Technical and Bibliographic Notes / Notes techniques et bibliographiques

The Institute has attempted to obtain the best original copy available for scanning. Features of this copy which may be bibliographically unique, which may alter any of the images in the reproduction, or which may significantly change the usual method of scanning are checked below.

L'Institut a numérisé le meilleur exemplaire qu'il lui a été possible de se procurer. Les détails de cet exemplaire qui sont peut-être uniques du point de vue bibliographique, qui peuvent modifier une image reproduite, ou qui peuvent exiger une modification dans la méthode normale de numérisation sont indiqués ci-dessous.

- ☐ Coloured covers / Couverture de couleur
- ☐ Covers damaged / Couverture endommagée
- ☐ Covers restored and/or laminated / Couverture restaurée et/ou pelliculée
- ☐ Cover title missing / Le titre de couverture manque
- ☐ Coloured maps / Cartes géographiques en couleur
- ☐ Coloured ink (i.e. other than blue or black) / Encre de couleur (i.e. autre que bleue ou noire)
- ☐ Coloured plates and/or illustrations / Planches et/ou illustrations en couleur
- ☐ Bound with other material / Relié avec d'autres documents
- ☐ Only edition available / Seule édition disponible
- ☐ Tight binding may cause shadows or distortion along interior margin / La reliure serrée peut causer de l'ombre ou de la distorsion le long de la marge intérieure.

- ☐ Coloured pages / Pages de couleur
- ☐ Pages damaged / Pages endommagées
- ☐ Pages restored and/or laminated / Pages restaurées et/ou pelliculées
- ☑ Pages discoloured, stained or foxed/ Pages décolorées, tachetées ou piquées
- ☐ Pages detached / Pages détachées
- ☑ Showthrough / Transparence
- ☑ Quality of print varies / Qualité inégale de l'impression
- ☐ Includes supplementary materials / Comprend du matériel supplémentaire
- ☐ Blank leaves added during restorations may appear within the text. Whenever possible, these have been omitted from scanning / Il se peut que certaines pages blanches ajoutées lors d'une restauration apparaissent dans le texte, mais, lorsque cela était possible, ces pages n'ont pas été numérisées.

☑ Additional comments / Commentaires supplémentaires: Continuous pagination.

The Canada Medical Record.

VOL. XXI. MONTREAL, MARCH, 1893. No. 6.

CONTENTS.

Original Communications.

PHYSICAL EDUCATION IN RELATION TO MENTAL DEVELOPMENT IN SCHOOL-LIFE.

BY THOMAS MORE MADDEN, M.D., F.R.C.S.ED.

The respective claims of physical and mental training, and the evils arising from the neglect or abuse of either, are obviously questions of the highest medical as well as social interest. This neglect now presents itself in two different aspects—on the one hand, the children of the poor in England are compulsorily subjected at an absurdly early age to a forcing and injurious system of mental cultivation. Whilst, on the other hand, in the case of those of a better social position, the physical powers are not uncommonly overtrained at the expense of the mental faculties. Of these errors, the former is the most important, and to its operation is, I believe, largely ascribable the apparent diminution of physical stamina observable in too many of the youth of the present day as compared with the physically more robust, if intellectually less cultured, generation of the pre-educational period. Looking at the overtasked and anæmic little children now chained to the desk by the School Boards, we might be tempted to believe

> "'Twas not the sires of such as these
> Who dared the elements and pathless seas;
> But beings of another mould—
> Rough, hardy, vigorous, manly, bold!"

At the present time, a large part of the first ten years of life, which should be primarily devoted to physical and moral training, is given up to the development of the mental powers: the child, when a mere infant, being compelled to attend some school, where the immature brain is forced into abnormal and disastrous activity. On its return home, jaded in mind and body to prepare for next day's task, such a child is necessarily unfit for the enjoyment of the physical exercise which is essential for its bodily development and

health, or for the still more important elementary training of the affections and moral faculties and instilment of religious principles, which are better acquirable from home teachings than from any School Board system. We are all of course agreed as to the duty of properly educating children so as to fit them mentally and bodily for the increasing requirements and competition of modern life. But as to the extent to which the former should be carried and the latter neglected in early childhood, there is unfortunately a great discrepancy between the rulers of the Education Department and the views of those who have to deal in disease with the consequences of the violation of the laws of nature. And hence, whilst little children are thereby overworked into disease or death, the physician must still raise his protesting voice, albeit it would apparently seem unheeded.

During the first eight or ten years of child-life, the amount of mental cultivation which a child's brain is capable of receiving with permanent advantage is much less than is commonly believed. No greater physiological mistake is possible than that of attempting any considerable degree of such culture until the sufficient development of the physical stamina and moral faculties is accomplished. The organ of the mind is as much a part of the body as the hand, and ere either can function properly, its vital force must be fostered and maintained by nutrition and developed by physical exercise. A large proportion of those who come within the provisions of the Elementary Education Code are semi-starved children of the poorest class, who, when thus debilitated by privation, are necessarily as much incapacitated for any mental strain as for the accomplishment of any herculean feat of physical strength, it being not less inhuman, injudicious and impolitic to expect the former than it would be the latter from those so circumstanced.

If the State, for reasons of public policy, determines that all children shall be compulsorily educated from their earliest years, it should certainly afford the means by which this may be least injuriously and most effectually carried out, by providing food and physical training as well as mental education for every pauper child attending an Elementary school.

Amongst the results of over-pressure in such schools under the Boards referred to are brain disease in all forms—viz., cephalitis, cerebritis and meningitis, as well as headache, sleeplessness, neuroses of every kind, and other evidences of cerebro-nervous disorders. On no other ground can the increasing prevalence of these affections amongst the little victims of the Educational Department be accounted for or explained, than by ascribing them to the new factors, "brain excitement" and "over-pressure," which in the case of young children are now too commonly disastrously associated with the process of misdirected education and neglected physical training.

In connection with the physical management of childhood, I may add a few words on the abuse of alcoholic stimulants. The evils resulting from the abuse of alcohol were never so prevalent as at present, and are traceable in the diseases of youth as well as in those of adult existence. The results of this acquired or inherited alcoholism are brought under clinical observation in the form of cerebral gastric and hepatic disorders, and especially cirrhosis of the liver, which as well as the protean forms of cerebro-spinal disease, and the various neuroses, are so frequently noticed in hospitals for children, and to which I have elsewhere directed attention. In the majority of these cases of juvenile alcoholism that have come under my care in the Children's Hospital, Dublin, this tendency appears inherited and most marked in those whose mothers were inebriates—intemperance in

women also bearing in other ways on the diseases treated in hospitals for children, where its effects are strikingly evinced by the moral and physical deterioration of the offspring of the drunken, and by their special predisposition to strumous, tubercular and other constitutional taints.

Under no circumstances should alcoholic stimulants be given to children, save in the guise and defined doses of other remedial agents—my experience in hospital and private practice, at home and abroad, having amply confirmed the view expressed in a work of mine published many years since, viz., that it is physiologically wrong, as well as morally unjustifiable, ever to allow a healthy child to taste alcohol in any form.

THE TREATMENT OF INCOMPLETE ABORTION.

By Edward P. Davis, A.M., M.D., *Professor of Obstetrics and Diseases of Infancy in the Philadelphia Polyclinic, Clinical Lecturer on Obstetrics and Gynæcology in the Jefferson Medical College, Clinical Professor of Diseases of Children in the Woman's Medical College of Philadelphia, etc.*

It is my purpose in this paper to discuss incomplete abortion, not the result of criminal interference; complete abortion, or the expulsion of the entire ovum without the assistance of the physician, will not be considered.

Incomplete abortion is most common in cases where a physician is not summoned at the beginning of the process. If called in time, before considerable hemorrhage has occurred, the physician may be able to check the abortion, or, by judicious management, to secure the expulsion of the ovum entire. In either event the prognosis for the mother's recovery is good, while in abortion checked by medical treatment the ovum may retain its vitality and secure adhesion to the lining membrane of the uterus.

Quite different is the case, however, where considerable hemorrhage with excessive pain has taken place before the physician sees his patient. He will frequently find her showing the effects of loss of blood, her clothing possibly stained with blood, and the birth-canal containing clots, or showing evidences of continuous but slight hemorrhage. Vaginal examination in these cases in multiparous women often reveals a portion of the ovum within the internal os uteri. If the genital canal be patulous, and the uterus be not firmly contracted, it will usually be possible for the physician to extract the remains of the ovum with his finger without especial difficulty. If the uterus be then thoroughly examined by the finger,—the patient anæsthetized, if necessary,—clots and *débris* are readily removed from the interior of the uterus, and a hot intra-uterine douche of creolin or carbolic acid, followed by the intra-uterine application of an iodoform gauze tampon, will complete the treatment of such a case.

It not infrequently happens, however, that even in multiparous women, after the first free hemorrhages have occurred with separation of the ovum, that the membranes rupture, the embryo escapes, and the placenta, with possibly the membranes, remains behind. If an interval of a few hours elapses before the physician's visit, he will frequently find in such cases the uterus contracted to such a degree that the introduction of the finger within the uterine cavity is impossible without forcible dilatation. Slight but persistent hemorrhage is often observed in this condition of affairs.

In primiparous women the uterus may so tightly contract upon a retained placenta or portion of an ovum that the introduc-

tion of a large uterine sound may be impossible a few hours after the actual escape of the embryo has taken place. This condition of contraction of the uterus with retention of a portion of the ovum is among the most trying and dangerous conditions which the physician is called to meet in obstetric practice. Radical statements are frequently made to the effect that such a woman is in immediate and great danger, and that the physician should not rest until the uterus has been forcibly dilated and the ovum eradicated. While there is danger in delay, if that delay be not accompanied by the observance of antiseptic precautions and by a judicious study of the processes by which nature treats these cases, there is greater danger in unwarranted interference, inflicting traumatism upon the genital tract, and exposing the patient to the added danger of septic contagion. It is a familiar fact that the uterus seeks to expel a foreign body, and that, sooner or later, a polyp which has become separated, a dead fœtus, a tampon introduced within the uterine cavity, are expelled by spontaneous uterine contraction. If this hint be taken, the practitioner will abstain from forcibly dilating a uterus holding in firm contraction a retained placenta, but will take advantage of the spontaneous relaxation and expulsive efforts of such a uterus, which, sooner or later, will bring the retained material within convenient reach of his finger or instruments. It cannot be too strongly insisted upon that such a policy is unsafe without the observance of absolute cleanliness and, better, antiseptic precautions. As illustrating the principles of treatment in thes ecases, I report the following instances of incomplete abortion, recently under treatment in the Maternity of the Jefferson Medical College Hospital:

Mrs. T., an anæmic, ill-developed woman, a multigravida, was brought by the ambulance to the Maternity in a condition of shock and collapse caused by profuse hemorrhage. The history given by the ambulance surgeon was that he had been summoned to the patient with the statement that she had just aborted at an early period of gestation; there were evidences of profuse and recent hemorrhage. The patient was made as clean and comfortable as possible, and brought at once to the Maternity.

