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CICATRICAL ECTROPION CURED BY TRANS- PLANTATION OF SKIN BY THIERSCH'S METHOD.

By F. BULLER, M.D.,
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Walter C., aged 5, fell against a hot stove in February last, severely burning left side of face. Admitted into hospital June 19. A dense cicatrix occupies a large surface below left eye, drawing the lower eyelid directly downwards fully half an inch. The exposed conjunctiva is somewhat thickened and in a state of chronic inflammation. The great disfigurement caused by this condition is still further increased by large cicatrices on the outer part of cheek and on the left temple, and it would be difficult to obtain a flap of healthy skin from the vicinity to restore the everted eyelid. For this reason, and in order to avoid additional cicatrices, it was decided to adopt the Thiersch method of transplantation. The patient being placed under ether, the face and right thigh were thoroughly washed and then cleansed with solution of perchloride of mercury 1 in 2000. The edges of both upper and lower lids were pared at two corresponding points and an incision through the partially cicatrized skin was made parallel with the edge of the lower eyelid, about 3 mm. from its border. The dissection was continued until the lower lid could readily be pushed into its proper place without traction on the cicatricial tissues below. This left a triangular raw surface extending the whole length of the

lower eyelid and about the same distance downward on the cheek. The lids were then united with two sutures. As soon as all bleeding had ceased a thin piece of skin about quarter of an inch wide was removed with a razor from the front of the right thigh and carefully spread over the upper part of the raw surface, covering its whole length at this part; two similar pieces, but shorter, completely covered the remainder of the raw surface. These again were covered over with short strips of antiseptic isinglass plaster, finally absorbent cotton sprinkled with iodoform was placed over all and retained with another bandage. At the end of forty-eight hours the dressings were removed. All the transplanted skin was found firmly adherent, of a healthy pink color, and free from moisture or discoloration at any part; it had, in fact, united throughout "by first intention." The iodoform dressing was reapplied for a few days as a precautionary measure, but at the end of a week all dressings were discontinued, the lower lid, still united to the upper by two firm bands of adhesion, presented in all other respects an almost normal appearance. It is intended that the edges of the lids be allowed to remain united for a few months, after which all danger of retraction of the renovated lid will have ceased, and the two bands of adhesion can be safely divided.

The writer believes that this method of skin grafting will prove of inestimable advantage in many blepharoplastic operations. In another case recently treated an extensive burn of both lids was grafted during the granulation stage by the same method, but a free mucopurulent secretion from the conjunctiva destroyed some of the grafts. Those that succeeded, however, greatly facilitated the healing process and obviated the cicatricial contraction to a considerable extent.

QUARTERLY RETROSPECT OF SURGERY.

BY FRANCOIS J. SHEPHERD, M.D., C.M., M.R.C.S., ENG.

Surgeon to the Montreal General Hospital; Professor of Anatomy and Lecturer on Operative Surgery, McGill University.

Transplantation of Nerve from Rabbit to Man.—Dr. Gersung of Vienna, assistant to Prof. Billroth, has recently performed a novel and interesting operation (*Brit. Med. Journal*, May 19, 1888), viz., the transplantation of nerve from the rabbit to man. The patient was Prof. von Fleischl, who occupies the chair of Physiology in the Vienna University. Sixteen years ago he accidentally wounded himself while performing a post-mortem examination, and severe inflammation of the whole right upper limb ensued. The terminal phalanx of the thumb became gangrenous, the stump left became painful, and later on reamputation was performed. This was followed by the formation of neuromata. For this condition the branches of the median nerve which supply the thumb were first resected, together with the terminal neuromata, and at a later period, when new neuromata began to develop, the central parts of the same nerves, together with the branches of the radial nerve which supply the thumb, were resected. Fresh neuromata now developed on the branches of the median nerve, which were treated without success by the injection of hyperosmic acid and electrolysis. Two years ago the neuromata were resected again, and the resection of the nerves was continued. The pain, however, recurred, and the suffering became so intense that the following operation was performed: On March 4th patient was put under the influence of chloroform, and the neuroma, which was situated behind the volar carpal ligament, was excised, the nerve being cut through behind the neuroma. The peripheral nerve stumps of the two digital branches were then sought for. A rabbit was now killed, and as long a piece as possible of the sciatic nerve of the animal with the two branches into which it divides was dissected from it. The sciatic nerve was afterwards inserted into the space between the central stump of the median nerve and its digital branches; the central end of the sciatic nerve was sutured to the connective tissue which covered the median nerve, and the

two branches were sutured to the digital branches of the median nerve. The portion of nerve measuring about six centimetres which was deficient was thus made up. After the operation, severe pain persisted for some hours, but then entirely subsided. Healing took place by first intention. At the time of writing two months had elapsed since the operation and the pain had not returned; sensibility was being re-established in the part. The ultimate result of this operation will be anxiously awaited, as the result, if favorable, will have much influence in introducing and giving a widely extended trial to an operation which promises to relieve a very painful affection.

Acro-megaly.—At a meeting of the Clinical Society of London, held April 13th, Mr. Rickman Godlee reported a case of the above affection. This affection was first noticed by Marie (*Revue de Médecine*, April, 1886), although Dr. Hadden and Mr. Ballance had previously published a case in Vol. XVIII of the Society's Transactions, 1885. The disease is named from the enlargement of the hands and feet, but the bones of the face also become hypertrophied. The long bones are usually unattacked. Mr. Godlee's patient was a lady, aged 41, who had applied to him on account of a great enlargement of the thyroid of about nine years' duration. The cyst was opened and drained. The patient, who had previously been of a slight figure and the possessor of a good voice, first noticed the disappearance of her high notes, then the swelling of the neck, and then the sudden stoppage of her menses at the age of thirty-six. Since that time there had occurred a gradual increase of the thyroid, accompanied by enlargement of the bones of the face and limbs, and especially of the lower jaw and hands and feet. Her present condition was as follows: Bones—Lower jaw much enlarged, so that the teeth, which spread out, could not adapt themselves to those of the upper jaw; the face has the shape of an egg with large end downwards; clavicle and ends of ribs massive, and sternum appears as if sunk down between them. All natural prominences of long bones much exaggerated, and the small bones of the hands and feet much enlarged, so that the extremities had become broad and spade-like. Marked

kyphosis of spine, causing considerable diminution in height. Cartilages of ears thick and stiff. Skin coarse, with large sebaceous glands in face. Muscles much wasted. Smell much impaired, but hearing normal. Vision good, and touch normal. Voice harsh, metallic and monotonous. In a condition of marked and increasing weakness, poor appetite, and excessive thirst. Pulse rapid; temperature normal. Intelligence perfect, and disposition placid. Mr. Godlee referred to (1) the connection between this remarkable condition of the bones and the abnormal thyroid noted in most cases, comparing it with cases of serous malignant tumors of the thyroid, which have a tendency to recur in bones; (2) the relation between the abnormal thyroid and the early stoppage of the catamenia, also apparently a common symptom of the disease; (3) the resemblances and differences between acromegaly and osteitis deformans; (4) the superficial resemblance, but wide difference, between acromegaly and myxœdema.

At the same meeting Dr. Hadden and Mr. Ballance brought forward a case which had been reported three years before; the case was now of five years duration, and was that of a woman aged 37. It followed a rheumatic swelling of the knees following scarlet fever. Her menses ceased and never returned; the face enlarged, also clavicle, hands and feet. The enlargement was general. The cranium was not affected, and the thyroid was distinctly atrophied. The tongue was hypertrophied. Attention was called to the chief points of difference between this disease, myxœdema, and osteitis deformans.

Dr. Wilks also reported a case of the disease in a young woman aged 28. She had been good-looking, but had become so hideous that the boys shouted after her on the streets; her features had become thickened and deformed, and her hands and feet large and uncleanly. The malady had lasted six years and there was amenorrhœa. She had lost the sight of both eyes. She finally died comatose, and his belief was that there was a tumor of the brain.

Dr. Godlee stated that in three cases of this disease there was found post-mortem some enlargement of the pituitary body.

Erb's paper collected eleven cases of the disease, and with the two now reported, brought the number up to thirteen occurring between the ages of 15 and 50. It occurs in both sexes. The first case reported occurred in a woman aged 58; the disease came on at the menopause. In some cases the lower jaw was not enlarged, and in others the long bones were distinctly enlarged.

The Influence of Antisepsis on the Kidneys.—At a recent meeting of the Berliner Medicinische Gesellschaft, Dr. Emil Senger read a paper on the above subject. He said that it is well known that after nephrectomy, or even nephrotomy, many patients die with symptoms of uræmia or anæmia, even when it has been ascertained beforehand by careful examination that the other kidney was quite healthy and capable of secreting the necessary amount of urea. Senger has proved by experiments on rabbits and dogs that our antiseptic remedies are the cause of these complications. He injected into the animals when in perfect health one-tenth to one-twelfth the amount of corrosive sublimate and carbolic acid necessary to kill them. He then extirpated one kidney and examined it microscopically, with the result that in all cases he found glomerulo-nephritis. There was exudation between the glomerulus and the capsule, and the epithelium of the tubuli contorti was almost entirely destroyed. He also found fatty degeneration of the liver and spleen, the heart-muscle, etc. The various antiseptic agents were found to be injurious in different degrees, corrosive sublimate being the most dangerous, then the others in the following order—iodoform, carbolic acid, salicylic acid, boric acid. Senger recommends surgeons to avoid antiseptics in operation on the thorax and abdomen, and urges them either to employ sterilized water or a solution of salt. By bacteriological and pathological researches he found, first, that this kills the streptococcus pyogenes aureus in twenty-eight minutes, and that the effect is independent of the degree of concentration, for a five per cent. solution of salt is just as effectual as a twenty per cent. Secondly, he claims to have shown that chloride of sodium does not in any way injure the organs, and that no dose is strong enough to kill any animal.—(*Brit. Med. Journal*, May 19, 1888.)

Treatment of Enlarged Prostate.—Mr. Reginald Harrison of Liverpool, in a recent lecture (*Lancet*, July 21, 1888) on the *Pathology and Treatment of Enlarged Prostate*, says:—“As to the treatment of prostatic hypertrophy when the part has to a large extent assumed the structure and properties of a fibroma, I would like to say a few words in conclusion. The degree of vesical irritation and obstruction under these circumstances is sometimes very intense, and various means have been proposed to deal with this condition by operative procedures having for their object either the section of the obstructing part with provision for more perfect drainage of the bladder by artificial means, or removal of more or less of the prostatic mass. In both of these directions considerable relief has been afforded. Having regard to the fibroid condition the part assumes, I have thought, if there is any truth in Apostoli's treatment, that it is possible it might, under these circumstances, prove serviceable. I have now this subject under consideration. I am aware that electrolysis has been practiced both in this country and in America, but I cannot say that as yet we have sufficient evidence to warrant its more general adoption. I would lay stress on the examination of the prostate from the rectum as determining our views in reference to the patient's future when retention of urine is due to this cause. When this happens in a person with a hard, nodulated prostate, where there is evidence to the touch that fibrous tissue predominates largely over the muscular, the power of the bladder seldom returns and the use of the catheter is generally perpetual; but when, on the other hand, the prostate is found soft and yielding to the touch, indicating that muscle still prevails, we may, as a rule, anticipate complete restoration of function.

Tumors of Bladder Diagnosed by the Electro-Endoscopic Cystoscope.—Dr. Max Nitze (*Lancet*, April 21, 1888) reports fifteen cases of tumor of the bladder diagnosed by this instrument during the last sixteen months. In eight cases the tumor was extirpated, seven by high section, and in the one case, a woman, through a dilated urethra. The article is accompanied by diagrams of the instrument which he invented, and to which

the name of Leiter has been attached without authorization by him. Leiter, in order to make the instrument, had first to buy the patent from Dr. Nitze.

Trephining for Meningeal Hemorrhage.—Cases of meningeal hemorrhage due to injury from blows or falls are not uncommon, and many cases could be saved if recognized early enough and operated on. At the meeting of the Medical Society of London held March 26th, Mr. Davis Colley showed a carman, aged 53, who, on October 21st, 1887, when driving a van, fell down a distance of twelve feet, striking the side of his head. He was insensible at the time, but recovered consciousness. He then had slight paralysis of the left arm and bruising of the right temporal region. There was no indication of fracture. An hour afterwards he had complete paralysis of the left arm and slight loss of power in the left leg and side of the head. Next day there was noticed a little numbness on the left side. He continued in much the same condition for ten days, passing his evacuations involuntarily; was very drowsy, with a slow, weak pulse, temperature below 97°F., and slight delirium. On the eleventh day Mr. Colley trephined immediately in front of the middle of the right fissure of Rolando, using a semi-circular flap. He came down on the centre of a large clot, which he removed partly with his finger and partly by irrigation with bichloride of mercury. There was no suppuration and the patient recovered rapidly. On the seventh day he was worse again: this was found to be due to pressure of the dressing. He could now move his arms well and grasp firmly. Mr. Colley remarked that cases of successful trephining in hemorrhage between the skull and dura mater were very rare. Mr. Jacobson had succeeded in finding only ten cases recorded during the last one hundred years.

Excision of the Tongue.—Mr. Walter Whitehead (*Lancet*, Jan. 28th, '88), in a paper on the above subject, states that he has now performed entire excision of the tongue by scissors in ninety-one consecutive cases. He has had a series of twenty-one cases without a death, but he does not give the total mortality in his ninety-one cases. Mr. Whitehead's method of excision

has already been before the profession for more than ten years, and has been, in fact, almost universally adopted by surgeons. In the present paper he contrasts this operation with removal of the tongue by the *écraseur* much to the detriment of the latter method. He holds that partial extirpation of the tongue is a wrong procedure, and advocates total extirpation in every case. He says that the patient can eat and speak better when the whole tongue is taken away than when a portion only has been removed, and that as no surgeon can define the ultimate limits of the disease when dealing with a cancerous growth, it is better to err on the right side and remove plenty. If the lymphatic glands are affected as well as the tongue, they may be removed at the same time as the tongue, or, what he considers a still better procedure, at a later period, as soon as the patient has recovered from the first operation. In removing the tongue through the wound he uses Mason's gag. In not one of his ninety-one cases has he been troubled with hemorrhage. The arteries are easily secured either before or after cutting them. He uses torsion entirely, and has abandoned ligatures. Since he has adopted torsion he has never had a case of secondary hemorrhage. After operation he made use of an antiseptic varnish to cover the wound, after having washed the wound thoroughly with perchloride of mercury solution. The varnish used consists of the ordinary constituents of Friar's balsam (Tinct. Benz. Co.), substituting a saturated solution of iodoform in ether for the rectified spirit. This dries immediately and leaves a firm coating on the wound which lasts for twenty-four hours. He prefers this to the sticky gauze of Billroth. When the varnish is used the patient can take food by the mouth the day after operation. After removal of the tongue Mr. Whitehead never encourages the patients to consider themselves invalids, in fact the less they adopt the recumbent position the better. Open air exercise (weather permitting) should be taken on the second day after operation, as it helps to promote rapid convalescence. Many of his cases of excision are alive after two, three, four and five years; one old lady whose tongue he removed in 1872 died from other causes in 1886. He looks

upon statistics in excision of the tongue as fallacious, and says if he were to select his cases he would be surprised if he ever had an unfavorable termination. He is in the habit of removing tongues far advanced with malignant disease merely for the sake of relieving the pain and removing from the mouth a source of intolerable disgust. In these cases and those where the glands are involved the death-rate is necessarily high.

Mr. Whitehead must see many of his cases at a very early stage of the disease. It has never been my lot to operate on a case of cancer of the tongue where the lymphatic glands were not involved. It is not every patient that will consent to a second operation for the removal of the glands. I have always removed the whole tongue by scissors after the method of Mr. Whitehead, but have also previously tied the linguals in the neck in all cases. I have also for some time employed with good results the mixture used to impregnate Billroth's sticky gauze as a paint, for I have not found the gauze to remain any time in the mouth. This paint of iodoform resin and spirit, with a little castor oil added, makes a capital protective antiseptic varnish. The early convalescence of Mr. Whitehead's patients is worth noting, and speaks well for his method; his advice to get them out of bed on the second day is quite a new departure in the treatment of excision of the tongue.

On the use of Rectal Insufflation of Hydrogen Gas to detect injuries of the Gastro-intestinal Canal in penetrating wounds of the Abdomen.—Prof. Senn of Milwaukee, at the last meeting of the American Medical Association (*Med. News*, May 15, '88), read a paper on the above subject and showed by experiments on animals how readily this method of diagnosis could be put in practice, and with what certainty wounds of the intestines could be detected by its use. Dr. Wm. Mackie (*Medical News*, June 9th, 1888) reports a case of *Gunshot Wound of the Intestine*, where the site of the injury was located by means of hydrogen gas. The patient was a colored man, aged 27, who had been shot in the abdomen with a 38 calibre pistol a little to the left of the linea alba and a little below the costal arch. The patient was etherized and rectal insufflation effected in the following

manner : A five-gallon rubber bag filled with hydrogen gas was connected by rubber tubing with a long glass tube of an extemporized chemical wash bottle half filled with water. To the short glass tube passing through the cork only was attached, by rubber tubing, the rectal nozzle of an enema syringe. This bottle was introduced so that the rapidity of the inflation could be judged of by the bubbling of gas through the water. When the rectal nozzle had been introduced, slow, steady and continuous pressure was made on the rubber bag. Under very slight pressure the gas commenced to bubble through the water. As inflation progressed the abdomen, previously flat on percussion from the umbilicus to the pubes, became resonant and the area of liver dulness diminished from below upwards. The inflation was continued until the abdomen became uniformly distended and tympanic throughout. Still no gas escaped through the wound of entrance until the abdomen was firmly compressed, when there was an intermittent escape of gas and blood through the wound. The gas, however, could not be lighted by the matches used ; but the escape of gas proved that the intestines had been injured and immediate laparotomy was performed. All the intestines were found distended with gas except the stomach and duodenum, and in each of these two wounds were found. These were closed, but the patient died thirty-six hours after of septic peritonitis.

