to the point of what appeared the approaching completion of the second stage, and yet I was asked to assist in an obstetric operation by administering an anæsthetic, although my senior had made previously some joke about the "healthy young animal" type of the pains, and they as far as I could see had not changed from that type. He applied the forceps; and by repeated efforts at traction effected delivery, lacerating the vagina and perineum. The immediate results were those we are familiar with, including an attack of parametritis; the remoter effects were prominent cicatrix of the vagina, and chronic bad health. I am reminded of the history from time to time by being consulted by the patient.

My enquiries into the need for such operations and their consequences have gone on intermittently ever since, and I have noted with great satisfaction the rising protest in Germany against the abuse of the forceps.

There is now a considerable literature on the subject of forceps deliveries. There is not time, nor is this quite the occasion for going into many details on the subject. I may, however, make some concise reference to certain facts recorded in this literature, as I consider it of the greatest possible value to those who may wish to form an independent judgment on the matter, on account of the large amount of material and the exactness with which the whole matter is put before the reader. In 1889 Munchmeyer* published a valuable article in which he gave an account of the cases of labour completed with forceps in the Royal Hospital for Women in

* "Archiv fur Gynakologie," Vol. 36.

Dresden from 1883 to 1888, and the last of this series of papers which I have seen is that by Dr. Béla von Walla, which he calls "Studien im Auschlurs an 115 Zangen operationen." It appears in the fifth volume of the *Monatschrift für Geburtshülfe und Gynecologie*. It is an account of the cases delivered with forceps in the University Klinik for Obstetrics and Gynæcology at Buda-Pest. From the 1st September, 1882, to December 31st, 1895, there were 11,064 women confined in this hospital. Of these labours 115 were completed with forceps, that is, in the proportion of 1.04 per cent. over the whole time, and in 1895 the percentage of forceps operations sank to 0.32. It is instructive to compare with this the frequency with which forceps operations are performed in other German University kliniks, and also to compare the most extreme cases with our own general practice. Wahl, in his paper, continuing the report of the Dresden Hospital begun by Munchmeyer, gives an interesting table, showing the relative frequency with which the forceps have been used at various maternity hospitals:—

Kézmarszky, Buda-Pest, 1874-1882.....	1.4 per cent.
Abegg, Danzig, 1872-1885.....	2.2 "
von Winckel, Munchen, 1884-1890.....	2.6 "
Leopold, Dresden, 1889-1894.....	2.56 "
Gusserow, Berlin (Charité), 1882-1886.....	2.66 "
Leopold, Dresden, 1883-1888.....	2.6 "
von Winckel, Dresden, 1879-1883.....	3. "
Ahlfeld, Marburg, 1881-1888.....	3.5 "
von Rosthorn, Prag, 1891-1894.....	3.63 "
Stuttgarter Geb. Austalt, 1872-1885.....	3.7 "
Braun, Wien.....	4.3 "
Kehrer, Heidelberg.....	4.6 "
Olshausen, Berlin.....	4.96 "
Fehling, Basel, 1887-1893.....	5.33 "
Sutugin.....	6. "
von Saxinger, Tubingen.....	6.5 "
Olshausen, Halle.....	8.4 "
Schauta, Innsbruck, 1881-1887.....	9.16 "
Schultze, Jena.....	11.6 "

As Wahl points out in the contribution from which I am now quoting, the great difference in these figures indicates a marked difference of opinion as to what are the indications for the use of the forceps. In Buda-Pest and in Dresden, the indications for the forceps are very strictly and narrowly defined, whatever may be the rule at other institutions. At some of the medical school hospitals it is unfortunately thought right to apply the forceps in cases of normal labour in order to give instruction to the students.

This is an excellent account of the forceps treatment of labour in the Dresden Hospital, which is given by Wahl.* It is, as already

* *Über die entbindungen mit der Zange an der Königh, 1894. Frauenklinik in Dresden in den Jahren 1889, bis 1. Januar, 1896. Archiv für Gynacologie, Bd. 50.*

mentioned, in continuation and supplement of Munchmeyer's report six years before, and deals with the cases delivered within the hospital from 1889 to the end of 1894—six years. The whole number of cases was 9,061; forceps were used in 232 cases, that is, in 2.5 per cent. An examination of the details gives some extremely interesting information, which, however, is not altogether relevant to the present purpose. The forceps were used only on certain exact conditions and indications. The cervix must be completely dilated, the membranes ruptured, and the sagittal suture as nearly as possible in the antero-posterior diameter of the pelvic outlet. There were 212 or 91.5 per cent. of typical cases for the application of the forceps; there were only 17 cases in the whole 9,000 in which the forceps were applied, while the head was at the pelvic brim. The final indication for resorting to forceps was always danger to the mother, to the child, or to both, and three to four hours was the period allowed for the second stage of labour. At Buda-Pest the time allowed for the second stage was five to six hours.

Remarkably interesting, too, is the information contained in this report regarding the morbidity and the mortality of both mothers and children. The results for both are as good as any ever published. The only point, however, to which I wish specially to call attention is the number and extent of the lacerations and injuries which are attributed to the forceps under conditions in which observations could be exactly made. Munchmeyer reports 85 per cent. of lacerations, including in this episiotomy performed by himself to prevent worse lacerations, and those small injuries which could be repaired with a single suture. Schmidt found 84.6 per cent. of lacerations of the vagina and perineum, two of the latter complete in 132 forceps operations at the Klinik of Basel. The latest results at Dresden, as given by Wahl, appear to be somewhat better. In 232 cases the percentage of injuries was 81.4 per cent. These included injuries to the vagina, to the cervix and to the perineum, some of which were slight, others extremely severe. There were lacerations of the cervix which required immediate suturing to stop the hæmorrhage, and there were six complete lacerations of the perineum. *Only 18 per cent. of the cases were uninjured.* Munchmeyer may well refer to the application of the forceps as the bloodiest operation in medical practice, and Wahl quotes with approval the opinion of Von Winkel, that, even in the hands of an experienced operator, the forceps is an instrument by no means devoid of danger. Compare these results of cautious forceps delivery with Dr. George Johnston's who had 752 forceps cases "without once injuring the soft parts," and yet he applied the forceps in the first stage.

It would be tedious and serve no good purpose to go on multiplying experiences. All that we see and all that we read seems to point to the fact that we have replaced the one great injury of parturition of former generations—vesico-vaginal fistula, by a host of others, vesico-vaginal fistula by laceration instead of by sloughing included. There is a general impression that sloughing was very common in former generations owing to long-continued pressure. It is extremely difficult to get any information on the relative frequency. I have gone through the 700 cases which form the material of Mauriceau's work, and have found only six cases in which incontinence of urine resulted from tedious labour. The utero-vesico-vaginal fistulæ which we have to deal with are not extremely rare, and these are invariably produced by premature application of the midwifery forceps in primiparæ. There can be no question that many other such fistulæ are produced, but we never see them, because the patients die in child-bed. In addition to the lacerations and disablement which comes from them as lacerations, there are numerous other acute and subacute troubles, such as parametritis and cicatrisation. When we see such injuries with attendant displacements so frequently produced, when we think of the extreme differences in the practice prevailing in one country and another, or among one class of society or another, is it not reasonable to conclude that there must be something seriously wrong with our theories or our practices, or with both?

My present purpose is not so much to attempt to prove anything to demonstration, as to call attention to certain obvious evils, and by a plain statement of facts to establish a *prima facie* case for closer investigation of the question:

“That from Discussion's lip may fall
The law which working strongly binds.”

I may, however, without irrelevance, remark now that I have myself a firm conviction that serious evils exist; that a vast amount of unnecessary misery is produced, and that it should not surpass the wit of man to find a remedy. I am quite aware of the difficulties that meet the individual practitioner. I have been too long a general practitioner, before specialising, to have missed my share of those experiences, and perhaps it may raise a smile if I say, from that point of view, “that the gossips being uneasy,” in the language of Smellie, is one of the real difficulties in the way of reform, if by “gossips” we mean those interested in the patient who may have some sort of right to ask questions or claim the privilege of offering well-meant but ignorant suggestions, concerning the “exhausted” condition of some vigorous young woman in the first

hours of a normal labour. It is only the formation of a strong professional opinion and then a public opinion that will enable the individual practitioner to hold on to the proper course without ruinous injury to his professional position and character. But I believe that just as twenty years ago we met with men who feared to suture a spontaneously lacerated perineum, lest they should be blamed for producing the injury, and now among their successors meet with few who would not fear to be blamed if they did not suture such a lacerated perineum ; so the same process of formation of opinion by the practice of men of clear views and strong will with regard to the forceps would bring about a similar reform.

Among the causes which give rise to the present abuses must be put in a high place our over-confidence in antiseptics. Too many of our practitioners think that they can do anything in the way of manipulation, digital or instrumental, if only they use some chemical solution with sufficient copiousness. This, I am afraid, is a fatal delusion. Such at least is the conclusion I am compelled to draw from my own experience of cases of puerperal fever seen in consultation. It is a pathetic and humiliating sight to see a healthy young woman dying in childbed, with her little wedding presents as yet untarnished around her, *because* the medical attendant has thought it right to risk the production of injuries in a first and normal labour under the mistaken impression that he can prevent bacterial invasion by means of some weak solution of permanganate of potash and mercury or other chemical which he calls an antiseptic. I believe in antiseptics certainly, but my faith does not carry me to the extreme point of the schoolboy's definition as to the faculty of believing what we know cannot be true.

But the great difficulty in the way of either prevention or reform of abuses is the want of systematic practical instruction in our Maternity Hospitals, the absence of the precept and example of the best available men at the bedside. The consequence is that our young medical practitioners at the commencement of their careers have to learn midwifery by a process which amounts to involuntary experiment upon their patients. While the German medical student learns midwifery and gynæcology as he learns surgery, and the subject ranks with medicine and surgery in the examinations, we are still content to insist as far as practical instruction in obstetrics is concerned merely upon a formal compliance with certain regulations which do not necessarily imply practical knowledge worthy of the name.

The solution of the problem before us must sooner or later be attempted ; that problem is : " How are we to proceed in order to

reconcile the avoidance of injuries to our patients which may carry important consequence to life and health in their train, with the use of the scientific resources of our generation which should enable us, under proper safeguards, to soothe and curtail the mental and physical suffering which at the best are inherent in the process of parturition ? ”

You have heard what I have to say. I do not assume the position of guide or philosopher ; I take the advantage of the opportunity you offer me to call the attention of the profession to what I believe to be a crying evil. If you, the professors of the science of obstetrics and gynæcology, believe the evil exists, you will find the remedy.

Progress of Medical Science.

MEDICINE AND NEUROLOGY.

IN CHARGE OF

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LUMBAR PUNCTURE.