On admission, she was exsanguinated; her pulse scarcely perceptible at the wrist; the surface of the body cold and clammy, her respiration sighing and feeble. Slight hemorrhage was present from the genital tract. The resident physician, Dr. Spencer, at once made an examination, finding the cervix uteri impervious to the finger without the exercise of considerable force. He accordingly tamponed the os uteri and vagina with iodoform gauze, carrying the end of the strip of gauze just within the cervix. The patient was then stimulated by hypodermic injections of strychnine and digitalis, by the external application of warmth, and the internal administration of alcohol and hot fluids. Two and a half hours after admission, the patient had reacted, and complained of slight uterine pain. The gauze tampon had become saturated with fluid blood, and slight oozing appeared at the vulva. As the patient's condition was favorable, and as the persistance of uterine pain since her admission gave reason to hope that if a portion of the ovum had been retained it would be found accessible, the patient was placed across a bed and the genital tract thoroughly irrigated with a one per cent. mixture creolin and hot water, at a temperature of 100° F. Digital examination revealed a small placenta in the cervix uteri, which had dilated sufficiently to admit the finger with ease. The placenta was removed by the finger, and the interior of the uterus thoroughly but gently curetted with the douch-curette, through

which a stream of hot creolin mixture constantly flowed. Decidua and clots were thus removed, the oozing of blood ceasing completely. The uterus was then tamponed with moderate firmness with a single piece of iodoform gauze, a portion of which filled the vagina without distending it. The patient required no subsequent treatment beyond the removal of the gauze twenty-four hours afterwards, and the washing out of the uterus at that time with the creolin mixture. An occlusion vulvar dressing was worn, and the external parts were carefully bathed with bichloride solution (1 to 2,000) after each micturition and defecation. Examination of the placenta showed it to be at about the eighteenth week of gestation. The relaxed condition of the patient's general muscular system, and the profuse hemorrhage from which she suffered, were explained in part by an examination of the thorax, where evidence of pulmonary consolidation, probably tubercular in character, was present. The placenta revealed no abnormity upon examination.

The difficulties often experienced in dealing with primiparous women are exemplified in the history of the following case:

Mrs. C., aged forty, married less than a year, a woman of good general development and health, was not positive that she was pregnant; while engaged in household work, necessitating the lifting of heavy articles she was taken with severe uterine pain and profuse hemorrhage. A physician was summoned, who diagnosticated threatened abortion. The hemorrhage, which at first had been profuse, gradually ceased, and on the following day the patient was brought to the Maternity in a carriage. On admission, it was found that a second free hemorrhage had occurred during the patient's transportation. The os and cervix were tightly closed, resembling those of the virgin woman. A slight but persistent hemorrhage was present. The vagina was moderately tamponed with aseptic cotton, thoroughly powdered with iodoform, and the patient kept quiet in the recumbent position. Twelve hours after admission the tampon was removed, the os and cervix remaining in the same impervious condition. A vaginal douche of bichloride of mercury solution (1 to 4000) was then given, and a tampon of iodoform gauze was applied. Eighteen hours after this the tampon was removed, when it was found that the os and cervix had considerably softened and partially dilated. A portion of the ovum, not distinguishable, was found within the cervical canal. Hemorrhage commenced with the removal of the tampon; the vagina was again douched, and a gauze tampon applied, the end of the gauze being inserted within the cervical canal. Uterine contractions with abdominal pain ensued, and slight staining of the gauze tampon was observed. There was no active hemorrhage, and the patient's pain and uterine contractions ceased after an hour or two. Four hours later hemorrhage began again, when the patient was anæsthetized, the tampon removed, and digital examination made, revealing an ovum at about the fifteenth week of gestation partially engaged in the internal os. The ovum was removed with the placental forceps and finger, its complete removal being accomplished by the use of the douche-curette, through which a stream of hot creolin mixture constantly flowed. The uterus was then tamponed with iodoform gauze, which was removed twenty-four hours afterwards and the uterus douched with creolin mixture. An uninterrupted recovery followed.

I desire to emphasize by the description of these cases the practical considerations which pertain in the treatment of incomplete abortion. Unless the physician is in possession of the complete ovum, no

abortion should be considered complete unless the interior of the uterus has been thoroughly examined by the finger or by the curette, and has been demonstrated to be empty. The history given by the patient is valueless as to the appearance of clots discharged, except in so far as it indicates a previous occurrence of considerable pain and hemorrhage. If pain and hemorrhage can be proved to have occurred, the escape of the embryo has probably taken place. There remains, then, for the physician the treatment of incomplete abortion. Thorough antisepsis, patience, and accurate observation of the condition of the uterus are prerequisites for success in treating these cases. We prefer the douche-curette whose edge is not a cutting edge, but is as sharp as that of a paper-cutter. The advantage of this instrument, originally devised by Carl Braun, is the little damage which it may inflict upon the uterus, and the fact that it permits the administration of an intra-uterine douche while the curetting is going on. In septic cases, where infected decidua and membranes are removed, the tampon of iodoform gauze may be replaced by a suppository, containing 60 grains of iodoform, and inserted into the fundus of the uterus; a narrow strip of gauze may be carried within the cervical canal, and the remainder packed about the os and cervix in the vagina.

Occasionally the uterus retains an ovum for an extraordinary period, its removal being finally accomplished without danger to the patient. Cholmogoroff* reports two cases of missed abortion which were remarkable for the length of time during which the ovum was retained. In the first of these cases the life of the embryo persisted for four months, while the product of conception was retained for seven months after the death of the embryo. The entire pregnancy persisted for eleven months. In the second case the embryo perished at three months, but was retained for two months after death in the uterus. In neither case was operative interference indicated; the patients were kept under observation, and the expulsion of the ovum followed spontaneously. Both patients made uninterrupted recoveries. Very similar instances are on record which serve to emphasize the fact that radical interference, without the co-operation of uterine dilatation and expulsive contractions, is contra-indicated in these cases.

The prognosis in cases of incomplete abortion depends upon the cleanliness and antisepsis observed in the care of the patient, and the judgment displayed in interfering with her. In a series of eighty-four cases of abortion reported by Kuppenheim,* of Heidelberg, in seven only did complications of any sort arise. The method of treatment employed was that which we have outlined, the finger being used, under careful antiseptic precautions, to empty the uterus, whenever possible, in preference to instruments.

In obscure cases where grounds for suspecting pregnancy exist, where pain, shock, and hemorrhage occur, the practitioner must keep in mind the occurrence of ectopic gestation with tubal abortion; such abortion is usually incomplete, the embryo and its clots partially escaping from the tube, while the chorion or placenta remains within its cavity. An admirable description of such abortion has been recently given by Sutton. An instructive case of tubal incomplete abortion in a primipara in early pregnancy is given by Renteln. Her symptoms were abdominal pain, giddiness and flooding, which increased in spite of rest and the administration of opium. The gradual development of a tumor led to a diagnosis of tubal gestation, and abdominal section confirmed the existence of tubal abortion.

* *Zeitschrift f. Geburtshulfeu Gynäkologie*, Band 22 Heft 2.

These cases and many others of similar nature emphasize the fact that pain and hemorrhage, accompanied by the possibility of pregnancy in cases where the uterus can be demonstrated to be but slightly enlarged, and empty, should give rise to a suspicion of ectopic pregnancy and abortion, and lead, after due consultation, to exploratory abdominal incision to confirm a positive diagnosis.—*Therapeutic Gazette.*

Society Proceedings.

THE FIRST PAN-AMERICAN MEDICAL CONGRESS,

TO BE HELD AT WASHINGTON, D.C.

September 5th, 6th, 7th and 8th, A. D. 1893.

President: WILLIAM PEPPER, M.D., LL.D., 1811 Spruce Street, Philadelphia, Pa.

Secretary-General: CHARLES A. L. REED, M.D., 311 Elm St., Cincinnati, O.

Treasurer: A. M. OWEN, M.D., 507 Upper Front St., Evansville, Ind.

Chairman of Executive Committee: DR. HENRY D. HOLTON, Brattleboro, Vt.

Committee of Arrangements: (Office Arlington Hotel, Washington, D.C.)

Chairman: SAM'L. S. ADAMS, M.D., 1632 K. St., Washington, D.C.

Secretary: J. R. WELLINGTON, M.D., 1416 Fifteenth St., Washington, D.C.

Extracts From Regulations and By-Laws.

MEMBERSHIP.

Members of the Congress shall consist of such members of the medical profession of the Western Hemisphere, including the West Indies and Hawaii, as shall comply with the special regulations regarding registration, or who shall render service to the Congress in the capacity of Foreign Officers. [*General Regulation* 2.]

CONSTITUENT COUNTRIES.

The following shall be considered as the constituent countries of the Pan-American Medical Congress:

Argentine Republic, Bolivia, Brazil, British North America, British West Indies (including B. Honduras), Chili, Dominican Republic, Honduras (Sp.), Mexico, Nicaragua, Paraguay, Peru, Salvador, Republic of Columbia, Republic of Costa Rica, Ecuador, Guatemala, Haiti, Kingdom of Hawaii, Spanish West Indies, United States, Uruguay, Venezuela, Danish, Dutch and French West Indies. [*General Regulation* 7.]

SECTIONS.

The Sections of the Congress shall be as follows:

(1) General Medicine, (2) General Surgery, (3) Military Medicine and Surgery, (4) Obstetrics, (5) Gynæcology and Abdominal Surgery, (6) Therapeutics, (7) Anatomy, (8) Physiology, (9) Diseases of Children, (10) Pathology, (11) Ophthalmology, (12) Laryngology and Rhinology, (13) Otology, (14) Dermatology and Syphilography, (15) General Hygiene and Demography, (16) Marine Hygiene and Quarantine, (17) Orthopædic Surgery, (18) Diseases of the Mind and Nervous System, (19) Oral and Dental Surgery, (20) Medical Pedagogics, (21) Medical Jurisprudence, (22) Railway Surgery. [*General Regulation* 8.]

LANGUAGES.

The languages of the Congress shall be Spanish, French, Portuguese and English. [*General Regulation* 9.]

REGISTRATION.

The Registration fee shall be $10.00 for each member residing in the United States, but no fee shall be charged to foreign members. Each registered member shall receive a card of membership and be furnished a set of the transactions. [*Special Regulation* 2.]

ABSTRACTS, PAPERS AND DISCUSSIONS.

Contributors are required to forward abstracts of their papers, not to exceed six hundred words each, to be in the hands of the Secretary-General not later than the tenth of July, 1893. These abstracts shall be translated into English, French, Spanish and Portuguese, and shall be published in advance of the meeting for the convenience of the Congress, and no paper shall be placed upon the programme which has not been thus presented by abstract. Abstracts will be translated by the Literary Bureau of the Congress at the request of contributors, and should be forwarded through the Secretaries of Sections. Papers to be presented to Sections must not consume more than twenty minutes each in reading, and when of greater length must be read by abstract not exceeding twenty minutes in length. Papers read by abstract may be printed in full in the transactions, subject to approval by the Editorial Committee. Papers and discussions will be printed in the language in which they may be presented. All papers read in the Sections shall be surrendered to the Secretaries of the Sections; all addresses read in the General Session shall be surrendered to the Secretary-General as soon as read; and all discussions shall be at once reduced to writing by the participants. [*Special Regulation* 3.]