In the *Medical News* of same date Dr. Wm. J. Taylor reports a case where hydrogen gas was used to determine the site of a fæcal fistula, whether it was in the large or small intestine. In order to determine the question Dr. Keen inflated the bowel with the gas in the way advised, and in less than half a minute, and before any gurgling was heard in the ileocæcal valve, gas was seen to bubble out of the fæcal opening, and on bringing a lighted candle near it the gas took fire. A small exploratory opening was then made in the abdomen and the fæcal fistula was found to arise from a carcinoma of the large bowel. The disease, however, had progressed far beyond operative relief, and the operation was not proceeded with.

Considerations on the Pathology of the Cæcum and Appendix.—Dr. Joseph Ransohoff of Cincinnati, in a paper on this

subject (*Med. News*, June 2, '88), says there are most excellent reasons for dividing inflammations in the right inguinal region into those of the cæcum, and those of the appendix, and each, again, should be divided into those of the part itself and those of its peritoneal investment. Thus the affections would be typhlitis and perityphlitis, appendicitis and periappendicitis. The inflammations of the appendix are of much more frequent occurrence than those of the cæcum proper. Perforations which occur in the cæcum are not often produced by foreign bodies; they are not infrequently produced by tuberculosis. In 25 cases of perforation in this region collected by the author only one was of the cæcum. Kraussold claimed that between the ages of 20 and 70 every third body will show traces of disease of the appendix, and that in tuberculous subjects it is often converted into a tubercular ulcer. In 60 examinations made by the author, in only 8 cases were there either abnormal adhesions, unusually hard fœcal masses, or cicatrices on the surface. This discrepancy may be due to the difference in food, where much vegetable food is taken, as in Siberia there is greater frequency of diseases in this region.

The history of appendicitis is like that of inflammation in any other narrow mucous canal with their catarrhal, ulcerative and cicatricial stages. Perforation is due in three-fifths of the cases to foreign bodies. In other cases the appendix degenerates into a retention cyst. In a fair proportion of cases (7 out of 25) no foreign body or fœcal mass can be found, nor can rupture of a cyst or tubercular ulceration account for the perforative peritonitis. In such cases the distal inch or two of the appendix is found gangrenous. This condition, Dr. Ransohoff thinks, is brought about by the displacement of the appendix and consequent torsion of its vessels. The exciting cause of perforative appendicitis is, in one-fifth of the cases, a violence from blows, excessive exercise, lifting, or vomiting. In cases of perforation where the contents of the appendix are thrown into the general peritoneal cavity, death ensues rapidly and before adhesions form. In many cases, however, gradual drainage prepares the way for limitation of the resulting abscess. The abscess from it may come to the sur-

face above or below Poupart's ligament, towards the hypogastrium, loin, or it may open into some hollow viscus, as cæcum, rectum, vagina, etc. Dr. Ransohoff appends the following aphorism to his paper: "Place not your faith in exploratory punctures; operate early and by lateral laparotomy where the symptoms are of the gravest and a tumor is not forthcoming; reserving the incision parallel to Poupart's ligament for abscesses that are palpable."

Laparotomy or Enterostomy.—Dr. Roswell Park of Buffalo (*N. Y. Medical Record*, March 3rd, 1888) gives a *resumé* of the recent literature on the treatment of obscure cases of acute intestinal obstruction; his conclusions are as follows: When a case of acute obstruction is seen *very* early, an exploratory laparotomy may be justified. When a case is seen very late, enterostomy is probably the only justifiable operation.

Laparotomy is especially indicated when the nature of the obstruction is recognized or made reasonably evident; when a small tumor indicating intussusception is made out; when the obstruction is caused by neoplasms which can be removed; when the condition of the peritoneal cavity demands washing out or drainage.

Enterostomy is especially indicated when no idea can be formed of the nature of the obstruction; when the malignant element includes hope of permanent benefit; when the abdomen is particularly tympanitic; when the patient's power has been undermined by the severity of the disease.

Laparotomy is the more radical and surgical measure, but somewhat the more dangerous.

Enterostomy is safer and quicker, causing little or no shock, but entailing certain very disagreeable sequelæ, suitable for all desperate and some favorable cases. Abdominal section should never be done in *extremis*; enterostomy may be.

Results of Laparotomy for Acute Intestinal Obstruction.—Dr. B. Farquhar Curtis, in a paper on this subject (*Annals of Surgery*, May, 1888) gives a series of tables showing the results of operations in cases of acute intestinal obstruction. He has collected 328 cases, with a mortality of 226 (68.9 per cent.)

In 101 cases the failure of the operation was due to the condition of the patient. In 28 cases the cause of obstruction was not found or could not be removed. In 17 cases sepsis, probably due to the operation, was the cause of death.

The reader is referred to this article for further information, and also to an editorial on the same subject in the same number of the *Annals*.

In the *Annals of Surgery* for August, 1888, is an interesting paper by Dr. H. E. Dalton of St. Louis on *Gunshot Wounds of Stomach and Liver treated by Laparotomy and suture of Visceral Wounds with Recovery*. Appended to the paper is a table of all the published cases of laparotomy for gunshot wounds—in all 69 cases, with 27 recoveries. In no case has Dr. Dalton been able to discover that the liver has been successfully sutured, and he thinks he is justified in claiming priority in the matter. In the *Brit. Med. Journal* for June 16, 1888, is an abstract from the *Riforma Medica* of a case of wound of the liver in a man aged 28 from knife stab, by Prof. Postempski. The wound was sutured with 6 chromised gut sutures, and the man made a good recovery.

Wounds of the Abdomen.—In the August number of the *Annals of Surgery* are reports of number of cases compiled from Russian sources of wonderful recoveries from stab wounds of the abdomen, with lesions and protrusions of the bowel. In one case, where the surgeon saw the patient twenty-four hours after the injury, which was caused by a staff armed with a pointed iron, he found a woman, aged 53, in a small hut, full of people, lying on a large wooden bench. She was pale and complained of agonizing pain; her belly was wrapped in a mass of dirty rags. The latter being removed, a loop of bowel was found strangulated in a clean cut wound situated $2\frac{1}{2}$ c.m. below the umbilicus. It was returned and the wound sewed up. The woman made a good recovery. Another case of stab wound of the abdomen, the patient a lad aged 17, was found in a loft crowded with laborers, and the abdomen was covered with dirty rags, on removing which the abdomen was seen to be covered with highly distended and congested intestinal loops,

amidst which omentum was visible here and there; a round worm and soft fecal matter present among the loops showed that the weapon had penetrated the bowel. The abdominal wound measured $1\frac{1}{2}$ inches in length. With great difficulty the man was placed under chloroform, for the struggles of the patient caused more bowel to protrude, besides there was not a single assistant and the room was small, hot, and sultry, as only Russian rooms can be in January. The bowel was finally returned, and the patient was quite well on the thirty-fourth day. Dr. Bekleinsheff observes that "the practitioner of this kind only too often finds himself in conditions in which one can venture to render medical aid only after summoning one's whole strength and courage. One single assistant is pure country air; to its agency the fact should be attributed that the rustic dirt does not give rise to such harmful consequences as are daily observed in towns in absence of ideal cleanliness."

Elements of Success in the Operation for Cleft Palate.—

Mr. Howard Marsh, in a paper in the *Lancet* of July 7th, 1888, draws attention to several important and essential points in the treatment of cleft palate by operation. He states that the mistake sometimes made is that of operating too early. It is possible to cure the slighter forms of cleft of the soft palate in children who are only a few months old, but even in the most favorable cases failure will be more frequent than success. It is better to postpone the operation until the child is two or three years old, or older still, unless he is well grown and strong. When the hard palate is involved the operation had better be postponed till the child is three and a half, and in the average run of cases it is better not to operate till the patient is four or five. Of course the earlier the operation the better the articulation, but if the success of closure of the palate was the only point to be considered, the best age would be between nine and twelve. Care must be taken to see that the child is in good health before operation is undertaken. The temperature should be taken morning and evening for three days before operation. Care must also be taken to ascertain that the child has not been

exposed to any of the exanthemata, especially scarlet fever. Should the patient have a cough or diarrhœa, the operation should be postponed. Again, the width and shape of the fissure is most important, also the conformation of the long arch of the palate. The mere antero-posterior extent of the cleft is immaterial; the really important points are the width of the fissure, the shape of its anterior end, and the height or pitch of the arch of the hard palate; the wider the cleft the more difficult it will be to close it. When the anterior end of the cleft is pointed like a thin wedge, the shape is favorable; but when the anterior end is rounded like the bow of a hair-pin, even though the cleft behind is not very wide, the difficulty of closure will be considerably increased. As to the arch, the higher the arch, the width remaining the same, the easier will the closure be.

In performing the operation, several points have considerable effect on the result. When the edges of the cleft have been pared, the soft parts on either side should be freely separated, not only from their general connections with the bones which they cover, but especially from their line of attachment to the posterior border of the horizontal plate of the palate bone. Separation should be effected by the free, though careful, use of blunt-pointed curved scissors, employed first to divide the structures along this line, and then the blades being closed, as an elevator, to complete the separation further forward. The palate will now hang in a flaccid state in its whole length, and its edges will admit of easy approximation. When the cleft is extensive the soft parts should be detached from the bones, not only along the borders of the cleft, but outwards and upwards nearly to the teeth. Another point is the relief of tension on the line of sutures by making lateral incisions. The incisions should run from before backwards and a little outwards, midway between the sutures and the alveolar process. The whole thickness should be divided only at the anterior half of the incision. The sutures should be of silver for the hard palate and of horse-hair for the soft. The first silver suture should be placed at the junction of the hard with the soft palate, then the soft palate should be closed to the tip of the uvula, and, lastly, the hard from behind forwards.

For four or five days after operation the child should be fed exclusively on milk and beef tea, with a little brandy added to the milk if necessary. From the sixth to the fourteenth day he may have bread-crumbs soaked in gravy, bread sauce made with milk, or finely browned potato in gravy. No solid food should be given until the palate has healed and the sutures have been removed. The palate should not be looked at for the first week, as opening the mouth does harm. The sutures should not be removed until the tenth day.

Mr. Marsh's directions are well worthy of attention; there is no greater disappointment to the surgeon than a failure in the operation for cleft palate. Not unfrequently the operator fails on account of the supervention of scarlet fever or other exanthem. With regard to the sutures, silk-worm gut is more easily managed than horse-hair, and silk than wire. The silk-worm gut may be left in indefinitely without causing any irritation.

A New Method for the Treatment of Indolent Ulcers.—Dr. F. Spaeth (*Centralblatt f. Chirurgie*, No. 14, 1888) says that the reason failure is so frequent in the treatment of indolent ulcers is because of the deficient nourishment of the surrounding tissues; for this reason many methods, such as Thiersch's, though temporarily successful, often fail. To bring about a better condition of the ulcer and its surroundings is his object. His method is as follows: The whole ulcer is divided from one end to the other by incisions which reach into the healthy tissue beyond, and transverse incisions are made in the same way, through the callous boundary of the ulcer into the healthy tissue. These incisions should be about two centimeters distant from one another. The incisions should extend not only through the skin, but into the subcutaneous fascia. The bleeding can be controlled by pressure, and the parts should be dressed with a firmly and evenly applied iodoform gauze bandage. This should be left on for from eight to fourteen days, when it is removed. The ulcer will be found to be granulating in a healthy manner, and now, if necessary, may be closed by the transplantation of skin. The results Dr. Spaeth has found excellent; the resulting scar is soft and well-nourished, and there is no tendency of the ulcer to relapse.

Primary Operations for Breast Cancer in von Bergmann's Klinik from the Autumn of 1882 to May 1887.—J. Rotter (*Müncher Med. Woch.*, 1887; No. 49) gives an account of 114 primary operations in which the breast, neighboring fat, pectoral fascia, portions of the pectoral muscle, and the axillary glands were removed. In only two cases were indurated glands not found in the axilla. Three times was the axillary vein tied and once the vein and artery. Once the pleural cavity was opened, but the patient made a good recovery. In five cases death shortly followed the operation—one each from hemorrhage of the stomach, lung embolism, brain embolism, collapse (after amputation of both breasts), and sepsis. In 30 cases the disease recurred in the breast wound. In 6 the disease returned in the opposite breast. In one case only was the axilla alone engaged. Twelve patients had recurrence of the disease in internal organs without local or regional recurrences. In 18 cases the cause of death was not ascertained. Thirty-four cases remained free from a recurrence of the disease up to date; 5, one to six months; 7, six to twelve months; 4, one to two years; 5, two to three years; 8, three to four years; and 5, from four to four and a half years, so that 13 may be regarded as definitely cured. These 13 recovered out of 43 operations from the autumn of 1882 to end of May 1884.

Excision of a Dislocated Spleen and subsequent Expectoration of the ligature of the pedicle.—Dr. T. H. McGraw of Detroit reports (*N. Y. Med. Record*, June 30, 1888) a successful case of extirpation of the spleen in a woman aged 40, and in the same paper mentions another case in a man aged 27, where death ensued 2½ hours after operation from hemorrhage.

QUARTERLY RETROSPECT OF GYNÆCOLOGY.

PREPARED BY T. JOHNSON ALLOWAY, M.D.,

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Stenosis of Cervical Canal.—Dr. More Madden says: "This is not only the most common of all the causes of sterility, but is, moreover, according to my experience, the one which proves most amenable to appropriate treatment. Believing as I do that though both dilatation and incision of the cervix may be successfully employed in many cases, I also know that both these plans very often fail in permanently overcoming the natural contractility of the cervical structures, and that after each operation the canal too commonly rapidly resumes its former condition, and frequently, from cicatricial contraction, becomes still less permeable than before the operation. Hence I now desire to direct attention to the advantage I have observed in the treatment of such cases from the method of procedure and the use of instruments by which the parts are so forcibly separated and torn apart rather than cut as to reduce any risk of their reunion. I will here refer to the method I employ in such cases in my hospital practice. The total number of cases on which I have operated during the last ten years now exceed four hundred. The operation should be undertaken a few days after the catamenial period, and should be preceded by daily hot water irrigations. Under ether the patient is placed in Sims' position and the cervix drawn down by a volsella. I pass my uterine director, which is a long probe-pointed instrument, and along its groove pass a triangular-shaped blunt-edged knife into the uterine cavity. It is then rotated and withdrawn in the opposite direction." Dr. Madden also employs Simpson's original metrotome for this purpose, and regards it as better than either Emmet's or Sims' instruments. Dr. Madden says: "The permeability of the cervical canal is best maintained by the use of the dilator. Immediately after the incision I employ one, not merely with the view of thoroughly expanding the canal and its orifice, but also for the purpose of tearing the divided tissues and vessels and thus arresting any excessive hemorrhage. The extent of dilata-

tion depends largely upon the indications of each case. As a rule, in ordinary cases expansion to the extent of $1\frac{1}{2}$ inches suffices. After thorough dilatation the cavity of uterus is washed out with hot carbolized solution. The cervix is now packed with absorbent cotton saturated in glycerine and carbolic acid, and plug the vagina with the same. The latter is removed in twenty-four hours, the former in sixty hours if not sooner expelled. A large-sized soft rubber stem is now introduced. The patient should be kept in bed for a fortnight after the operation and the uterine cavity daily washed out with plain or medicated water. Before the patient leaves her bed a carefully adjusted Hodge pessary is introduced to support the pelvic floor. The patient should remain in bed during the next menstrual period. She should then wear a soft rubber stem until the approach of subsequent period."—*Brit. Med. Journal*.

In regard to the time the operation of dilatation should be performed I think Dr. Goodell's advice is better than Dr. Madden's—namely, midway between the periods. I also deprecate very much doing the operation on the side. The lithotomy, with Simon's speculum, is the proper position, carried out as the Germans do. Here we can pull the uterus down more easily, and can keep up a constant stream of boiled water running between the blades of the dilator during the whole period of the operation. In this way coagulated blood is not allowed to form in the wound fissures—a frequent source of infection—and the instrument is managed much more easily.

I do not agree with Dr. Madden in his partiality for Simpson's metrotome over Sims'. It, of course, is largely a matter of fancy, but a skilled operator will always prefer an instrument which does not work as a machine turned by a spring or stop-screw, but that which is under the special control of his own judgment. In speaking of the dilatation or divulsion part of the operation, Dr. Madden performs simply Dr. Goodell's operation of divulsion or rapid dilatation originally suggested and practised by Dr. Ellwood Wilson of Philadelphia. In all of these cases it is well to thoroughly curette the endometrium, and where there is much papillary erosion of the cervix to excise the mu-

cous membrane of the cervix in its entirety after Schröder's method.