Fleischmann (*Deutsche Zeits. für Nerv.*, July, 1897, Medicine) reports on the lumbar puncture of fifty-four patients in the service of Lichtheim at Königsberg. He agrees with nearly all others that the procedure is without serious therapeutic value. Even in so-called serous meningitis only one of the four cases upon which it was practised showed any good results from the operation. In accord with previous observers, however, is the conclusion that the technique is simple and facile, and the few unpleasant results of no serious import and not to be regarded as a contraindication. Together with most other investigators of the subject, he lays most stress on the diagnostic importance of the abstracted fluid.

Puncture was done fifteen times in twelve cases of tubercular meningitis, and the bacilli were found nine times in eight patients ; while of five punctures in two cases of epidemic cerebro-spinal meningitis only one yielded the Weichselbaum coccus.

Four cases of purulent meningitis are recorded. Pus corpuscles and streptococci were found in the fluid of two, streptococci without pus in one, and many white blood-

corpuscles without micro-organisms in the fourth—that is, a positive finding, more or less conclusive, in all.

In studying this, as indeed all other reports on this subject the thought is inevitable that even when lumbar puncture is an undoubted diagnostic aid, the information thus obtained, considering the present status of therapeutics, is not of great practical value. As between tubercular meningitis and purulent meningitis, or as between the former and brain tumor, or even as between tubercular meningitis and serous meningitis, it must be acknowledged that a positive diagnosis is really of no very great value in directing the treatment or affecting the result of the disease.

Of the cases reported in detail we may mention three of serous meningitis, as the disease is not very well known, and the cases illustrate some of the difficulties of diagnosis by means of lumbar puncture.

A young woman of 24 years was taken suddenly ill with violent headache, nausea, and vomiting. There were soon added attacks of general convulsions with loss of consciousness and moderate cervical pain. Seven days after the onset examination showed elevation of temperature, a dicrotic pulse of 44, pain on bending the head forward, and double optic neuritis. The following day the patient vomited several times and had a general convulsion lasting about two hours. Afterward she was quite rational and without fever. The next day there was removed by lumbar puncture twenty-five cubic centimeters of fluid which contained one part per thousand of albumen, and in which a slight coagulum formed spontaneously. No immediate good effects of the puncture were discernible, but the patient gradually improved, and four weeks after the beginning of her illness was completely well, the persisting optic neuritis (which also rapidly improved) being the only sign of disease. The percentage of albumen in the fluid as well as the spontaneous formation of coagulum pointed to an inflammatory affection. As the patient belonged to a tuberculous family and had herself suffered from scrofula and bone tuberculosis, tubercular meningitis was suspected, but examination of the fluid for tubercle bacilli was negative, and purulent meningitis was excluded on account of the low percentage of albumen, the absence of pus corpuscles, and micro-organisms. The rapid recovery of the patient was considered to verify the diagnosis of serous meningitis.

The second patient, a sailor aged 22, who had also had tuberculous osteitis, was taken with headache, nausea, vomiting, cervical rigidity, and sleeplessness. The pulse was only 36. After a couple of weeks he improved rapidly, but four

weeks after the beginning of the trouble the same symptoms returned, with a pulse of 48 and double optic neuritis. Three months later lumbar puncture was made and fluid removed which contained only three-tenths of one part of albumen per 1000, and did not coagulate. After four weeks a second puncture drew fluid of the same character. There was no perceptible effect from the operation, but the patient improved and was discharged cured four months from the first onset of his sickness. In this case the small amount of albumen in the fluid and its failure to show coagulation indicated a non-inflammatory affection, and yet the course and termination of the disease seemed to prove it a serous meningitis.

In the third case autopsy confirmed the diagnosis. A child of three years who had had eclampsia at ten days suddenly became ill with fever, headache, vomiting, loss of consciousness, and rigidity of the entire body, but remained sick only a short time. Three weeks later she had a fit with loss of consciousness, clonic spasm, followed by loss of speech and paralysis. On admission there were rigidity of the spine, impaired consciousness, rotatory movements of the head, continual grinding of teeth, slight paresis of the right side, and double optic neuritis. During the period of observation the pulse remained high, the temperature occasionally high but generally normal. The spinal canal was punctured twice, the fluid containing only a trace of albumen and developing no cloudiness. Three weeks after admission the child developed pneumonia, which was quickly fatal. The autopsy revealed internal hydrocephalus, spinal meningitis, catarrhal pneumonia, and swelling of the intestinal follicles. This case, as well as others, goes to show that the serous meningitis of Quinke is probably not a perfect entity, but that approximately the same symptom-complex may be developed by a variety of conditions. It will also be noted that the qualities of the fluid indicating inflammation—viz., large proportion of albumen and spontaneous coagulation—were wanting, although distinct inflammation was present.

In another case in which the diagnosis lay between tumor and abscess, the high pressure—equal to forty-five millimeters of mercury—decided the observer in favor of tumor—a conclusion shown to be correct by operation and autopsy.

Another interesting case was that of a boy of eight who became rapidly sick with all the principal symptoms of meningitis, but a few days later the condition seemed somewhat anomalous, and a lumbar puncture was made for diag-

nostic purposes. The fluid was clear, contained only a trace of albumen, and showed no sign of cloudiness on standing; hence an inflammatory affection of the [cerebro-spinal meninges was excluded. This being done, typhoid fever seemed the most probable disease, and the serum test being used gave a positive result—the correctness of which was fully confirmed by the subsequent course of the case as well as by the diazo-test of the urine.

CHOKED DISC AND BRAIN TUMOR.

Jacobson (*Centralblatt für Nervenl. und Psychiat.*, June, 1897, *Medicine*) reports a case of cerebral tumor somewhat unusual in several respects. The patient, a child of five, while confined to the bed with a series of acute diseases gradually developed spastic weakness of the left side with some anesthesia. This paresis continued to increase after the patient was out of bed and constituted the only symptom, except moderately choked discs and toward the last a few attacks of faintness without loss of consciousness. The choked discs completely disappeared and did not return, and because of this and the inconspicuous general symptoms the author was inclined to diagnose a focus of cerebral softening rather than tumor. The autopsy revealed a tumor about the size of the thumb in the left cerebellar hemisphere, and another as large as a small apple in the right cerebrum that destroyed the entire lenticular nucleus, most of the posterior limb of the internal capsule, and part of the optic thalamus. Both were solitary tubercles. Jacobson explains the absence of severe general disturbance, as well as spontaneous disappearance of the choked discs, by the fact that the bones of the cranial vault had become very thin and elastic, allowing them to bulge, thus in some degree preventing great increase of intracranial pressure. He does not consider, however, that the disappearance of choked disc from relief of pressure is absolutely conclusive proof of the mechanical (pressure), as opposed to the toxic, cause of this condition, as an operation relieving pressure may be conceived to allow of the re-establishment of a natural circulation in the lymph channels, which permits removal of the toxic agents that presumably cause the optic neuritis.

In the discussion Oppenheim confirmed the disappearance of the choked discs in the present case in spite of the continued growth of the tumor, and was inclined to favor the mechanical origin of optic neuritis.

Schuster also reported the disappearance of choked disc in a tumor case. A young woman who presented all the

principal symptoms of tumor was put on inunctions of mercury and large doses of potassium iodide, whereupon the headaches ceased and the choked disc disappeared. Some months later she suddenly died, and the autopsy revealed in the left posterior fossa a glioma the size of a hen's egg, which showed no trace of any action of the iodide.

Greiff thought that clinically as well as pathologically a difference should be made between pure choked disc (passive congestion) and optic neuritis. The latter means severe change in the nerve fibres; the former may exist to a marked degree without damage to the optic nerve and with normal vision and visual fields.

A REVIEW OF THE LITERATURE OF KOCH'S TUBERCULIN.

The *International Medical Magazine* for December, 1897, contains this article by J. Dutton Steele, M.D., Philadelphia. A brief résumé is given of the experience of those who have used tuberculin R since its discovery some eight months ago. E. Buchner employed the method of pulverization of the bacilli, an account of which was published in 1893. He ground them in the moist state with sand. The dose of the material diluted with glycerine or salt solution to the proper strength is from 1-500 of a milligramme to 20 milligrammes, the maximum dose being seldom reached. The initial dose of 1-500 milligramme is doubled every second or third day, or by slow degrees of increase if too much reaction is produced. The cure is finished when 20 milligramme doses have been reached, which occurs in from sixty-five to seventy days. After this the patient will not react to ordinary tuberculin. Various micro-organisms have been found contaminating the specimens of tuberculin R, and some have contained live tubercle bacilli, and samples vary in their potency. Considerable local irritation, sometimes abscesses, follow the hypodermic injections. Fever and nervous disturbances follow, and isolated cases of albuminuria are reported. A résumé of the reports on its use is thus given, and the following conclusions are drawn :

i. The new preparation if uncontaminated does not seem to be more harmful than the old tuberculin if very carefully given. The dosage suggested by Koch is probably too severe. Much is left to be desired in the preparation of the material. In its present form it is usually contaminated. The greatest element of danger is the possibility of the presence of living tubercle bacilli. It may also contain streptococci, diplococci, staphylococci, and various saprophytic bacteria.

Certain outputs of the substance are clearly stronger than others and more likely to cause serious reaction.

2. The injections are accompanied by much discomfort to the individual. The point of entrance of the needle usually becomes the seat of considerable inflammatory reaction and occasionally of abscess formation. Much of this may be accounted for by the contamination of the preparation or faulty asepsis in its administration; but, even in the absence of the former and with extreme care in the latter, as in the series reported by Bussenius, some infiltration may occur. Very marked systemic reaction occurred in some part of the course of injection, but there is a reasonable suspicion that this may be caused by the apparent variation in strength of the preparation. It is possible that, if this uncertainty is overcome, immunity against the products of the microbe may be reached without undue reaction.

3. The immediate effects of the preparation upon existing lesions of the lung, larynx, bladder, and middle ear are too indefinite to admit of any certain opinion being formed concerning them. In lupus, in various suppurating tracts, and in one noticeable case of tuberculosis of the uterus and its appendages, the remedy seemed to be of value; but whether of greater worth than the old tuberculin can only be determined by longer observations.

4. Koch's experiments upon guinea-pigs apparently established the fact that in them an immunity against both the bacteria and their products could be obtained, and, inasmuch as several patients after completing the course of injections stipulated by Koch received large doses of the old tuberculin without reaction, it would seem as if an immunity against the products of the bacilli could be produced in man. Whether such individuals possess also an immunity against the bacteria themselves, and therefore are protected against reinfection, must be settled by observations extending over a longer period of time. The observation of Baudach in this connection is pertinent: "The question of the production of immunity is unsettled. If there is none produced, then the only point of difference between tuberculin R and the old tuberculin is the greater toxicity of the former." The class of cases in which the use of the remedy is justifiable is naturally very limited.