LITERARY BUREAU.

The Secretary-General may at his discretion organize a Literary Bureau, which shall consist of such number of linguists as he may determine, whose duty it shall be to do all necessary translating for the Congress, compensation for which service shall be determined by the Executive Committee. Certain members of the Literary Bureau may be designated by the Secretary-General as an Editorial Committee. It shall be the duty of the Editorial Committee to determine the eligibility of all contributions before the same shall be published in the Transactions, and to supervise the publication of both the Book of Abstracts and the Transactions. All work done by the Editorial Committee and by the Literary Bureau shall be subject to approval by the Secretary-General. [*By-law V.*]

Section on Physiology.

ADVISORY COUNCIL.—Dr. W. H. Howell, Boston, Mass.; Dr. C. F. Hodge, Worcester, Mass.; Dr. W. G. Thomson, New York, N.Y.; Dr. F. S. Lee, New York, N.Y.; Dr. G. T. Kemp, Brooklyn, N.Y.; Dr. John Marshall, Philadelphia, Pa. ; Dr. W. S. Carter, Philadelphia, Pa.; Dr. J. W. Warren, Bryn Mawr, Pa.; Dr. R. M. Smith, Philadelphia, Pa.; Dr. F. T. Mall, Chicago, Ill.; Dr. Jacques Loeb, Chicago, Ill.; Dr. J. J. Abel, Ann Arbor, Mich.; Dr. Henry Sewall, Denver, Col.

MEDICO-CHIRURGICAL SOCIETY OF MONTREAL.

Stated Meeting, November 11th, 1892.

JAMES STEWART, M.D., PRESIDENT, IN THE CHAIR.

New Members.—Dr. J. R. Spier and Dr. A. S. Wade were elected ordinary members.

Rhinolith.—Dr. Birkett exhibited a rhinolith or nasal calculus removed from a woman aged 35, who for the past six or eight years had suffered from a chronic discharge from the left nostril. On examination, the entrance of the nostril was seen to be blocked by granulation tissue, and a probe, on being passed in one-quarter of an inch, impinged on a hard body. After reducing the temporary hyperæmia with cocaine, a body could be observed under the inferior turbinated bone, and was readily removed after being broken into two or three pieces, followed by complete relief to the catarrh.

Dr. Proudfoot had removed a somewhat similar concretion from the nose of a child who suffered from a very fetid nasal discharge. The concretion was about the size of a marble, and he experienced some difficulty in fracturing it. The nucleus was found to be a small roll of paper. He thought that these concretions were generally phosphatic.

Carcinoma of the Ovary.—Dr. Lapthorn Smith exhibited the specimens, and reported the case as follows :—The patient from whom I removed these two tumors was a married woman, 42 years of age, the mother of five children, the youngest of whom is 14 years of age. She has never suffered with her periods, and the menopause was passed three years ago. She had always enjoyed good health until June last, when she began to vomit constantly. In July her abdomen began to swell and in September she first began to notice a swelling of the feet and legs. She then presented the following appearance. She was sitting bolstered up in a chair, her face dark red in color and almost cyanosed, her abdomen enormously distended, and her feet and legs swollen and pitting deeply on pressure. Her heart was extremely weak, rapid and intermittent, and at first I thought her a case of heart disease, gradually filling up with water, but I failed to detect any organic murmur or evidence of dilatation. She had been vomiting incessantly for several weeks, her bowels were very constipated, and she was passing only two or three ounces of dark-red urine daily. The abdomen was so much distended that a careful examination only revealed the fact that it was full of liquid and under great tension. Neither did an examination per vaginam show any indications of the presence of a solid tumor, the vaginal vault being merely bulged downwards by the weight of the superincumbent fluid. The urine contained one-fourth albumen. Under treatment with small doses of calomel and bicarbonate of soda the vomiting was stopped, and after a few weeks further treatment with digitalis the quantity of urine secreted in the twenty-four hours rose to sixteen ounces, and the albumen disappeared. The legs became less swollen, but there was no improvement in the distension of the abdomen. As her condition was serious I determined to tap her, and, if necessary, perform abdominal section. I, therefore, took her into my private hospital on the 1st of October, and on the following day I introduced a very fine trocar into the abdomen, half-way between the umbilicus and pubis, and thus removed two gallons and a half of straw-colored fluid in half an hour, without the patient experiencing any faintness or other unpleasant symptoms. As soon as a gallon of water had escaped, the abdominal walls became sufficiently relaxed to permit me to feel two large solid tumors floating freely in the abdomen; when all the water had escaped, the liver could be found very much enlarged. Although I feared that these tumors might be malignant I urged their immediate removal. It is interesting to note that during the

days following the tapping the quantity of urine passed in twenty-four hours rose to thirty-five ounces, and became quite clear in color. I presume that this may be explained by the removal of the pressure of the ascitic fluid which pressed heavily enough upon the kidneys to flatten them out or collapse them, and so diminish the circulation through them. On the 5th of October, two days after tapping, I removed these tumors—one weighing, after the operation, seven, and the other five pounds. I was assisted by Drs. Springle and Ritchie. The peritoneum was very much thickened, and the omentum was shrivelled up like a piece of scorched leather close up to the liver, which latter organ was very much enlarged and covered with metastatic deposits, but there were no adhesions. The abdomen was flushed with plain hot water, and the wound closed with silkworm gut sutures and buried in dry boracic acid powder. A drainage tube was left in for three days, and the silkworm gut sutures were left in twenty-four days, causing no discomfort whatever. She walked out of my hospital on the 30th October, looking and feeling very much better than when she entered.

The tumors present a fairly regular and very smooth appearance, there being only here and there smooth raised patches on their surface about an inch in length. On section, the cut surface appears like pure fibrous tissue, but, on microscopic examination by Dr. Bruère, the characteristic cells of carcinoma could be detected. As there were no papillary or other cysts anywhere in the structure, this is without doubt primary cancer of the ovaries, although the disease is somewhat rare. The most interesting point in the case was the entire absence of symptoms pointing to disease of the ovaries. The patient maintains that she never had the slightest pain in the region of the ovaries. Unless I had removed the fluid it would have been impossible to have recognized the presence of the tumors, and the patient would have been dead ere now.

With regard to the advisability of operating, Winkle claims that isolated primary cancer of the ovary may be completely cured by early extirpation, although it fails, of course, to produce a radical cure when adjacent organs, especially the peritoneum, have already become affected. When the carcinomatous tumor can be readily extirpated the operation will remove the source of the ascites and tension, and at least temporarily contribute to the patient's comfort. He mentions three cases which not only bore the operation well, but were improved for months afterwards. I was somewhat surprised to find the patient make such an easy recovery from the operation, although I have noticed in other cases that a diseased peritoneum tolerates interference much better than a healthy one. She had none of the usual discomforts which generally follow an abdominal section, and would have been able, and was willing, to get up, if I had allowed her to, two or three days afterwards.

Dr. Gardner considered the case interesting and instructive as illustrating abdominal dropsy. He thought it was the rule, when the dropsy does not yield to constitutional treatment, that tapping should be performed so that a diagnosis can be made. He had not met with cases in which he could not detect the growths by vaginal examination. Extirpation of these masses often lead to latency of symptoms of symptomatic cure, even though their structure may be declared to be malignant.

Dr. Bell asked what were the evidences of cancer of the liver, and if there were any lymphatic infiltrations. The tumors were encapsulated, and he would not expect them, from their gross appearance, to be carcinomatous, nor would he expect a patient who was suffering from such extensive cancer to make so good a recovery.

Dr. Smith, in reply, said that no one could see the peritoneum roughened and thickened, or see the condition of the omentum, without deciding that the condition was cancer. He thought that the enlargement of the liver and the nodular character of the organ pointed to its involvement.

Uterine Myoma.—Dr. Wm. Gardner exhibited an enormous tumor removed from a women aged 47. The symptoms had been rapid enlargement of the abdomen since last July, with some hemorrhage. The diagnosis had been difficult, but he had inclined to myoma; the rapid growth was remarkable. The tumor was removed by total abdominal extirpation.

A ready Method of Cultivating the Bacilli of Diphtheria.—Dr. Wyatt Johnson said that about a year ago he had given some results of the cultivation of the bacillus of diphtheria in blood serum, as (if the case is seen early) it afforded a very valuable method of diagnosis. It is known that the bacilli are distinguished by their rapid growth on albuminous substances within eighteen to thirty-four hours after being sown they become quite distinct, while putrefactive bacteria do not attain any material dimensions in that time. The difficulty of obtaining blood serum is so great that this method of diagnosis has not come into general use. The egg has been known for a long time to be an excellent culture medium, and recently it has been recommended by Sakarhof to cultivate the diphtheria bacillus upon it; the method he used consists in maculating slices of hard-boiled eggs, sterilized, and placed in sterilized tubes. This method being somewhat complicated for general use, he (Dr. Johnson)

had made a modification, which consisted in obtaining a hard-boiled egg and simply cracking it at one end and removing the shell membrane, which leaves a perfectly sterile surface and which may be inoculated with a sterile wire. Place the egg upside down in an egg-cup and leave it in a warm place. He had not as yet worked with the method sufficiently to say whether it has precisely the same diagnostic value as the growth on blood serum.

Dr. Mills asked Dr. Johnson to state briefly the symptoms in animals following inoculation. Some conditions of the throat in animals look like diphtheria, but are really not so.

Dr. Johnson said that there were two conditions known as diphtheria in animals,—one in pigeons and the other in calves; they resemble diphtheria anatomically, but the organisms causing them are quite distinct. If a guinea-pig is inoculated with 0.5 c.c. to 1 c.c. of the broth-culture of the diphtheria bacillus the animal dies in from 24 to 48 hours. At the site of the inoculation there is extensive œdema and hemorrhage with, sometimes, necrosis at the point of inoculation; there is a bloody serous effusion into the pleural and peritoneal cavities, and the organs show fatty degeneration. The diphtheritic affections commonly supposed to be communicated by the milk are usually anginas due to pathogenic streptococci.

Case of Pediculi Pubis on the Scalp.—Dr. G. G. Campbell exhibited a specimen of pediculus pubis which he had found on the scalp of a child who was brought to him for a peculiar appearance of the eyebrows, which proved to be due to the ova of the pediculus; on examining the head the pediculi pubis were found. Dr. Campbell said that most authorities deny that such a condition is ever found, and he had only been able to find one recorded case.

Empyœma of the Antrum of Highmore.—Dr. Birkett read a paper on this subject.

Discussion.—Dr. Major said that the paper covered the ground so fully that there was but little to add. He had, several years ago, tabulated 189 cases of myxomatous polypi, and among them antrum disease occurred thirteen times; more recently he has had ten cases, seven having myxomatous polypi, and the remaining three hypertrophy of the turbinated bone. The origin of the disease is no doubt from dental causes, even though the teeth may appear good; and whether it may be secondary to nasal disease, or that nasal disease follows antrum disease, is not settled. As to symptoms, the old classical appearance of deformity of the face is not now looked upon as a necessary feature; the odor of the pus is perfectly characteristic, and is not at all like that due to syphilis; another symptom is the redness of the gums, and is important at least as corroborative. He fully agreed with everything Dr. Birkett had said about surgical treatment. He uses a steel-worker's drill, which is reduced to fit a dental engine; the operation takes two or three seconds, and is entirely painless. He looks upon the drainage-tube more as a means for washing out the cavity than simply for drainage. He then proceeded to explain the kind of tube he is in the habit of using; after the opening has been made a wooden plug is introduced into it and a plaster cast is taken of the mouth and teeth, and upon this model a tube, which exactly fits the opening, is made.