Endometritis and Sterility.—“Chronic endometritis is incompatible with fecundity, and as long as that disease exists to any serious extent the patient must remain barren. In such cases not only is impregnation mechanically obstructed by the viscid glairy secretion by which the os and inferior segment of the cervical canal is sealed in all cases, but also the inflammatory action going on within the uterus may prevent the formation of the membrana decidua; and hence the ovum, even though impregnated, is necessarily thrown off without any manifestation of its existence in the fertilized state. Also, the diseased condition of the lining membrane of the uterus may be extended to the Fallopian canals, obliterating for a time their internal orifices, so as to oppose an insurmountable barrier to impregnation. Again, the uterine secretions in cases of endometritis may be inimical to the active existence of the spermatozoa. Dr. Madden recapitulates as follows :

1. That congestive hypertrophy of the uterus, and especially of the cervix, is a very common cause of sterility.

2. That these conditions are, in the majority of cases, occasioned by constitutional causes, one of the most frequent of which is the scrofulous diathesis.

3. That these diseases require constitutional as well as local treatment, and would again urge the benefits to be derived in such cases from certain mineral and thermal waters.”

Ovarian and Tubal Sterility.—Dr. More Madden says:—“Ovarian inflammation is one of the most frequent consequences and accompaniments of endometritis. In these cases the inflammation extends from the uterus along the Fallopian tubes to the ovaries, and this to a great extent accounts for the fact just mentioned that patients suffering from endometritis are invariably sterile. In such cases the inflammatory action is generally attended by a viscid exudation, by which the tubes, and especially their uterine orifices, are mechanically sealed against the possibility of impregnation. Independently, however, of its frequent sequence on endometritis, tubal obstruction, productive

of dysmenorrhœa and sterility, may also arise from those possible graver, but, according to my experience, comparatively exceptional diseases, namely, idiopathic salpingitis and pyo-salpinx, in the treatment of which operative procedures, involving loss of all future conceptive ability by the complete removal of the uterine annexa, are now so readily resorted to by some practitioners. For my own part, having in not a few cases seen all the supposed symptoms of pyo-salpinx subside completely without any surgical interposition whatever, it would seem to me quite as rational to amputate the breast for an ordinary mammary abscess as to remove the Fallopian tubes merely because they may be the seat of serous or purulent exudations. In some cases of the latter kind there is, as I can vouch from clinical experience, no absolute impossibility of reaching and removing such collections by aspiration or even by catheterization of the Fallopian tubes. Many years ago, having occasion to use the sound in a patient suffering from dysmenorrhœa and sterility, I was surprised, there being no enlargement of the uterus, to find the sound pass in up to the handle, and on palpation discovered that obviously it had entered the right Fallopian tube. A year subsequently that lady gave birth to her first child after eight years of married life. Since then I have more than once succeeded in accomplishing by a little careful manipulation what in the first instance was but a happy accident. And hence I endeavor to impress on those who attend my hospital practice the fact that the catheterization of the Fallopian tubes, when employed by a practised hand and with due caution, is a feasible, and in some exceptional instances may possibly prove an effectual method of treating certain cases of dysmenorrhœa, sterility, and other morbid conditions. Sterility may also arise from causes irrespective of any physical lesion; and although impregnation in no way depends upon the sexual organism, unquestionably it may be prevented by strong mental emotion or by personal dislike. In some instances, however, sexual incongruity productive of sterility coexists with conjugal affection. Thus I have more than once been consulted by sterile patients, happily married, desirous of offspring, and not suffering from any physical disability, who

informed me that, though warmly attached to their husbands, not only was there absolute sexual indifference, but even positive repugnance to coition, any attempt at which in one of these cases invariably produced nausea. In that case I may add that the last-mentioned symptom was allayed by the use of cocaine suppositories. Still more commonly is sterility dependent on abuse or abnormal irritation of the sexual organs, and hence the general sterility of prostitutes. In the treatment of infecundity, independent of any local disease, malformation or displacement, or of any obvious derangement of the general health, or other tangible cause, and in which the mineral waters have either been tried without benefit, or are contraindicated or not available, a course of sea-bathing, whatever may be its *modus operandi*, is a prescription the occasional efficacy of which in such cases I have seen proved by experience."

I do not agree with Dr. Madden in the analogy he draws between the Fallopian tubes and the breasts as points of abscess formation. The comparison is absurd when we consider the difference in mortality and importance between these organs from a surgical standpoint.

Neither do I accept Dr. Madden's views as being sound regarding the treatment of pyo-salpinx other than surgical. If Dr. Madden has seen a few cases of *supposed* pyo-salpinx subside on medical treatment they should be eliminated as unproven, and were in all probability patients possessing healthy tubes. Bandl speaks of the great difficulty of diagnosing, with any degree of accuracy, hydrops tubæ. He says: "The certain diagnosis of a hydrops tubæ is only possible in the very rarest cases when there is a coincidence of many favoring circumstances since we have seen no characteristic symptoms, and since we can only suspect it when women complain of pain in the lower abdomen. We can only obtain a diagnosis by the bimanual examination. This will only be certainly possible in those cases where the tubal tumor has no special adhesion to its surroundings, so that we can detect the seat of the tumor and the nature of its connection with the uterus. If the tubal tumors are sunk in Douglas' pouch, if they are adherent, or if inflammatory pro-

cesses lead us to examine the patient, the characteristic form of the tumor is usually lost and may be mistaken for various conditions, such as small ovarian tumors, soft fibroids, or sacculated exudations. Cases in which tubal tumors have been recognized during life are rare."—*Cyclop. Obst. and Gyn.*, vol. xii.

Dr. Madden says "there is no *absolute impossibility* of reaching and removing collections within the tubes by aspiration or even by catheterization." There are few endeavors in surgery absolutely impossible, but I think these two procedures are almost on the border line. To encourage attempts in this direction is certainly not good teaching. Dr. Madden may have been under the impression that he passed the sound through the Fallopian tubes in one of his cases cited, and the fact of the woman becoming pregnant afterwards is no proof at all, it is merely a coincidence. Dr. Madden will require to bring more substantial proof than he has done of the ease and feasibility of catheterizing the Fallopian tubes before he will impress the specialist in gynæcology, even when conducted by so practiced and cautious a hand as Dr. Madden possesses.

Bandl says in regard to catheterization of the Fallopian tubes* : "When we undertake to sound a diseased tube, we must take into consideration the fact that in the cadaver, under normal conditions, the tubes of married or unmarried women cannot be sounded by large or small sounds, as has been proved by Albers, Hennig, Wegner and myself. Also during life, with wide uterine cavities, the dilatation may give rise to the idea that possibly the situation of the tubes, which has never occurred to me, may be found and the sound passed. We must always take into consideration the fact that the sound can be passed through the uterine substance near the opening of the tube. This easily happens when the uterus is still in the condition of puerperal involution, as was observed by Robt, Rückard and Lehmus, that on the thirty-fourth day after delivery it is easy to pass a sound through the uterine wall into the abdominal cavity, and Wegner demonstrated by necropsy the presence of perforation of the muscularis of a dilated and partly fatty uterus. In the

* *Cyclop. of Obst. and Gyn.*, Vol. XII.

same manner the sound was easily passed through the uterus in four other cases. Hönig describes perforation of the uterus, and Alt two cases where the sound was passed from six to seven inches into the uterus of a recently delivered woman, causing perforation; Tait also described such cases in the *Lancet* of 1872-3. Perforation of the uterus with the sound can very easily occur in extra-uterine pregnancy, a case of which we have ourselves observed and described. In this case, by very light pressure the sound was passed nine inches, perforated the uterus and produced the impression that the tube had been sounded; but the necropsy showed a perforation close to the uterine opening of the right tube. It is interesting to notice that in almost all described perforations of the uterus reaction did not occur. It was so in four cases of Robt, Rücklard and Lehmus, in three cases of Lawson Tait's, in our own, and also by Zini, who could in seven cases in the first six weeks after involution pass the sound eight inches into the uterus, and often felt the knob of the sound through the abdomen to one side of the median line without reaction. From these various observations it is doubtful whether a tube has been sounded, and it is certain that the greatest care is necessary in such an undertaking."

Puncture of tumors of the Fallopian tube through the vagina is an exceeding difficult and hazardous thing to do, chiefly on account of the difficulty in making an accurate diagnosis, but also of the danger of wounding the intestine. Simpson was probably the first to employ it, and to him is credited the cure of some cases by this method. Who knows but Tait's improved method of dealing with such cases may not have been an outcome of some of the disastrous results witnessed in Simpson's practice.

Mr. Tait's Method of Flap-Splitting.—Dr. H. T. Hanks of New York writes a paper in the *International Journal of Surgery and Antiseptics*, describing and illustrating the method of operating on vesico-vaginal fistula, ruptured perineum and umbilical and ventral hernia. He describes Tait's method as follows: "The patient is placed in Sims' position, varying somewhat according to the location of the fistula. He then inserts

the Ferguson speculum and brings the fistula in exact view. Then with a delicate pair of scissors he incises at the proximal and distal extremity of the fistula the mucous membrane of the vagina for one-third of an inch. This is a preparation for the splitting up of the mucous membrane of the vagina from the mucous membrane of the bladder for a depth of from one-twelfth to one-eighth of an inch all around the fistula. This work thus far is all done with the same pair of scissors through the cylindrical speculum. The speculum is then removed, the index finger introduced, and with his finger-nail he makes sure that the two laps are properly separated, going over the same course that he has already cut up with the scissors. Then pushing the vesical flap forward into the bladder, and turning the vaginal tissues backwards into the vagina. In this way the wound is made ready for the suture. If the fistula is of small or medium size, one suture completes the operation. A delicate Peaslee needle, single curve with carrying-thread, is the only instrument that Mr. Tait uses in introducing the suture. He inserts the point of the needle at the proximal end of the wound, and passes it to the right or left, as the case may be, through the tissues directly underneath the angle of the flaps, all the way around to the distal extremity of the wound, where he makes the point emerge into the vagina again. He now threads the delicate silver wire wholly by the sense of touch into the carrying-thread and withdraws the needle; the fistula is now half surrounded with the suture. Exactly the same course is pursued in passing the needle on the opposite side; and when the needle is withdrawn the suture will have completely surrounded the fistula. While drawing up and twisting the wire, he keeps one finger in the fistula to make sure that the mucous membrane of the bladder is pushed into that viscus, and the mucous membrane of the vagina is drawn upward into that passage. The parts are then drawn together and held in apposition in precisely the same manner as a purse is drawn up by a purse-string."

In the operation for laceration of the perineum the same method of flap-splitting is carried out, without removing any tissue, and the purse-string suture is used to bring the parts

together. If the tear is extensive, and much splitting is found necessary, several sutures are used. But Mr. Tait's operation is especially adapted to cases of complete laceration, where the rectum is involved more or less. On comparing the diagrams of Dr. Hanks' paper showing this operation in cases of laceration of the perineum, and some of those in the *Handbook of Medical Sciences* illustrating the "one suture operation" in the article on "Primary Perineorrhaphy," we are struck with the similarity of the two operations in principle.

Peritoneal Drainage with Iodoform Wicks.—Dr. L. Piskacek (Vienna) protests against the indiscriminate use of abdominal drainage after laparotomies. According to him drainage is indicated (1) in cases of extra-uterine pregnancy, where entire removal of the sac is impossible; (2) in cases of interligamentous cysts, where after the enucleation of the cysts large cavities result; (3) after incomplete ovariectomies, *i.e.*, in cases where a part of cyst-wall must be left behind; (4) if on account of extensive and firm adhesions the peritoneum is torn in many places, much secretion collects, and the operation is protracted; (5) after unclean operations, *i.e.*, where the abdominal cavity becomes contaminated with pus from purulent cysts or abscesses. Strict antiseptics is practised at Briesky's clinic. In place of sponges, pads of corrosive sublimate gauze are used. Catgut is never employed, as it cannot be rendered perfectly aseptic. Kocher has recently shown that in a large number of cases infection of wounds is attributable to the catgut suture. In answer to the question whether the drainage should take place through the abdominal wound or through Douglas's cul-de-sac, the author expresses himself against the latter on account of the danger of entrance of air and germs from the vagina through the drain. He recommends the use of iodoform wicks as a drain, numerous experiments and the abundant clinical material at Briesky's clinic having convinced him of their superiority. Briesky has used them exclusively for a year in peritoneal drainage, both after vaginal hysterectomies and laparotomies. Their advantages over other forms of drains are: (1) Great absorbent power; (2) no occlusion by coagular and dried secretions, as in fenestration.

trated drains ; (3) absorption not interfered with by the twisting and doubling up of the threads ; (4) may be retained for long periods without irritation ; (5) are easily manipulated and very cheap. The one drawback to their use—the adhesion of the threads to the granulations—may be obviated, if care is taken at the time of their removal to first draw out the threads in the centre of the drain ; the peripheral ones are thus loosened and may be readily withdrawn. The author has also used strips of iodoform gauze as drains, but found their absorbing power only one-third as strong as that of the wicks. As used in Breisky's clinic the wick is composed of fifty threads of cotton yarn, about ten inches long. They are rendered aseptic by boiling in 1 to 1000 sublimate or in a 5 per cent. carbolic solution, then soaking for twelve hours in a mixture of iodoform 5 parts, glycerine 10 parts, and alcohol 70 parts, or in a 10 per cent. solution of iodoform in ether. After laparotomies the wick is inserted so that its lower end rests near Douglas's pouch and the upper protrudes for about three inches from the lower margin of the abdominal wound. It is not removed until the wound-canal has become so shallow that retention of secretions is no longer feared, although in three or four days the threads may be gradually shortened, beginning with those in the centre of the drain. After vaginal hysterectomies two wick drains are inserted in the vaginal wound and the vagina tamponed with iodoform gauze. The gauze is renewed in three or four days, but the drain remains until healing is accomplished. In cases where this method was used protrusions and adhesions of the intestine were never noticed, fever remained absent, and the vaginal wound was usually closed when the wick was removed.—*Medizinische Jahrbücher*, 1888.

Ovariectomy in a Patient aged Eighty-two years and four months ; recovery.—The patient (under care of John Homans, M.D., Boston) was a widow and had been the mother of five children, the youngest being 43 years old. Dr. Homans says : “ On examination I found a tumor of the left ovary, apparently without adhesions, in an active healthy woman. The presence of the tumor had been known for about two years, and it had grown

rapidly during the last six months. The lady said that if the tumor was likely to render the remainder of her days uncomfortable she would like to have it removed. On Jan. 28, '88, I removed the cyst, which proved to be one of the left ovary, somewhat multilocular and papillomatous. The fluid weighed thirteen pounds, and the solid portion one and three-quarter pounds. On the sixth day the temperature rose to 100.5°F., but subsided the next day, and the patient went home on March 2nd. The oldest women on whom I had previously operated were each 73 years of age—one on November 19, 1881, and the other on December 26, 1883. Both of these ladies are now living in good health. Sir Spencer Wells' oldest case was 71, and Dr. Keith's 73. Mr. E. Matthews Owens of Australia has just operated successfully on a patient aged 79 years and 10 months. I could find no case as old as 80 years, but to make assurance double applied to Dr. J. S. Billings at Washington, and at his request Dr. Lorini made a thorough search without finding any case recorded older than 78 years of age. It will be seen from the above that not a single case of ovariectomy in a woman 80 years old or older has ever been reported, if Dr. Lorini's search has been exhaustive, and I think we may consider it so".—*N. Y. Record*, May 5, 1888.

The *British Medical Journal*, May 26, 1888, in an editorial on this case, states that "Olshausen notes that Schröder successfully operated on a patient aged 70, and on another aged 80. Dr. Miner described in the *Buffalo Med. and Surg. Journal*, Sept., 1866, the removal of a multilocular ovarian tumor weighing 19½ lbs. from a woman aged 82. She died fourteen days after operation. Dr. Homans' patient is probably the oldest who has recovered from ovariectomy."

Rupture of the Fallopian Tube; Recovery.—The patient (under care of Dr. Duchamp, Lyon), who had last menstruated on April 30, 1887, was suddenly attacked on 17th of June with syncope, vomiting, and a feeling of something having given way in her abdomen. Duchamp was called in consultation on the following day and found her in a condition of collapse. The pulse was almost imperceptible, the abdomen markedly distended,

and extremely tender in the umbilical region. The patient was vomiting greenish matter. On being questioned, she stated that the pains had commenced just above the pubic region, and were accompanied for about half an hour by vesical tenesmus. Examination of the vagina disclosed nothing definite. An intra-peritoneal pelvic hemorrhage was suspected, and in the afternoon of the same day laparotomy was performed, after previous catheterization and thorough disinfection of the abdomen. A spray was not used. The abdominal cavity contained a quantity of fluid and clotted blood, of which 2.5 liters were evacuated, and a foetus about two cm. long extracted. Old peritoneal adhesions were found and a perforation of the left tube. The tube and ovarian ligament were tied with carbolized silk at two places close to the uterus, and the remaining part of the tube and the ovary excised. Recovery followed promptly, and three weeks after the operation the patient was discharged cured.—*Lyon Medicale*.