STREPTOCOCCUS SERUM (MARMOREK) AND STREPTOCOCCUS TOXIN.

By FERDINAND SCHENK, M.D.

The following experiments were undertaken as a continuation of the work of Borneman published in the same

journal in 1896. Four horses were immunized, all with the streptococcus Marmorek; all of them reacted strongly to the injections at first, but subsequently seemed to suffer no bad effect from active virulent cultures. All had previously been rendered immune to diphtheria. The streptococci were the same as those that had been supplied to Borneman by Marmorek himself, their virulence having been maintained by successive passage through rabbits. Altogether sixty preventive experiments were made with various quantities of the serum-test obtained from these horses, reaching from 0.2 c. c. to 5 c. c., and the animals were subsequently inoculated with from 0.01 to 0.001 of a c. c. of virulent culture. Of these animals twenty-three survived—that is to say, 36.5 per cent. Those that died had an average existence slightly longer than that of the control animals. Of the latter 11.4 per cent. only survived. Twenty-one animals were tested regarding the curative powers of the serum, as much as 10 c. c. having been given twenty-four hours after the injection of 0.001 c. c. Of these only two survived. Rabbits were taken and streptococcus culture injected into the ear, to develop erysipelas. In spite of the preliminary injection of antitoxin, control animals reacted quite as well as those that had been protected. When more virulent serum was used, the animals died quite as promptly as the control animals. In six animals the serum was employed after the development of erysipelas; one survived and the others died of streptococcus infection. Having reached the conclusion that the antistreptococcus serum was of no value, Schenk undertook to find out whether the streptococcus really produced toxin or not. He at first endeavored to kill the micro-organisms by means of mixing carbolic acid with infusions of the spleen and liver. Injections of this, however, caused death by carbolic-acid poisoning. An attempt to sterilize the cultures by heat (56°) rendered them innocuous. He then filtered cultures of streptococcus, and found that the filtrate was virulent, causing death within a few hours, but not giving rise to the typical picture of the streptococcic death, and it was not possible to cultivate streptococci from the blood or organs. This proved conclusively that toxins must be present in the culture, and, as a matter of fact, he was able to precipitate them with solution of chloride of zinc without altering their virulence. It appears that when animals have been preliminarily treated with streptococci serum the micro-organisms, although they produce death, show considerable diminution of their virulence. Schenk appears to ascribe this, to some extent at least, to the protective action of the serum, although in general he agrees with Petruschky in denying it any real

curative or preventive value.—*Wien. klin. Woch.*, October 28, 1897. *International Medical Magazine*.

HYPNOTIC CREED.

The *Hypnotic Magazine* promulgates the following articles of belief, invites opinions, and announces that any proposition proven unsound will be stricken out:

1. The subject, or hypnotized person, is always responsible for his actions.

2. The subject's moral resistance is as strong in the hypnotic as in the waking state.

3. The subject will not accept a suggestion, or a post-hypnotic suggestion, which conflicts with his principles or his all-potent instinct of self-preservation.

4. The subject submits to be hypnotized; he cannot be influenced against his will.

5. The subject can break the hypnotic sleep and return to his normal state of consciousness, even in defiance of the operator's suggestion.

6. The subject is never unconscious; the subjective mind is always on the alert.

7. The suggestions which can be made to take root most readily in the subjective mind, are those which are to the therapeutic advantage of the subject.

8. Suggested sense delusions are accepted by the subject with the sub-conscious understanding that they are produced merely for the purpose of experiment.

9. A subject of good moral character cannot be induced by hypnotic suggestion to perform an act which he would consider immoral or even undignified in his waking state.

10. A subject of loose morals will exhibit the same characteristics in the hypnotic state, but will refuse to commit a crime which endangers his person (see "instinct of self-preservation," No. 3).

11. A crime committed through post-hypnotic suggestion by a subject (if such a thing were possible) would be assuredly bungled, since the carrying out of a complicated post-hypnotic suggestion entails a return to the state of active somnambulism, in which state inductive reasoning is impossible.

12. The assent of the subject is always necessary to the carrying out of every suggestion.

13. Auto-suggestion is more powerful than the suggestions of another.

14. The only harm which can result to a subject lies in the possible ill results of foolish tests which the subject is willing to carry out.

SURGERY.

IN CHARGE OF

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CHRONIC CONTRACTION OF THE FIBRES ENCIRCLING THE VESICAL NECK AND ITS TREATMENT.

In the *American Journal of the Medical Sciences* for Oct., '97, Dr. Fuller describes a chronic contraction of the prostatic fibres encircling the vesical neck which he regards as a pathological condition resulting from a continued functional contraction due to some settled disorder of the sexual apparatus, the rectum, the kidney, or other part. The leading symptoms, of gradual development, is a partial or complete inability to void urine. At first there is a hesitancy in starting the stream, and dribbling follows with inability to completely empty the bladder. The symptoms, at first intermittent, become permanent, and are followed by complete retention. Three or four years may elapse before continued catheterization is necessary.

The diagnosis is made largely on the clinical history of the case and by excluding other causes of retention, as organic stricture, enlarged prostate, or spinal disease and resulting vesical atony. To diagnose between muscular contraction of the neck due to existing irritation, and chronic contraction, remove any exciting cause of the former, such as seminal vesiculitis, pyelitis, or rectal disease, if possible, and note the result. The only absolute diagnosis, however, is the feeling to the finger-tips of the ring of hardened fibres on making a perineal boutonniere incision.

The author cites several cases, each with an interesting history, in proof of his observations, and concludes his remarks as follows :—

“The only treatment for chronic contraction of the prostatic fibres encircling the vesical neck which in my experience has shown any favorable results consists in thoroughly rupturing or in cutting through them. This can be accomplished by means of the finger or the knife, as the case may be, introduced through a perineal incision. Perineal vesical drainage should be practised after the operation. Treatment such as this at my hands has been followed by complete disappearance of all subject symptoms.”

BUNION.

Parker Syms (*New York Medical Journal*, Oct. 2, 1897) says the cause of this deformity of the foot is the wearing of shoes which are faulty in shape or are ill fitting. A shoe that crowds the toes together or pushes the great toe backward will tend to produce this trouble. In this class are shoes with the following characteristics: First, shoes with narrow points, with the point in the median line; second, shoes that are too short; third, shoes that are so loose at the instep as to allow the foot to ride forward, and thus bring direct backward pressure on the toes; fourth, the worst of all, are shoes which combine two or all of these defects.

This deformity has been ascribed to osteoarthritis, to suppurative arthritis, to rheumatism, and to gout; but bad shoes are its cause, and the arthritis is the result of the displacement they produce, and of the injury they do to the joint.

The condition will vary a good deal in different instances. In mild cases there is but slight deflection of the toe outward, and little or no dislocation. From this stage or degree on the increased deformity is owing rather to pathological changes than to mechanical conditions. A chronic arthritis is established. The internal lateral ligament is stretched, the external one is contracted. The joint surfaces may become eroded or eburnated. The weakened support finally allows complete dislocation, so that the toe will lie at an angle, perhaps a right angle, across its fellows. The tendons will of course become disp'aced. Some surgeons have made the mistake of considering the displaced sesamoid bones (in the tendons of the flexor brevis) as the cause of the trouble and not as one of the results.

In operating the writer makes an incision about an inch in length on the dorsum of the toe. In a mild case, after retracting the tendon of the extensor proprius pollicis outward, he chisels off all the overprominent portion of the inner side of the head of the metatarsal bone, removing as much bone as is necessary to do away with all protuberance; he then sutures the wound and lets it heal under one dressing. Usually the patient can walk about after the first week.

In more severe cases, where there is a marked adduction as well as lateral dislocation, Syms removes the head of the metatarsal with a chisel or bone forceps, and also cuts off the prominent inner side of that bone. To resect the head of the metatarsal bone it will be necessary to divide the lateral ligaments and completely dislocate the toe. This can be done with ease and satisfaction through the simple straight

incision described. It is necessary to remove so much bone that the toe will readily come into place and have no tendency to displacement. If this is not accomplished by the first ablation more bone must be removed.

The dressing must be carefully done and close attention given to the after-treatment, which should include the application of a plaster splint. The writer advises never to operate during an acute attack of inflammation; always to treat the deformity, and never operate on the bursa, for it will take care of itself after its cause is removed—the exceptions to this rule are the removal of callosities from the bursa when they exist, and the incision of bursæ when they suppurate; never to make the operation incision around or through the the bursa.—*Medicine.*

CAMPHOR IN HEART FAILURE.

C. C. West (*Philadelphia Polyclinic*, Oct. 16, 1897) recommends the hypodermic administration of camphor according to the following formula :

Camphor.....	1 part.
Olive oil.....	10 parts.

Inject two syringefuls into each arm (about 5 Cc. altogether).

With the ordinary needle the injection is difficult, because of the thickness of the oil. One having a slightly larger bore has been found excellent. In a case now under observation, in which the patient has a number of times been absolutely pulseless and apparently lifeless, its use was followed by the most gratifying results. It is given throughout the illness, whenever the pulse fails, to supplement other cardiac stimulants.—*Medicine*, Dec., '97.

N. B.—This is useful in cardiac depression during operation.

WHAT PRODUCES AND WHAT PREVENTS ANKYLOSIS OF JOINTS.

Dr. A. M. Phelps arrives at the following conclusions: (1) That a normal joint will not become ankylosed by simply immobilizing it for five months. (2) That motion is not necessary to preserve the normal histological character of a joint. (3) That when a healthy joint becomes ankylosed, or its normal histological character changed, it is not due to prolonged rest, but to pathological causes. (4) That immobilizing a joint in such a manner as to produce and continue intra-articular pressure will result in destruction of the head of the bone and the socket against which it presses. (5)

That atrophy of the limb muscles will follow prolonged immobilization of a joint. The question of ankylosis is determined by the severity and duration of the inflammation, the presence of intra-articular pressure, the subsequent cicatricial contraction of soft parts around the joints, the tissues involved, and the amount of destruction of bone and cartilage.—*Lancet-Clinic*, July 10, 1897.

INTRAVENOUS SALINE INJECTIONS IN COL-LAPSE.

After an operation by Dr. Leonard A. Bidwell for intestinal obstipation, the following history is given: "The patient rallied well after the operation, and only vomited slightly. On the following day brandy, milk, and barley water were given by the mouth, and, as no flatus escaped on passing a rectal tube, an enema was ordered, but without any result, as the rectum was blocked with stoney feces. About mid-day on the second day after the operation the bowels acted four or five times copiously without any further enema, and all the abdominal distension disappeared. The patient, however, became considerably collapsed, but rallied after champagne and hypodermic injections of strychnine. At 9 p. m. she became worse and appeared almost moribund; her pulse was small and flickering, and the skin was cold; she also vomited slightly. My house-surgeon, Mr. Pardoe, immediately injected four pints of normal saline solution into the median basilic vein; almost directly after this the pulse became firm and full, and there was no more vomiting. The further progress of the case was quite uneventful. When last seen, four months after the operation, she was in excellent health, and did not have any trouble with her bowels."—*British Medical Journal*, May 8, 1897.

