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THE
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Original Communications.

H. EMATOCELE.

BY J. SPENCE, M.D., TORONTO.

F. S., æt. 24, servant, fair complexion, good physique. Had pelvic peritonitis six years ago in England; was in bed three months at that time.

History of present trouble: Was taken with severe pelvic and abdominal pains Dec. 29, 1889, while hanging clothes on the line in the yard. She complained of intense pain over the bowels and in the back. She continued moving about and doing some work, notwithstanding her severe pain; till January 3rd, when I first saw her.

Her face was pale, anxious, and pinched; the tone of her voice was an indication of intense suffering. She stood bent over to relieve the abdominal pain, which, she said, was much easier in that position. Pulse was feeble, quick, and very weak; temperature normal. She became unwell on the 28th, she said, and thought she caught cold hanging out clothes on the 29th. Found great tenderness over the lower part of the abdomen, being most tender over the left inguinal region. A hard swelling, having about the circumference of a cricket ball, is also found here. Swelling is hard and resisting, and feels like inflammatory induration. Percussion gives a dull note on the left side to the upper margin of the tumor, but gives a bowel sound on the right side.

On vaginal examination, find a dilated os, soft, and pointing to the pubes. A hard, resisting swelling filling Douglas' cul de sac and extending behind, laterally, and as far as one can feel, in front also of the uterus, and indistinguishable from the body of the uterus, the hardness of which is in marked contrast with the softness of the dilated os.

Vomiting is very severe and persistent.

Treatment.—Ordered absolute rest and gave anodynes to relieve the pain. Also ordered saline purgative tonic, giving ʒi. mag. sulph. every four hours till bowels move.

4th.—Patient no better. There is great tenesmus of uterus and bowels, and dysuria. The abdominal pain is paroxysmal; vomiting continues. The bowels continue obstinately constipated, though there is a constant feeling as if all would be well if they would move. Urine has to be drawn off. This condition of affairs continues till the 7th, when a decidua is expelled, but no fœtus was seen. My patient, who up to this time was supposed to be single, produced a certificate of marriage, stating that she was unwell for the last time about six weeks ago. There is considerable hemorrhage now, though there has been some all along.

The pallor and weakness and vomiting continue, and the tumor seems to become larger, extending across to the right side and filling the peritoneal cavity to within about two inches of the umbilicus. It is with great difficulty that the catheter is passed into the bladder, so great is the mechanical pressure against its neck. The

bowels still continue constipated to the 10th. Dr. Cameron saw her in consultation on this date. Does not think operation advisable at present. Continue the sulphates, and also gave pulv. glycyrrhizæ co., ʒi., every three hours till bowels move.

Patient keeps about the same, with slight improvement, till the 22nd, when she becomes suddenly worse. She has taken 2 oz. of pulv. glycyrrhizæ co., and about 6 oz. of mag. sulph., without any effect on the bowels. On the 23rd the symptoms are very grave. She is more blanched and faint, and more deathlike; the abdomen is more distended, the mass being harder and more tender, and extends almost as high as the umbilicus on the left side, but extends higher towards the left kidney than in the median line. This mass covers the entire abdomen below the umbilicus. The hard mass in Douglas' cul de sac touches the vulva and almost protrudes. The patient continues vomiting, and the pain and distress are intense.

Dr. Cameron again sees the patient in consultation on the 25th. He advises an operation, as he considers the case as probably an extra uterine pregnancy. He also advises grain doses of iodoform, ac. salicyl, and ergotine, in capsules, three times a day (this treatment is continued till recovery), till the 27th. If not improving then, advises to call Dr. U. Ogden.

On the 27th Dr. Ogden recommends an operation, to take place in two or three days if considerable improvement has not taken place. His reasons for advising an operation are, 1st, the case is probably abdominal pregnancy; 2nd, on account of the large size of the tumor, suppuration would be apt to occur and the patient most likely die; 3rd, recovery would be facilitated and a prolonged sickness cut short. Bowels have not moved yet. All agree that the prognosis is very grave in any case. On Dr. Ogden's advice mag. sulph. in ʒi. doses every hour in cold water is given. This is continued for 30 hours, and still the bowels do not move. On 29th they move a little. The other symptoms continue as bad as ever, only the general appearance is better. On the 30th I telephoned Drs. Cameron and Ogden to come, with a view to operating.

On telephoning to Dr. Ogden I reported that I thought there was a slight improvement. He

answered: "Let her improve, then." She kept about the same for a few days, after which there were more visible signs of improvement, vomiting gradually ceasing, appetite improving, and the bowels moving every day and the tumor becoming smaller.

On February 5th she had a slight recurrence of the hemorrhage. There was considerable discharge of blood from the vagina. There was increased vomiting, increased pain, and great distress. She was also very feverish for her (her temperature in no part of her disease exceeded, up to this date, 101½°). She had at this time all the ordinary symptoms of la grippe. This condition culminated on the 9th in a short fit, in which, while she retained consciousness, there was trembling of the voluntary muscles, oscillation of the eyeballs, nictitation, squint from paralysis of the external rectus, and dilation of the pupils. Could protrude the tongue, swallow. Reflex is normal, urination very free, pulse 110—130 in minute, temp. 102°. This occurred about 10.30 p.m., and lasted about an hour. From this date her progress was rapid. She sat up in bed on 16th February. She began to pass urine without the catheter on the 2nd of February. Vomiting continued in the mornings till 28th February,

The only remark I have to make on this case is: I believe this almost hopeless case of hæmatocele, and one the cause of which could not be determined, but which was taken to be an ovum escaped into the peritoneal cavity, did infinitely better by the expectant treatment than she could have done by the operative.