When should the Abdomen be Opened?—Dr. A. W. Johnstone, in *Progress*, says: "What the general practitioner wants to know is not how to make a preparation, but what it will do after the druggist furnishes it to him, and the most that he requires of laparotomy is how many, and what particular kind, of his cases can be cured by it. What I mean by opening the abdomen is ovariectomy in its strictest sense, for I believe the time is not far distant when he who, in the ordinary sense, *taps* an ovarian tumor will lay himself liable to malpractice. The teachings of all most successful operators now are, never to meddle with an ovarian tumor in any way until you are ready to take it out. It is true that now and then we are called to neglected cases whose surroundings are so bad that removal to a more healthy point is necessary, or whose respiratory apparatus is so hampered by pressure as to make an anæsthetic dangerous, and to gain a little time we sometimes tap such cases, but the radical operation ought always to follow in a few days, so that tapping ought never to be thought of except as a very rare *preliminary* to ovariectomy. In case of accidents which will occur to tumors, such as twisting of pedicles, inflammations, suppurations, ruptures, hemorrhages, peritonitis and the like,

we now demand immediate removal ; so that whenever any unusual symptoms develop in the course of a tumor, our rule is, no matter what they may be, to operate at once, provided the shock is not so great as to make any additional disturbance certain death ; even in these cases, if any reaction takes place, our only course is immediate operation. These accidental things, the most common of which is suppuration, furnish a very considerable proportion of hysterectomies done, but as this introduces us to the subject of operations on the non-gravid uterus, I will give Keith's indications for operating.

1st, In very large (upwards of 20 lbs.) rapidly-growing tumors of all kinds in young women.

2nd, In all cases of real fibrous cystic tumors, if they can be removed, also in all cases of suppurating tumors, in most cases of the œdematous tumor ; these often grow to an enormous size, far larger than any ovarian tumor. I have seen one that would not be less than two hundred pounds in weight ; sometimes large quantities of red serum can be removed with much relief. I have several times been able by this means to carry patients over the menopause, when the necessity for puncturing ceases.

3rd, These tumors seem to open up the broad ligaments, more than the ordinary hard tumor. Some that I have removed have had very extensive pelvic attachments. These tumors are much reduced by free purgation.

4th, In cases of large bleeding fibroids of any age, provided the patients are not approaching fifty years of age, and provided the lives are practically useless, and that further experience in the operation shall show that the mortality of hysterectomy is likely to diminish.

5th, In certain cases of tumors surrounded by free fluid, the result of peritonitis, provided the fluid shows a tendency to re-accumulate after two or three punctures."

There are several other conditions which could be added to this list, but more especially that of suspected threatening rupture of foetal sac in ectopic pregnancy.

Ether or Chloroform.—In the *Philadelphia Medical Times* the views of Dr. Hunter McGuire are given. He is wedded to

neither ether nor chloroform. In very feeble people or those suffering from prostration or shock, or loss of blood, he prefers ether. In the very young, or the very old, or in cases where cardiac or renal or pulmonary disease is suspected, he regards chloroform as safer. That both agents kill, all must admit. Which is the more dangerous is undetermined. Chloroform is the more powerful and immediately dangerous anæsthetic; when it kills it does so by shock, but when the vapor is withdrawn and consciousness returns the danger is absolutely over. Ether may kill, but is less likely to do so, and the danger is not over when the anæsthetic is removed. Alarming symptoms may occur by cardiac paralysis a few moments after, or by acute nephritis or pneumonia, hours or days after the administration. In acute or chronic diseases of the kidneys or lungs, ether is more dangerous than chloroform. Both anæsthetics may produce death if too concentrated a vapor is employed; both may kill during the period of muscular excitement, or by paralysis of the respiratory nervous centres. In giving chloroform it is better to begin with a small quantity, allowing plenty of fresh air until the patient has become accustomed to its use. The patient should never be alarmed or surprised with too concentrated a vapor. It is unwise to give alcohol immediately before the anæsthetic. It is hazardous to operate during partial anæsthesia from chloroform. Ether is the safest. While chloroform is safer in organic valvular disease of the heart, it is more dangerous than ether in a heart weak from fatty degeneration, or from loss of blood, or great anæmia from other causes. Of all elements of danger from chloroform, fear on the part of the patient is the greatest. Ether is then the safer. If there be much terror on the part of the patient, it is better to administer hypodermically a quarter of a grain of morphine and one one-hundredth of a grain of atropine, and wait fifteen or twenty minutes before giving the anæsthetic. The immunity of children to chloroform, and soldiers and women in confinement, he ascribes to absence of fear.

Intra-uterine Medication.—Dr. Robert Bell (*British Medical Journal*) considers the uterus in a large majority of cases the source of the mischief in many of the various affections to which

the tubes and ovaries were liable. It is therefore by suitable treatment of the uterus that such evils were to be averted. Iodised phenol is the preparation which gives the best results. It is aseptic and antiseptic in the highest degree, and the carbolic acid exercises a powerful anodyne effect on the endometrium; it possessed also powerful alterative properties. In treating cases of long-standing endometritis it is necessary to remove the glanular condition of the mucous membrane as a preliminary to the strictly medical part of the treatment. This is effected by means of the curette. He has also found intra-uterine medication useful in a class of cases where it was not usually employed—namely, in displacements. Displacements were invariably associated with a softened condition of the uterine walls from a congested condition of the parts. In conjunction with the use of pessaries, intra-uterine medication did much permanently to remove the displacement.

Effects of Exposure of the Intestine.—At the meeting of the Berlin Obstetrical and Gynecological Society, Prof. Olshausen read a communication on a hitherto unrecognized cause of death after laparotomy where intestine has been allowed to lie outside the abdominal wall for a prolonged period. Here, surgeons are careful to prevent prolapse of the intestines. Coils which adhere to a tumor and cannot be at once separated are carefully covered with flat sponges, or with towels wrung out in hot water which often contains an antiseptic compound. As soon as the adherent coils are separated from the tumor, all bleeding points being secured, they are carefully replaced. As soon as the tumor is extracted through the abdominal wound, or, indeed, whilst it is slipping out of the incision, a broad flat sponge is slipped into the peritoneal cavity to prevent any chance of prolapse, and to protect the gut from the suture-needles. The abdominal incision is, moreover, always made as short as possible so as to avoid the sudden escape of coils of intestine. The Germans are less particular about eventration. Dr. Martin, in 1885, publicly recommended the dragging out of a large amount of intestine in cases where the tumor lay deep in the abdominal cavity, and declared that the greater part of the intestinal tract might be left hanging

out of the abdomen during the whole operation, so that the surgeon might have plenty of room for manipulating the tumor. "This eventration," said Dr. Martin, "is quite free from danger; I have practised it in at least 90 per cent. of my cases without seeing any evil results." Prof. Olshausen was more cautious, and directed attention to certain cases of collapse, often fatal, which followed cases of abdominal section and were not accompanied by symptoms of peritonitis. He concluded that prolonged exposure of the intestines in laparotomy might cause disturbance in the circulation in the walls of the gut, ending in venous stasis and serous infiltration, with ultimate formation of ecchymoses. At the same time the muscular coat is paralysed, often for several days; if the paralysis does not abate, symptoms of ileus set in. Fatal results of this kind are probably caused by the absorption of decomposing material in the intestinal canal.—*Brit. Med. Journal.*

Abdominal Section, with reopening of the wound on the eighth day for Purulent Peritonitis.—E. F., aged 26, was admitted into the Sydney Hospital on August 31, 1886, complaining of pain in the back, bearing down, and dysmenorrhœa. Micturition was frequent, difficult, and painful. Sexual intercourse invariably painful. These symptoms dated from last confinement, 2½ years previously. She had had two children, and suffered from *phlemasia alba dolens* after the first, and "inflammation" after the second. The os was found to be eroded, everted, and lacerated. The uterus was large and heavy. A hard tender mass occupied the position of the left broad ligament, and the right ligament was thickened and tender. An operation was refused at the time, and when readmitted in October she was very much worse. The uterus was fixed in a mass of inflammatory exudation which extended half-way to the umbilicus. Abdominal section was performed on January 13, 1887. The pelvic organs were found to be all matter together, but with great difficulty the left broad ligament was isolated and found to contain a cyst the size of an egg. The uterine appendages were then ligatured and removed. The hemorrhage was arrested with difficulty. On the third

day, as all discharge had ceased, the drainage-tube was discontinued. Severe shooting pain at intervals. On the fifth day pus began to flow from the track of the drainage-tube, and the tongue was dry, the temperature rising to 102.2° at night. On the eighth day the wound was reopened and an immense quantity of fetid pus evacuated. The abdominal cavity was then thoroughly washed out and the wound closed, a fresh drainage-tube being inserted. On the second day the patient was much better, in spite of a phlebitis of the left internal jugular, left axillary, and right femoral veins. On February 9 the drainage-tube was removed, and on March 26 she was discharged in fair health, pus, however, still escaping through the track of the tube. She markedly improved in health, and resumed cohabitation. She had an attack of hæmatocele on May 12. The menses appeared every month in variable quantity, and were accompanied by flushes and other nervous and vascular phenomena characteristic of the menopause. She gradually though slowly advanced towards good health.

The above is a most instructive case, and proves the wisdom of active interference in all such cases without hesitation.

Ovarian Tumors in Pregnant Women.—Dr. Braxton Hicks, in the *British Medical Journal*, says that in two recent cases of ovarian tumor, associated with pregnancy, the removal of the tumor had been followed by recovery. In the first, labor had continued thirty hours. The tumor came down and prevented the head being seized with forceps; turning was tried and found impossible. The child was finally delivered with long forceps, and was still living. The placenta required removal. The tumor grew rapidly after delivery, and was removed. It was adherent everywhere, and was compound in character, nearly colloid. The patient made an excellent recovery. In the second case there was an ovarian tumor which reached rather above the umbilicus. It was diagnosed to be composed of two cysts. The woman had missed two periods, and it was proposed to wait until after the middle of pregnancy. However, the cyst became tense with pain, and was removed. The pedicle was found twisted, and the tumor adherent and becom-

ing necrosed. No uterine action came on for two weeks, when an ovum was expelled. The cases showed that when ovarian tumor and pregnancy were concurrent, if the tumor gave signs of irritation, the sooner it was removed the better. Dr. Handfield-Jones speaks of the rapid growth of ovarian cysts after the uterus had been emptied. He has known them within two months attain enormous size, and contract adhesions.

The second case here cited resembles somewhat one in which I assisted my colleague, Dr. Wm. Gardner, a short time since in removing an ovarian tumor at the same term of pregnancy. Our case, however, went to full term and was safely delivered.

Correspondence.

The following is from a private letter received from Dr. H. S. Birkett, who is at present in Berlin :

BERLIN, W., 2nd August, 1888.

We visited Bergmann's clinic, and were fortunate to see quite a number of operations, and thus learn somewhat of his methods. The preliminaries of an operation are as follows: The part to be operated upon is thoroughly scrubbed by means of a nail brush, with hot water and soap. Next, irrigation of the part with bichloride solution (1-2000); the region surrounding the part to be operated upon is covered with towels wrung out of bichloride solution (1-2000), thus leaving the part to be operated upon exposed. The surgeon and his assistants wash their hands, first with hot water and soap, next in bichloride (1-2000) and finally rinse them in rectified spirits. The solution for irrigation is bichloride (1-2000); the instruments are kept immersed in sol. carbolic acid (1-30); the the ligatures are cabolised catgut; sutures are also catgut, and twisted silk; the dressings are of fine gauze, impregnated with iodoform, and this is the only way in which iodoform is used; the absorbent material consists of large quantities of washed gauze, whether impregnated with bichloride I do not know; no sponges are used, but portions of this same kind of gauze are substituted; gauze bandages are used. Mixture of chloroform and ether is the anæsthetic.

The operating room is specially suited to its purpose. The floor is tiled, the light comes through a glass roof, no side windows being present; electric light is also supplied if necessary.

Another clinic of interest which was visited was that of Dr. Joseph—skin clinic.

Among many interesting cases seen was one of leucoplasia buccalis. Joseph's treatment of such cases is the use of lactic acid, beginning with 30 per cent. solution in glycerine. This is applied every two weeks, and by means of a stiff brush, the application is rubbed into the affected parts until bleeding is produced. A gargle of precipitated chalk is subsequently used by the patient. The solution of lactic acid is gradually increased to 50 per cent. The case at that time certainly had undergone marked improvement under its use. Joseph also recommends its use in lupus, applied in the same manner.

Upon another occasion we saw a marked case of Addison's disease. The most striking point was the increase of pigment in the axillary regions, flexor surface of arms, and the mucous membrane of mouth.

Hospital Reports.

MONTREAL GENERAL HOSPITAL.

UNDER CARE OF DR. SHEPHERD.

(Reported by J. F. SPRINGLE, M.D., House Surgeon.)

CASE I.—Nephrotomy for supposed Calculus in the Kidney. Rapid recovery and relief of symptoms.

William B., a strong, healthy-looking young man, aged 24 years, was admitted to this hospital on June 22nd, 1888, complaining of severe and more or less constant pain of a lancinating character in the left lumbar region, and shooting down through the groin to the left scrotum at times. His present affection dates back as far as the year 1880, when he was suddenly seized with an agonizing pain in the region of the left kidney and radiating along the course of the ureter down to the scrotum and end of the penis. The left testicle was tightly drawn up. The patient states that his water was decreased in amount from the

beginning of the attack, high-colored, and depositing some sediment, but did not notice any blood (?). Micturition was frequent, and but a few drops were passed at a time; the stream frequently was interrupted, at which times the patient suffered spasmodic pains. At the end of the second day of the attack the pain was suddenly and completely relieved and the patient felt as well as ever he did. After relief he noticed that his water was increased in amount, dark in color, and with increased deposit; no blood. Did not notice any hard substance in the urine, and experienced no sensation of any passing through the urethra. The patient was free from further attacks for three years, during which time he says he felt no pain in the back. His water gave him no trouble, but he noticed a more or less abundant sediment all this time. This second attack was attended with the same symptoms, but was more prolonged than the first, lasting one week. No blood was observed. A third attack occurred six months later, and for the last four years the patient has never been free from a constant pain, with occasional exacerbations in the left lumbar region. Frequency of micturition, with pain and burning at the end of the penis during the act, now became the rule. Never noticed the passage of a stone or any gritty substance. Deposit has lessened in amount, and no blood has passed to the patient's knowledge. His urine was not examined microscopically. Finding that he was not receiving any benefit from treatment outside he decided to enter the hospital.

Family history excellent. No history of gravel or stone, nor of malignant or tuberculous disease. Patient is a carter, and has enjoyed good health up to and during the intervals of the attacks.

Present condition.—Patient is a well nourished and well developed man, apparently enjoying good health. Sleeps poorly. Complains of pain over the region of the left kidney of a dull, aching character and of constant duration. This pain becomes sharp and lancinating on moving about much. Patient finds that a sitting posture with the knees drawn up relieves him somewhat. No bulging of the affected area is to be observed. On palpation of the abdomen, nothing is elicited beyond that deep pressure

causes intense pain over the left kidney. Heart and lungs are found to be normal. Liver and spleen normal. Lymphatic glands throughout the body are not enlarged. No evidence of scrofulous taint. Bowels are regular. Urine: quantity per diem, 50 ounces, amber in color, acid; specific gravity 1026; very slight trace of albumen; no bile or sugar; amount of urea excreted per diem 350 grains. Patient still suffers from pain and burning at the end of the penis.

After consultation with his colleagues, Dr. Shepherd decided to explore the kidney for stone.

Operation, June 27th.—Dr. Shepherd operated to-day at 2 P.M. The patient was first etherized and an attempt was made to obtain some further information by palpation, but without result. The patient was placed on his right side, with a hard, round pillow under the loins to separate the ribs from the ilium, and an incision was made immediately below the last rib, extending from the edge of the erector spinæ muscle forward and downward for some four inches; the abdominal muscles were cut through and the quadratus muscle reached. This muscle was cut across to give more room. The lumbar fascia was cut through and the kidney easily reached, it appeared perfectly normal. On examination with the finger no stone was felt. A small incision was then made in the lower end of the kidney with a bistoury, and a short-beaked sound introduced through the incision into the pelvis and the calyces carefully explored but without result; the incision bled freely, but the hemorrhage was easily arrested by pressure. The wound was washed out with a weak bichloride solution (1-5000) and brought together with silk sutures except at the posterior end, where a large drain was introduced. The parts were dusted over with iodoform and dressed with washed gauze, and a jute pad and a bandage applied. The patient recovered well from the operation, which occupied only a very short time. At 8 P.M. he complained of a great deal of pain of a tight girdling character.

June 28th.—The dressings being soaked with bloody discharge and urine, fresh ones were applied. The wound looks well and the drainage is good. Passed 19 ozs. of urine in last 24 hours.

Still complains of the same pain as last night. 29th—Pain is very severe and of a shooting character; no discharge or urine has come through the dressings; urine 30 ounces per diem. 30th—Patient is feeling very comfortable, suffering no pain whatever; the dressings are still quite dry; urine 38½ ounces per diem.

July 2nd.—Dressed for the second time; patient sleeps and eats well, suffers no pain; urine passed for the last 24 hours measures 31 ounces, contains deposit of urates and a small quantity of pus, very few blood cells. 7th—The wound has healed well. 10th—Patient was allowed out on gallery to-day; is feeling well. 25th—Patient left the hospital to-day. The wound is entirely healed; no pain has been experienced except on the day before yesterday, when the patient again experienced the pain of a colicky character, which lasted forty-eight hours and suddenly disappeared.