GANGRENE FROM CARBOLIC ACID.

Czerny (*Munch. Med. Woch.*, April 20, 1897) says that, in spite of the repeated warnings which have been given on this subject, there is not a year passes in which he is not able to show to his classes cases of gangrene brought about by the use of carbolic acid solutions as dressings.

They are generally produced by the continued use of moist dressings containing the officinal 3 per cent. solution of carbolic acid and applied as an antiseptic dressing for minor wounds of the extremities. The anæsthetic action of the carbolic acid makes the patient unmindful of the insidious action of the drug, and he is much surprised to see the fingers whiten and finally turn black; a line of demarcation

shows itself sharply, and amputation finally becomes necessary.

The author illustrates his subject by the report of three cases which were sent in from the country to his clinic. The danger of the solution, even a 1 per cent., is very great if the use is prolonged, and he advises that carbolic acid should never be used as a moist dressing. Other antiseptics are fully as efficient without this danger.—*The American Journal of the Sciences*, October, 1897.

EUCAINE "B" AS A LOCAL ANÆSTHETIC IN SURGERY.

Lohmann contributes to the *Therapeutische Monatshefte* for August, 1897, an account of his experience with this drug in minor surgery. He early abandoned weak solutions, preferring those of ten per cent., with which he obtained excellent results. He has employed the drug for opening abscesses, incising carbuncles, suture of tendons, removal of foreign bodies, and the exarticulation of fingers.

In the treatment of abscesses and carbuncles from fifteen to twenty minims of the ten-per-cent. solution was employed. For large abscesses three or four times this quantity was used. He is convinced that any abscess can be painlessly opened with this drug, as an amount equal to forty-five grammes maybe administered to an adult without fear of toxic symptoms.

He finds that Eucaine "B" has many advantages over cocaine. Not only is it less toxic, but it does not decompose under sterilization, and while dose for dose its anesthetic power is much less than cocaine, its employment in a ten-per-cent. solution gives us a very powerful local anesthetic without danger of toxic symptoms.—*Medicine*, Nov.

STERILIZATION OF CATGUT BY FORMALIN AFTER HOFFMEISTER'S METHOD.

Vinberg (*American Gynecological and Obstetrical Journal*, June, 1897) describes this process as follows: "The gut is first immersed in a solution of formalin of from two to four per cent., according to the size, and allowed to remain in this solution for a period of from twelve to forty-eight hours. The formalin is then removed by washing in running water for twelve hours. It is then boiled in water for fifteen minutes, after which it is transferred to a vessel containing alcohol, where it may be kept until required for use. Carbolic acid in the proportion of two to four per cent. is added to the alcohol and makes the gut more firm, but it should be removed to plain alcohol some time before using.

The secret of success in this method of preparation is to keep the gut in a high state of tension until after it has been boiled. Hoffmeister recommends that the gut be rolled tightly on glass; and Lange, of New York, has devised a small steel frame for this purpose.—*Medicine*, Nov.

THYREOID TREATMENT AS A MEANS OF CONSOLIDATION IN FRACTURE.

Gabriel Gauthier contributes to the *Lyon Medical* of June 27, 1897, abstracted in the *British Medical Journal* of September 18, 1897, an account of his experience with thyreoid feeding in delayed union of fractures. He was led to try the remedy because of its value in cases of disordered nutrition such as myxedema and rickets.

Hanau and Steinlein have called attention to the condition of the bones in dogs in which the thyreoid had been removed. Experimental fractures in thyreoidectomized dogs were slow in uniting. The suggestion was made first by them that thyreoid feeding might be useful in delayed union of fractures.

Gauthier reports two cases: One a girl with a fracture of the leg, had no union at the end of 110 days, though all the usual means were resorted to. A fortnight after beginning the treatment the bone was consolidated and a month later she was walking. A man with delayed union of the radius was given thyreoids, and at the end of a month there was a firm callus.

The reporter admits that the material is too scanty to allow of a definite opinion, but thinks the results are suggestive and encouraging.—*Medicine*, Nov.

OBSTETRICS.

IN CHARGE OF

H. L. REDDY, M.D., L. R. C. P., London,

Professor of Obstetrics, University of Bishop's College; Physician Accoucheur Women's Hospital; Physician to the Western Hospital.

MAY A NEPHRITIC MOTHER NURSE HER CHILD?

Not only she may, but she should, says Dr. M. Gamulin (*Le Scalpel*). As a rule physicians do not allow women, with any form of nephritis, to nurse their children.

It is considered especially inadmissible in patients whose diet is restricted to milk exclusively. The author has made observations on 158 women from Baudelogue's clinic, who,

while suffering with different forms of nephritis, nursed their own children. The latter developed as normally and increased in weight as regularly as the children whose mothers were healthy.

To the mothers the nursing was not only not injurious, but it seemed to do them good, as the exercise of this physiological function usually does. Only in cases of progressive albuminuria, and where the child loses in strength and weight, the nursing should be discontinued. (In a case under our treatment, where nursing was persisted in against our advice, the albuminuria became greatly aggravated.)—*H. L. R.*

TWO CASES OF PUERPERAL SEPTICÆMIA TREATED BY ANTISTREPTOCOCCIC SERUM.

Richard Richmond reports the following cases: Case I., a multipara had a chill the third day after delivery with a temperature of 102.2° and feelings of great discomfort. The lochia was scanty, pale and somewhat fetid, and there was tenderness over the uterus. A calomel purge and five-grain doses of quinine were given; there was slight temporary improvement, but three days later the temperature was 101.6° , and 10 c.c. of antistreptococcic serum were injected, the quinine being stopped. The next day the temperature was normal, and so continued; 5 c. c. of the serum were injected on that and the following day. All unpleasant symptoms subsided, and the patient soon recovered. The second case was a primipara, who was taken with a chill on the fourth day following a difficult case of breech presentation, with laceration of the perinæum. Vaginal douches of bichloride (1-2000) were given, and quinine administered. The temperature of 101.2° continuing, an injection of 8 c.c. of serum was given followed by 5 c.c. on the following two days. The temperature dropped to normal, there was no fetor to the lochia, and the general condition was good. Three days later the temperature rose to 104° ; the lochia was very offensive, and there was great tenderness of the abdomen, with some exudation to the left of the uterus. The uterus was irrigated with bichloride solution (1-4000), hot fomentations were ordered for the abdomen, and 10 c.c. of serum were injected. The following day the temperature was 100° , and 5 c.c. of serum were injected. The intra-uterine douche was repeated the following day, and the injections of serum continued for a week. But the temperature remained about 100° for twelve days, rising once to 102° . After that the progress toward recovery was slow but uneventful.—*Am. Gynæc. & Obstet. Jour.*

ON THE INDICATIONS FOR AND METHOD OF WASHING OUT THE PUERPERAL UTERUS.

The writer arranges in a tabular form the principal conditions in which, in his opinion, the uterine douche should be used. There is no doubt that serious symptoms may follow this procedure, and it should not be lightly undertaken.

The indications are briefly as follows:—

(1) In cases of uterine tenderness and offensive lochia, with elevation of temperature and pulse rate. The finger should first be introduced into the cervical canal to ascertain if the uterine discharge is offensive. It is advisable to give chloroform, and explore the uterus with the finger before douching.

(2) When, with rapid pulse and rise of temperature, there is doubt about the complete removal of the placenta, or when portions of membrane are known to be retained.

(3) After the birth of a "putrid" fœtus. In many cases, however, a macerated fœtus is quite aseptic, so that, it seems to us, this is not always necessary.

(4) If the involution of the uterus is much delayed, due usually to retention of clots, more especially if there is any pyrexia.

(5) In certain cases where, as the result of acute flexions of the uterus, the lochia are retained, and decompose.

(6) In all cases after curetting of the uterus.

(7) In all cases in which the hand has been introduced into the uterine cavity, as in post-partum hæmorrhage, adherent placenta, etc.

(8) As a first step in all cases of septicæmia.

The author draws attention to several points in the technique of the operation. The patient should lie upon her back, with the shoulders raised and the head low, to facilitate free discharge of the fluid. In some cases it is better to place the patient on her side, having elevated the shoulders.

It is necessary also to assure oneself that the os uteri is sufficiently open. If it has closed a double-channelled catheter must be used, preferably of glass. A douche is much preferable to using a syringe. It is also essential to maintain pressure on the uterus to prevent fluid passing into the Fallopian tubes. Dr. Mills advises that an assistant should hold the fundus uteri, with a hand at each side, so as to compress the entrance to the Fallopian tubes. This is more especially important, as the uterus is often atonic, and the cavity very large.

The solution recommended is weak perchloride of mer-

cury, avoiding its use, however, in severe anæmia and disease of the kidneys.

It is usually advisable to administer chloroform the first time that the uterus is douched out.

PUERPERAL SEPTICÆMIA TREATED WITH ANTISTREPTOCOCCIC SERUM—RECOVERY.

G. T. Howard, of Melbourne (*Intercolonial Med. Jour. of Australia*, October 20, 1897), reports a case of primipara, who was delivered by forceps after a tedious labor, with lacerations of the cervix and perinæum. The latter was immediately repaired. Placenta was easily expressed and the uterus irrigated with a one per cent. solution of carbolic acid. The next day the temperature was 101.6° and on the day following 103.2°. This continued until the fifth day, when curettage was performed, bringing away some shreddy lymph. The temperature persisting on the sixth day, 10 c. c. of antistreptococcic serum was injected; this was repeated twice at intervals of about fourteen hours. Each injection was promptly followed by a fall of temperature, succeeded by a slight rise. After the third injection the temperature was 100°, continuing so for three days, and not until three weeks after the confinement was the temperature normal. Vaginal irrigations of perchloride of mercury were used for a week after the curettage, then carbolic was substituted.—*Am. Gynæc. & Obstet. Jour.*

PUERPERAL INFECTION TREATED WITH INJECTIONS OF ANTI-STREPTOCOCCUS SERUM.