Dr. Shepherd had seen three cases lately, two having had sinuses above the pre-molar tooth; he removed the tooth and scraped through into the antrum with a Volkman's spoon. He did not see the use of so many instruments, and thought too much stress was laid upon the washing out of the antrum; in empyæma of the thoracic cavity a general washing is done once only.

Dr. Buller quoted a case of iritis following the operation by a general surgeon, and thought that the success of the special surgeon was entirely due to his attention to detail and to the instruments he uses.

Dr. Proudfoot fully agreed to the necessity of frequent washing of the cavity, for the cleaner the parts are kept the better for the patient.

The late Dr. Geo. Ross.—The following resolutions of regret at the death of Dr. George Ross were proposed by Dr. F. J. Shepherd, seconded by Dr. A. Proudfoot, and carried by a silent standing vote:—

"*Resolved*,—That this Society has learned with the profoundest sorrow of the death of Dr. George Ross, a past-President and one of its foundation members. Dr. Ross's wide clinical experience and intimate knowledge of disease, combined with his remarkable powers of observation and judicial criticism, made him a most valuable member. The various papers and reports contributed by him from time to time to this Society were always received with the greatest interest and listened to with the closest attention.

"*Resolved*,—That Dr. George Ross' death, at the early age of 47, is a grievous loss to the medical profession of Canada, of which he was so great an ornament, and in which he exercised so great an influence, not only as a clinical teacher and writer, but as an active member of the various medical societies and corporations in whose work he took such a prominent part.

"*Resolved*,—That a copy of these resolutions be sent to the relatives of the late Dr. Ross and to the daily press."

THE SECTION ON LARYNGOLOGY AND RHINOLOGY.

The Section on Laryngology and Rhinology of the Pan-American Medical Congress is now thoroughly organized with Secretaries in all the countries of South America as well as in the United States and Canada.

The President, DR. E. FLETCHER INGALS, of Chicago, is making a thorough canvass to secure a large number of good papers for the Section, and aided as he will be by the able Secretaries, Drs. Murray and y Alonso, and the corps of honorary presidents, he feels assured of the success of this department of the Congress.

All Physicians interested in this Section are requested to correspond with the secretaries for the United States:

DR. J. MARON y ALONSO, Spanish-speaking, Las Vegas, N.M.

DR. T. MORRIS MURRAY, English-speaking, Washington, D. C.

THE ELEVENTH INTERNATIONAL CONGRESS OF MEDICINE.

ROME, Sept. 24 to October 1, 1893.

President.—PROF. G. BACCELLI, Rome.

Treasurer.—PROF. L. PAGLIANI, Rome.

Secretary General.—PROF. E. MARAGLIANO, Genoa.

The Inauguration of the Eleventh International Congress will take place the 24th of September, 1893, in the presence of H. M. the King of Italy.

The work of the Congress will begin in the nineteen sections on the morning of the 25th of September. It will be continued in accordance with the arrangements to be made and published both for the general sessions and the sections. Some of the general sessions will be devoted to scientific addresses delivered by scientists of all nations.

LIST OF THE SERIES.—1. Anatomy. 2. Physiology. 3. General Pathology and Pathological Anatomy. 4. Pharmacology. 5. Internal Medicine. 6. Diseases of Children. 7. Psychiatry, Neuropathology and Criminal Anthropology. 8. Surgery and Orthopedy. 9. Obstetrics and Gynæcology. 10. Laryngology. 11. Otology. 12. Ophthalmology. 13. Odontology. 14. Military Medicine and Surgery. 15. Hygiene. 16. Sanitary Engineering. 17. Dermatology and Syphilidology. 18. Forensic Medicine. 19. Hydrology and Climatology.

REGULATIONS.—1. The Eleventh International Congress of Medicine will be inaugurated in Rome, on the 24th of September, 1893, and will close on the 1st of October.

2. Any physician may become an active member of the Congress by fulfilling the conditions of membership, inscribing his name, and securing his admission ticket.

3. Scientists of other professions, who, through their special studies, are interested in the labors of the Congress, may acquire the rights and assume the duties of active members, and participate in the work of the Congress, both by communications and discussions.

4. The fee for admission to the Congress is twenty-five francs, or five dollars.* It entitles to a copy of the Transactions of the Congress, which will be forwarded to the members immediately after publication.

5. The character of the Congress is strictly and exclusively scentific.

6. The work of the Congress will be divided amongst nineteen sections; every member is requested to indicate, on paying his admission fee, the section for which he desires to be inscribed.

7. The provisional committee will arrange the appointment, in the opening session, of the permanent officers. They will be a president, three vice-presidents, a number of honorary presidents and secretaries. Each section will elect, in its first meeting, its president and a certain number of honorary presidents, who shall alternately take the chair during the session. Some of the secretaries will be chosen from among the foreign members, in order to facilitate the recording both of communications and of discussions in the different languages.

8. There will be daily sessions, either general or sectional. The times and numbers of the general sessions, and the business to be transacted in them, will be arranged by the President of the Congress.

9. The general sessions are reserved, (*a*) for the consideration of the common work of the Congress and of its common interests, (*b*) for addresses and communications of general interest and importance.

10. The addresses in the general sessions, and in such extraordinary sessions as may be arranged, will be delivered by members chosen by the committee for the purpose.

11. Papers for and communications to the Congress must be announced on or before June 30, 1893. A brief abstract of every paper and communication, with their conclusions, must be sent to the committee on or before July 31st. All of them will be printed and distributed to the members by authority of the President. Such as arrive after that date cannot be expected to find a place on the regular order of business, and will be accepted only if time will permit.

12. The business of the sections will be arranged by their presidents, who will also

---

* Money order or check to the Treasurer, Professor Comm. L. Pagliani, Rome, Italy

determine the hours of meeting, avoiding those reserved for the general sessions. Two or more sections may hold joint meetings with the consent of their presidents. There will be no vote on scientific questions.

13. Fifteen minutes are allowed for the reading of a paper or communication. In the discussion every speaker can have the floor but once, and for five minutes only. To close the discussion the author of the paper is allowed ten minutes. Additional time may be given him by the president, by special resolution of the section, if the importance of the subject under discussion appear to require it.

14. The manuscript of all addresses, papers and communications read either before a general session or a section must be handed to the secretary before the close of the meeting. A special committee on publication appointed by the president will decide which or what part of them shall be published in the Transactions of the Congress. Such members as participated in the discussions are required to hand to the secretaries their remarks, in writing.

15. The official languages of the sessions are: Italian, French, English and German. The regulations, programmes and daily bulletins will be published in the above four languages. During the meetings, however, a member may be permitted to use, for a brief remark, any other language, provided some member present expresses his willingness to translate such remarks into any of the official languages.

16. The president directs the discussions according to the parliamentary rules generally obeyed in similar assemblies.

17. Persons not classified under Article 3, who are interested in the labors of a special section, may be admitted by the president of the Congress. They will receive a special ticket on paying their admission fee; will not be entitled to a copy of the Transactions; and cannot speak in the general sessions nor in any section other than that for which they were inscribed.

18. The president may invite or admit students of medicine to attend and to listen. They will be given a special admission ticket, free of charge.

General Information.—Journeys and Reduction of Fares.—The provisional committee has made arrangements with the different Italian and foreign railway and navigation companies, in pursuance whereof special reduced prices have been granted on the steamers and railways of this country and of the countries which the members of the Congress are to traverse.

In Italy the members of Congress will find tickets for round trips, starting from Rome; they will thereby be enabled to visit the most important cities and the various universities. In regard to this, further notice will be given.

The ladies of the members will be furnished ladies' tickets, which will enttile them to the reduced fares granted to the members, and to participate in the festivities connected with the Congress.

Festivities.—Besides the receptions which the kind and hospitable citizens of Rome will offer to the members, the Italian colleagues will endeavor to return to the best of their power the kindness they experienced during their stay abroad.

On some evening, yet to be decided, the members of the different sections will join at a dinner which will be given in one of the first hotels of Rome.

The Italian physicians have formed special committees to show the most hearty and kindly hospitality towards the foreign colleagues.

International Exhibition of Medicine and Hygiene.—On the occasion of the Eleventh International Medical Congress, an Exhibition of Medicine and Hygiene will be inaugurated in Rome, which will gather all that may practically interest physicians and specialists. A special committee has already insured the co-operation of all the most important manufacturers of the world.

Hotels.—All the first and second-class hotels of the Italian capital will afford to the members, during their stay, all desirable comforts.

DOUBLE MOVEABLE KIDNEY CURED BY OPERATION.

Rotch (*Boston Med. and Surg. Journ.*, May 26th, 1892) relates a case of double movable kidney which had been cured by operation. The patient was a nulliparous, unmarried woman, aged 27, who had had good health till December, 1890, when she noticed something "shaking in her abdomen as she walked," and a little later she experienced a sensation of something slipping forward into the left inguinal region when she stooped. In January, 1891, she fell upon the ice, and then noticed a resistant mass in the left inguinal region, and soon afterwards a similar mass on the right side, Three weeks later these became very painful. On examination of the abdomen, double moveable kidney was diagnosed. On September 22nd an incision was made in the left lumbar region at the outer side and parallel with the erector spinæ, and carried down to the kidney; silk sutures were then passed through the capsule of the kidney and fixed to the quadratus lumborum muscle, and the wound closed. From this operation the patient made a good recovery. On November 27th the right kidney was treated like the left, three silk sutures being passed through the capsule of the upper, middle and lower parts of the kidney and fixed to the

muscles in the wound. The patient recovered from this, and was quite well on December 28th, the wounds having healed. On February 6th she re-entered the hospital with a discharge of pus from the right cicatrix. This was investigated and a ligature removed. Rapid healing ensued, and on February 21st, both kidneys were found to be fixed in position in the lumbar region.—*Brit. Med. Jour.*

CRANIECTOMY.

ESTOR (*Nouv. Montpellier Méd.*, June 4th, 1892) reports a case in which he performed craniectomy on a microcephalic child presenting the usual symptoms. A considerable amount of bone was removed, the hole left in the skull being 11 centimetres in length by 2 in width. There was no appreciable improvement in the mental condition, the only benefit resulting from the operation being that the child gained the power of stooping to pick up things without falling. Estor thinks the cases recorded up to the present, while not sufficiently numerous to form the basis of a definitive judgment on the value of the operation, are not very encouraging. Even in the cases in which distinct improvement has taken place, this has not been lasting.

THE SURGICAL TREATMENT OF PERITYPHLITIS.