The urine has been collected and thoroughly examined during his stay in hospital, and no stone or gravel has been found. On the whole, the patient feels a great deal better than at the time of his entrance. His temperature on the day after the operation was 100°F. in the morning and 101°F. in the evening; beyond this it never exceeded 99°F.

Patient presented himself at the hospital August 13th. Has had no return of pain since leaving hospital, has gained flesh, and feels well.

Remarks.—This case is a good example of the benefit derived from simple exploration of the kidney, even when no cause can be found for the severe pain. The symptoms in the case which made the existence of stone probable were the severe and sudden attacks of pain, followed by sudden relief, the course of the pain and the after-continuous pain referred to the region of the left kidney; also the severe pain felt on deep pressure over the region of the kidney. The absence of history of pus and blood in the urine was against the diagnosis of stone. However, as the simple cutting down on and exploring the kidney is a comparatively harmless operation, and one which often gives relief when no stone is found, it was decided to give the patient the

benefit of a more immediate examination of the kidney than could be made through the abdominal walls by palpation. The rapid recovery of the patient and the complete healing of the wound without suppuration was satisfactory; also the absence of urine in the dressings after the first day. In cases where the fibrous pelvis of the kidney is incised, a troublesome fistula is nearly always the result, but when the fleshy portion is incised this complication rarely occurs. It was remarkable with what ease the pelvis and calyces of the kidney could be explored with the short-beaked sound, such as is used in exploring a child's bladder. This method of examination was first introduced by Mr. Jordan Lloyd of Leeds.

CASE II.—*Fracture of the Sixth and Seventh Cervical Vertebrae by the handle of a railway hand car. Death in fourteen days.*

John D., aged 25, was admitted to this hospital on July 12th suffering from paralysis of the trunk and lower extremities.

On June 30th last, while sitting upon a hand-car, the patient received a severe blow upon the back of the neck from one of the handles which was moving at a rapid rate. He was knocked off the car, was not stunned, but was unable to get up.

Dr. Williams, of Algoma Mills, who saw him a few hours after the accident, found him quite conscious, but with complete loss of motion, sensation and reflexes below the eighth rib. Sensation over the remainder of the body was intact, but the extensors, pronators and supinators of the upper extremities were paretic. He complained of severe pain over the lower part of the neck and between the shoulders; was able to move his head and neck, though with difficulty and pain. Priapism was present for about nine hours after the injury, and he had retention of urine and fæces for three days.

The temperature remained normal until July 2nd, when it commenced to rise steadily. On evacuating the bladder the urine was found to be ammoniacal with traces of mucus, followed in a few days by much blood and pus. Latterly he has suffered from incontinence of urine and fæces. Temperature reached $102\frac{1}{2}^{\circ}$ on July 7th and 103° on July 10th.

Condition on admission.—Patient is a strong, heavy, well-nourished man; the condition of the patient was as described; pulse 120, respirations 30, temp. $99\frac{1}{2}^{\circ}$ and 103° at 8 p.m. on day of admission; is conscious but drowsy. The patient does not complain of any pain, but of great thirst and distress in breathing. The face is flushed, lips and tongue are dry. Pupils equal and active. Respiration is altogether diaphragmatic. The abdomen is distended and tympanitic. Urine and fæces are voided involuntarily. On passing the catheter about 25 ounces of very foul smelling urine was drawn off, the latter portion of which consisted almost entirely of blood and pus. The lower portion of the sacrum is red and inflamed, and here and there are to be found a number of incipient bed-sores. The skin on malleoli of both legs is congested and appears as if going to slough. There is complete motor and sensory paralysis from the line of the nipples down. The upper extremities are parietic, with exception of the flexor muscles, which are still strong. Sensation in the upper extremities is intact. On pressing upon the lower cervical spines, the patient complains of slight pain. On passing the hand over the spinous processes of the cervical vertebræ an indefinite irregularity is felt, and the spine of the seventh appears to be more prominent than usual. No crepetus can be elicited. On admittance was placed upon a water bed, bed-sores dressed and the head fixed in position. The urine was drawn off three times a day.

July 13th.—Patient is very drowsy, sleeping most of the time. During sleep the respiration is stertorous. Patient can be easily roused, but soon relapses into a semi-comatose condition. Temperature 102° . Rectum was emptied of fæces by means of an enema. *14th.*—Died this morning at 5.30.

On post-mortem examination the lamniæ and bodies of the sixth and seventh cervical vertebræ were found to be fractured into several pieces. In the cord inflammatory softening extended throughout the lower cervical and upper dorsal region. Heart normal. Lungs found to be filled with mucus, and patches here and there of broncho-pneumonia were observed.

UNDER CARE OF DR. FENWICK.

CASE III.—*Suture of Nerves and Tendons at the Wrist Joint.*

Gabriel D., was admitted to this hospital at 8 P.M. on May 2nd last suffering from a large and deep wound opening the right wrist joint, inflicted by a circular saw. The patient was much weakened by loss of blood when first seen by the House Surgeon.

On examination a deep lacerated wound, at the back of the wrist, is found, severing all the extensor tendons of the thumb carpus and fingers. The supinator longus tendon, radial nerve and artery were torn across. The lower ends of the ulna and radius and the proximal line of bones of the carpus were torn and splintered. The flexor tendons and the ulnar artery and nerve were uninjured. At 9 P.M., Dr. Fenwick, assisted by Dr. Shepherd, brought the several tendons and nerves together with fine catgut sutures and fine silk. The arteries were tied with catgut ligature. A quantity of splintered bone and torn ligamentous tissue was removed. The wound was thoroughly irrigated with sublimate solution 1-2000, and edges were brought together with silk. Two drainage tubes were inserted at each end of the wound. The arm was then placed upon a straight splint extending from the elbow to the tips of the fingers and the wound dressed with iodoform gauze and rubber dressing.

May 17th.—Suffers great deal of pain at the tips of the fingers. Temperature 99°. Pain is greater at night, necessitating the administration of morphia. *18th.*—Feels easier. Temperature 100°. *23rd.*—Dressed for the first time to-day; dressings soaked with discharge. Edges of wound united in places. A pocket of pus which had formed in the forearm was opened and drained. Sensation has returned to the back of the hand and fingers, it having been absent in all except the little and ulnar side of the ring fingers. Limb was dressed and supported upon an inclined plane, the splint was removed. A great deal of sloughing is taking place in the wound on account of the extensive laceration of tissue. *28th.*—Dressed. Sensation improved; can feel a slight touch of the finger or prick of a pin.

June 5th—Temperature has been very irregular, reaching 101° to 103° at night and falling to normal in the morning. Suffers much pain at night. Several collections of pus were opened. Sloughing still continues. Sensation about the same. *8th.*—Better sensation. Temperature is lower and patient suffers less pain at night. *15th.*—Dressed. Wound looks much cleaner and healthy granulations are beginning to appear. No pain. Sensation improved. Can extend fingers and thumb slightly. Temperature normal. *21st.*—Dressed. Has now fair sensation in fingers. Exit to-day. Is to return to the Out-door Department to have his dressings applied.

This patient presented himself at the hospital August 12th. He had fair motion of the fingers, and sensation in the back of hand was quite normal. Still two or three sinuses on the line of the wound which lead down to necrosed bone. A day or two ago removed the remains of scaphoid bone.

Reviews and Notices of Books.

A Handbook of the Diseases of the Eye and their Treatment. By HENRY R. SWANZY, A.M., M.B., F.R.C.S.I., Surgeon to the National Eye and Ear Infirmary, Ophthalmic Surgeon to the Adelaide Hospital, Dublin, Examiner in Ophthalmic Surgery in the Royal University of Ireland, and to the Conjoint Board of the King and Queen's College of Physicians and Royal College of Surgeons of Ireland. Second edition with illustrations. London: H. K. Lewis, 136 Gower street, W.C. 1888.

This is a handy volume of 438 pages, in twenty-two chapters, the first three of which are devoted to "elementary optics, the physiology of vision, refraction and accommodation and the examination of the eye. These important subjects, though briefly discussed, are placed before the reader in an unusually clear and attractive manner, numerous illustrations being given in elucidation of the text. The diseases and injuries of the eye are treated of in the usual anatomical order, and the author has

succeeded in condensing his material without leaving out anything of practical importance. All the standard operations on the eye are well described, with the addition of recent modifications and improvements. In the operation of extraction of cataract much importance is justly given to the antiseptic precautions which during the last few years have come into general use, and, from a purely surgical standpoint, the book shows abundant evidence that it is the work of a careful and painstaking operator. As a new feature in what is still to be regarded as one of the smaller treatises on ophthalmology, we notice a chapter devoted to the motion of the pupil in health and disease. This will be of special interest to those who are occupied with neurology. The chapters on diseases of the optic nerve, amblyopia, and amaurosis are also deserving of special mention and will repay perusal. The work is fully up to the times, containing the substance of all acknowledged recent advances in the science of ophthalmology. We cordially recommend it to the student, the practitioner and the specialist.

A Clinical Atlas of Venereal and Skin Diseases, including Diagnosis, Prognosis and Treatment.
By ROBERT W. TAYLOR, A.M., M.D., Surgeon to Charity Hospital, New York, and to the Department of Venereal and Skin Diseases of the New York Hospital; Late President of the American Dermatological Association. Illustrated with one hundred and ninety-two figures, many of them of life size, on fifty-eight beautifully colored plates. Also many large and carefully executed engravings throughout the text. Parts I and II—Venereal Diseases. Philadelphia: Lea Brothers & Co.

The first two numbers of this the latest venture of these enterprising publishers are devoted entirely to venereal diseases. Besides numerous illustrations, many of life size and all life-like, Dr. Taylor has added a full text equal in scope to that of almost any of the ordinary treatises on the subject. Each of the figures has a short but very clear description attached, and in some instances also the main clinical features of the case

depicted are given. The work will be completed in eight folio parts, measuring 14×18 inches, and containing, besides the illustrations, altogether about 400 pages of text. The price per part is \$2.50, and two parts are to be issued every two months. The atlas will be found invaluable to the teacher, but it should really be in the hands of every general practitioner. Judging from the numbers before us, the work is going to justify the most sanguine expectations entertained regarding it.

Dissolution and Evolution and the Science of Medicine: An Attempt to Co-ordinate the necessary facts of Pathology and to establish the first principles of Treatment. By C. PITFIELD MITCHELL, M.R.C.S., Eng., author of "The Treatment of Wounds as Based on Evolutionary Laws." London: Longmans, Green & Co.; New York; 15 East 16th street. 1888.

This work is professedly an attempt to apply the principles of the synthetic philosophy of Mr. Herbert Spencer to the science and practice of medicine; and though no absolutely new principles are furnished, the work gives evidence of at least the kind of originality that is implied in a successful application. If the philosophy offered is not sufficiently far-reaching, does not take a broad enough survey of the facts, or omits those that have essential bearing, we must credit this under the circumstances to Spencer, and not to the author of this work. The book is divided into three parts, which treat of general disease, special disease and implications respectively, and the author employs recognized authoritative accounts of disease on which to base his own theories. Following Spencer, he believes that the facts of disease, like the other phenomena of nature, may be grouped under the principles of either evolution or dissolution, which are the reverse of one another. They are in some degree synonymous with construction and destruction taken in their literal acceptance. Thus, Dr. Mitchell would rank the phenomena of inflammation under the conception of dissolution. But one asks after reading the explanations given here and elsewhere in the book, Is this view any more than one aspect of

a very complicated subject—a mode of survey only? If we change position, will not the subject appear differently? Does this rank as one of the “eternal verities,” and if so in what sense? It is somewhat strange that Spencer should have done more for this age in one respect than any other man in pointing out the limit of human knowledge and in showing that many conceptions, real as we think, attaching to certain terms, are absolutely unthinkable at all, and so tend to make men humble, and at the same time that he should build up a system of philosophy implying almost audacious self-confidence. Will this system stand? That Mr. Spencer will be regarded as one of the greatest intellectual embodiments of this or any other age we have no doubt; but will his explanation of the universe be regarded as other than a splendid but partial view—one of the many sides of truth? Inflammation may be a dissolution, but is it not also from other points of view an evolution. We cannot but believe that there are more things in heaven and earth, medicine included, than is dreamt of in the Spencer-Mitchell philosophy. Notwithstanding there are few recent books that we hail with greater pleasure than this one. As our author well says, “The raw material of medical science grows with an acceleration of rate that gives acuteness to the need of central truths about which facts may be organized.” Truly, and we are sometimes tempted to ask, When will medicine be in actuality a science or have a philosophy of its own? If the prevailing leaning to bacteriological investigation opens our eyes to the fact that man is a part of nature and that disease is no entity but a modification of natural function in consequence of the reaction between the organism and the environment, including all the effects of heredity; in other words, if medicine is recognized as a department of biology, as a result of these investigations more than others, as we believe will be the case, then will accrue to the profession a gain above all the immediate and direct profit springing from the bearing of micro-organisms on disease. All honor then to such men as the author of this work, who endeavor to furnish such conceptions as will tend to show us the need of broad generalizations. What is wanted is

some fertilizing idea that will awaken thought in many minds and turn our eyes from the narrowing inspection of isolated groups of facts to broad surveys of Nature as she appears in disordered animals. At present it matters not so much whether the 'central truths' are considered such by all or not; they will beget other and higher ones. There is room for many works on evolution as applied to disease. The subject is as yet in its infancy, and there are but few to notice the infant. No thoughtful unprejudiced man can read such a work as this without being the better. Such views dignify the healing and preventative art and enable man to walk erect in the universe.

T. W. M.

The Extra Pharmacopœia, with the additions introduced into the British Pharmacopœia, 1885.
By MARTINDALE and WESTCOTT. Fifth edition. London: H. K. Lewis, 135 Gower street, W.C. 1888.

In the three years which have elapsed since the last edition of the "Extra Pharmacopœia" was issued, wonderful strides have been made in therapeutics and pharmacy, and many new remedies, which are proving of great service, have been introduced. Among the latter may be enumerated the important group of antipyretics, namely antipyrin, antifebrin, salol and phenacetin, also saccharin—all derivatives of coal tar. Cardiac remedies have been reinforced by the preparations of strophanthus, sparteine and caffeine. Sal alembroth and the fusosilicate of sodium (Salufer) have been added to the long list of antiseptics. Cocaine and ichthyol—the latest addition to the pharmacopœia of the dermatologist—are also fully described. The authors have added, besides, numerous additional formulæ and have embodied those of the "Unofficial Formulary" of the British Pharmaceutical conference. This little book is full of information and should be in the hands of every general practitioner.

Selections.

A Successful Case of Total Extirpation of the Larynx — A case in which the whole of the larynx was extirpated for epithelioma was communicated to the meeting of the Victoria Branch of the British Medical Association, on April 25th, 1888. The patient was a man aged 62, a native of Germany, residing at St. Kilda, Victoria, who began to lose his voice in the early part of 1887, when Dr. Cox of Melbourne diagnosed a smooth growth below the left vocal cord, but the patient refused treatment. His voice was regained for about four months, but he again became hoarse, and in September he began to suffer from cough, attacks of spasm, and inability to lie down. Laryngoscopic examination on October 1st showed a small ulcer below the left vocal cord, and Dr. W. Gardner of Adelaide, who happened to be in Melbourne, concurred with Dr. Fox in making the diagnosis of cancer. Dr. Cox then removed with the laryngeal forceps a small portion of the growth, which was examined by Professor Allen, who pronounced it to be epithelioma. On the following day Dr. Gardner, assisted by Drs. Cox and Yorke, removed the whole of the larynx. Next morning the patient almost died of suffocation from blocking of the tracheotomy tube; but Dr. Yorke sucked the tube clear, and restored the patient by performing artificial respiration. After that his progress was uninterrupted. Jelly was taken by the mouth on October 10th; on the next day he was able to get up, and on Christmas Day he was able to go out in the city unattended. The patient attended the meeting of the Branch in excellent health; there were no signs of recurrence of the disease, and he could speak in a whisper intelligibly to those around. An artificial larynx of silver was made for him, but he preferred not to use it. The report published in the *Australian Medical Journal*, May, 1888, contains an addendum by Dr. Gardner, giving his reason for preferring total extirpation as a rule. There are (1) diminished probability of recurrence *in situ*; (2) diminished risk of blood and pus passing down the wound into the trachea, this being prevented by the immediate insertion of a rectangular tube into

the trachea ; (3) greater facility in administering the anæsthetic during the later stage ; (4) scepticism as to the results after partial excision turning out eventually to be so much better as is now said ; (5) diminished risk of perichondritis. In this particular case the disease was so nearly in the middle line that removal of half the larynx was contra-indicated. Examination after removal showed that all the cartilages of the larynx were so completely ossified that to obtain a view of the interior it was necessary to split the organ down both back and front. The growth infiltrated the soft tissues immediately below the left vocal cord, which was itself ulcerated at its posterior part. The growth extended downwards to the lower border of the cricoid cartilage, and was broken down in the centre, leaving a rounded ulcer with hard irregular edges. It may be added that the time occupied by the operation from the commencement of the administration of chloroform was fifty-five minutes, and that the highest temperature after the operation was 100.4°F.—*Brit. Med. Jour.*

Death under Chloroform.—The following particulars of the death of a patient in the Royal Berks Hospital, when under the influence of chloroform, have been forwarded to us by the house-surgeon, Mr. E. Deane, L.R.C.P., etc. The patient was a man aged 26, who was admitted to the hospital on March 13th, 1888, for large urethral calculus, which was extracted successfully by median perineal section, the patient taking chloroform very well. After the operation a small perineal fistula was left, which it was thought desirable to close ; accordingly, on June 29th, the patient having been duly prepared (bowels opened, and allowed no food after breakfast), chloroform was administered by Mr. Deane on a Skinner's inhaler. The patient did not seem to take it well, his breathing being rather bad. In about twenty minutes' time, the operation being nearly completed, the patient was sick, and directly afterwards the pulse stopped. The usual means of resuscitation were adopted without avail for fully half an hour. The total quantity of chloroform used was one ounce. The heart was examined before administration : no valvular disease was detected. At the post-

mortem examination the heart was found perfectly empty, and the muscles thin and flabby. There was no valvular disease, and the other organs were normal.—*Brit. Med. Journal.*

Diphtheria.—Dr. John G. Meachem, in the *Medical Standard*, says: I do not make local applications of silver nitrate or iron persulphate to every case which comes under my care, as I did at one time, since I found that the fright given to many children caused far more injury than the application did good. I have almost entirely abandoned local applications to that class of patients, and now give remedies so often that all indications for local treatment are quite as well filled as they would be pro-banged or brushed. If patients suffer severe pain, let the location be where it may (and a great proportion of cases in the early stages do so suffer), I always begin with a good full anodyne, for which I prefer Dover's powder if the stomach be in the state to tolerate it, but if not, morphine acetate. If upon the examination of the throat the parts are found highly inflamed, with or without exudation, the patient is put at once upon the following mixture:

℞	Potass. Chlorat.	-	-	ʒi
	Tr. Ferri Mur.	-	-	ʒiii
	Aquæ Puræ.	-	-	ʒiv.