T. J. Henry, of Grafton, N. S. W. (*Australasian Med. Gaz.*, October 20, 1897), attended a primipara, aged fifteen years. She had been in labor for twenty-four hours when first seen, and the os was not then fully dilated. After a tedious second stage forceps were applied and a male child weighing eight pounds was delivered. There was no laceration. Seven minutes after birth there was a sudden hæmorrhage. The placenta could not be expelled by Crede's method, and the hand had to be inserted into the uterus, Bimanual compression failed to check the hæmorrhage, but injections of very hot water ultimately secured contraction of the uterus. No secundines remained in utero. On the fifth day the patient had prolonged rigors, temperature 104.6. The uterus was irrigated with a two per cent. lysol solution. This was followed by a fall of one degree in temperature;

20 c.c. of antistreptococcic serum was injected and three hours later the temperature was 100°. The following day the temperature having risen to 101°, the uterus was again irrigated, and the injection of serum repeated. In four hours the temperature was normal. A vaginal douche of lysol solution was given the day following, and the patient was up and perfectly well on the eleventh day. The infection was probably due to intra-uterine manipulations necessary to control hæmorrhage.—*Am. Gynæc. & Obstet. Four.*

BROW PRESENTATIONS AND THEIR TREATMENT.

Rose discussed this subject at a recent meeting of the Hamburg Medical Society, and reports a case of a brow presentation in which the head was firmly fixed in the pelvis. The membranes had ruptured six hours before. There was danger from rupture of the uterus. An attempt to deliver with forceps failed. Rose then introduced a finger into the mouth, pulling down the chin and rotating the same entirely. After this delivery was completed with the forceps.—*Amer. Four. Obstet.*

Medical Society Proceedings.

MONTREAL MEDICO-CHIRURGICAL SOCIETY.

Stated Meeting, October 29th, 1897.

ROBERT CRAIK, M.D., PRESIDENT, IN THE CHAIR.

Dr. Geo. Fisk, of Montreal, was elected an ordinary member.

ULCERATION OF THE BOWEL RESEMBLING TYPHOID FEVER.

Dr. J. G. ADAMI showed this specimen, a report of which will be published later.

Dr. A. G. NICHOLLS stated that at the time of the autopsy Peyer's patches higher up in the ileum showed signs of healing typhoid lesions. The spleen had not been that of typhoid fever, being rather smaller than normal.

Dr. WYATT JOHNSTON thought that the ulcers were strongly suggestive of typhoid fever, especially as they were accurately in connection with lymphatic structures. They, however, showed more evidence of cicatrization than was usual, and there was an absence of pigmentation, whereas healing typhoid ulcers were usually slaty. He considered that the absence of the serum reaction was not of much moment at so late a stage. Several fatal cases had been recorded where it was absent just before death. The blood from the

present case gave negative results; even in 1—2 dilutions. He thought that the nature of the disease here could only be decided from cultures. It was not unusual to find the spleen not enlarged at this stage of the disease.

CHOLECYSTITIS ENTERICA.

Dr. C. F. MARTIN read the report of this case.

Dr. JAMES STEWART referred to the great difficulty met with during life in making a diagnosis in this case. Thus, appendicitis, typhoid perforation, and cholecystitis were all entertained. A definite diagnosis of typhoid had been made before the patient entered the hospital, and by some the symptoms were all explained by a perforation having taken place. Others considered the case to be one of appendicitis, and the unusual seat of the pain for this condition did not entirely exclude this disease, as in some cases the appendix had been found lying quite as high up in the abdomen. The limited localization of the symptoms over the gall-bladder pointed strongly to this organ, and caused him to decide upon cholecystitis; the absence of jaundice was, however, confusing. The fact that typhoid bacilli might be the cause of a cholecystitis was not admitted by the surgeons.

PYOPNEUMOTHORAX.

Dr. W. F. HAMILTON presented a patient and demonstrated the above condition, drawing attention to the following points of interest in the case:

1. The occurrence of pneumothorax was of tuberculous origin, as bacilli had been found in the sputum and also in the purulent effusions from the pleural cavity on two occasions.

2. The case had an exceptionally chronic course, fourteen months having elapsed since it was first recognized.

3. There was strong evidence to show that the tuberculous process began in the left lung, and after pneumothorax occurred the process had not manifestly advanced.

4. The freedom from fever, chills and sweats was to be noted as rare with pus formation, while an increase in the body weight had been observed.

5. The recurrence of febrile temperature, with increased cough and expectoration, was simultaneous with signs of commencing lesion in the opposite lung.

Dr. J. B. McCONNELL said that it was stated that ten per cent. of all cases of phthisis developed pneumothorax, accounting for nine-tenths of the cases. An interesting point about the present case was why, with such a large amount of pus being produced in the thorax, there had been no temperature and the patient's strength had been maintained so long.

Dr. GEORGE WILKINS referred to another instance in which a large amount of pus had been present in the thorax for considerable time without causing any elevation of temperature. The patient was a young man who came to his office complaining of a small tumour in the right side which turned out to be empyema. The only subjective symptom was shortness of breath.

TYPHOID FEVER WITHOUT INTESTINAL LESIONS.

Dr. A. G. NICHOLLS read a paper with the above title.

Dr. WYATT JOHNSTON thought the case reported was an extremely interesting one, and pointed out that this was one of the cases where serum diagnosis had given a positive result which the post-mortem had apparently shown (until bacteriological examination was made) to be incorrect. He thought it was very important in any case where there was discrepancy between the serum test and the diagnosis to do the test quantitatively.

Dr. JAS. STEWART said that this case illustrated the great practical value of bacteriology in clinical medicine. At the outset, during life, the serum diagnosis had been the only means of determining the nature of the disease, and after death, if it had not been for the bacteriological examination made by Dr. Keenan, the real disease would have been overlooked.

Dr. GEO. WILKINS had hitherto believed that typhoid fever always required the presence of an ulcerative condition of the intestines. Although the lymphatic tissue was the usual channel of entry of the bacilli, he thought that there must be other sources as well, otherwise it would be difficult to explain the presence of bacilli in the urine in the cases cited, where the lymph glands were not involved.

Dr. J. B. McCONNELL thought that one was not warranted in making a new type of "typhoid without intestinal lesions," as, even in the case reported, there were slight lesions in the lymphatics. The idea that it was possible to have such slight intestinal involvement enabled us to take a broader view of the disease, and cease to describe as complications those nephritic, pulmonary, cerebral and other varieties occasionally met with, but rather to regard the affection as one in which the specific cause might exert its influence in various parts of the body and produce its typical manifestations from other points than the intestinal canal.

Dr. NICHOLLS, in reply to Dr. Wilkins, said that he did not mean to imply that the bacilli were confined to the lymphatic system. They eventually did get into the blood and thence to all parts of the body. Dr. Adams had suggested that the lymphatic system acted as a sieve, and thus accounted for the relative infrequency in which they were found in the blood.

In reply to Dr. McConnell's criticism on his choice of a title, he pointed out that the intestinal lesion had been so slight that had it not been looked for specially it would not have been detected during an ordinary examination. The hyperplasia of the Peyer's patches affected was so extremely slight that the condition did not suggest typhoid fever.

Stated Meeting, November 12, 1897.

ROBERT CRAIK, M. D., PRESIDENT, IN THE CHAIR.

EXCISION OF THE TONGUE.

Dr. G. E. ARMSTRONG exhibited a patient operated upon for cancer of the tongue and gave the following report:

I have recently had in the wards of the Montreal General Hospital an unusual number of cases of cancer of the tongue. There has been a marked difference in the location of the cancer. In this man the disease began on the right border of the tongue, well back, opposite to the molar teeth. He first entered the Montreal General Hospital in June last. The growth was then small and limited to the border of the tongue. A small piece was snipped off, and Dr. Wyatt Johnson reported it to be an epithelioma. The man declined to have any operation performed, saying that he preferred to die with his tongue in his mouth. He returned to the hospital in the beginning of October. Infiltration had taken place rapidly during the interval and in a downward direction. The whole floor of the mouth was involved. He could hardly speak so that he could be understood, and he said that the constant pain day and night was so severe that he could get but little rest, and begged to have the tongue removed on account of the pain. The deep involvement of the floor of the mouth and the presence of enlarged glands in the submaxillary region determined me to remove the tongue by Kocher's method. I performed the tracheotomy and excised the tongue at the same operation, and I saw no reason to regret doing so. The lateral incision of Kocher enables one to remove enlarged lymphatic glands and the submaxillary gland. The mouth is then entered laterally just beneath the lower jaw. The patient being tracheotomized, the pharynx can be plugged with a sponge and blood be prevented from entering the air passages. The access to the floor of the mouth is good, and during convalescence the patient breathes a pure air through the tracheotomy tube, and thus the danger of aspirative-pneumonia is lessened. I believe this method of removing the tongue to be an admirable one, when the floor of the mouth is deeply infiltrated and the glands at the side of the neck enlarged.

In another case upon which I have just operated, the disease was seated just at the bottom of the frænum. It was placed so low just below the border of the jaw that it was difficult to remove a piece for the microscope. In this case I did the old operation, originally devised by Roux, and generally known in England as Syme's. That is a median incision through the lower jaw. This method enabled me to get well at the seat of the trouble, and I think I effected a more thorough and wide removal of the diseased area in this case by a Syme's operation than I could have done by any other.

I think that most surgeons consider Whitehead's operation, with or without preliminary ligature of the lingual arteries, as the operation for removal of cancerous disease of the protruding portion of the tongue, but I am satisfied that it is unwise to allow oneself to be limited to one operation. Disease chiefly seated in other than the protruding tongue may sometimes be more thoroughly extirpated by other methods.

But in the future we must aim at arriving at a correct diagnosis earlier in the course of the disease, and by early and complete extirpation strive to remove the whole of the affected area, which all pathologists agree is at first a local disease, and thus prevent recurrence.

DEATH BY ELECTRICITY.

Dr. WYATT JOHNSTON reported five cases, in three of which death was due to the passage of the electrical current through the body. In one of the others a motor man, having climbed to the top of his car to look after the trolley wire, received a shock which caused him to fall to the ground. He picked himself up and was sent home, but died a few hours later from what the autopsy showed to be a fracture of the base of the skull, with intracranial hæmorrhage. The medico-legal diagnosis was very easy in this instance, but was less so in the second case, where a line-man working in wet weather on the cross bars of a telephone pole received a shock from an electric light current which had fouled a telephone wire. He was seen to fall to the ground and died a few minutes later. An autopsy by Dr. Villeneuve showed the cause of death to be a hæmorrhage at the base of the skull, some of the blood having been inspirated into the lungs and finer bronchi. Examination made independently by both himself and Dr. Villeneuve showed no signs of burning on any part of the body. The company were held responsible, although the fact that death was not due to the shock was evidenced from the time that must have elapsed to allow the blood to be drawn into the lungs.

Case three (communicated by Dr. Villeneuve) was that of a man who picked up one end of a broken live wire to show that there was no danger in so doing. The marks of the burning were present on the hands and ecchymoses on the surface of the body. No autopsy.

In case four a man made a connection between two wires by stepping on one while the other was touching his arm. The leather in the sole of his boot was burnt and his jersey charred, but the burns upon the skin were of a very slight degree—an interesting point.