SCHEDE (*Deut. Med. Woch.*, June 8th, 1892) records 18 cases. The inflammatory processes in perityphlitis nearly always take place within the peritoneal cavity, and the appendix is almost exclusively the starting point. A blocking of the appendix takes place most frequently by a concretion, and much more rarely by a foreign body. It may even be due to a contracting cicatrix, or perhaps to catarrhal swelling. The integrity of the appendix is preserved in the slighter forms, the mucous, or muco-purulent, secretion escaping into the cæcum. Relapses are, however, frequent, and sooner or later severe forms are noted. Three cases of relapsing typhlitis are then recorded, successfully treated by excision of the appendix. In severe cases, with much inflammatory exudation, perforation is said to be seldom absent, yet they mostly run a favorable course, as adhesions have been formed. An abscess with muco-purulent or fæco-purulent contents may arise. In general, one may wait until the abscess comes near the abdominal wall, unless severe symptoms are present. Three successful cases are recorded in which the operation was undertaken in the interval after severe attacks. In each case centres of thick and more or less inspissated pus were found. The appendix was removed. The author then comes to the well-recognized group of very serious and dangerous cases with rapid perforation before adhesions have been formed. Three such cases were operated upon, and two died. The third one was probably saved by the perforated appendix being in the sac of an inguinal hernia. In the remaining cases unusual complications were present. One simulated intestinal obstruction. A median incision was made, but the patient died. Incision over the cæcum, which, owing to diagnostic difficulties, was not adopted, might have let out the pus without infecting the peritoneal cavity. In the other cases adhesions about the cæcum caused some obstruction to the passage of the intestinal contents along with other symptoms. The worst case died. In another case the cæcum was excised with good results after a second operation. At times there may be, as in Cases 15, 16 and 17, such thickening as to suggest malignant disease, especially if it occur in elderly people. Here, too, the cæcum had to be excised in one case. It was successful. The last case was one of carcinoma of the cæcum, believed to be secondary to typhlitic changes. The extensive disease was excised, but the patient died.—*Brit Med. Jour.*.

Progress of Science.

THE DIAGNOSIS AND THE SURGICAL TREATMENT OF HEMORRHOIDS, INTERNAL, EXTERNAL, INFLAMED OR ULCERATING, BY FULL BUT GRADUAL ANAL-DILATATION; BY LOCAL ANALGESIA, COMBINED WITH PRESSURE-MASSAGE; ALSO A FEW NOTES ON HEMORRHAGIC HEMORRHOIDS.

BY THOMAS H. MANLEY, M.D.,
Visiting Surgeon, Harlem Hospital, New York.

I have already, in different medical periodicals of late years, been permitted to occupy space, in setting forth, in diverse contributions, the structural anatomy and functions of the *intestinum amplum;* or the large pouch-like terminus of the rectum, the greater part of which is lodged in it, immediately contiguous to the ischiatic fossa.

This being the case, I will not occupy time, in the present instance, in considering structure and rectal phenomena in the ano-rectal district, but, after a few reflections in a general way, proceed at once to diagnosis and treatment.

In the beginning, I may say, that since I commenced to make a critical study of ano-rectal diseases, I have found to my amazement and confusion on making a large number of examinations on the dead and living body, that a hemorrhoidal or varicose state of the vascular part of the lower rectum was present in more

than ninety per cent. I discovered by interrogating the living, that of those in whom pathological changes of a hemorrhoidal order was present, not more than *ten per cent.* ever were aware that they had piles at all. We must then infer that something more than the mere presence of a few scattering tabs of tissue around the anal margin or small neoplasmata within should co-exist, to bring into play that most agonizing disorder designated hemorrhoids—a condition which, of all others, can make one's life wretched and miserable. And when intermittent paroxysms of furious itching, pain and straining come on, particularly when one "turns in" for a night's rest, the distress and torture which they often excite are something dreadful.

We will in this issue discuss the subject from a medical standpoint, and illustrate the share a disordered system contributes in the etiology; but what I wish to particularly emphasize is, that if we would strike at the root of the malady, we must address our attention to something besides the deeply congested varicosities which line the walls of the bowel, and endeavor to institute a line of treatment which will not involve a mutilation and loss of blood, or perhaps lay the foundation for subsequent dangerous consecutive hemorrhage, ulcer, or fistula, and something which will not inflict great shock to the system, but will be permanent in its results.

I may say here, that the measures which will be recommended are only for those chronic intractable hemorrhoids, which simple, constitutional and local measures will not control, which are of a chronic character and rebellious to local treatment.

DIAGNOSIS.—Let us be sure that "we have caught the hare before we light the fire to cook him."

How many poor creatures there are with an itching, irritable, painful rectum, with their anal excavation plastered over with various "pile ointment," partaking freely of bilious medicines, who are as innocent of hemorrhoids as the unborn babe? Any trouble in the rectum is almost invariably set down as "piles."

Here are a few illustrations. Patient sent to me by a practitioner for unmanageable piles. I examine his rectum, and find an immense punched-out tuberculous ulcer.

A young woman comes to me with "ulcerating piles." The salves do her no good. Her rectum is full of ulcerating and sloughing condylomata. Papa—her husband—had been cured of his piles (?)

A physician comes to me from the country with his patient, who had terrible bleeding piles, which terribly exsanguinated her. On examination high up, I find two or three angiomatous polypi. A young physician brings his father to me to examine his rectum, as he has been latterly under treatment for piles. He has a rectum as hard as a horn, which, at the sphincteric orifice, is one mass of cancerous deposit.

Many come to be treated for hemorrhoids, who have fissure, ulcer or stricture of the rectum.

Hence, from the foregoing, it is clearly evident, that before we think for a moment of healing chronic piles, we must assure ourselves that our patient really has the genuine article.

Now, in reaching a diagnosis of hemorrhoids, we must depend mainly on the faculties: the hearing, touch and sight. In the large majority of cases, a skillfully conducted oral examination, along with the cautious but searching glance of the eye, will aid enormously as a preliminary. You will see the hectic of phthisis, the tinged anæmic skin of cancer, and if the patient has, so-to-speak, "held on to his hair," in syphilis, by putting this and that together you will draw out enough to give you good reason to suspect it. By this sort of an examination, too, one will lead the patient on, until you secure his full confidence, as you may anticipate him in many details.

In simple chronic hemorrhoids there will seldom be much difficulty in reaching definite conclusions as to their presence, before we touch them.

EXAMINATION OF THE RECTUM.—Two things are quite indispensable for a rectal examination: They are first, touch; and second, good light—the use of vision.

Now, the first is the most valuable in a general way, because with many sensitive, modest women a visual examination often is refused, is only very reluctantly consented to, so that if you can not only make an examination, but also treat her affection under her clothing, and cure her, you will, for her lifetime, have the fullest measure of her gratitude. Thoroughly scientific examination of hemorrhoids is not always possible without a full exposure of the closed or opened anal portal. It is almost unnecessary to say that in malignant diseases or polypi, the sense of touch is quite enough as a local diagnostic resource.

TECHNIQUE OF RECTAL EXAMINATION.—When a thorough and complete examination is imperative, as in cases of ulcerating or bleeding hemorrhoids, the patient should be placed on a table from three to four feet high: if a male, in the dorsal decubitus; and, if a female, on the left side. And I may say here in parenthesis, that chronic pathological changes in the rectum are comparatively very rare, except in proportion in middle-aged or old people. We must have good light. Now, it must not be inferred, when good light is mentioned, that a voluminous glare is needed. On the contrary, what we need is not brilliancy, but a *contrast light.* If we have clear sunlight, it is simple; but if on the contrary the day is gloomy, or an examination is made in the darkness of night, a simple tallow-dip, lumin-

ous candle, or two, both lit at once, the light reflected with a common hand-mirror into the rectum, or on the cutaneous margin of the anus, will answer.

However, before we proceed to inspection we should first make a digital examination. I would recommend the amateur to first familiarize the touch, and acquire the *tactus-eruditus* by examining the recta of the healthy in every possible instance when a pretext presents itself.

The patient being now resting comfortably, and not unduly exposed, it is well always to assure him or her that there will not be much pain inflicted, and that he must not resist us. The anal sphincter is always closed by a tight grip in hemorrhoidal disease, and acts not altogether unlike a stricture in the dry urethra in the first passage of instruments. We must then commence manipulations on the sphincter-ani by a species of coaxing, "catch it off its guard," and then thoroughly subdue it.

To commence with, I generally sponge the part freely with warm water, after which, with my index finger well-warmed and oiled, the pulp is brought slowly up against the anal folds. At first the corrugations of the sphincter plaits are drawn tighter than ever, but the finger is kept there, and gentle but steady pressure is begun against it, when we are soon conscious of a giving way as the tip enters. Now that we are within the anal cul-de-sac, into the rectum, we give our patient a little rest, and we need a little ourselves, for we would succeed with these cases without torturing our patient; we commence cautiously and slowly, so that, after the sphincter is passed, we are often not a little fatigued. At any rate the hand is tired. I have spent twenty minutes more than once in making my finger pass the sphincter. The tip of the finger is now kept in the rectum, without advancing farther, for at least five minutes. In the meantime, its point being slightly worked while there by the weight of the hand, quiet but steady tension is made in the direction of the long axis, of the longitudinal fibres of the sphincter-ani.

A little fresh oil is now dropped on the engaged finger—the part exposed—and it is sent into the webbing. A "to and fro" motion now is given this finger before another is introduced. It is lifted up in the direction of the bladder, turned towards the sacrum, and the ischial tubers partly withdrawn and again reintroduced.

After this manipulation, we commence the passage of the index of the left hand, following on the same lines as the first, then the middle finger of each hand, if necessary, though very often but the two indices are required.

By this procedure, when proper precautions are observed, the anus is amply dilated to permit a thorough inspection. The loss, temporarily, of sphincteric contractile power is manifested by the free escape of fæces.

We commence our ocular examination at the verge of the anus.

QUESTIONS TO BE ANSWERED.

1. Has our patient piles? If so, of what type.

2. Are they simple or complicated with fissure, ulcers, abscess of fistula?

3. Has the patient an entire absence of hemorrhoids, and is he rather suffering from a neoplastic infectious malady, as cancer, syphilis or tubercle, and, if malignant, where is its precise seat?

It might be said that it was rather premature to put questions before we have employed the speculum and other mechanical means as an aid to exploration.

Under ordinary circumstances the less instrumentation in anal examinations the better. Many times the brethren have written me, "Whose special anal speculum do you recommend?" My answer is that the best is "none at all" in uncomplicated cases. With the sphincter amply dilated—and no speculum should ever be employed until this has been secured, as a preliminary measure—the rectum rolls out, prolapses, and we have under our eyes the entire field of pathological changes.

In those in whom the anus is well stretched, if any sort of speculum is useful, nothing in my hands serves more admirably than a Simon's vaginal, well-warmed and oiled, and very gently introduced. The blade of this instrument being about four inches in length—about one-half the length of the entire rectum, and all that part of the tube which is uncovered by peritoneum—we have at our command a clear sweep of the whole field. With a tampon placed high up, the mucous membrane well drenched and this speculum raised, depressed, or turned anteriorly first, posteriorly second, to the right third, and the left side lastly, a thoroughly complete inspection is always a simple procedure in appropriate cases. Certainly, in those whose lower passage is the seat of stricture or malignant disease, this instrument must not be employed. Indeed, in this class of cases an ocular inspection is quite unnecessary.