M. Sig. A teaspoonful every hour in a tablespoonful of warm water, and this is continued for twelve hours, when it is given every two hours.

If the breath be foetid, the following is alternated with the iron and potash:

℞	Pot. Permanganat.	-	-	grs. iv
	Aquæ Dist.	-	-	ʒi

M. S. From five to twenty drops in a dessert-spoonful of water.

If patients sleep quietly and nicely they are not disturbed for their medicine. This, in my judgment, is a point not sufficiently regarded in the treatment of many diseases of children. I administer stimulants pretty early in diphtheria, for which the alcoholic are preferred, as they are much more easily adminis-

tered than ammonia carbonate, though the latter is no doubt otherwise fully as effective.

Carbolic and alkaline washes and gargles are very useful in patients who have age and sense to use them, and the same may be said of atomizing. All detached portions of exudation should be carefully removed. Forceps and scissors are often required for this work. The terrible fœtor arising from these when decomposed is greatly modified by their removal.

It is always prudent to give two or three doses of quinine every twenty-four hours. For many years I have been very careful about the use of cathartics, since the disease often progresses with double violence after active cathartics. I use only the mildest laxatives. Patients must be constantly and preserveringly sustained. Since great difficulty exists in the alimentation of children, concentrated food should be the main reliance. Egg, pure milk, essence and extracts of beef, and the malt preparations, are very good. Malted milk is an excellent and convenient preparation.

Powerful emetics in diphtheritic croup, like copper sulphate, tartar emetic, etc., I have discarded since no permanent good results from their use. My treatment is confined, when emetics are employed at all, entirely to fluid extract of ipecac, the careful and judicious use of which affords great comfort and relief. Mucous collections which gather in the throat are thus dislodged and thrown out which cannot be expelled in any other way, while but little exhaustion follows the action of ipecac.

As convalescence advances, nothing is so useful in bringing back the lost powers of the system as the syrup of iron iodide given in doses of from four to twenty drops in simple syrup three or four times daily. It is an admirable remedy.

The various forms of paralysis consequent on diphtheria are pretty sure to pass away in a few weeks, or at most two or three months. For these cases iron and strychnia with electricity are the only necessary remedies.

Do cases of true diphtheritic croup ever recover? I answer yes; three, and three only, of my patients in such cases have recovered, the last of which was a few weeks ago; all have been

girls, and neither could speak above a whisper for a period of fourteen days. A complete cast of the windpipe was ejected by the last patient, and though considerable exudation occurred after, there was not sufficient to completely shut off the air from the lungs. Another member of the family had diphtheria in a very violent form at the same time, but no croup symptoms. These patients contracted the disease from a cousin who died in less than a week from the appearance of the attack.

Infantile Constipation.—Dr. Edwin B. Shaw, in the *Medical Index*, says :—In cases where there is no deficiency in the biliary and intestinal secretion, but rather a paresis of the muscular fibres of the bowels, I have succeeded admirably with the fluid extract cascara sagrada, or the cascara cordial, but in other cases where the passages were dry and hard, I have failed most signally after a most patient and thorough trial of the drug. In these cases where there is a deficiency of the intestinal juices, I can most heartily commend to the consideration of the profession the small doses of podophyllin. For a babe from nine months to a year old I would prescribe the following, to be used for at least two weeks, and longer if found necessary :

℞	Resinæ podophyl.	-	-	gr. ij
	Sacch. lact.	-	-	ʒss
	M. et ft. chart. No. xxxij			

Sig.—One at night in a little milk.

The proper dose can be determined by trial. My aim is to produce a soft, easy discharge every day, and let me insist on the importance of *appointing a regular time to have the bowels moved*. Nothing should turn the nurse aside from attention to this most important duty. It is remarkable at what an early age an infant can be taught what it means to be placed on his little chair. I have often known mothers to commence to educate their babes in this direction as early as the fourth month.

Treatment of Warts.—Roesen (*Münchener Med. Wochen.*) has found the following procedure very serviceable in removing warts and callosities, etc. :—The thickened epidermis

is slightly moistened with an antiseptic solution (boracic or salicylic acid) and then covered with a fairly thick layer of pure crystallized salicylic acid. Over this is placed moist borated lint in four layers, a piece of gutta percha fabric, and a bandage. In the cases of small warts and callosities, the dressing is allowed to remain for five days. On removal it will be found that the thickened tissue is somewhat shrunken and has separated from the subjacent parts, which are covered with perfectly normal skin, presenting no traces of injury or bleeding. The author has never seen any caustic effect from this application on the surrounding and subjacent tissues. If the callosity is of any considerable thickness, as is often seen on the sole of the foot, the dressing should be left in place for ten days, or renewed after five days. The great advantage of this application is that the effects of the salicylic acid are localized to the thickened area.—*Journal Amer. Med. Ass.*

Poisoning from the local use of Cocaine.

—Dr. L. G. Broughton, of Reidsville, N.C., reports the following interesting and instructive case in the *North Carolina Med. Journal* :

On July 3rd Miss Ella Frost, a music teacher in our town, was taken with severe toothache, and soon consulted Dr. C. A. Rominger, a most excellent dentist, who placed in her tooth cavity a small piece of cotton upon which he put three drops of a 20 per cent. solution of the muriate of cocaine. Soon afterwards she experienced complete relief of pain, and said she felt "very happy." The pain having been relieved entirely by the cocaine, she went home. Upon her arrival she said to the family that she felt tired and must go to bed. The family were persuaded that, from her appearance, there was something radically wrong, and sent immediately for me. When I arrived, which was in a few moments after she had taken her bed, I found her entirely unconscious, breathing very irregularly, and only twelve to the minute, pulse 47 to the minute, pupil on the right side (side in which the cocaine was used) was very much dilated, tongue drawn to the left side, and the whole system in an extreme

state of relaxation. She responded not at all to a pin which was stuck in her right arm, and all efforts to arouse her sensibility were in vain.

The history having been given me, I at once diagnosed *cocaine poisoning*. Not having seen many accounts of cocaine poisoning I was somewhat at a loss as to what to do, and to some extent was fearful of the termination of the case. I remembered, however, having read only a short while ago in the *Therapeutic Gazette* of a case treated by whiskey, consequently I administered a large quantity of French brandy hypodermically and did not get any benefit. I then gave a large quantity by mouth, and not much good result, but I think some. My next idea was to administer strychnia hypodermically, which I did, using 1½ grain, and in a few moments she began to rally, and in two hours was *completely* out from under its influence except a general relaxation, which I think the whiskey helped to produce.

I am satisfied that strychnia is the antidote to cocaine. I know that it was the prime factor in the restoration of this patient. It was a 20 per cent. solution used in this case, which is the strength generally used by dentists. The dentist in this case had used it many times and never had any bad results. I have myself used it many times. Only a short while ago I used the same strength of solution in an operation on the cervix uteri, and was charmed with it. So we may safely say it was idiosyncrasy in this case, but I think it should teach us that it is a dangerous remedy and should be used with extreme care.

There were peculiarities in this case—one was the slow, feeble pulse. I notice in *every* case that I have seen reported the pulse has been quick and fast. I don't know why this was. If any one has had any experience with strychnine in the treatment of conditions of this kind, I should like to have them report it.

Treatment of Eczema.—Mr. J. A. Wetherell says: What is to follow has particular reference to the eczema simplex affecting the fingers and hands. The best procedure, possibly, will be to divide the subject into sections.

1. *Medical Treatment.*—(a) External. I dip pieces of lint,

sufficient to surround the fingers separately, in pure liquor carbonis detergens, and apply them, surrounded by gutta-percha tissue, at bedtime. They are allowed to remain on all night. Considerable smarting is at first caused, but it soon disappears. On removing the lint in the morning the skin looks sodden, the former vesicles are often raised into small bullæ, which, however, ere long get absorbed and dry up. During the day the hand is left exposed to the open air, or, better still, kept gloved in thin kid. They are washed every third day with lanolin coal-tar soap. To render the skin more pliable and soft a little lanolin is rubbed in every morning. In the course of three or four days the upper hardened cuticle comes off, in some cases as a whole, in others in large flakes, leaving a clean smooth surface, healthier, with more tonicity in it, and not so subject to undergo the catarrhal multiplication so characteristic of eczema. When much redness or heat exists, or there is an acrid discharge, or the implicated surface is extensive, we may moderate the strength of the alcoholic solution of coal-tar by mixing it with (1-10 or 20) cold water; or the alkaline bathing, to be presently mentioned, may be tried. If there are only a few vesicles, I have often touched them over with a little pure carbolic acid, so as to bring away a mere shell of epidermis of limited area. Let us now briefly review a few of the other local methods adopted. As to ointments—*e.g.*, of bismuth, zinc, etc.—all I have to remark is that they are, like the tar method of Hebra, simply disgusting. Even the lowest menial does not care to parade the streets with his fingers or hand bandaged up with so many white linen rags, to say nothing of the small amount of relief producible. Huile de cade or oleum rusci pyroligneum painted over the parts every day or two will soon dispel an ordinary case; but what about the, to most people, disgusting smell? The treatment, verily, is worse than the disease. Bathing with saline or alkine waters, such as are found at Harrogate, Bath, etc., alternating or combined with the application of spirituous alkaline lotions, I have great faith in, especially where the disease is extensive or there is much exudation—*e.g.*, in eczema rubrum, or the case is intractable to other means. Watering-places and the sea-side,

however, are not always near ; nor could the patient always afford to go to them. The various gelatine, collodion, or other impermeable coatings, I consider worthless. (*b*) Internal—Drugs, as such, are not required. To speak of treating the gouty or rheumatic diathesis by colchicum, etc., is simply ridiculous. Such terms as these should, in my opinion, be abolished, or applied only where actual attacks of gout or rheumatism exist or threaten. Should we not rather speak of such as “ a constitution with a tendency to excessive formation of uric acid,” or even as “ uratic.” To give large doses of arsenic is sheer waste of material. Very small doses often dispel scaliness ; but it should only be administered in the form of some mineral-water, as La Bourboule, Woodhall, etc.

2. *Dietetic Medication.*—Avoid stimulating and indigestible substances, as pickles, tea, etc. In other words, the chief materials of diet should be lean meat, milk, or cocoa to breakfast, old bread, fresh vegetables (except starchy bodies, as potatoes) ; no pastry. Avoid all that disagrees, especially beer and malt liquors.

3. *General Indications.*—Cleanliness in everything is very essential ; clothe and diet the patient according to the changing season ; avoid all local irritants ; take plenty of fresh air and exercise, and by these means alone regulate the bowels and other emunctories.

In spite of all rules, cases now and then occur which withstand all treatment, baffle every effort, and cling to the sufferer for a lifetime. Such must be attacked on general principles. The plan cannot be a stereotyped one.—*Lancet*, June 2, '88.

The Late Emperor Frederick.—A full report of the post-mortem examination upon the body of the late Emperor Frederick has been published. The macroscopic changes are summarized as follows : Cancerous destruction of the larynx, with secondary disease of a rather large lymphatic gland at the lower part of the left side of the neck, and a cutaneous nodule on the right side near the wound. Œsophagus unaffected. Inflammatory destruction of the upper portion of the windpipe and

the neighboring parts. Numerous bronchiectases, with putrid contents. Near these, broncho-pneumonic suppurating gangrenous patches. The microscopical report signed by Virchow and Waldeyer says :

1. The larger nodule at the base of the epiglottis shows, on the outside, still unchanged mucous membrane with cylinder epithelium, but in the interior, an alveolar structure with epidermoidal contents. The cells of the latter are large and highly developed ; concentrically arranged cell-groups were not observed.

2. The cutaneous nodule on the right side of the wound in the neck is covered with extremely attenuated, but otherwise unchanged, epidermis ; the cancerous proliferation reaches close to the surface ; its chief development is situated in the deeper parts, where, also, here and there, "nests," with a concentric arrangement of cells, occur. Some normal constituents, such as sweat-glands, are to be seen between the cancerous masses.

3. The lymphatic gland on the left side of the neck shows the highest degree of change. The normal structure has disappeared, and is replaced by a loose alveolar tissue, the spaces of which are closely filled with epidermoidal cells having large nuclei ; many of these cells possess small, bristle-like fringes (*Burstensaume*).

4. The contents of the bronchial tubes correspond exactly in their composition with the description given by the undersigned Professor Virchow (in his report of May 19th of the present year) on the solid particles found in the expectoration. Moreover, in certain places, a more abundant collection of small, bright fat-globules, like the globules in milk, was observed.

5. In the foci in the lungs were found thick clusters of pus-cells, but no cancer-cells. The natural alveolar structure was still perfectly distinct.—*Medical Record*.

Valuelessness of Iodoform in Tubercle.

—Rovsing has made a special study of the action of iodoform on tubercle bacilli, and has come to the conclusion that it is practically worthless as an agent against them. The *Lancet* com-

mentary on the article of Roving says that he "has found that the growth of tubercle is in no way retarded by the presence of a very considerable quantity of iodoform. He has more than once inoculated the two eyes of a rabbit with pure and iodoformed tubercle respectively, and has invariably found that the morbid process was communicated to the eye containing the iodoformed tubercle some time before the other was affected, the irritation produced by the iodoform in the tissues appearing to cause them to form a more suitable soil for the development of tubercle than those of the other eye, which were not similarly exposed to irritation."—*St. Louis Med. and Surg. Journal.*

The Treatment of Tension as met with in Surgical Practice.—In a lecture delivered before the Royal College of Surgeons of England, Mr. Thomas Bryant summarized his views as follows :—

1. The pain associated with every form of inflammation of the bone or of the peritoneal covering is due to tension, and the severity of the pain is a fair measure of its intensity.

2. In acute inflammation of the bone or its periosteum, tension is the chief cause of necrosis ; and in the subacute and chronic forms, it is a potent cause of their chronicity, as well as of the destructive changes which, as a rule, follow.

3. The relief of tension, wherever met with, when the result of inflammation, is an important principle of practice which should be always followed. In bone, the principle is most imperative, on account of the difficulties under which neutral processes act in that direction, by reason of the absence of elasticity or yielding in bone, and by reason of anatomical arrangements of its vessels which favor blood stasis.

4. To relieve tension in the softer tissues of the body, the local application of leeches, local or general venesection, acupuncture, aspiration, punctures and incisions may be requisite ; whereas, to carry out the same practice in endostitis or periostitis, subcutaneous or open incisions down to the bone, and the drilling, trephining or laying open of bone by a saw, may be required, the choice of method having to be determined by the requirements of the individual case.

5. In the early or hyperemic stage of inflammation of bone, before destructive changes have taken place, experience seems clearly to indicate that the relief of tension—as indicated by a dull, aching pain, etc.—by means of drilling or trephining into bone, may arrest the progress of the disease, and help toward a cure by resolution; whereas, in the exceptional cases in which this good result does not take place, suffering is saved and destructive changes are limited.

6. In articular osteitis, of every kind and variety and in every stage, this mode of treatment cannot be too strongly advocated, as tending toward the prevention of joint disease.

7. In acute or chronic abscess of bone, diaphyseal or epiphyseal, the abscess cavity must be opened as any other of the soft parts, drained and dressed in the most appropriate way—the principles of treatment being the same in hard or soft tissue, although they are modified by the anatomical conditions of the parts.—*Medical Press*, July 11, 1888.

Oil of Turpentine as a Hemostatic in Epistaxis—In cases of obstinate epistaxis in which other means had failed, Dr. W. Eurye, of Budapest (*Orrosi Heti Szemle*, 1887, 12), upon a recommendation in Billroth's *Surgery*, used tampons saturated with oil of turpentine, with surprisingly prompt success. In one case in which the bleeding had continued for eight days and resisted all internal and external measures, threatening acute anæmia, the application of three tampons moistened with oil of turpentine at once permanently checked the hemorrhage. To prevent intense irritation of the nasal mucous membrane it might be well to dilute the oil.—*Medicin. Chirurg. Rundschau*.