Selections.

SACCHARIN.—It seems that our Government like that of France, does not regard saccharin in a very favorable light, as not only this substance itself, but compounds containing as little as one-half of one per cent. are chargeable with a rate of ten dollars per pound. This, if carried into effect, will forbid the use of the new sweetener as a dietary substance, and this is probably a wise restriction.—*Canadian Pharmaceut. Journal.*

DEATH FROM SEPTICÆMIA AFTER WOUND OF THE HEART.—Dr. R. M. Hall, of Baltimore, reports in the *Medical Bulletin* for March a case

of a colored woman, twenty-one years of age, who received a penetrating wound of the chest. The injury was done with the blade of a pocket knife, which passed completely through the right ventricle of the heart, a little to the left of the septum. Two days after the injury the patient had a miscarriage, and, although antiseptic injections were used, she died four days later, or six days and fifteen hours after receipt of the wound. There was only a small amount of clotted blood in the pericardium after death, and the wound in the heart was closed by a plug of fibrin. Had not the abortion occurred the patient would probably have recovered, and the gravity of the wound not have been discovered.—*Kansas City Med. Index.*

DEATH FOLLOWING THE INJECTION OF COCAINE INTO THE URETHRA.—Before performing an internal urethrotomy, the author, M. Simes, injected one gramme of a five per cent. cocaine solution into the urethra. The patient, aged 29 years, was, independent of his local trouble, in good health. Immediately following the injection, contraction of the muscles of the face took place, then dilatation of the pupils, arrest of respiration, and epileptiform convulsions. The convulsive phenomena increased in severity, the respiratory movements became more and more feeble, the cyanosis intense, and at the end of twenty minutes the patient was dead. At the autopsy the lungs were much congested, but normal, the left ventricle contracted. Post mortem clots were found on the right heart.—*Gaz. degli ospitali.*—*Lyon Medical.*

THE MICRO-ORGANISMS IN CHEESE.—Professor Adamez, of Larnthall, in Switzerland, has isolated nineteen varieties of microbes in a single variety of cheese in the fresh condition. In each gramme of this product he counted from 90,000 to 140,000 bacteria, which in seventy days had multiplied to 800,000. In the soft varieties the number is still greater: 1,200,000 in a gramme of cheese thirty-four days old, and 2,000,000 in another forty-five days old. These figures refer to the interior; in the rind, three to five millions of organisms were counted per gramme.—*Lyon Medical, March 16, 1890.*

G.A.F.

SWELLING OF THERAPEUTIC ORIGIN—SUBCUTANEOUS INJECTIONS OF METALLIC MERCURY.—At the Society of the Medical Sciences of Lyons, M. Augagneur exhibited fragments of a tumor of therapeutic origin. A patient, suffering from a mild attack of syphilis, was given two subcutaneous injections of metallic mercury in the buttock, one containing six grammes, the other three. The attack progressed, producing some manifestations in the mouth. The interesting feature of the case was, that the patient suffered very frequently from attacks of ulcerative stomatitis, occurring at short intervals, particularly after a blow on the buttock. A month ago, after a fall on the buttock, he again had a serious attack of stomatitis, and was admitted into l'Antiquaille. Suspecting that the metallic mercury had not been absorbed, M. Augagneur decided to remove the swelling which had formed about the situation of the mercurial injection; he did, in fact, express metallic mercury from the Gluteus maximus after removing the greater part of the muscle. This case demonstrates the uncertainty and danger of this treatment. The mercury is probably absorbed as a chloride.—*Lyon Medical, March 30, 1890.*

G.A.F.

TREATMENT OF SOFT CHANCRES BY THE SUB-BENZOATE OF BISMUTH.—Iodoform is perhaps the best local application for the treatment of chancroid or soft chancres, but its characteristic odor renders its use difficult in city practice, unless the patient keeps to his room. We are glad, therefore, to welcome the appearance of a new remedy, highly extolled by Mr. Finger, who has substituted the sub-benzoate of bismuth for iodoform. The chancroid is powdered with the sub-benzoate, covered with cotton wool, and a small dressing applied. This operation may be repeated once or twice a day. When the first application is made the patient feels a slight burning sensation, easily borne. The sub-benzoate causes no local irritation; in three or four days, more rarely in five or six, the chancroid assumes the appearance of a healthy ulcer. An ointment of the strength of two per cent. of carbolic acid is all that will be necessary to complete the cure. The sub-benzoate of bismuth is obtained by heating the sub-nitrate of bismuth in presence of nitric acid and benzoate

of soda. It appears as a fine, light, white powder, having a slight pungent odor.—*Bulletin Medical, Feb. 19th* — *Lyon Medical, March 2nd, 1890.*

G.A.F.