In case five a man received the fatal shock from a badly insulated wire while sitting between two other men upon the cross bar of an electric light pole. Some minutes elapsed before the body was taken down, and during this time the current was passing. The burns here also were extremely slight in spite of the long exposure, and no second point of contact could be found. A small morsel of a clay pipe which the man held between his teeth was inspirated into the smaller bronchi, and the blood at the autopsy was found fluid, and remained so for one week. This condition was due to the continuous passage of the current, other causes of absence of clotting having been examined for and excluded.

It was not generally known that not only the fatal shock but also the typical changes could occur with such slight lesions through contact with a live wire.

Dr. G. P. GIRDWOOD related a case of lightning stroke which had come under his observation, and in which very extensive burning of a slight degree had occurred without a fatal result. He pointed out that the effect of the electric fluid upon the body depended both upon the suddenness of the shock and the duration of the current, the latter factor producing the electrolytic action upon the fluids of the body.

Dr. F. W. CAMPBELL referred to a case where a man, after exposure to a very severe thunder-storm, but without being actually struck by the lightning, had gradually lost every hair on his body. Other instances of baldness produced under similar conditions were also on record.

EXPERIENCES OF TWO HUNDRED AND FORTY-EIGHT CASES OF ABDOMINAL SECTIONS.

Dr. LAPTHORN SMITH read a paper with the above title. The cases extended over a period of eight years, and showed a total mortality of $6\frac{1}{2}$ per cent., varying between 17 per cent. in 92, to $3\frac{1}{8}$ per cent. in 96.

The cases included the removal of two large tumors of the kidney, eleven large ovarian tumors with two deaths, fourteen abdominal hysterectomies with four deaths, nine ventral and umbilical hernias with no deaths and sixty-two double pus tubes with five deaths.

He alluded to the many cases in which it had been impossible to obtain the patient's consent to an operation, although he could confidently say they would be benefited thereby; of such were cases of diseased tubes suffering from recurring attacks of pelvic peritonitis and incurring the risk of having recto or vaginal fistula formed with perhaps fatal results. In cirrhotic ovaries, operation was not proposed until a year of local treatment had failed to obtain relief.

With regard to the conservative treatment of diseased ovaries, *i.e.*, cutting out cysts without excision of the organ, Dr. Smith stated that his experience led him to the conclusion that it was a mistake.

Among the interesting cases mentioned was one of obstruction of the bowels occurring ten days after removal of the appendages. At the second operation, performed nine hours after *æ*cal vomiting had set in, the bowel was found kinked and adherent to the abdominal wall, and on being freed a perfect recovery resulted.

Seven cases of tubal pregnancy, in four of which a correct diagnosis had been made, were reported. All recoveries. The particulars have been already published.

Hernia following operation had been unknown during the last three or four years; this he attributed to the fact that the sutures were left in place for one month. Since using the Trendelenburg posture, drainage had been practically discarded altogether; the abdomen was flushed out with a large quantity of salt solution, and from one to eight quarts of it left in the abdomen. This procedure served to satisfy thirst, prevent adhesions, wash out the kidneys and strengthen the pulse.

Dr. F. A. LOCKHART thought that Dr. Smith was to be congratulated on his success with his cases of ectopic gestation. He felt that the question of conservative surgery was a trying one, whether it arose concerning the surgery of the pelvis or that of other parts of the body. It was always a difficult matter to decide whether or not one ovary was to be left, but thought this should always be done when it was healthy. Even if after operation the remaining organ gave trouble, this was often to be accounted for by its increased activity, causing it to become swollen and tender, and rest and local treatment often effected a cure.

Stated Meeting, November 26th, 1897.

ROBERT CRAIK, M. D., PRESIDENT, IN THE CHAIR.

Dr. R. A. Kerry and Dr. D. D. McTaggart were elected ordinary members.

LICHEN RUBER.

Dr. F. J. SHEPHERD exhibited a patient, a man aged 35, who had suffered from lichen ruber for seven years. Coincident with the appearance of this disease he became paralysed in the left side; especially was the paralysis marked in the left arm. The patient's appearance was very characteristic; the general redness of the surface, with some healthy patches of skin on abdomen and back; the loss of hair of head, eye-brows, eye-lashes, pubic hair, and axillary hair; the ichthyotic appearance of the skin in parts and in other places such as legs, elbows, buttocks, the acuminate condition of the eruption about the hair follicles and the plugging of the follicles with dried epidermis; the absence of any tendency to form vesicles or pustules.

This disease is sometimes called "pityriasis rubra pilaris," and there has been much discussion about it, it having been confounded with pityriasis rubra, lichen planus, etc. It was first described by Duvergie, then more fully by Hebra, who included with it the lichen planus of Erasmus Wilson, which inclusion has caused much confusion.

The prognosis is always grave, no case of true lichen ruber having had a favourable termination. Treatment is of but little use. Cod liver oil and local washings and the application of unguents is all that can be done. Arsenic is only of use in the early stages.

The paralysis existing in this patient Dr. Shepherd thought was an accidental complication and not the result of the disease.

Dr. W. F. HAMILTON, a few months since, had had under his care an old gentleman of sixty years of age suffering from Bright's disease, whose body from head to heels was covered with an eruption presenting the following characteristics: Very deep redness, desquamation, areas of a peculiar coppery colour, evidently staining due to former involvement of the part, enlargement of the glands in the neck and axilla, and extensive papular areas which seemed due to local irritation from scratching. Dr. Hamilton had been puzzled between lichen ruber and pityriasis rubra. The disease had lasted twenty years and involved every part except the face and the hands. Finally, the case was looked upon as one of pityriasis rubra with nephritis. The patient died a few weeks ago from Bright's disease.

REMOVAL OF FOREIGN BODY FROM THE CHEEK.

Dr. J. M. ELDER exhibited a steel pen which he had removed from the cheek of a young man. The history, in brief, was as follows:

The patient, aged twenty-four, consulted him for a swelling

on the left cheek; and, on examination, a fluctuating tumour was found high up under the zygoma at the anterior border of the masseter muscle. Seventeen years previously, while running with a pen in his hand, the boy had fallen and the penholder had entered his left cheek in an upward direction opposite the angle of the mouth. The penholder was withdrawn, and as there was no nib on it none was supposed to have been there at the time of the accident. On opening through the buccal mucous membrane, some fluid and pus escaped, and Dr. Elder had great difficulty in removing small portions of the nib that were caught in the forceps. The wound soon healed, but two weeks later a fluctuating abscess formed opposite the old scar on the skin. This was incised and by means of a fenestrated Volkman's spoon, the pen, as shown, was turned round, the point gripped with the forceps, and drawn out without difficulty. The interesting point of the case was the length of time a steel object could remain in the tissues without being very much corroded, and without causing any symptoms.

Dr. ROLLO CAMPBELL referred to a case he had seen in the London Hospital of a somewhat similar nature. A patient shortly after being sent in was found to have some interference with the venous return through the back of the orbit and died that night with symptoms of pressure on the brain. At the autopsy, a portion of a penholder was found, the supposition being that it had entered through the nose.

DIABETES MELLITUS.

Dr. RIDLEY MACKENZIE reported this case.

Stated Meeting, December 10th, 1897.

ROBERT CRAIK, M.D., PRESIDENT, IN THE CHAIR.

Drs. W. M. F. Nelson, M. Lauterman and G. D. Robins were elected ordinary members.

INTRALIGAMENTOUS MYOMA.

Dr. WM. GARDNER reported this case, and exhibited the tumour which he had removed as follows:

Madame V., æt. 32, married nine years, nullipara, was admitted to the gynæcological service of the Royal Victoria Hospital on November 6th, 1897, complaining of abdominal pain and enlargement, profuse and painful menstruation, and difficult and painful micturition and defæcation.

Soon after her marriage the patient noticed a lump of the size of an orange in the hypogastrium. There was progressive enlargement for two years subsequently, when a surgeon of another city operated, removing a part of the tumour. The same surgeon again operated two years later, but with only partial success.

On examination the abdomen was enlarged equal to a six months' pregnancy by an uneven, very firm, almost hard, fixed mass. Vaginal palpation revealed the pelvic cavity completely filled almost to the lower outlet by the tumour. The examining finger

could be passed upwards only close to posterior surface of the pubes, but could not be made to reach the cervix uteri or fundus of the vagina. The operation was exceedingly difficult, tedious and long, involving, as it did, a most extensive enucleation, during which important blood-vessels and the left ureter must have been in imminent danger. The position of the uterus and bladder pushed up into the abdominal cavity, and to the extreme right of the pelvic brim, must have involved immense stretching of this duct, and a very close relation to the tumour, in a furrow of which it may have lain, as so often observed in similar cases. These dangers were, however, averted.

The altered relations of the peritoneum, by reason of the situation, size and direction of the tumour, were interesting. The anterior lamina of the broad ligament was raised so that on the left side the perineum was separated from the anterior abdominal wall to the extent of at least eight inches, while behind the tumour had separated the layers of the meso-colon of the sigmoid flexure and lay closely in contact with it.

The operation was completed by amputation of the uterus at the supra-vaginal cervix, and the packing of the enormous cavity, now, however, much contracted, by iodoform gauze. The considerable loss of blood and long duration of the operation brought the patient before its close to a very critical condition. By the use of sub-mammary transfusion of normal salt solution and hypodermics of strychnia, she was kept alive and got to bed. Reaction was not fully established till six hours later.

Convalescence has been retarded by a severe attack of bronchial catarrh and some suppuration of the cavity whence the tumour was enucleated, but there is no reason to doubt ultimate complete recovery. The weight of the tumour was six pounds.

Dr. F. J. SHEPHERD asked, regarding the enucleation of these large tumours, whether it was ever done rapidly, or always slowly, as in the present case, ligating the vessels as one went along. From his experience with tumours of the thyroid he had come to the conclusion that the slow method was always the best, the rapid being often disastrous.

CASE OF RUPTURED TUBAL PREGNANCY—LAPAROTOMY— RECOVERY.

Dr. G. T. Ross said that he had visited the patient (on 28th November), and her history in brief was as follows; After the last *accouchement*, ten years previously, menstruation had been regular until November of the present year, when about a week after the ordinary period she had had another bloody discharge, lasting seven days, and, following that, more or less nausea and vomiting until, on November 26, she had unusually severe pain on the right side for twenty-four hours with chills and fever. The family physician at the last named date called in a consultant, when pregnancy was diagnosed and a favourable prognosis given. Three days later Dr. Ross was asked to see her, and the following condition was present:

Patient was found with a temperature of $101\frac{1}{2}^{\circ}$, and pulse of 122, great prostration, blanched face and anxious countenance. Nausea and vomiting were present. There was great tenderness over the abdomen extending up to the epigastric region, but palpation gave no evidence of any special resistance or any tumour. *Per vaginam*, the uterus was not found enlarged, but there was specially great tenderness on the right side of this organ. Although there were few positive symptoms pointing to extra-uterine foetation, he regarded the case as such, to the exclusion of other conditions, considering that rupture of a tubo-ovarian gestation would account for most of the symptoms. On his advice the patient was removed to the hospital and a laparotomy performed.