Tannin in Dilatation of the Stomach.—Dr. H. Boulland, thinking that tannin—which acts on the retractibility of the mucous membrane, and is at the same time absorbent and antiseptic—might be useful in dilatation of the stomach, has employed it in many cases with success. In cases in which constipation was present, Dr. Boulland ad-

ministered doses of 10 centigrammes ($1\frac{1}{2}$ grains) instead of 20 centigrammes (3 grains). By this means the regularity of the bowels was not interfered with, and the dilatation decreased in proportions analogous to those obtained by washing out the stomach. In twenty days, the stomach was reduced nearly to its normal condition. At the same time, the patients took frequent but light meals, chiefly of pasty substances, and no starchy matter. When the dilatation is due to a tumor, tannin does not give better results than other methods. It diminishes mucous secretion, however, and renders the digestion less painful. Dr. Boulland has found the hemostatic properties of tannin equal to those of ergotin and perchloride of iron. In particular he has used it with success, in many cases of epistaxis, when all other means had failed.—*British Medical Journal*.

Angina Pectoris.—In illustration of the pathological anatomy of angina pectoris, Dr. Huchard, at a recent meeting of the Société Médicale des Hôpitaux, related the case of a woman, aged 58 years, who was affected with angina pectoris. The examination of the heart established the existence of aortic stricture and insufficiency of action. Antipyrine and digitalis aggravated the state of this patient, who was only relieved by the employment of the iodide of potassium in large doses. As often happens in such cases, this patient died suddenly. At the autopsy was found a dystrophic sclerosis of the myocardium. There existed besides a dilatation of the aorta, a dilatation of the right coronary artery, and a stricture with obliteration of the left coronary artery. Dr. Huchard remarked that this case is interesting in more than one point of view. It is the one hundred and tenth case of angina pectoris in which was found, at the autopsy, a stricture with obliteration of one of the coronary arteries. It furnishes, besides, a remarkable example of what has been termed pseudogastralgiic angina, which was exemplified in the patient under notice, as she had for a long time been considered to be affected with ulcer of the stomach, but at the autopsy this organ was found to be perfectly healthy.

The author added that this case is also interesting in a therapeutic point of view, as it proved once more the efficacy of the iodide treatment, which he had for so long a time employed against angina pectoris. What creates the danger, observed Dr. Huchard, is not the pain, nor the paroxysm of angina pectoris in itself; it is the ischæmia of the myocardium and arterial hypertension. To combat this ischæmia and this hypertension recourse must be had first to the iodides and to trinitrin afterward.—*Paris Letter N. Y. Med. Record.*

Purulent Conjunctivitis of the Newly Born.—Korn (*Arch. f. Gynakologie; Amer. Jour. of Ophth.*," Nov., 1888) is of the opinion, from his own observations, that the infection of the eyes of babies probably does not take place while they pass through the vagina, but later, and is artificial, and due to unsatisfactory cleansing. In fact, the eyes of the babe are sufficiently protected to make the entrance of mucus into the conjunctival sac almost impossible. Only a face presentation might favor this accident. Hence he thinks it possible to dispense with the nitrate of silver in these cases. The baby is to be washed with water, without paying any attention to a previous cleansing of the parturient mother. The results were equally good with this method, as soon as the nurse became accustomed to scrupulous compliance with the orders. Out of one thousand babies treated in this manner, only 0.4 per cent. were affected during the first four days of life by purulent ophthalmia. In summing up the results of his experiments, he formulates the following propositions: 1. Credé's method of preventing purulent ophthalmia is absolutely certain and trustworthy when applied in the proper manner. 2. The active part in Credé's method is the nitrate of silver, which is a specific against the gonococcus. 3. The infection of the baby's eye with the poison does not take place in the vagina, but always after birth. 4. The most scrupulous cleanliness during birth and the puerperal state is sufficient to reduce the affections of the eyes to a minimum, and most probably can prevent them altogether. 5. The method is very simple and can be learned by any nurse.

The Relative Value of Antipyrin and Antifebrin.—Dr. W. G. Barr, of Bridgport, Illinois, has made a most careful clinical study of these remedies as well as of quinine on himself whilst suffering from neurasthenia complicated with malaria. He thus sums up his experience in the *Therapeutic Gazette*. This table, he says, will suggest the relative use of the two former drugs:—

<i>Antipyrin.</i>	<i>Antifebrin.</i>
Lowers the temperature in half an hour.	In an hour or more.
Effects last two hours.	Effects last six hours.
More diaphoretic.	More diuretic.
Depressing after effects.	No after effects.
Cerebral sedative.	Cerebral, vaso-motor and muscular stimulant.
Dose 15 to 30 grains.	Dose 5 to 15 grains.
Tolerance from continued use.	Tolerance from continued use.

FINAL SUMMARY.

<i>Quinine.</i>	<i>Antipyrin—Antifebrin.</i>
Is a tonic of marked effect, and its long-continued use in considerable daily doses improves malarial anæmia.	There is good reason to believe that a long-continued use (four to six weeks) of these drugs or any of the aniline products produces a decomposition of the coloring matter of the blood.— <i>Therapeutic Gazette</i> , Oct. 1887.
Quinine is antiseptic.	Antifebrin is not antiseptic, while antipyrin seems to be.
Antiperiodic.	Not antiperiodic.
Sedative only in doses so large that the stomach may not tolerate enough to produce the effect.	Analgesic.
Produces deafness.	Does not produce deafness.
Is prophylactic against attacks of true malarial poisoning.	Is not prophylactic against malaria.
Reduces temperature in some forms of malarial fevers, but has little effect in typhoid fevers.	Reduces temperature in all cases of fever.
	Remarkable effects in migraine, and substituting morphia almost entirely.

—Paper by Dr. R. F. Lewis in *N. C. Medical Journal*.

The Treatment of Chronic Diarrhœa.—A correspondent of the *Medical News* sends the following pre-

scription: "Many years ago I suffered severely from that trouble; I considered it incurable. Being in Paris, one of the best physicians there assured me that it could be cured by a diet of racahout, and it was. Afterward I found one could not get the acorn meal that forms the active part, but knowing that its usefulness must depend on the tannin it contains, I tried substituting for it the following:

Powdered Chocolate, pure	- -	$\frac{1}{2}$ lb.
Rice Flour	- - - - -	$\frac{1}{2}$ "
Powdered Sugar	- - - - -	$\frac{1}{2}$ "
Tannin	- - - - -	$\frac{1}{2}$ oz. (120 grs.)

The tannin, or the rest, separately, has little effect. Together they restore the tone of the alimentary canal and nourish as well as cure. One thing is essential, that is long cooking, not less than half an hour. If simply boiled a few minutes, the harsh taste of the tannin is very strong; with a good half hour's cooking that disappears wholly. It is impossible to distinguish the medicine from ordinary broma. I think this has something to do with its curative powers and with the ease of digestion by the most irritable stomach. The remedy is too valuable not to be more widely known. 'The amount to be taken is a teacupful morning and evening at meals.'

The Treatment of Serious Forms of Granular Conjunctivitis. — Abadie (*Ann. d'oc.*, Nov.-Dec., 1887) recognizes two factors in the pathology of severe granular conjunctivitis: 1, The presence of the microbe; and, 2, the state of the tissue in and on which it develops. The accessory factors are: The state of the adjacent parts, lacrymal passages, palpebral fissure, and the reaction of the general nervous system of the individual. For some time past he has in rebellious cases combined systematically daily scarifications of the conjunctiva with cauterization. If there is great irritation and marked reaction, he begins by applying leeches to the temple. Then he instills a solution of cocaine, and, after anæsthesia has been produced, he makes slight scarifications in the conjunctiva with Desmorres's instru-

ment, beginning usually with the superior *cul-de-sac*. The parts are allowed to bleed freely, and are consequently cauterized with the glycerole of copper. This treatment is repeated daily, and gradually the conjunctiva becomes thinner, less red, more elastic, the pannus gradually disappears, and the infiltration of the underlying and neighboring tissues slowly recedes.

Hot Water in Diseases of the Eye.—

Connor (*Centralblatt f. prakt. Augenheilkunde*) recommends baths of hot water as an excellent means of treatment in various disorders of the eye—from simple catarrh and phlyctenulæ to scleritis, iritis, and hyperæmia of the retina. When, with the instillation of a mydriatic, the pupil fails to dilate sufficiently, hot water aids the action; in catarrhal and purulent ophthalmia, it limits the inflammation; in glaucoma and dacryocystitis, it diminishes pain. There are no contraindications to the use of hot water, which acts with varying efficiency according to the method of application. The author usually has a drinking glass filled with hot water, the patient so inclining the head that the affected eye is immersed. The water remains warm for a considerable period, so that the eye may be bathed for some time without discomfort.

If one so choose, he may add antiseptics to the water. This method has the advantage over poultices that its execution does not require an expert. The local action may be thus tabulated: 1. Contraction of the blood-vessels of the eye and of contiguous structures; the ophthalmoscope shows the retinal vessels contracted after such a hot bath. 2. The hot water washes away deranged secretions and excretions, and destroys the germs contained; the bacillus of anthrax, for instance, is destroyed by a temperature of 96°F.; many eyes can support a higher temperature. 3. The healing activity of the reparative tissue or protoplasm is stimulated. 4. The hot water acts directly upon certain conditions of muscular weakness or spasm.—*Memo-rabilien*, July 6, 1888; from *Centralblatt für die gesammte Therapie*, 1888.

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LOCAL ANÆSTHETICS.

When Herr Koller first demonstrated the remarkable properties of cocaine, surgeons naturally exclaimed *eureka*, believing that at last they had come into possession of a safe and efficient anæsthetic for use in minor operations. Nor have they in the main been disappointed. The ophthalmic surgeon and laryngologist have, at any rate, no cause for complaint, because in cocaine their fondest expectations have been realized. All the ordinary operations on the eye are now performed with its assistance, and we have yet to hear of any untoward result following its application in such cases. In operations on the throat and nose more care is required in the employment of the stronger solutions lest absorption through abraded surfaces may take place, but the risks in this connection are not great, and the danger can usually be readily overcome. It is, however, where the drug has to be injected hypodermically and is thus placed beyond the possibility of removal that its dangerous qualities become evident. Thus several cases have been recently reported where fatal syncope followed its employment in this way. The injection of ten minims of a ten per cent. solution into the gum for a tooth extraction caused symptoms of the most alarming kind. It is therefore far from safe in all cases. It is true the susceptibility to the action of the drug is not universal, depending evidently on some idiosyncrasy in the individual himself, but how is it possible to foresee or detect this peculiarity? On this account, therefore, the scope for usefulness of the drug is destined to become limited. Besides, the fact of having to

inject it hypodermically militates seriously against its use, the introduction of the needle often causing as great pain as a moderate incision.

What we want then is some local anæsthetic which, by its mere contact with the skin, will deaden the sensibility of the part so that an incision can be made without pain to the patient. Thus buboes, abscesses of all kinds, whitlows, etc., could be incised, and wens and other small tumors removed without pain or risk to the patient, and with infinite comfort and satisfaction to the surgeon. It may be said that ether and rhigolene spray will answer all these indications, but in our experience they do not. Ether is very inefficient and rhigolene is too dangerous a preparation for every day use.

Some time ago a French surgeon, M. Debobe, noticed that when he applied the chloride of methyl to the skin in the form of spray the cold engendered by its passage from a liquid to a gaseous state induced almost perfect local anæsthesia. Other experimenters have very recently discovered that the spray was not necessary, but that by simply saturating pellets of cotton wool and placing them on the part to be incised or on the seat of pain, as in neuralgia, an actual freezing took place. The skin in a few seconds becomes blanched, indurated, parchment-like, and depressed, allowing of incision, scarification, etc., to be made without sensation. We trust this remarkable property of the chloride of methyl has not been over-estimated, because we see in it a valuable substitute for cocaine in a large class of surgical cases. Very recently, also, another local anæsthetic has been discovered accidentally, namely, helleborein; but it is probably suitable only for ophthalmic practice. The anæsthesia produced by it is said to be of longer duration than that obtained with cocaine.

In fine, there are few subjects of greater interest and importance to the general practitioner, as well as the surgeon, than that of local anæsthesia, and we trust that, with the co-operation of our chemical friends, no time will be lost in finding something that will meet all the indications referred to.

CANADIAN MEDICAL ASSOCIATION.

It is to be hoped that the meeting of this Association, which is to take place in the city of Ottawa on the 12th, 13th and 14th days of the present month, will be numerously attended. The profession of Ontario should especially be well represented, Ottawa being so easy of access. We wish also to see a large contingent from the province of Quebec and the Maritime Provinces. We can hardly expect many of our Manitoba brethren owing to the great distance, although we shall be disappointed if the usual delegation be not present. We regret to notice of late years the almost total absence, from the meetings, of our French-Canadian confreres. This is the cause of considerable regret, not only on account of the loss socially which is thus sustained, but because they have now in their ranks some of the ablest members of the profession in the Dominion, whose contributions to the science of medicine would, we think, be much more widely read and appreciated if they appeared in connection with the transactions of such a general association as that under consideration. We hope to find these gentlemen in force at the coming meeting. The Canadian Medical Association must not be allowed to die of inanition. It is the only means by which, as Canadian physicians, we can keep in touch with each other, and while we wish the various provincial societies every possible success, we trust that in their time of prosperity they will still continue to contribute to the support of the parent Association.

BRITISH MEDICAL ASSOCIATION.

The fifty-sixth annual meeting of this Association was held the other day in Glasgow, under the presidency of Professor Gairdner, of the University of Glasgow, and appears to have been a most successful affair. In an able address, entitled "The Physician as Naturalist," Dr. Gairdner defends the profession from the charge of atheism which is so often hurled against it by the ignorant and bigoted. Speaking of the physician of the future, he thinks that he will be more inclined

than ever to study his Bible, "but he will study it in the spirit of modern scientific freedom and of historical research, not under the influence of mere tradition and ecclesiastical authority. And thus only, as it seems to me, can the reconciliation of science and religion ever be brought about."

The address in medicine was delivered by Dr. Clifford Allbutt "On the Classification of Diseases by means of Comparative Nosology;" that in surgery by Sir George McLeod "On the Progress in Surgery during the last Half Century." These men are both giants in their respective spheres, and their addresses were able and original. But the most remarkable contribution presented on that occasion was undoubtedly a paper or address by Dr. William MacEwen, of the Royal Infirmary, Glasgow, "On the Surgery of the Brain and Spinal Cord." He begins his paper in a modest fashion, with an account of several cases in which the lesions were diagnosed and localized and then exposed by operation, completing this portion of his paper with the following statistical resumé: "Of twenty-one cerebral cases (exclusive of fracture of the skull with brain lesions or other immediate effect of injury) in which operations have been performed by me, there have been three deaths and eighteen recoveries. Of those who died all were *in extremis* when operated on. Two were for abscess of the brain, in one of which the pus had already burst into the lateral ventricles; in the other, suppurative thrombosis of the lateral sinus had previously led to pyæmia and septic pneumonia. The third case was one in which there existed, besides a large subdural cyst over the one hemisphere, extensive softening at the seat of cerebral contusion on the opposite hemisphere, accompanied by œdema of the brain. Of the eighteen who recovered, sixteen are still alive in good health, and most are at work, leaving two who have since died, one eight years after the operation, from Bright's disease, she in the interval being quite well and able to work; the other forty-seven days after the operation, after the abscess was perfectly healed, from an acute attack of tubercular enteritis."

Then follow the reports of six cases in which the cord had been exposed for the relief of paraplegia caused by pressure.

In reference to these cases he remarks: "The spinal membranes and the cord itself can be exposed, and neoplasms and encroachments upon the lumen of the canal may be removed therefrom without unduly hazarding life. Such interference is unsparingly condemned by writers on the subject, their remarks, however, being applied to injuries, as no such operations have hitherto been contemplated in idiopathic cases. They contend that they are full of danger, being difficult, prolonged, and attended with profuse hemorrhage; secondly, that the operation could hardly benefit the patient, and, thirdly, that no one has been able to present a successful case. Each of these points has now lost its validity."

It is said that the address attracted a large audience and that it was received with enthusiastic applause, a hearty vote of thanks being subsequently carried. Our personal estimate of Dr. MacEwen's remarkable ability as a surgeon—made many years ago—is, we are happy to find, at last becoming verified.

—The treatment of wounds by continued irrigation is an old method which is being revived by Mr. Treves of the London Hospital. If our memory serves us, some of the surgeons engaged in the American Civil War were strong advocates of this plan, and practiced it extensively. About ten years ago cases of lacerated wound were constantly treated after this fashion in the Montreal General Hospital. We do not pretend to say that anything like the elaborate apparatus devised by Mr. Treves, for the supply and removal of the water, was in use, nor were the parts subjected to the treatment for the same length of time (several weeks), but it was nevertheless carried out very thoroughly until all inflammatory action had subsided and the granulation process had fairly set in. We have always thought well of the method in appropriate cases, and shall await with interest the results of Mr. Treves' experiments in connection therewith.

—Dr. Lennox Browne uses cocaine now entirely as an anæsthetic when performing tracheotomy, injecting five minims of a ten per cent. solution on each side of the middle line. He thinks

it diminishes hemorrhage during the operation, whereas both ether and chloroform are known to increase it.