EXCEPTION TO THE LAW OF BANNES (otherwise Law of Colles).—By Dr. L. Merz. It is generally admitted by syphilographers that a nursing mother is never infected by her syphilitic child. This precious immunity which preserves from a terrible contagion the person most directly exposed, and which allows these unfortunate little beings, objects of loathing and fear for all who approach them, to enjoy the inestimable advantage of being nursed and cared for by their mothers, is known in science under the name of Colles' Law (or more correctly, according to Professor A. Fournier, as the Law of Bannes). It is looked on as being absolutely established, and Dr. Merz, in the Bibliography of Infantile Syphilis, cites but one exception to this law, published by Zingales in 1882. The Professor of the Medical School of Algiers publishes another exception. A man 34 years of age contracted, when 29 years old, a syphilis of moderate intensity, which, three years later, again revealed its presence by the appearance of a fresh crop of mucous patches in the mouth. His wife became pregnant six or eight months after this fresh attack, which occurred two months after her marriage. Pregnancy was normal. Confinement took place at term, on the 1st of October, the baby, a boy, being apparently sound and healthy. In about fifteen days mucous patches appeared on the lips, tongue, and cheeks of the child, and a discrete pemphigus on his legs and arms. The mother was submitted to the mixed treatment, and the child was free from eruption in ten days. One month later, painful fissures and an indurated chancre appeared on the left breast of the mother, with an indolent enlargement of glands in the axilla. The chancre disappeared in fifteen days, and was followed thirty days later by a magnificent roseola, with falling of hair and mucous patches on the inner surface of the right cheek. The anti-syphilitic treatment on which the mother had been placed when the child first showed signs of the disease had been rigorously carried out. The mother did not exhibit any other manifestations; the

milk remained abundant, and nursing was not interfered with. Both are, or appear to be, cured at the moment of writing. In addition, M. Merz quotes a case in which the law of Colles was confirmed. M. X., 37 years of age, two years married, contracted syphilis when 26 years old; manifestations until 32nd year, moderate intensity. Mrs. X., seven months after her marriage aborted at three months; a year later she was prematurely confined about the middle of the seventh month of a puny, sickly child. The mother nursed him for three months, then seeing that the child was covered, particularly on the face, with an eruption of papules and crusts, which she attributed to her bad milk (she had always been anæmic), she engaged a wet nurse. Six weeks later, the unfortunate nurse, who had been carefully examined and found healthy before being engaged by Mrs. X., developed an indurated chancre on the left breast, followed by a roseola and by alopecia. The mother had no syphilitic manifestations whatever.—*Bull. Med. de l'Algérie.*—*Arch. de Tocologie.*—*Lyon Medical, Feb., 1890.*

G.A.F.

THE THERAPEUTIC USES OF IODOI.—Elsewhere is published a paper by Dr. Cerna on the use of iodol, in which he details instances where the drug, when used internally or externally, did great good in diseases widely separated from one another. It has always seemed to us that the profession was too much inclined to pass this drug by as one which could only be considered a substitute for iodoform, and an almost useless addition to internal medicine. Some years ago Cervasato published the results obtained by him from its use in the treatment of scrofula and respiratory affections of a chronic type, and in the treatment of tertiary syphilis. He claimed that it does not readily produce iodism, even when used in the dose of 15 to 45 grains a day, and that the stomach is not disturbed by its employment. Still further back Stembo wrote a paper asserting its value in diphtheria, when it is applied locally to the affected area, using it alone, or in the form of a solution made up as follows: R.—Iodoli, ℥ss; alcohol, fʒss; glycerini, fʒiiiss.—M. S. To be painted over the part.

The number of cases treated by him was

seven, and every one recovered in from four to six days. The advantages he found consisted in its harmlessness, its lack of odor and taste, the painlessness of its application, as well as the avoidance of untoward after-effects.

In cases where a discharge from the middle ear needs a dry antiseptic powder, iodol may be used in place of iodoform with success, and without the disagreeable smell of the latter drug. Under these circumstances Purjesz has found it useful in both the acute and chronic forms of this troublesome malady, as it always stopped the discharge in a few days in the acute attacks in his hands. When employed in the ear it may be applied once or twice a day, care being taken that it does not produce too much irritation in the part affected.—*Med. News.*

ELEVEN CASES OF INTUBATION IN YOUNG CHILDREN.—The details of eleven cases are given, O'Dwyer's instruments being used, and tracheotomy being resorted to in those cases in which it was thought that an open wound would give better relief. This was the case in three patients—large quantities of mucus obstructing the tube, and giving rise to constant and ineffectual cough. The author thinks that the tracheotomy tube gives a better chance than intubation in feeble children, when there is broncho pneumonia present with the diphtheria. No serious difficulty in feeding was experienced, fluid food being given in all cases. After the tube had been inserted, the string was left attached in all cases except one, the free end being secured to the left temple by strapping, and not withdrawn, as usually recommended. The hands were fastened to the side of the bed with a flannel bandage, sufficiently long to give the child freedom to play with its toys, and yet not reach the mouth.