Dr. LAPHORN SMITH reported the operation as follows: The patient, whose history has been already given by Dr. Smith, was a Jewish woman, Mrs. K., 28 years of age. The operation took place just a week ago to-day, and there is hardly any doubt but that she will make a good recovery.

On examining her I found her with a very weak and rapid pulse, slightly elevated temperature and distended abdomen. On examination the uterus was found normal in size and position, and nothing could be made out the matter with the tubes and ovaries. It was thought advisable to delay operating a little until the bowels could be moved and the pulse improved. This proved unwise, however, for her pulse grew worse, until it reached 150, and in twenty-four hours she was vomiting worse than ever, some of the ejecta appearing decidedly fecal. This led me to suspect the possibility of obstruction of the bowel, and made me more anxious still to operate at once and at all hazards, although she refused to submit to operation until the last minute. On opening the abdomen, back blood gushed forth, and on introducing the hand large clots could be felt filling the cavity. The right tube, from which the blood was pouring, was seized and tied and removed with the ovary. The foetus, about an inch and a half long, was found among the clots. The foetus and placenta had been expelled through the tear in the tube, the distended and torn tube being entirely empty. The quantity of clot and fluid blood removed was estimated by my assistants at between three and four quarts. After this had been removed a gallon of hot salt solution was poured into the abdomen and left there. Besides that she received three quarts of salt solution by enema the first day, which she retained, and two quarts the second day, by the end of which time her pulse, which was 150 before the operation, had fallen to 80. I think we have reason to be proud of our profession when we see a general practitioner of it diagnosing accurately and at once such an obscure case. Unless this diagnosis had been made and acted upon, this woman was condemned to certain death.

This is my ninth case of laparotomy for tubal pregnancy, and so far all the patients have recovered.

I would like to call attention to the value once more demonstrated in this case of artificial serum in the abdomen and administered by enema. The result on the patient's pulse was marvellous and unmistakable.

INTESTINAL RESECTION IN A CHILD AGED FOUR.

Dr. E. A. ROBERTSON read the report of this case.

SIR WM. HINGSTON said he had nothing to add to the report of the case, which was very clearly given; but had a suggestion to make in the way of a correction of terms. He had always objected to the term "exploratory incision," as he did not consider that an operation for the purpose of establishing diagnosis was justifiable. In this case it was not an exploration; the diagnosis was made beforehand, and not till then did they proceed to perform the operation. Although death had taken place, it did not alter his opinion that the operation was a justifiable one, and the only one possible under the circumstances.

Dr. F. J. SHEPHERD was much interested in the case, but must take exception to some points raised by Dr. Robertson. He did not believe in fæcal accumulation as a cause of tumour; when there was a fæcal accumulation it was always produced by a stricture either malignant or otherwise. No operator had ever seen such a condition simulating tumour, and he was not aware that any pathologist had ever seen it *post-mortem*. Another point was the mortality statistics presented by Dr. Robertson; in abdominal surgery old statistics were useless, or worse, they were misleading; methods had so altered in the last ten years that one should not go back beyond that period to obtain a basis for estimating mortality. He did not agree with Sir William Hingston concerning the uselessness of exploratory operations; he thought in cases like this it was impossible to make a positive diagnosis, and that an exploratory operation was justifiable. He would like to ask how Sir William, in this case, made a positive diagnosis of mesenteric tumour. He would like to draw Dr. Robertson's attention to a paper on Solid Mesenteric Tumours in the July number of the Annals of Surgery, where 57 cases are collected, also to the speaker's own case which was shown to this Society last winter.

SOME RECENT GALL-STONE CASES.

Dr. JAMES BELL read a paper with this title.

Dr. F. J. SHEPHERD considered cholecystotomy one of the most successful operations in modern surgery. Incision of the common duct was not to be classed in the same category, as it was a much more serious operation. He was surprised that among such a large number of cases there was no case of malignant disease. The frequency with which gall-stones existed in the female gall-bladder was not sufficiently recognized. Dr. Shepherd thought it was due to the constriction of the abdomen which caused obstruction of the cystic duct. In a case last summer, the speaker had cut down and come upon a distended gall-bladder which simulated appendicitis. The case recovered.

Dr. SHEPHERD also asked whether, after incision of the common duct, Dr. Bell preferred to sew it up or simply to pack it round with gauze, leaving in a drainage-tube. In a recent article, Mr. Jordan Lloyd mentions that he cut down on the ureter for impacted

stone; after first making an abdominal incision to determine the place of the stone, he opens into the ureter outside the peritoneum and does not close the incision up again; no leakage of urine took place from the incision in the duct.

Dr. W. F. HAMILTON referred to the following case of cholelithiasis as of interest. A young French-Canadian, a painter, came to the hospital complaining of severe pain in the region of the liver off and on for five to seven years. At that time there was a slight icteroid tinge to the conjunctiva; the urine contained bile, and there was tenderness over the gall-bladder. The temperature was slightly raised. The speaker suspected catarrhal duodenitis, and expected catarrhal jaundice to develop. The following morning, however, on examining the stools, quite a large gall stone was found. The surface of the stone suggested the presence of others. He left the hospital in a few days fully relieved.

Dr. G. A. BROWN drew attention to the fact that some days might elapse after the stone had left the duct before it appeared in the stools. He related one in which three days had passed before it was found in the stools.

Dr. E. A. ROBERTSON thought the statement that the stone was sometimes passed without causing any symptoms was most improbable.

Dr. BELL, in reply, said that two of the cases had been sent to him as cases of appendicitis, and that the physical signs and symptoms had given good ground for this diagnosis. He always sutured the gall-bladder to the peritoneum only, and always closed the incision in the ducts by suture, using fine silk as suture material. He also introduced a drainage tube and packed off the space with gauze, but did not feel safe in trusting to these alone; where it was possible, he preferred to close the incision by suture. He did not think the incision in the ureter, as mentioned by Mr. Jordan Lloyd for the removal of ureteral calculi, was quite a parallel case, as there was always a great flush of bile when the stone was extracted from the common duct. Besides, the ureteral wound was entraperitoneal. He was quite sure that gall-stones often existed for a very long time without giving rise to any symptoms, and referred to case IX. in this series as evidence that a number of stones had existed for a long time in the gall-bladder, and only gave rise to symptoms when disturbed by an accident. One case had had high runs of fever, and three of the cases where cholecystitis existed (besides the typhoid case) had had moderate fever. He had not discussed the prevention of gall-stones, as the cases reported were those in which the stones not only already existed, but had given rise to serious symptoms. He was quite sure, however, that the size and number of the stones found in a given case was not determined by the age or sex of the patient. In general terms, he thought it might be stated that stagnation of the bile in the gall-bladder was an important factor in the causation of gall-stones, and that constriction of the waist as seen in women, and certain positions, such as that assumed by a man sitting at a desk, contributed to this end by making it more difficult for the gall-bladder to empty itself.

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Editorial.

COMPLIMENTARY SUPPER TO DR. W. H. DRUMMOND, AUTHOR OF "THE HABITANT."

Few authors have their first literary ventures so thoroughly appreciated and the true merits of their production so early recognized as has Dr. Drummond, our esteemed *confrère*, in the issue of his book of poems entitled "The Habitant."

The new field from which the material of these poems has been culled is one belonging almost entirely to our Province of Quebec, and has, under the hand of one who during a lifetime has been able to observe all the traits of character peculiar to the habitant, proved a fertile source of interest, and the author, who is thoroughly imbued with true poetic genius, has woven in a unique production descriptive and historical pictures of their peculiarities, brimming with pathos and humour.

It is not surprising that readers in this Province who are familiar with the characteristic features of this class of our rural population and their attempt to express themselves in English should thoroughly appreciate the truthful representation these poems convey, but it is a matter for the fullest congratulation to Dr. Drummond and this country that this work has been eagerly sought after and praised not only by readers in Canada but throughout the United States and in England, so that publishers and author have been gladdened

by the demand for edition after edition in a manner quite unprecedented in the annals of Canadian authorship. Hence it is easy to understand the appropriateness of the slight token of appreciation conveyed in the complimentary entertainment given to Dr. Drummond by his *confrères* in this city. For once, the members of our profession in meeting together eschewed medical topics entirely, and the after-dinner oratory, songs and recitations suited the event which the gathering was intended to celebrate. We thoroughly sympathize with the sentiments of Dean Craik as expressed during the evening, when he urged more recreation for the members of our profession in the way of keeping abreast in general literature, and dropping entirely from time to time medical subjects and taking more interest in general literature, art and science and subjects other than professional. This spirit of outside interest, and even of a disposition to contribute to general literature, seems to be growing in our profession. We may not all possess the attainments of a Conan Doyle, an Oliver Wendell Holmes or a Drummond, but occasional attention to topics outside of medical would serve as a recreation and broaden our ideas, and put us more in harmony with the highest interests of the community in which we reside. It is interesting to note in this connection that two novels have recently appeared in the United States by members of the Medical Profession. One by S. Weir Mitchell, entitled "Hugh Wynne, Free Quaker, some time Brevet Lieutenant Colonel on the Staff of His Excellency General Washington." It is said to have had a very large sale, and to be a charming historical novel, very interesting, with artistically depicted characters, and giving an insight into the character of one of the noblest names in history, George Washington. This is only one of a number written by Dr. Mitchell. The other is by Dr. Alexander J. C. Skene, entitled "True to Themselves. A Psychological Study"—his first venture in this line, and is said to be worthy of the eminent medical author. We give the following account of the supper to Dr. Drummond as reported by the *Montreal Medical Journal*.

On the evening of December 23rd, Dr. W. H. Drummond was entertained at supper in the St. James Club by the

following medical friends: Drs. Armstrong, James Bell, Birkett, A. A. Browne, K. Cameron, F. W. Campbell, G. G. Campbell, Craik, Elder, England, Evans, Finley, W. Gardner, Garrow, Girdwood, W. D. Hamilton, W. F. Hamilton, Sir W. Hingston, J. A. Hutchison, Lachapelle, Lockhart, McCallum, McCarthy, McConnell, Tait McKenzie, McPhail, Perigo, Shepherd, Grant Stewart, J. Stewart, Webster, Wilkins, C. W. Wilson.

The supper was decided upon only two or three days beforehand, and no effort was made to organize a large and formal gathering. Had such a plan been attempted there would have been no difficulty in getting together a very much larger body of Dr. Drummond's medical brethren, who would have been glad to do honour to the author of "The Habitant."