—Dr. Gramshaw has had remarkable results in the treatment of typhoid fever by means of the mixture of carbolic acid and iodine. His formula is as follows: Carbolic acid, 12 minims; tincture of iodine, 16 minims; syrup of orange peel and water to eight ounces. Of this mixture he gives an ounce every four hours. Of a total of 116 cases treated in the course of seven years in this way he has had only one death. The good effect of the treatment is said to be manifested early in a fall of temperature, a lowered pulse rate, and a cessation of the diarrhoea. This method of treating typhoid fever has a strong advocate in Dr. George Ross of this city.

Personal.

Dr. W. W. Chalmers, McGill, '88, has settled in the town of Magog, Que., and is doing remarkably well.

Dr. H. D. Fritz, McGill, '88, is at Joggins Mines, Nova Scotia—prospects excellent.

Dr. R. T. Berry, McGill, '88, has made the rising city of Pullman, Ill., his resting place.

Dr. F. Z. Kenney, McGill, '88, thinks there is no place like home, and has consequently begun practice in St. John, N.B.

Dr. C. E. Park, McGill, '88, is evidently of the same opinion, and hence is to be found at Durham, Ont.

Dr. J. D. Flagg, McGill, '87, has been recently appointed Demonstrator of Anatomy in the Medical Faculty of the Niagara University of Buffalo. We wish him every success in his new position.

There are no less than three graduates of McGill in the teaching staff of the College of Physicians and Surgeons of Chicago—Dr. L. St. John ('72), Professor of Clinical Surgery; Dr. C. Rutherford ('82), Professor of Anatomy; and Dr. J. B. Loring ('83), Demonstrator of Chemistry.

We regret exceedingly to have to report the death of one of the most promising of McGill medical students—W. L. Hilton ('91), of Montreal. He was drowned by the upsetting of a canoe on Brome Lake on the 22nd ultimo. His companion, Miss Archibald, of Montreal, was also drowned.

Medical Items.

—Jabconski of Poitiers favors the isolation of tubercular patients, and proposes an ordinance excluding consumptive children from the public schools.

—The death of Dr. J. Milner Fothergill removes from English medical society a very prominent figure. He died recently of diabetes, from which he had suffered for many years. He will be best remembered for his interesting and voluminous writings chiefly on the subject of Dietetics.

—There are 16,930 practising physicians in England, a proportion of 1 to every 1642 inhabitants; and an increase in number of 21.7 per cent. since 1881. The largest number is found at Brighton, where there is 1 physician to 727 persons; next comes London with 1 to 939.

—Dr. F. Bramann, first assistant in the University Surgical Clinic, who performed tracheotomy on the late Emperor Frederick, has qualified for the position of *Privatdocent* in the University of Berlin by an inaugural dissertation on “Myotomy and Tenotomy To-day and in the Pre-antiseptic Period.”

—The sanitary press is discussing the comparative advantage and disadvantage of having trees near a house. The general conclusion is that no tree should be planted nearer to a house than its own length when full grown. Trees not only moisten the air about them, but the earth also. Sunshine should have access to a house at all times.

—Dr. W. Wylie reports (*Brit. Med. Journal*) a unique case of *entire absence of both mammæ*. The girl, unmarried, 21 years of age, had recently given birth to a healthy male child, and had made an excellent recovery. Her mother had long been aware of the fact that there were no breasts, but stated that she had always enjoyed good health, and had menstruated regularly from the age of 15 years. The nipples were also absent.

—Doctors who wish to report their cases in the journals are compelled to be very careful in France. The Criminal Court of Besançon has recently fined an alienist \$100, and compelled him to pay the family \$400 damages for having described, under the title, “An observation on rational lunacy” (*folie raisonnante*), a case in such a manner that the identity of the patient was discovered.

—The International Hygiene Society has opened two kiosks for ladies in London. These will afford writing and reading rooms, and two large swimming baths, surrounded by recreation grounds. It is proposed to establish fifty similar places in London for ladies (women?), about one hundred in the city for men, and swimming and shower baths in East London.

—Instead of sponges Billroth uses gauze prepared as follows: The absorbent gauze is cut into pieces eight inches square, and of these seven are folded and sewed at their edges. These are boiled twice in one day, one hour each time, in a sublimate solution of 110 degrees. They are then placed in jars and carefully covered. Gauze thus prepared is thoroughly antiseptic. Every attempt with such gauze to cultivate micro-organisms has failed.—*Bull. Med.*

—An East Indian morning draught called “tiger’s milk” is not generally known. Add the beaten yolks of three eggs to two tablespoonfuls of powdered white sugar, three cloves, the rind of half a lemon and half a pint of Imperial Crown brandy. Pour over it a quart of new warm milk, stirring rapidly, and serve immediately. This is recommended for those who live in malarial districts and for delicate persons before breathing the crisp air of autumn or winter. A wineglassfull will be sufficient in this climate.

—A list of Chinese medicines, printed for the use of the customs officers of the Treasury Department, reminds us of the strange pharmacy of the mediæval period in Europe. They are imported chiefly for the use of the Chinese doctors of the Pacific slope, and include such alleged substances as tigers’

bones, rhinosceros' horn, elephants' gall, asses' glue, snake-skins, fowls' gizzards, dried silkworms, crabs' eyes, dragons' teeth, hedge-hogs' skins, fossil crabs, fossil teeth, horse tails, straw, glass, cow hair, Job's tears, "insects of nine smells," puff-balls, ground blood, cows' knees, tree-bugs and centipedes. —*Medical News.*

—An impecunious medical student advertises thus in a Dublin paper: "Matrimony.—Young gentleman reading for the medical profession is desirous of making the acquaintance of a young lady; one with some means preferred; widow not objected to; all communications will be regarded as strictly confidential; enclose carte if convenient."

—English teetotalers received a painful knockdown blow at a meeting held at Lichfield on Tuesday under the auspices of the Church of England Temperance Society. Dr. H. M. Morgan, the principal practitioner in the city, who had been one of the leading lights of temperance and a total abstainer, startled the brethren by announcing that he had changed his views and joined the ranks of moderate drinkers, partly for example and partly for experiment. He had abstained totally for six or seven years, but he had become convinced that his health had suffered thereby. He had consulted many eminent physicians in London and Birmingham, and all had advised him that total abstinence would prove seriously injurious. Now he had gone back to the juice of the grape, and while admiring total abstinence very much in the abstract, he concluded it was not good enough in real life.—*Exchange.*

—The habit of discussing fees is considerably ingrained upon some American physicians. According to Dr. Warren-Bey, the French set a good example in this matter. Nothing, he says, offends a French physician more than an inquiry in regard to his charges for professional services or for money to be directly paid to him. Although at heart extremely solicitous respecting his fees, he considers it *infra dig.* to discuss them, and he expects every client to take a hint from the louis conspicuously displayed upon the mantel-piece, and to add his

quota to them before leaving the room. In consultations it is the duty of the regular physician to obtain the fee—one hundred francs in ordinary medical cases—and then to hand it to the consultant, sealed up in an envelope, in the most quiet manner possible, and never in the presence of the patient or his family. No conversation on the subject is admissible, and the matter is treated as if it were the least important thing in the world. One excellent custom in connection with consultations prevails here: the regular physician, as well as the consultant, receives an extra fee—usually a double one.—*Paris Letter.*

—During the winter session of 1887-88 over three hundred and thirty-five different physicians attended the courses of instruction at the N. Y. Post-Graduate Medical School and Hospital, 226 East 20th street, New York city, an increase of more than 60 per cent. over last year. In the Hospital Department about four hundred operations were performed, all of major importance. To all of these matriculates had access, as the hospital is used solely as a means of clinical instruction. This remarkable increase in the matriculation list has necessitated both larger clinical space and hospital accommodation, so that a new clinical amphitheatre has been erected, and will be used for the first time at the opening of the winter session, September 17th, 1888. A new and commodious laboratory has also been erected and furnished with the latest apparatus for the study of normal and pathological tissues. The nose and throat clinical room has also been enlarged. Professors Abraham Jacobi, Robert F. Weir, Joseph E. Winters, E. Bolton Bangs and Peter A. Callan have been appointed to the Faculty. The sessions of 1888-89 promises to be the most prosperous ever held.—*Com.*

ANODE AND CATHODE.—A writer in *L'Electrothérapie* suggests that it is easy to remember that anode corresponds to the positive pole, and cathode to the negative pole, if one reflects that the word anode contains an "n," while the word positive does not, and cathode contains no "n," while negative does. That seems to be about as useful as most mnemonic formulæ.

THE GERMAN PHYSICIANS OF THE LATE EMPEROR.—The German Emperor has conferred on Professor von Bergmann the Star and Cross of the Royal Order of Hohenzollern, and on Professors Gerhardt and Schrötter the Order of the Red Eagle (of the second class).

SCIENTIFIC CONGRESSES IN 1889.—In connection with the exposition in Paris in 1889 there will be held international congresses of hydrology and climatology, of hygiene, of dermatology and syphilography, of electricians, of physiology, and of therapeutics. The committees on organizations have been appointed, and it is probable that the names of the officers will be soon announced.

FETID SWEATING OF THE FEET.—The *Kriegs-Sanitas Ordnung* recommends a powder composed of three parts of salicylic acid, ten of starch, and eighty-seven of talc. Five grammes suffice for one application, but this remedy being not always convenient, the Prussian military laws prescribe a salicylic suet (salicylic acid, two parts; mutton suet, 100 parts).—*Archives de Med. et de Pharm. Militaires.*

QUEER REMEDIES.—A correspondent of the *Philadelphia Medical and Surgical Reporter* says that he knows a man in his neighborhood, styling himself a physician, who recommends the following for epilepsy: Take the false tongue of a new born calf, which, he says, grows under the real tongue during intra-uterine life; dry thoroughly and powder, and give from five to ten grains three times a day.

A MISHAP TO AN AMATEUR DOCTOR.—The newspapers record a somewhat amusing incident that lately happened to a person who tried to bring a man out of an epileptic paroxysm by pouring cold water into his mouth and upon his neck. After a slight struggle, according to the account, the epileptic sank back apparently dead, whereupon the manipulator of the water became intensely anxious and placed his ear at the mouth of the patient, who straightway caught the ear between his teeth and proceeded to chew it until "its beauty had vanished." An ar-

rest on a charge of mayhem followed the epileptic's return to consciousness, but a police justice discharged the prisoner, on the ground that he was not responsible for what he might have done while in a fit.

FOR ECZEMA OF THE ANUS AND GENITALS.—Lustgarten recommends the following ointment in this painful affection:—

Oleate of Cocaine - - $\frac{1}{2}$ to 1 part.

Olive Oil - - - - - 2 parts.

Lanolin - - - - - 10 parts.

M.—Apply this ointment twice a day to the affected part.—*Gazette de Gynécologie*, July 15, 1888.

A NATURAL CUBIC CENTIMETRE MEASURE.—Everyone has at his disposal a cavity, viz., the external auditory meatus, whose cavity is about a cubic centimetre. The right meatus holds a little more than the left, and the capacity increases slightly with the height. The exact average capacity in one hundred men, according to Hummel, is 1.06 c.c.

RATHER SWEEPING.—From the following item, which we find in the last number of *The Quarterly Journal of Inebriety*, it seems evident that in the future there will be few marriages in Kentucky: “A very curious and suggestive bill has been introduced into the Legislature of Kentucky, which prohibits marriage with an idiot, lunatic, pauper, vagrant, tramp, drunkard, gambler, felon, or any person rendered physically helpless or unfit for the marriage relation, or any person with a violent temper, or who has, within one year, been a frequenter of any immoral house.”

LOOKING FOR PRACTICE.—The following advertisements from the *London Times* would seem to indicate that the rising young physicians in England are not devoid of ingenuity, even though their self-respect be not great: “A Young Medical Man, of great abilities and high testimonials, is, from want of means, prevented from obtaining a practice. Would any benevolent lady or gentleman of influence assist him by obtaining an appointment or otherwise? Address,” etc. “To Philanthro-

pists.—Young Doctor, highest credentials, living West End, will attend, gratis, limited number of patients annually recommended by any philanthropist paying sufficient for rent and taxes.”

TREATMENT OF CRACKED NIPPLES.—Cracked nipples are treated with great success by Pinard, as follows: As soon as there are any appearances of cracks, or even tenderness of the nipples, a compress, folded in four and steeped in boracic acid solution, three or four per cent., is applied. Oil silk is placed over the compress to prevent evaporation. Over this a layer of cotton wadding, and the whole secured by a bandage. Another method is that pursued by Monti, who covers the fissures with caoutchouc dissolved in chloroform (traumaticine), and this protects the fissures against the saliva of the infant.

PRESERVATION OF CATGUT LIGATURES.—Prof. Gross is not at all in favor of carbolized oil as a preservative of catgut ligatures, claiming that it merely forms a nidus for germs. He recommends putting the animal ligature in a weak chromic acid solution and glycerine for about a week and then placing in the following mixture until needed:

Alcohol	- - - -	15 parts.	
Glycerine	- - - -	1	“
Acid Carbolic	- - - -	10 per cent.	M.

The placing of the catgut in a 1-1000 corrosive sublimate solution just before using makes it soft and pliable.

A COLLAPSED DRUGGIST.—“I want some consecrated lye,” he slowly announced as he entered the store. “You mean concentrated lye,” suggested the druggist as he suppressed a smile. “Well, maybe I do. It does nutmeg any difference. It’s what I camphur, anyhow. What does it sulphur?” “Eighteen cents a can.” “Then you can give me a can.” “I never cinnamon who thought himself so witty as you do,” said the druggist in a gingerly manner, feeling called upon to do a little punning himself. “Well, that’s not bad, either,” replied the customer, with syruptitious glance. “I ammonia

novice at the business, though I've soda good many puns that other punsters reaped the credit of. However, I don't care a copperas far as I am concerned, though they ought to be handled without cloves till they wouldn't know what was the madder with them. Perhaps I shouldn't myrrh-myrrh. We had a pleasant time, and I shall caraway—" It was too much for the druggist. He collapsed.—*Detroit Free Press.—Medical Herald.*

SIR ANDREW CLARK, M.D., F.R.S.

"Stafford," writing an "Open Letter" to one of the lay newspapers, has the following anent Sir A. Clark, president of the Royal College of Physicians of London:—

It would not be bad business to decoy you away from your consulting room at any given date. and just pocket the pile of guineas under which your *escretoire* may be said to groan daily. It would be an amazingly good haul for an enterprising nobisman, and *entre nous* your banking account must be so beautifully swollen by this time that you would never miss them.

Truly, the general practitioner is but a poor devil when compared with an illustrious specialist like yourself. What are the paltry family bills which are so long in coming in, and of which no careful medico dare press the payment, beside the glittering series of one-pound-ones or two-twos, or even three-threes, as the scale may be, which are actually forced into the luxurious lap of the man who has made the special study of some popular complaint his own? Fancy an ante-chamber crowded with people desirous, and even impatient, to part with their coin! It is better than discovering a petroleum well in one's back garden, or blundering in a Welsh gold mine!

No one can deny that you have won your spurs by constant hard work; and now that you have been on the war-path for about forty years, you have found out that dieting is the best panacea for the fashionable ailings of your aristocratic *clientèle*. You ride your little *liver* hobby-horse, and truly I believe you are right. One half of the failures in life may be attributed to the unconscionable behaviour of the average

organ, so denominated, and any man who appears as the *hepaticus* apostle deserves the gratitude of the whole world—in fact, they should all desire you to be a long-liver.

Like a great many more eminent physicians, you hail from the land o' cakes. Aberdeen is not only your birthplace, but the cradle of your education, and you have managed to wrest as many medals from your national extra-academical Medical School as would gladden even the soul of an enterprising soap-boiler who sends his superfine wares to every possible exhibition.

It was not, however, till 1854, when you joined the Royal College of Physicians, and settled in the metropolis, that you gave a real impetus to the spreading of your reputation, which may be said now to be European.

Among your most distinguished patients, the G. O. M. has perhaps helped you along more than anybody else. Judging as an humble outsider in these matters, I should say that W. E. G. must be one mass of liver, and therefore an admirable subject for your skill. I doubt, however, whether your patching him up, and keeping him jolly and healthy, meets with universal approbation. I should say, on the contrary, that some anti-Home Ruler would be glad of the chance of administering some quiet but efficacious prescription which would promptly remove him from the scenes of political warfare.

Your manner towards those who consult you, unlike your celebrated predecessor, Dr. Abernethy, is *sauve*, not to say mellifluous. "No coffee, a little cocoa, dry toast, a chop well done or its equivalent, a pint of claret, and no more," is your usual two guinea *formula*, and the delicious air of modest conviction with which you utter the words renders the advice concentrated balin of Gilead to the dyspeptic victim who clamours at your door.

I remember some few years ago the nephew of a well-known statesman called upon you in your professional capacity. The young gentleman had arrived at the stage of suffering when it would be considered imprudent to attack any kind of breakfast except that which one could, so to speak, uncork. "What do you usually drink!" you asked the youthful but fervent admirer of Bacchus. "Brandy and sola, as a rule," replied the ingenious lad. "Ah, every S. and B. you take is like putting a nail in your coffin." "Then," remarked the logical visitor, "my coffin by this time must be entirely made of nails."—*Hospital Gazette*.