The advantage of having the string was found in one case where the tube slipped below the vocal cords, but was readily withdrawn. The author's experience with O'Dwyer's tubes is, that should there be any membrane or collection of mucus exciting cough in a fairly vigorous child, the tube acts as a moderately tight wad, offering just sufficient resistance, that an energetic cough causes its immediate expulsion, and with it, any mucus or loose membrane that may lie below it. Complete relief, which is of very

variable duration, is due to the temporary displacement of the œdema of the cords, from the pressure exerted by the tube.

A tracheotomy tube, on the other hand, cannot, when tied in, be expelled, and the removal of the inner tube is frequently quite insufficient to enable the child to rid itself of the cause of the obstruction, and a skilled nurse or medical officer should be within call. The amount of practice required to intubate, fairly rapidly, cannot be compared with that required for tracheotomy. Two assistants are essential in intubation, one to hold the child, and another to steady the head and control the gag. Too much stress cannot be put on the importance of keeping the patient's body and head held fair and square before the operator. The results obtained by the author in the eleven cases mentioned, and in five others subsequently intubated, were, seven recoveries and nine deaths. The average age of the fatal cases was under two years, and of those cases which recovered, five years.—*Jour. of Laryngology.*

TREATMENT OF SYCOSIS.—For purposes of convenience, I will divide the treatment in two stages, viz., the curative, and the prophylactic. When the curative treatment is undertaken, it has been my practice, lately, to epilate as thoroughly as possible. Where a large area is involved this cannot be done at once, but will have to be performed at successive daily sittings. Care must be taken to epilate thoroughly, and the vibrissæ, in the nostrils, should not be overlooked. Any pustules or small abscesses should be opened and their contents evacuated. When hairs are extracted the pus contained in the follicle should be evacuated, as much as is possible. I pay no attention to the tubercular infiltrations, as they disappear in a short time under the medication employed. As soon as the last hair of that sitting has been extracted, apply campho-phenique pure, and order the patient to make a similar application at night. This simple treatment constitutes the curative portion.

After a variable time it will be observed that pustules are a very unusual lesion, and it is then the proper time to institute the prophylactic treatment. This is absolutely essential for two reasons. In the first place, a few micro-organ-

isms may be deeply lodged in some crypt; and, if the patient is permitted to neglect all treatment, they will constitute a focus from which a general infection will spread, and a consequent relapse will occur. In the second place, the omission of any treatment exposes the patient to the dangers of a fresh infection from without. Having had sycosis once shows a susceptibility to the disease, which is increased by the fact of having contracted it. For these reasons a patient, who is apparently cured, should be subjected to a further course of treatment. The prophylactic course is very simple. I order the patient to shave every morning. He is directed to make his lather with a bichloride of mercury soap, using a 1 in 1000 bichloride solution in water. He is also cautioned to render aseptic his razor, shaving brush, etc., by some simple means. After having shaved, a bichloride solution is ordered to be applied, the strength varying from 1 in 500 to 1 in 1000, according to the tenderness of the skin. At night the same application is made, or sometimes varied by ordering lanolin to be rubbed in.

I have had a happy experience by the use of this method. The curative treatment has accomplished its purpose in from two weeks to three months. The duration of the disease when I saw it varied from three weeks to seven years, in different individuals. In long standing cases the tubercular masses disappeared under the influence of the campho-phenique, which besides being antiseptic, has marked reducing powers. The slight dermatitis which exists at the termination of the curative treatment, disappears spontaneously under the prophylactic treatment.

The duration of this latter treatment is indefinite. I have some patients who have pursued it for about two years. They have never experienced any relapses, and are so well pleased with the results that they prefer continuing it to running the risk of contracting the disease once more.—*Ohmann Dumesnil in St. Louis Med. and Surg. Jour.*

PHYSIOLOGICAL ACTION OF ANTIPYRIN.—In some experiments upon the action of the drug upon the brain, where the crura cerebri were cut, the temperature rose rapidly in a most ex-

traordinary manner. Thus, in a dog in which the cut passed through the posterior portion of the crura, the temperature was found to be 110° Fahrenheit in the rectum, and 112° were recorded in the abdominal cavity some time after death. Usually, however, a temperature of 105°-106° was noted under such circumstances.

This fact is of interest, especially in a consideration of the well-known antipyretic action of the drug.

In the normal animal, antipyrin does not lower the bodily temperature, even if given in toxic doses, while this certainly does occur, to a marked extent, in the presence of fever. In the above case high fever was observed, and antipyrin had been administered in quite a large dose; why, then, did it not affect the temperature?

Certainly a probable action of the drug upon the thermal centres directly offers itself as a ready answer to the question; the thermal centres being thrown out of action in the above cases, it could no longer exert its influence upon the tissues through the thermal nerves.

We certainly have reason to believe that heat-production or heat-regulation, or both, are under the control of a cerebral centre or centres.

In all cases of fever, in which the body temperature is lowered by the drug, the following is the probable action: the abnormal constituents of the blood, whether they be products formed by the action of bacteria, or otherwise, or reflex causes, having their origin in an abnormal condition of the nerves leading to the thermal centres, act upon the latter, stimulating them if they are heat-producing, paralyzing, or, at least, lessening their irritability if heat-regulating, or both, if both exist. Antipyrin, on the other hand, if administered under such circumstances and effecting a reduction in the temperature, must act in exactly in an opposite manner to result in a lowering of the temperature.