HAS OUR PATIENT HEMORRHOIDS, AND, IF SO, OF WHAT DESCRIPTION?—Time will not permit the consideration of the diverse variety of piles. In a physical examination you cannot confound hemorrhoids with other affections. In a young or middle-aged man, or woman, with no pronounced cachexia, before we examine, we may quite assure ourselves of their presence.

ARE THE HEMORRHOIDS COMPLICATED WITH ULCER, FISSURE OR FISTULA?—Hemorrhoids provide the ground-work of the greater part of the cases of ulcers and fissures. So-called fistula in ano is almost invariably consecutive to hemorrhoids. It is misnamed "fistula-in-ano" for the reason that, in the greater part of these cases, the fistula externally appears at some distance from the anal verge, and, internally, starts at a point some distance above the outlet. In fact, they

clear the anus altogether, and nowhere in their sinuous path touch it, except in few cases.

With chronic hemorrhoids, then, we must always look for those lesions so ominously consecutive to them. My own observations, in a considerable number of cases, incline one to regard hemorrhoids as an exciting factor in the etiology of epithelioma in elderly people.

Is our Patient suffering rather from Gonorrhœal Infection Through Rectal Coitus, Tubercular Ulceration, Syphilitic Hyperplasia or a new growth of Sarcomatous or Cancerous origin?—Many an unfortunate has been turned away with a few purgative pills, a pile ointment or lotion, by the attending practitioner, who never had hemorrhoids in his life, and a mere placebo given for such serious pathological conditions, which, if treated early and energetically, may be arrested at the start; but which, when once the work of diffusion and infiltration into the loose cellular tissues, the perineum, the prostate or bladder, the vagina or uterus in the female has begun, we are often limited in our practice to palliative measures, as radical resources are now quite out of the question.

Gonorrhœal-proctitis is often met with in our larger cities. Its onset is sudden, and it is rapid in its destructive consequences. The agonizing straining it occasions is something harrowing. It may advance upward and involve the peritoneum. It may be easily diagnosed by the quality of the discharge and the virulence of the inflammatory changes. Cancer and syphilis, when present in the rectum, in their early stages, are not so easy to determine. We must depend largely on the clinical history, with reference to heredity, pre-existing lesions, etc. If one be in much perplexity, he should give the patient the benefit of the doubt, and put him through a thorough and extended mercurial course. If cancer be diagnosed, however, it is well to always determine, with as much certainty as possible, its precise location and extent, for when it begins near the anal verge, it may be readily and safely extirpated, while, on the contrary, if it be lodged in the rectal walls a finger's length beyond the anus, the case is beyond the reach of art to more than relieve, when we must give a prognosis accordingly.

Tubercular ulceration of the rectum is a much more common malady than is generally supposed.

It manifests itself by almost intolerable itching, nocturnal, tenesmic straining, and a copious emission from the rectum of a mucopurulent discharge. Many of the symptoms common to hemorrhoids attend this malady, so that, unless a special and very careful examination of the rectum be made, one is liable to overlook its real character, and employ temporizing remedies, when, by the use of proper measures, its course may be cut short in almost every case in which there is not an infection of important organs.

The Various Surgical Operations for the Radical and Permanent Cure of Hemorrhoids. — Having determined the probable presence of piles by such subjective symptoms as leave little doubt as to their true character, or, after verifying, by an ocular inspection, their actual presence, our next concern is to cure them. But let it be clearly understood here that only in those severe, chronic, refractory cases should operative measures be advised or practised, for, of all regions of the body, the ano-rectal is one of the most dangerous for surgical interference, unless special precautions are always observed.

The nerve supply to the rectum is from the pubic and fourth sacral. The sphincter and levator-ani are animated from the same source. The terminal filaments of these freely inosculate with small sciatic, sacral plexus and great sciatic; the anus is chiefly supplied from the sympathetic. Hence, with its abundant nerve supply, we can readily understand why so frequently in operations in this situation shock is altogether out of proportion to the extent of mutilation. The immediate operative-mortality in hemorrhoidal operations, at St. Mark's Hospital, London, was but 1 to 670 operations. Allingham, in 1,600 operations, had no deaths.[1] This was much lower than Cripps' or Carding's.

But if the *operative mortality* is low, the consecutive pathological lesions and effects on the general system are many in those on whom operations are performed which entail the loss of blood or mutilation of tissue.

Cripps,[2] in speaking of the consecutive or secondary hemorrhage, says:—"There is nothing which so taxes the resources of the surgeon as in cases of recurrent hemorrhages after operation. The dangers are grave, the patient and friends being powerless in the emergency, and are wholly dependent on the surgeon's prompt action."

But supposing the surgeon cannot be found until the escape causes mortal symptoms, or is only controlled when so much has been lost as may forever leave a shattered constitution, the consequences must be disastrous. Hence, those hemorrhoids which admit of a cure without the scalpel should be treated by such means as will not imperil our patients' lives or leave the parts favorable to other subsequent lesions.

Surgical Procedures commonly employed in Non-Hemorrhagic Hemorrhoids.—Injection, ligation and excision are the most common means resorted to by surgeons until recently. Not long since Whitehead devised an operation which takes his name. Its complete performance always entails a considerable sacrifice of

[1] Allingham on the Rectum, p. 127.

[2] Cripps on Diseases of the Anus and Rectum, p. 110.

healthy enteric tissue, a large loss of blood and a tendency, on union, of a subsequent annular rectal stricture. When primary union fails, after the operation, an enormous hiatus in the rectum remains, which only heals after a long lapse of time, by a tedious process of granulation.

If it were not for the dangers of secondary hemorrhage, and impossibility of preventing infection of the wound, the complete and radical excision of the masses would be a most satisfactory operation.

Ligation is not as useful as one might suppose. It is quite impracticable in hemorrhoids high up as well as in those with broad, sessile bases. When the rectum is the seat of active inflammation, or when degenerative interstitial changes in the walls of the hemorrhoid have occurred, we can do nothing with the ligature. The range of the employment of ligatures in hemorrhoids is definitely limited, and when employed in selected cases, many cases have been permanently cured.

It is well to note the phenomena by which the evolution to health is effected. The necrotic gangrenous changes in the hemorrhoid often produce a tendency to consecutive fistula at the root of the sloughing tumor.

Injection directly into the hemorrhoid of coagulating or caustic substances is another expedient. It is unnecessary to name all the substances which have been employed for this purpose. Suffice it to say that their name is legion. Their *modus operandi* is on the theory of an irritant, mechanical inflammation, with an aseptic shrivelling or resorption and atrophy, which effaces the hemorrhoids. Crystal carbolic acid reduced by heat has met with the most favor; a drop or two injected into each mass. The operation is simple, but we can readily see that except in distinctly pedunculated piles, this phenating of the inner walls with an escharotic will not avail. In those masses composed of mixed vascular, angiomatous elements, it has no place, and is almost certain to cause future trouble if resorted to. There are many other operative procedures which are, however, with few exceptions, all derivatives of the three above named.

Hemorrhagic Hemorrhoids, or Bleeding Internal Piles.—A contribution on hemorrhoids, it is feared, might be regarded as inexcusably defective, if it did not make some reference to *bleeding piles*. Hence, before concluding with the subject of treatment of the non-hemorrhagic variety, this phase of the disorder should be glanced over.

Without entering into the subject of the pathology of this phase of the malady under consideration, at the outset, we may ask, assuming that a correct diagnosis has been made, is it always judicious to interfere in those cases in which the loss of blood is not of such frequency or quantity as to make its impress on the general health? My impression is that for those who live on rich food, take insufficient exercise, or manifest a propensity for internal inflammation, an occasional spontaneous rectal phlebotomy is often most salutary in its consequences.

[1]Montague reports a singularly interesting case, cited to him by Larrogue.

A mademoiselle, a lady of rank, he says, on approaching the age of puberty was pronounced by skilled physicians hopelessly ill with pulmonary disease. But her menses coming on, all her lung symptoms vanished. At the age of 44, her menopause arriving, pulmonary symptoms again set in in an aggravated form. Now, she had a copious hemorrhoidal flux, and perfect health was again restored. These bloody fluxes continued from the rectum, from time to time, till she was 66 years old, when they ceased, and the lung symptoms now set in with mortal effect.

Bodson of London, in 1832, reported another remarkable case in the *Lancet* for January of that year, which seemed to strongly confirm Montague's view.

He was consulted by a young gentleman of 24 years of age, who had been married two years. He was emaciated, stooped and feeble. Examination of the chest revealed clear evidence of incipient pulmonary disease. Thinking that perhaps the young man had indulged excessively in the conjugal relations. he was ordered to sleep in another bed from his spouse. This, however, had no effect. Now, Bodson remembering that he came from a hemorrhoidal family, determined to try the effect of bleeding at the anus.

With this end in view he applied eight leeches at the verge of the young man's rectum, with the most desirable effect. The cough ceased. He commenced to gain in flesh, and was soon wholly restored to health.

But we will meet cases in which the loss of blood is excessive, our patient's health is shattered, and even life threatened. Such a case was sent to me this past summer by Dr. Acker, of Croton on-the-Hudson. She was bleached as white as marble, and bled terribly. Such cases must be promptly dealt with.

If the hemorrhage is small, simple astringents may suffice. If it be excessive, ice must be passed into the rectum, or even digital pressure employed, until the immediate bleeding ceases. Radical and permanent treatment embraces *complete* anal dilatation, the rolling out of the rectum, and thorough destruction of the fungous mossy masses or papillæ, which occasion all the trouble. The actual-cautery, Paquelins or the galvano, is a sovereign remedy for this condigion.

Cocainization, Dilatation and Pressure-Massage as a Radical Remedy.—Except for bleeding hemorrhoids and those complications

[1] Traité des Hémorrhoïdes, Fluxes, Hémorrhoïdaire; etc.

previously noted, this therapeutical tripod, employed with the minutest attention to detail, has, in my hands, enabled me to dispense with every sort of cutting operation which entail the loss of blood in hemorrhoids of every description.

The *rationale* of the treatment consists in rigorous asepsis, local analgesia with subcutaneous cocainization, dilatation and pressure-massage.

To my mind it possesses very great advantages:

1st. In avoiding the loss of blood.

2d. In avoiding consecutive inspection.

3d. In not leaving a condition favorable to stricture.

ADVANTAGES TO THE PATIENT.—1st. The operation is less expensive to the poor, as assistants may be dispensed with.

2d. He may continue at his usual occupation the next day after treatment.

3d. The dangers attendant on pulmonary anæsthetics are entirely escaped when organic disease is present.

PREPARATION OF PATIENT AND TECHNIQUE OF OPERATION.—The day before operation the bowels should be well cleared by a saline laxative.

Before operation is commenced the patient may have a substantial meal.

Before the patient is placed on the table for operation, the colon should be well washed out with sterilized water, and the perineum should be shaved and scrubbed. Now, from two to four ounces of whiskey or brandy should be given; and we are ready to commence preliminaries.