The Chair was occupied by Sir William Hingston, who presided with his customary grace and dignity, his remarks being at all times characterised by their fitness and felicitousness. After the toast of "The Queen" had been drunk, Sir William proposed "Our Guest" in a very happy speech, expressing the genuine congratulations of those present on Dr. Drummond's literary venture, with the hope that it might be only the precursor of a long series of successes.

Dr. Drummond replied in the following words:

Mr. Chairman and Gentlemen, or if you will permit me to use the term inclusively, *friends*, I am naturally very proud, and very, very grateful for the position in which I find myself placed to-night, for in the wildest flights of imagination the diaphanous casement of my brain (as dear old Father Prout puts it) had never, I assure you, been penetrated by the thought that some day, "Some day," or rather some evening, my beloved *confrères*, the medical men of Montreal, would extend to me the honour of a dinner—and when the news was gently conveyed to me the other day by our genial friend, Dr. Armstrong, it was as unexpected as undeserved. However, when a committee of physicians and surgeons, such as the present one, unanimously decide upon the line of treatment in any particular case, what can the wretched victim do but submit quietly to the anæsthetic and let them "Fire away, Flanagan."

But seriously, Mr. Chairman and Gentlemen, Why this special act of favour? Was it a recognition of the fact that my attempt to provide for our country a literature purely "Canayen" in character had met with a partial degree of success?

It could not have been for any other reason. My name will probably never be found in medical text-books, attached

for instance to some great medical or surgical discovery, but in conjunction with my good friend, Dr. Charlie Wilson, perhaps for a few years there may linger in the minds of those present to-night, memories (not altogether unpleasant I hope) of the Wilson-Drummond enunciation; for, gentlemen, I have no hesitation in saying that, so far at least as *you* are concerned, to Dr. Wilson belongs the major part of the *discovery*. For from the very first moment that the Doctor left his native fastnesses of Buckingham, P. Q., for, possibly, the more congenial atmosphere of Montreal, he patiently experimented and demonstrated, largely before medical audiences, until now the Wilson-Drummond enunciatory *rôle* is apparently accepted by some of the most distinguished men in the profession.

“There was a Duke of Buckingham, who never did a thing
But strut around the court, and keep the lasses on a string,
I believe His Excellenza was perhaps a trifle gay,
But the *present* Duke of Buckingham isn't built that way.”

No, gentlemen, Dr. Wilson was the first to recognize the premonitory symptoms of the hitherto unknown Canadian disease. What did he do? Being of course a firm believer in the science of inoculation, he at once proceeded to infuse, cautiously perhaps at first, little by little, virus, supplied *not* from the laboratory of Merck, but from the Wilson-Drummond laboratory, into the systems of those who would consent to the operation, the Doctor, naturally, hoping by this means to stay the threatened march of the disease. Medical men are ever, in the interests of science, among the first to risk experiments, hazardous not only to life, but also to reason, and many underwent the painful ordeal. The disease, however, continued to spread; the devoted Doctor laboured assiduously, and the amount, especially of night work, which he was compelled to undergo, threatened seriously to undermine his health.

New centres of contagion sprang up, and the disease, which at first was purely *endemic*, at last became *epidemic*, and the unfortunate enthusiast of inoculation was reduced to despair.

Finally, one never-to-be-forgotten evening, while the Doctor and myself were closeted together in the sacred recesses of my most private boudoir (garnished with the usual accompaniments) he, my friend, Dr. Wilson, broke the Sabbath stillness of the surrounding air by exclaiming, “Billy, for God's sake what is to be done? You will have to write a text-book, a kind of *vade mecum*, paying particular attention to the disease which I, alas! have so vainly endeavored to combat. Then everyone can have the disease all to themselves, and *stick to it*.”

And this, gentlemen, is the story of “The Habitant.”

In the analysis of everything that is human, the medical man is indeed a *specialist*; therefore, if in painting types, in delineating human weaknesses, passions, and foibles, I have gained your applause, I am more than satisfied that my work has at least been *fairly* well done."

After Dr. Drummond's speech, a very pleasant time was spent, contributions in the shape of song, speech or story being furnished by each one present. It is impossible to refer to these in detail, yet it will not be invidious to single out two or three for special mention. Dr. Wilson's recitations of selections from "The Habitant" were a great treat. They were rendered in a most sympathetic spirit and with rare artistic finish. There is no doubt, as the Chairman stated, that a considerable proportion of the interest which has been taken in Dr. Drummond's poems, in Montreal at least, has resulted from Dr. Wilson's masterly presentation of them during the past few years.

Dr. Drummond's reading for the first time of a new poem entitled "*Phil-O-Rum's Canoe*," was listened to with keen interest.

Another feature of the evening was Dr. Craik's closing speech, which focused the attention of all present. In a few well chosen sentences, the Dean spoke weighty words of wisdom regarding the importance of literary studies to the medical man, who, too often, owing to the pressure of his work, allowed his mind to be cramped within the purely professional limits of his life. He urged upon his hearers the value of continual attention to "*Belles Lettres*," not merely as a pleasant recreation in itself, but also as a means of opening new avenues of interest, of keeping the mind in a sympathetic attitude towards the whole world of thought—in a word, of enabling them to attain the highest ideal of the cultured physician.

We congratulate Dr. Drummond on the success of the supper given in his honor; still more on the triumphal progress which his book has made.

We doubt if any poet has ever known ten thousand copies of his first volume to be bought by a ravenous public within a few weeks of publication. Yet this has been Dr. Drummond's good fortune.

We do not know what his future literary ventures may be, but we feel sure that they will be worthy of the man,—worthy of his first success. Modern literature has too many examples of men who having achieved fame by their early strenuous labours, thereafter pour forth their drivelling, slovenly stuff upon the credulous public.

It is some satisfaction, however, to know that such per-

sons sooner or later find their Gehenna, though too often with the spoils of unrighteous mammon, which they have gathered in their downward course.

We trust also that Dr. Drummond, having proved himself a master in delineating various types of French-Canadian character in the well-known patois of the *habitant*, will soon cultivate the muse in pure rich mother English.

Dr. Drummond's work is an evidence of his exquisite cultured poetic faculty.

It is not too much to expect that, following Kipling's example, in having first achieved a reputation as a truthful and sympathetic painter of the scenes and types familiar to him from early days, he may wander far afield in fancy's realms, achieving for himself a splendid reputation as one of the great imperial singers of our race.

PROVINCIAL MATRICULATION EXAMINATION.

Dr. Belleau, Secretary of the College of Physicians and Surgeons, has received the following bill from Major Pinault, M.P.P., sanctioned Saturday last, and we have to thank him for forwarding us a copy. It is very important to medical students:—"An Act to amend the law respecting admission to the practice of medicine in certain cases. Whereas there are at present in the Universities of this Province nearly two hundred students who have commenced attending the medical course before having obtained a certificate of admission to the study of medicine; whereas the fact of their not having been regularly admitted to the study of medicine exposes them to lose the benefit of several years of medical studies; therefore Her Majesty, by and with the advice and consent of the Legislature of Quebec, enacts as follows:—1. Notwithstanding article 3,978 of the Revised Statutes, the College of Physicians and Surgeons of the Province of Quebec is authorized to admit to practice the medical students who, on the first of November, 1896, had commenced attending the medical course in a duly incorporated University of the Province of Quebec, before having obtained a certificate of admission to the study of medicine, and to grant them the necessary license to practice medicine, surgery and obstetrics in the Province after having passed the examinations required for admission to study and those required for admission to practice. 2. This Act shall come into force on the day of its sanction."

PUBLISHERS DEPARTMENT.

CONTINUED GOOD RESULTS.

The January 1894 number of *The Quarterly Journal of Inebriety* published under the auspices of the American Association for the Study and Cure of Inebriates, Hartford, Conn., U.S.A., says through its able editor, T. D. Crothers, A.M., M.D.—“Antikamnia is one of the best remedies in influenza, and in many instances is very valuable as a mild narcotic in neuralgias from alcohol and opium excesses. We have used it with best results.” In a letter of more recent date to the Antikamnia Chemical Company, Dr. Crothers writes: “Antikamnia continues to improve in value and usefulness, and we are using it freely.” *The Edinburgh Medical Journal*—Scotland—says, regarding antikamnia: “In doses of three to ten grains, it appears to act as a speedy and effective antipyretic and analgesic.” *The Medical Annual*, London, Eng., says: “Our attention was first called to this analgesic by an American physician who we saw in consultation regarding one of his patients who suffered from locomotor ataxia. He told us that nothing had relieved the lightning pains so well as antikamnia, which at that time was practically unknown in England. We have since used it repeatedly for the purpose of removing pain, with most satisfactory results. The average dose is only five grains, which may be repeated without fear of unpleasant symptoms.”

The Living Age issues for January show that the spirit of its founder still lives; but they show more. Their contents are gleaned from a wider field, and there is an up-to-dateness in the articles which evidence renewed life and vigor. The recent enlargement of the magazine, the addition of new departments, the widening of its scope by the introduction of translations from prominent Continental authors on topics of present interest, and the presentation of American literature, are evidences of enterprise that will be appreciated by its readers, and furnish what was needed to make *The Living Age* a complete compendium of the world's best current literature.

Space will allow for the enumeration of a few only of the many papers presented in the January numbers. These include “Brunetiere's Impressions of America,” from the *Revue des Deux Mondes*; “The Unrest of the Nations,” from the *Spectator*; “Modern Education,” by Prof. J. P. Mahaffy; “Ramozan,” by Hugh Clifford; “Blackwoodiana,” by Herbert Maxwell; “The Dual and Triple Alliance and Great Britain,” by Francis de Pressense; “Henrich Heine: A Centenary Retrospect,” by Edward Dowden; “Women at Oxford and Cambridge,” from the *Quarterly Review*; “Some Reminiscences of Thomas Henry Huxley,” by St. George Mivart; “The Evolution of the Idea of God,” by Andrew Lang; “Black and White Rights in Africa,” by H. R. Fox Bourne; “The Farm and the City,” by Walter Besant; “Scandinavian Literature,” by David Anderson, and “The New Learning,” by Herbert Paul. Fiction includes an instalment in each number of the serial “With All Her Heart,” from the French of René Bazin; “Louey,” a touching story of self-sacrifice; “A Simple Story,” by Mme. Marguerite Poradowska, adapted for *The Living Age*, and several short stories. The Poetry is also worthy of mention, notably “Old Lovers,” by E. Nesbit, and “In the Twilight,” by E. S. S. W.

The publisher's offer of the eight numbers of 1897, containing the opening chapters of the serial “With All Her Heart,” free to all new subscribers for the year 1898, still holds good. Send \$6.00 to The Living Age Co., Boston, and receive the benefit of this offer. In no other way can so much reading matter of equal quality and variety be obtained.

Wanted—Trustworthy and active gentlemen or ladies to travel for responsible, established house. Monthly \$65.00 and expenses. Position steady. Reference. Enclose self-addressed stamped envelope.

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