At the same time nitrogenous waste is decreased (as Samadovsky showed) by antipyrin, in the normal as well as in the feverish animal, but that this decrease of waste is not due to an action of the drug upon the thermal centres, but upon the tissues themselves, is apparent from the fact that the temperature of the normal animal is not affected by it, however large the

dose might be. This, then, explains the reason why antipyrin is such a powerful antipyretic, since it acts on both the thermal centres and the tissues.

The styptic action of the drug is most marked, and has been ascribed by some to an action of the drug upon the vasomotor system. While this may be the case, it is certainly only a partial cause, since the antipyrin influences the clotting power of the drug in a most remarkable manner: thus in one case, when 50 cc. of blood were allowed to flow into an aqueous solution of antipyrin (gr. x in 10 cc.), a clot had formed one minute later already of such strength that the entire beaker could almost be inverted.—*Simon and Hoch, in Johns Hopkins Hospital Bulletin.*

THE PHYSIOLOGICAL AND THERAPEUTICAL PROPERTIES OF EXALGINE.—Exalgine is a compound occurring in colourless acicular crystals, readily and completely soluble in water, to which a small proportion of spirit has been added soluble also in hot water, and to a less extent in cold. Drs. Dujardin-Beaumetz and Bardet ascertained that in medicinal doses the effect of the drug was, under certain circumstances, to abolish the sensation of pain without affecting tactile sensibility. If pushed, it brought about a marked and persistent fall in the temperature, but only in doses larger than are necessary to produce the maximum of the analgesic effects. Speaking generally, its effects resemble those of antipyrin, but exalgine was found to affect sensibility to pain more particularly, the antithermic effects being quite secondary in importance. Moreover, the effects of exalgine were obtainable with doses far less than those of antipyrin. It is eliminated in the urine, the quantity of which it lessens, and this effect is particularly well marked in diabetic polyuria, in which both the amount of the urine and of the sugar are diminished. Given, however, in medicinal doses, even when repeated, no gastro-intestinal irritation, rash, or cyanosis, were noticed by their observers, though in one instance, probably due to some idiosyncrasy on the part of the patient, a slight ephemeral erythema followed its administration. The usual dose is from two to five grains, cautiously increased to eight grains if necessary. It is not desirable to

exceed from six to twelve grains in twenty-four hours. As exalgine is essentially an analgesic and not an antipyretic, its use is contra-indicated when the temperature is above the normal. I have found it to be best administered in a little whisky or brandy and water, but where for any reason the addition of spirits is not desired, the drug can be given in wafers or gelatine capsules. Though almost insoluble in cold water, exalgine dissolves readily enough in the stomach, owing to the acidity of the gastric juice. As has been experimentally proved, it acts very promptly, and the effect has often been to secure more than a passing relief from pain. In one or two cases in which the dose was pushed to fifteen grains, the result was an appearance of intoxication, with slight noises in the ears lasting for some minutes. The drug is usually given morning and evening, just after getting up, and just prior to going to bed, but as it has no direct effect on the stomach there is no objection to its being given at any time during the day, even before a meal, provided only the smaller doses are prescribed. It has been remarked that the analgesic effects of exalgine have been particularly satisfactory in obstinate cases, which antipyrin and the salicylates had failed to relieve. The converse may also be true, but I have, so far, not had an opportunity of making comparative observations in this respect. The affections in which exalgine has produced the best results are those of which neuralgic pains are the most troublesome feature. In neuralgia proper, both a *frigore* and congestive, the relief is immediate, and often lasting. Moreover, neuralgic pains associated with affections of the female reproductive organs, have appeared singularly amenable to its sedative influence. Neuralgia of the dental nerves, tic douloureux, and the like, belong to the category of cases in which exalgine is almost always a specific, at least that is what the experience of the cases thus far treated by means of the drug would lead one to infer. Fraser, of Edinburgh, found small doses of exalgine ($\frac{1}{2}$ to 2 grains) very efficacious in the treatment of a large number of cases of sciatica, herpetic neuralgia, cardiac angina, pleurodynia, rheumatic synovitis, gastralgia, etc., and in several cases of locomotor ataxy the "lightning" pains were promptly overcome. The only precautions to

be observed in prescribing exalgine are:—1. To commence with doses not exceeding from two to five grains. 2. Not to give more than from ten to twelve grains in twenty-four hours. 3. To consider the febrile condition as a formal contra indication. With these precautions, exalgine may be ordered with confidence and without hesitation.—*A. S. Gubb, in Medical Press and Circular, Feb. 26, 1890.*

EXPERIMENTAL RESEARCHES UPON THE DIPHThERIA BACILLUS.—Klebs in 1883 published experiments, in which he found two different micro-organisms in diphtheritic products. Loeffler found Klebs' bacillus in the deeper layers of the false membrane, and obtained pure cultures of it, demonstrating experimentally its eminently pathogenic properties. The bacillus lived and died *in situ*, being never found in the blood, or viscera, but acted upon the constitution by producing a poison. The streptococci, which have been found in false membranes, predominate, especially in post-scarlatinal diphtheria, and to them is due the necrobiosis of the tonsil occurring in this form of diphtheria. Contrary to the diphtheria bacillus, they are found in internal organs (heart, liver, spleen, and kidneys). Their pure cultures never produced false membranes in animals, and they are therefore not pathogenic of diphtheria. The inoculation of Loeffler's bacillus upon scarified surfaces always produced false membrane identical with human diphtheria, their inoculation in cellular tissue produced vascular lesions, œdemas, hæmorrhages, etc. Loeffler, however, remarked that the bacillus had not been isolated in some typical cases of diphtheria, it had further been found in the saliva of a healthy child, and animals which survived the inoculations did not present paralytic phenomena. Later on, Loeffler demonstrated a pseudo-diphtheritic bacillus which had no pathogenic action upon animals.