The index-finger being introduced into the rectum, the subcutaneous and intra-sphincteric injection of cocaine solution (1 to 100) is commenced, making but four independent punctures; but, after Reich's plan, spraying the subcutaneous muscular and cellular tissues, in a *radiated* direction, until the entire annular zone of the anus is analgized. This completes the first stage of the operation. Now, a tampon of gauze is introduced, as high up as the vesico-rectal fold of the peritoneum, and a long, thin fringe of cocainized gauze is passed through the anus, as far as the tampon, and allowed to remain for a moment in contact with the nude mucous membrane, when it is withdrawn. Now anal dilatation is completed. This must be thorough, until all resistance to the distending digits is at an end. The rectum is then thoroughly flushed with sterilized water, when we commence the third and last stage of the operation.

We now, with the index and middle finger in the rectum, and the thumb resting externally against the verge, separately seize the hemorrhoids and violently compress them between the finger and thumb. If they are very large and numerous, then, in order to do the work of compression radically, the intestine should be prolapsed slightly, and each caught and separately emptied of their blood; and have the walls well rubbed together, being alternately compressed and twisted on their bases or pedicles, until we are assured of an active, traumatic inflammation immediately setting in. When there is a large cluster on the outside in order to make analgesia doubly certain, douche them with a syphon of acid carbonated water, or, in want of these, pour a pitcher of iced water from a height slowly on to them. These are seized and twisted in the interval. The rectum is again flushed and the tampon removed, when an opium suppository is introduced. Now, as the sphincteric power is temporarily crippled, there is an escape of fluid fæces, unless we adjust a firm, substantial compress, which, while obstructing them, gives great comfort to the hemorrhagic parts.

When pressure-massage has been thoroughly carried out there is practically nothing more to do. Consecutive inflammation effectually destroys the endothelial lining of the hemorrhoids; their bloody contents, first coagulating, disintegrate and are absorbed in time, leaving, as a residue, a few scattered atrophied stalks to mark the former site of the hemorrhoidal varices.

For the past two years this has been the procedure which I universally employed in hospital and out of it. The number, during the past year, was unusually large, and, as far as we could follow the cases, or trace them, through the physicians who sent them, the results have in all cases been satisfactory and the cures permanent.

For the village and country practitioner the method is a most valuable acquisition, commending itself equally for its simplicity, efficacy and permanence of cure.

PRURITUS ANI.

℞—Hydrargyri chloridi corros., gr. ij.
Acidi hydrochlorici ..... gtt., x.
Aquæ..... ℥ viij.
M. S. Apply locally, lukewarm.
—*Laplace.*

℞.—Argenti nitratis..... gr. xx.
Aquæ..... ℥j.
M. S. Paint over itching surface.
—*Bartholow.*

℞.—Cocain. hydrochlorat..... gr. v.
Lanolini..... ℥ j.
M. S. Apply locally, after washing with warm water.
—*Besnier.*

℞.—Acidi carbolici..... gr. vj.
Aquæ..... ℥ j.
M. S. Apply thrice daily.—*Heath.*

℞.—Benzoini, pulv. finiss..... ℥ j.
Hydrargyri ammonial..... ℥ ss.
Lanolini ..... ℥ j.
M. S. Apply twice daily. Avoid coffee, malt liquors, sugar and excess in meat.—*Waugh.*

THE CANADA MEDICAL RECORD.

PUBLISHED MONTHLY.

Subscription Price, $2.00 *per annum in advance. Single Copies*, 20 *cts.*

EDITORS:

A. LAPTHORN SMITH, B.A., M.D., M.R.C.S., Eng., F.O.S. London.

F. WAYLAND CAMPBELL, M.A., M.D., L.R.C.P., London

ASSISTANT EDITOR

ROLLO CAMPBELL, C.M., M.D.

Make all Cheques or P.O. Money Orders for subscription or advertising payable to JOHN LOVELL & SON, 23 St. Nicholas Street, Montreal, to whom all business communications should be addressed.

All letters on professional subjects, books for review and exchanges should be addressed to the Editor, Dr. Lapthorn Smith, 248 Bishop Street.

Writers of original communications desiring reprints can have them at a trifling cost, by notifying JOHN LOVELL & SON immediately on the acceptance of their article by the Editor.

MONTREAL, MARCH, 1893.

Dr. Blackader has been elected to the Indoor Staff of the Montreal General Hospital, to fill the vacancy created by the death of Dr. George Ross. He had not any opposition. The only person who could have made the contest a lively one did not, for reasons best known to himself, materialize as a candidate, so the worthy doctor had a walk over. We congratulate him on the bother, worry, annoyance and loss of temper which was thus saved him.

The vacancy created on the Outdoor Staff by Dr. Blackader's promotion, brought about two hundred governors to the Hospital to vote. Dr. C. E. Cameron and Dr. Lafleur were the candidates. The former, backed by a few friends, made a splendid fight; but the influence of McGill was for Dr. Lafleur, and it carried the day by a small majority.

We think Dr. Cameron and his friends now know how he might have been elected. If they don't—we do.

The whole subject of Medical attendance at the Montreal General Hospital must come up for discussion, just as soon as the old wing is made new. In the meantime, it might be just as well for the profession in Montreal to think the matter over.

We believe a thorough reorganization of its Medical Staff is essential. The institution is outgrowing the combination which has for years practically controlled it. Montreal is becoming a large metropolitan city, and those connected with Medical schools are but a small minority of the profession. Let outsiders insist that they have rights. They have the power to make those rights felt, and they should do it.

The union of McGill and Bishop's Meds. at the Academy of Music on the occasion of the recent University Medical night, is a good omen. It was pleasant to see the flags of both Schools hanging from the gallery, while the voices of the two Schools blended in melodious notes. The combined procession, after the performance was over, visited several of the professors and serenaded them. They were very enthusiastic when they arrived opposite the house of the Dean of Bishop's College Faculty of Medicine. He appeared at the window, and gave the boys some good advice which they evidently appreciated, as they loudly declared before they left that "he's all right."

The new professor of Pathology at McGill, Dr. Adami, has created a most favorable impression. We cordially welcome him to his new position and work. If physiognomy is true, then Dr. Adami must be a good fellow, and such are always welcome in Medical circles in Montreal.

Were Dr. Adami's remarks at the McGill Medical Dinner in December last intended to be sarcastic, when, in replying to the toast of the Faculty, he said

that it was the first temperance dinner he had ever attended? Temperate it had been to him and those near him, but as he stood up and looked before him, if the array of dark-colored bottles was any indication, then it was not a temperance dinner.

The worthy professor said that as his little speech was the first he had made in Montreal, he felt that a little stimulant would not be a bad tonic. A representative of a rival Medical school having become surreptitiously possessed of some of the article, passed it to him. The compliment was appreciated, and showed the full confidence he placed in the people among whom he had come to live. No suspicion of a poisoned cup troubled his mind, even although it came from an oppositition member.

Bishop's College was the first to start annual Students' Dinners, and it was fully intended that they should be on temperance principles; others followed, and McGill at all events followed closely in the temperance line. For the first two or three years, so far as having anything of the character of wine on the table, their temperance character was pretty well observed. But oh, what a terrible lot of men the students had to go and see.

Now, their apparently temperance character is not so marked, but we question if less liquor is not drank. Certain, at all events, they are a vast improvement on the old time "footing sprees."

The Medical Staff of the Ottawa Protestant Hospital have had a tussle with the outside profession, and have come off second best. The outsiders complain that only the Staff are permitted to attend patients in the private wards of the Hospital. In other words that an yone who, either from choice or force of circumstances, occupies a private ward, must select his Medical attendant from the Hospital Staff.

This is a monopoly with a vengeance, and we congratulate the profession in Ottawa that they have at last had courage to protest against it. Their courage also carried their point. At a meeting of the local Medical Society held on the 14th January, the matter was brought up for discussion. A telegram to a Montreal paper says, the debate lasted "five and a half hours, and was of a very lively character." A resolution of the Society, expressing itself in favor of the private wards being thrown open to all legally qualified medical men in Ottawa, was carried by a large majority.

Then a new and unexpected change of base was inaugurated. The outside doctors said they would be willing to forego what they had been contending for, if private wards were abolished. The opinion was expressed that such wards should not be connected with a Hospital supported by public subscription. A resolution to that effect was unanimously passed.

What a singular termination! To us it looks like the Hospital Staff, finding themselves beaten, had cunningly laid a trap into which the outsiders stupidly fell; that they would rather have the private wards abolished than allow outside men to use them for their patients. In gaining this point, however, all who voted for it committed themselves to an expression of opinion which will find few sympathisers.

That opinion was adverse to the establishment of private wards. In this they are wrong. Private wards are in reality an essential part of all hospitals, especially in large cities. They, however, never

should be a tax on the Hospital funds; on the contrary, they should be a means of contribution to the general support of the institution.

While looking after the mote in the eyes of our brethren at Ottawa, how do we stand on this very same question in Montreal? Not just where we think we should. The private wards of the Western, Notre Dame and Hotel Dieu hospitals are open to the entire profession, but those of the Montreal General Hospital are closed to all but members of the Staff. It is true this institution now has but few private wards; still if vacant they should be rented to the first comer.

When the old wing is remodelled, there will be an increased number of private wards. The "General" is a democratic hospital in a sense, and the outside Medical profession can make themselves heard if they desire to do it. Perhaps they may. The movement in Ottawa was a surprise. Is there another in store for us here?

THE MEDICAL BILL.

After a good deal of knocking about between the two branches of the local legislature, the proposed new Medical Bill for the Province of Quebec has been withdrawn. It had some good points in its favor, but what killed it was the reciprocity clause which allowed foreigners to be licensed without examination. The Universities were naturally opposed to having their rights and privileges curtailed by having their graduates compelled to pass another examination before the Provincial Board. If the latter learned body will excuse us for making a suggestion, we would urge it to do well two things which it already has full power to do: First, to limit the number of practitioners by raising the standard of candidates who are about to begin the study of Medicine, so that it would be impossible for those who are uneducated and unrefined to become medical students after a few months' training; and second, to employ a detective and a smart young lawyer to harass and persecute in every possible way the numerous charlatans who infest the Province. We feel sure that no one would begrudge the annual fee of two dollars if the College of Physicians would do something in return for the money. But we cannot wonder at the young practitioner objecting to pay to the funds of the College when he sees the latter allowing advertising charlatans to take in by their nefarious methods as many hundreds of dollars in a week as he does in a year by hard and honest work. The officers of the College may say that it is difficult to prevent these eminent quacks from practising here, but the Ontario College succeeded in driving them out of the country, and the authorities in Ireland succeeded in landing them in gaol or penitentiary; so that the thing is not impossible.

The raising of the standard by the Medical Board above referred to would only apply to those who desire to practise in this Province; the universities may safely be left to deal with the question of the entrance examination of those who intend to practise elsewhere. If the miners of British Columbia or the lumbermen of Michigan and the medical boards of these countries are all satisfied with an M.D. who knows nothing of Greek or Metaphysics, that is their affair and not the business of our Medical Board, which has only to look after those practitioners who are manufactured for use in the Province. As we have often said, each Province or State should see that its own professional men are not subjected by over-crowding to too keen a struggle for existence.

ALBUMINURIA AND LITHÆMIA.

We are pleased to notice in an editorial of the *Northwestern Lancet of* 15th Feb.,

1893, with the above heading, that the same views are expressed as have often appeared in our own columns regarding the curability of albuminuria when it is associated with either oxaluria or lithæmia. The writer does not seem to see the direct relation of the lithæmia and oxaluria to the albuminuria. As we have already pointed out, urine loaded with either is exceedingly irritating, probably because there are many fine sharp-pointed crystals in it held in suspension, which in passing down the long fine urinary tubules scratches their mucous membrane. That these crystals exist there can be no doubt, for we sometimes find them remaining in the calyx of the kidney and forming the nucleus of a stone in the kidney; at other times they pass down to the bladder and act in the form of gravel. We have many times seen patients with not only albumen but also casts, whose urine became perfectly normal under treatment with diuretics and copious draughts of pure or slightly alkaline water. The whole trouble is due to eating too much in proportion to the mechanical work performed, and then not drinking enough water to wash out the partly burned nitrogenous products. Our confrère says that in chronic nephritis the urine is generally clear and free from urates. The last paragraph of his editorial is especially worthy of consideration, and we therefore quote it in full:—

The importance of carefully distinguishing between these two forms of albuminuria cannot be too strongly dwelt upon. The importance is first of all to the patient, who must suffer cruelly in mind from an error in diagnosis. Next concerned is the reputation of the physician, who is led through a too hasty conclusion to commit a serious error. But the profession as a whole is deeply concerned whenever one of its members in good standing makes a mistaken diagnosis of so serious a disease as chronic nephritis, for when the victim fails to die, contrary to all expectation, it brings the whole science of Medicine into distrust, and it is no doubt just such cases as these described that have made the reputation of some "Safe Kidney Cure" or "Golden Medical Discovery," which flaunts abroad testimonials from men given up to die of Bright's disease by reputable medical men.

A NEW JOURNAL.

The *Woman's Medical Journal*, devoted to the interests of Women Physicians; it is edited by E. E. Roys-Gavitt, M.D., and Claudia Q. Murphy, managing editor; business manager, Margaret L. Hackadorn. Recorder Publishing Co., Toledo, Ohio. Price $2.00 a year. We extend to our youngest sister a hearty welcome, for, as she says, no matter how full the ranks of medical journalism may be, there is always room for one more. This one's first number presents a very promising appearance, and will no doubt receive as it should the unanimous support of the ever-increasing numbers of female physicians throughout the world. We wish it success.

LAVAL UNIVERSITY.

This time-honored institution has for some years past been arranging for suitable accommodation for its Montreal Medical Faculty. Although wealthy, the expenses of its medical and other faculties have been so much greater than the receipts from them, that it has not been able so far to provide the necessary amount of money. The Sulpicians have generously come to its assistance with a gift of $104,000, and work is to begin immediately on the new building, which will be situated on St. Denis street near Sherbrooke street. Laval has done a noble work in the past in the cause of higher education, and has made many a financial sacrifice rather than lower its standard of excellence. Among the latter may be instanced just two: that of remitting half the lecture fees to those medical students who would first take the degree of

B.A., and that of sending to Europe for further study, at its own expense, young graduates in Medicine who showed marked ability for teaching. From its very inception the *annus medicus* at Laval has always consisted of ten months, while other universities are only recently seeing the necessity of keeping the student at work for more than six months of each year. We feel sure that with a well equipped school in this great city, and with two large hospitals at its disposal, it will reach a higher point of eminence than it has ever reached before.

CORRESPONDENCE.

214 HOME INS. BUILDING, CHICAGO, ILL.
January 31st, 1893.

To the Editor :—

SIR,—Herewith please find the circulars of announcement of the International Congress of Charities, Correction and Philanthropy, which is to be held in Chicago during the week commencing June 12th, 1893.

Your attention is particularly directed to the work of Section 3, which "covers the Hospital Care of the Sick, the Training of Nurses, Dispensary Work, and First Aid to the Injured."

We respectfully request that you give the Congress all the attention your inclinations and space will allow, in order that it may have as wide a publicity as possible.

The Committee of Organization is very desirous of securing a large attendance from abroad, in order that the Congress may have the greatest possible beneficent effect upon the philanthropic and penological work of the world; and it trusts that you will aid it in every possible way through your valuable Journal.

Thanking you in advance for any favors you may extend to us, I have the honor to be,

Yours very respectfully,
NATHANIEL S. ROSENAU,
Sec. Committee of Organization.

PRELIMINARY MANIFESTO OF THE SECTION OF NERVOUS AND MENTAL DISEASES OF THE PAN-AMERICAN MEDICAL CONGRESS OF 1893.

St. Louis, Jan. 13, 1893.

To the Editor of THE CANADA MEDICAL RECORD, Montreal, Canada.

DEAR DOCTOR,—I take pleasure in transmitting herewith a manifesto of the preliminary organization of the important section of Psychiatry and Neurology of the forthcoming Pan-American Medical Congress, with request that you publish the same in your estimable Journal with editorial endorsement, and cordial invitation to the medical profession of your section to co-operate in promoting the success of this Section at the coming Congress, by suggestion, by offering papers to be read, by promptly signing as members, by letters and by advice to the Executive President of the section, or to its English-speaking Secretary Dr. A. B. Richardson, Columbus, Ohio.

Valuable papers have been promised from distinguished savants in Neurological and Psychological Medicine, but many more are desired and desirable. The Spanish, French and English languages will be spoken in the section, and it is especially desired to secure as good a representation of the profession and make as good an exhibit of the advance in Neurology and Psychiatry as may be possible.

This, together with a desire for closer confraternity between the profession of the North and South American States, as well as the welfare of our common humanity, of which the coming Congress will be promotive, are chief among the exalted purposes of this section.

Physicians who may desire to identify themselves with this Section are requested to do so at once.

Fraternally,
C. H. HUGHES,

Executive President Section on Diseases of the Mind and Nervous System. Pan-American Medical Congress.

BOOK NOTICES.

A TREATISE ON DISEASES OF THE RECTUM, ANUS AND SIGMOID FLEXURE, by Joseph M. Mathews, M.D., Professor of Principles and Practice of Surgery, and Clinical Lecturer on Diseases of the Rectum, Kentucky School of Medicine; Visiting Surgeon Sts. Mary and Elizabeth Hospital; Consulting Surgeon Louisville City Hospital; Consulting Surgeon Jennie Cassady Free Infirmary for Women; late President Mississippi Valley Medical Association; President Louisville Clinical Society; Vice-President Louisville Surgical Society; Member International Medical Congress, American Medical Association, Southern Surgical and Gynæcological Society, Kentucky State Medical Society, State Board of Health of Kentucky; orator of the American Medical Association on Surgery, 1891, etc. With six Chromo-Lithographs and Numerous Illustrations. New-York: D. APPLETON & COMPANY, 1892.

The author says:—I have written this book because of a desire to record my indivi-

dual experience of fifteen years as a rectal specialist, in answer to the demand of my students and friends. During this time I have learned that many things that are taught are not true, and that many true things have not been taught. I have, therefore, not taken other men's opinions as my guide, but have accepted as truths only those things which could be substantiated by fact, and here recorded them. In differing from others on any special point, I have tried, first, to state fairly and fully their views, and then my own. The verdict is left to the reader. I have introduced several chapters which are new to books on this subject. Among these will be found the following: Disease in the Sigmoid Flexure, the Hysterical or Nervous Rectum, Anatomy of the Rectum in Relation to the Reflexes, Antiseptics in Rectal Surgery, a New Operation for Fistula in Ano. I have styled the book: A Treatise on Diseases of the Rectum, Anus and Sigmoid Flexure. In embracing the sigmoid flexure in the caption, I do so because I have become convinced of its great importance as a seat of disease and the utter lack of attention which it receives. From all time it has been recognized that serious pathological changes take place in it, but the works are singularly silent as to how to treat it when diseased. The chapter on The Hysterical or Nervous Rectum is embraced mainly to give my reasons for opposing some views of the learned and distinguished Prof. Goodell. The chapter on the Anatomy of the Rectum in Relation to the Reflexes is made to follow that of the Hysterical Rectum, in order to account for some vague affections of the lower bowel. The subject of the "reflexes" is one of the most important before the profession to-day. The chapter on Antiseptics in Rectal Surgery is inserted to demonstrate that such precautions can be practised in this line of work. A New Operation for Fistula in Ano refers to my method of treating the disease by a *fistulotome*. Although several have claimed the introduction of this little instrument, the dates, I am sure, will give me priority.

Although we have only had this work in our possession since a couple of weeks, we have consulted it freely during that time, and have already learned much from it which has been of practical value to our patients: To mention one only, we had a case of papillomatous ulceration of the sigmoid flexure, in which the patient had been obliged to get up from six to twelve times a night for several years, and only passed blood and occasionally papillomatous tumors the size of a bean. We were unable to find anything in any of the books concerning this condition, but on looking it up in the work under review, we find that the following was recommended to be injected:

℞ Sweet almond oil	oj
Subnitrate of bismuth	ʒ ij
Iodoform	ʒ j

M. Sig. — Shake well each time before using.

The point of a Davidson syringe should be tightly fixed into the larger end of a Wales rectal bougie; the bougie, well anointed with vaseline, should be pushed into the rectum about three or four inches, and then one syringeful of hot water thrown in front of it. It can then be passed into the sigmoid flexure. One bulbful of the oil preparation should now be drawn into the syringe and injected. An additional bulbful of hot water should now be drawn into the syringe, and thrown behind the oil, thus pushing it all into the sigmoid flexure. The intrument is then to be withdrawn and the patient told to rest on left side, the buttocks elevated.

The author gives many interesting cases, showing how often serious disease of the rectum is overlooked simply for lack of making an examination. He gives very many valuable methods of treating fistulæ, but we are surprised not to see any mention made of the modern method of opening up the fistulous tract, carefully dissecting it out and then replacing the cut surfaces in exact apposition so as to obtain union by first intention. We recently performed this operation, and after dissecting out the fistulous tract we denuded sufficient surface to repair a lacerated perineum with commencing rectocele. The parts healed by first intention, and all stitches were removed at the end of ten days, absolutely without pain after the first day or two, instead of leaving an open suppurating sore for many weeks. The book is liberally illustrated, and the mechanical work is fully up to the Appleton's high standard. It may be obtained from all booksellers or from the publishers.

HANDBOOK OF INSANITY FOR PRACTITIONERS AND STUDENTS. By Dr. Theodore Kirchhoff, Physician to the Schleswig Insane Asylum, and Privat Docent at the University of Kiel. Ilustrated with eleven plates. New-York: WILLIAM WOOD & COMPANY, 1893.

This is one of the Medical Practitioners' Library, and is a translation of the well known German text book. It is one of the most complete works on the subject we have ever seen. The author is certainly very advanced in his views on these diseases, being totally opposed to restraint and a firm believer in gymnastics or other active exercises and occupations as curative agencies. It is difficult to give any adequate idea of the scope of the book in a review but the general practitioner who desires to obtain the latest views on the treatment of insanity can hardly do better than to purchase this book.