In 1888, Roux and Yersin verified Loeffler's researches, with the important addition that they were able to produce experimentally in pigeons and rabbits late paralyses, which resembled post-diphtheritic paralysis in the human subject, and they obtained solutions from their cultures which acted as chemical poisons retaining pathogenic action. In 1889, con-

tinuing their researches at the Pasteur Institute, they succeeded in producing the same paralyses in a dog, and also toxic albuminuria. In 1889, d'Espine made experiments to show the action of various antiseptics upon Loeffler's bacillus, which he demonstrated to be the specific bacillus of diphtheria. Kolisko and Paltauf also found the bacillus in fifty cases of diphtheria, and never in the pseudo membranous sore throat of scarlatina and measles. Ortmann also isolated the bacillus in fifteen out of sixteen cases from diphtheritic false membranes, and Spronck, of Utrecht, repeated the experiments of Roux and Yersin, producing late paralyses and albuminuria from the injection of filtered cultures in the rabbit and pigeon. He also, with Wintgens and Doets, isolated the bacillus from the false membranes, in seven cases of diphtheria. Zarinko, from twenty cases of epidemic diphtheria, isolated and cultivated Loeffler's bacillus in eighteen, which in eleven cases of catarrhal origin (common catarrh, scarlatina, measles) the bacillus never occurred. In eighteen cases where examination of the apparently normal pharynx was performed, the bacteriological results were negative.

D'Espine and de Marignac isolated Loeffler's bacillus in eleven cases of diphtheria. These results were negative in four cases, of which only two exhibited the clinical aspects of diphtheria; in one of the others, of scarlatinal origin, the streptococcus was found also in the last case of "diphtheria" of the wound after resection of a knee.

The normal diphtheria bacillus resembles the tubercle bacillus in length, and its form varies much with the age of the cultures, the medium of cultivation, and method of coloration. The authors give the following method for detection of the bacillus in false membranes: A small thin piece is stretched over a cover glass, dried over a flame, and rapidly coloured with gentian blue. The bacilli appear under the form of slightly curved sausage-shaped organisms, strongly coloured, and having nearly always the same length. They are most numerous in recent membranes. Gramm's method of coloration is serviceable to detect saprophytic bacilli from diphtheritic in false membranes, the former being entirely decolorised, the latter not.

The authors discuss the action of light and

drying, of oxygen and its deprivation, and of heat and antiseptic substances upon the bacillus of diphtheria. With regard to the latter they find that boracic acid, chlorate of potash, alum, and lime water, have little destructive influence upon the bacilli, while salicylic acid $\frac{1}{1000}$, and even $\frac{1}{2000}$, citric acid and citron juice are very active in arresting the development of Loeffler's bacillus. The survivance of the bacillus in the dry state can be prevented in sick rooms by good aeration, disinfection of walls, floors, and clothing, and as milk is a medium for extraordinary propagation of the bacillus, its use should be interdicted when coming from a house in which diphtheria has occurred.

Irrigations of salicylic acid, one to two per cent., repeated every hour or two hours, is the best local treatment.—*Journal of Laryngology.*

CASE OF TRANSFUSION.—On the night of October 27 I was sent for to see a young girl who had been confined by a midwife 13 days before of her second illegitimate child. She had fainted twice during the evening and this had induced them to send for a doctor.

On my arrival, the patient was too weak to give an account of herself, but enquiry elicited that she had fainted immediately after the confinement, and again on the seventh day, as well as twice previous to my being sent for, and that bleeding had been going on continuously since the delivery. This was not considered unusual or important, and with the view of "strengthening her" she had been allowed up a few hours the last two days. It was while sitting in a chair that the fainting had occurred this evening. The midwife who confined her was present and said she had only seen her twice since delivery, which was natural, except for the faint afterwards and a rather too free flow of blood. The after-birth, she said, came away all right.

The patient was very restless, the pulse a mere thread, 156 to the minute, temperature 103, respirations sighing and voice weak. On vaginal examination I found a profuse discharge of watery blood. In the vagina was what seemed like a bag of coarse sand, but which I soon found to be the placenta, which had undergone calcareous degeneration and was firmly attached to the almost completely inverted uterus. Owing to the relaxed condition of the

parts reduction was easy, but some little difficulty was experienced in peeling off the placenta. The uterus was drenched with hot carbolised water and then with perchloride of iron and water, 1 in 20. By this time the pulse was uncountable and the tendency to faint marked. I gave half-dram of ether hypodermically, and finding this had no effect determined to try transfusion as a last resource. The apparatus used was a pint douche can with a rubber tube attached, into the other end of which I inserted a canula of my aspirator. A teaspoonful of salt was dissolved in a pint of water at about blood heat, and with the help of Dr. A. T. O'Reilly I proceeded to open the median basilic vein, which showed more prominently than the median cephalic. A string having been tied around the upper arm, the vein was exposed by a transverse skin incision, there being so little subcutaneous tissue that great care was necessary to avoid an accidental wound. The vein was then lifted up by a director passed beneath it and a small longitudinal opening made to admit the canula. The blood which flowed out was thin and watery, in fact merely serum. While the saline solution was flowing from the canula this was inserted upwards into the vein, and the can raised only slightly above the level of the patient so that the fluid should not enter at too great a pressure. When about one-third of the pint had entered a distinct improvement took place, the pulse became fairly regular, 144 to the minute, and the patient said "I am better now." Unfortunately I continued to allow the solution to flow, and in a few seconds the pulse failed again, the respirations became laboured, and the patient much distressed. I immediately ceased the transfusion, but the symptoms grew worse, there were the terrible precordial anxiety, pains and oppression in the chest, gasping for breath, and other symptoms characteristic of capillary thrombosis. The patient was evidently past all aid, and died just three hours after I entered the house. The transfusion in this case had a distinct but very temporary good effect. Perhaps if I had ceased directly the improvement occurred the result might have been different, but I do not think so, as owing to the septicæmia which was undoubtedly present, we had to deal not only with a dangerously diminished quantity, but also with a poisoned

quality of blood. In the exhaustive lectures on transfusion by Dr. William Hunter, delivered before the Royal College of Surgeons and published in the *British Medical Journal* for April last, it is clearly shown that the distressing disturbances, sometimes seen to follow transfusion, are due to capillary thrombosis, and not to any over-filling of the system with blood or too rapid injection, which are usually considered the producing causes. Why this capillary thrombosis should occur in one case or experiment and not in another is as yet not clearly understood, but everything points to the condition of the recipient's blood at the time of operation as the main factor. It is much more likely to follow the injection of blood than of saline solution. Defibrinated blood is more dangerous than ordinary blood because the proportion of the white corpuscles is much higher, and the disintegration of these and the blood plasma seems to be the immediate cause of thrombosis. Dr. Hunter lays stress on the fact that the chief value of transfusion is physical, restoring a volume of fluid to the vascular system sufficient to enable the circulation to be carried on. Blood possesses, in addition, a physiological value in its greater power of stimulating the vasomotor centres, but this advantage is more than counterbalanced by the greater difficulty and danger attending its use. Great care should be taken to see that the temperature of the solution should not be above that of the body.—*R. Worrall in Austral. Med. Gaz.*

A PHENOMENAL CASE OF GASTRIC ULCER.—F. T., æt. 34, Swede laborer, good family history, enjoyed very good health until Nov. 15; from that date until the 25th he was attended by Dr. A., who diagnosed typhoid fever. For a few days he had had general malaise, then repeated chills and attacks of vomiting; a week later severe abdominal pain and tenderness, with some tympanitis. The least pressure upon the abdomen caused pain, and at the end of the second week a cough came on which caused great pain in the epigastrium.

On the 25th he fell under Dr. B's care, who diagnosed typhoid fever with a complicating right pneumonia. For a few days, until the pneumonia resolved, the fever was pretty steady and high, 104° to 104½°. There was rusty

sputum, cough, and pain in side. Dec. 14th the patient was so far convalescent that the physician ceased to call. Patient was taking nourishment and gaining strength, but not out of bed, and there was no enlargement in the left side. Dec. 19th the doctor was again called, and found what he thought was an enlarged spleen. The tumor then filled the left side from the fifth rib to near the iliac crest, and across to near the mesial line, even beyond the middle line at a point above the umbilicus. The tumor, hard and non-fluctuating, projected very prominently in the left hypochondrium. It must have arisen very quickly, as the doctor was absent but four days, and the friends called him as soon as they noticed it. From Dec. 19 to Jan. 4 a pretty steady temperature of from 100 to 101, bowels constipated, and a good deal of vomiting.

Jan. 4 the patient was taken to the hospital. A prominent tumor occupied the left side, extending from the fifth rib to near the iliac crest, felt hard, but gave indistinct fluctuation. When patient lay on his back there was flatness in the axillary line from the fourth rib downwards, and the respiratory murmur, bronchial in character, was distinctly heard over the dull area, while on the right side the flatness disappeared and was replaced by hyper-resonance to near the ninth rib; bronchophony. Over the right lung vocal fremitus, bronchial breathing and bronchophony.

Diagnosis.—Enlarged spleen, with abscess and left pleurisy with effusion. The tumor became more flat under the ribs, softer, and distinctly fluctuating. On Jan. 18 he was aspirated in the 8th interspace, axillary line. First came a quantity of apparently pure blood, followed by 24 oz. of most foul pus with a fecal odor. The patient died the following night.

Autopsy.—Body moderately emaciated. A large pus cavity, with walls ¼ inch thick, was found to occupy the left side of the abdomen cavity. It was wholly infra-diaphragmatic, that organ being crowded upwards, and extending from the fourth rib to near the iliac crest. It was somewhat cone shaped, with the base directed upwards, and extended from a little past the mesial line, in the epigastric region, around to the left to near the spinal column, and still contained three quarts of dark, thin,

purulent, offensive matter. Stomach and splenic flexure of the colon lay behind the sac, being crowded downwards, so that the colon was behind and below the sac. It appeared to be between the greater omentum in front, and the stomach, pancreas, spleen, left kidney and splenic flexure behind, the spleen and left kidney being intimately embedded in the posterior wall of the sac. Pancreas healthy, spleen slightly small and rather hard, evidently the result of pressure. Liver and kidneys healthy. No evidences of enteric fever or other intestinal abnormalities. Heart remarkably small, contracted, and free from clots. A serous effusion into the left pleural cavity. Until the spleen was found and examined the sac was supposed to spring from that organ. Two fistulous passages, readily admitting the tip of the little finger, were found to connect the sac with the alimentary canal. Two funnel-shaped, round ulcers existed on the greater curvature of the stomach, one $\frac{3}{4}$ of an inch, the other $1\frac{1}{2}$ inches from the pylorus. At the bottom of these ulcers perforations nearly a half inch in diameter opened directly into the abscess cavity. It was clearly a case of two round ulcers of the stomach, running a very rapid course, with perforation and encapsulation of effused gastric contents and exudates. The perforations were evidently primarily from the stomach and not the reverse, as the gastric ulcers were typical and funnel-shaped, with smaller perforations at the bottom.

It is certainly wonderful that gastric ulcer should run such an anomalous course, and it is not strange that the physicians were thrown off the right scent, by the strange course of the disease.

That a patient should be brought, in two months, from supposed health to death by such a series of unusual events, seems worthy of note.

It shows in connection with the case above referred to: (a) how rapidly destructive gastric ulcers may at times be; (b) how masked the symptoms occasionally are; the wonderful powers of the peritoneum, under some circumstances, to fence out offending matter.—*James H. Dunn, in Northwestern Lancet.*

SACCHARINE.—Saccharine is said to be soluble in 330 parts of water, but it is found that for

the commercial article sometimes 600 parts of water are necessary, and sometimes as much as 1200 parts. From the published analyses it is very evident that the substance, as placed on the market, is very far from pure, and, furthermore, that the methods of manufacture must vary, as there is no uniformity nor regularity in the impurities.

As to the physiological action of saccharine there is some divergence of opinion, which may be accounted for by the great variation in the composition of the commercial substance. Pure saccharine may exert a very disturbing influence upon digestion if used in sufficiently large amounts. A committee, looking into this question for the sake of public hygiene in France, reported that in the proportion of 1 or 2 to 1000 it hinders the fermentative action of saliva, and in amounts of 2 or 3 to 1000, it interferes with the gastric action on albuminoids. The action of the pancreas is also retarded. Hence, some maintain that its use should be altogether prohibited, and especially that it should not be used, as is so often recommended, by diabetic patients, for whom a good digestion is so essential. Others say that the amounts entering into use with foods are so small that no effect upon the digestion can be observed, even after prolonged use. It is not one of those substances stored up in the body and so acting cumulatively, but is passed off largely unchanged and mostly within twenty-four hours through the urine. Stevenson and Wooldridge maintain that it is harmless, even in comparatively large doses, and when the use is long continued. Dujardin-Beaumetz says that it yields good results with diabetic patients, and that it is a question whether one can continue taking it with impunity. Bruylants concludes from his experiments that in the amounts in which it is generally used it cannot be regarded as an antiseptic, and that it has no injurious action, unless there be a possible harmful effect after long continued use.

Animals show great repugnance to food sweetened with saccharine. Bees, wasps, dogs, and cats, all readily detect the presence of the saccharine, and refuse to touch it. Dogs refuse to lick hands that have been moistened by a solution of saccharine, and not even great hunger can drive cats to partake of their

ordinary food sweetened with the same solution.

In pharmacy its use must be restricted, as it cannot substitute sugar in coatings, nor in dilutions, nor do the directions for preparing the saccharine syrup seem satisfactory. It is reported as quite incapable of disguising the bitter taste of quinine, and similar bitter alkaloids. It is used in medicines for diabetic patients. In wine it is not only a sweetening, but a preserving agent. In fruit-acids, liquors, glucose syrup, and confectionery, it is unquestionably used. Grape-sugar is also sweetened by it up to the standard of cane-sugar, and then used to substitute the latter. Chocolate and cocoa are sweetened by it, instead of by sugar. There is at present but one factory, that near Magdeburg. The yield from this is something less than 30,000 pounds a year, and this corresponds to 15,000,000 pounds of cane sugar. But to produce this amount this one factory already consumes two-thirds of all the phosphorus made in Germany. Of course more phosphorus can be made, but the extension of this manufacture means a very widespread upheaval and changes among the other industries. For hygienic or financial reasons the various nations have begun to consider the importation of saccharine and its results.

As in many countries an important part of the revenues comes from the tax upon sugar, the question of the evasion of this tax by the use of glucose, sweetened with saccharine, becomes a serious matter. It is interesting, therefore, to note the position of the various governments towards this American invention.

Italy taxes saccharine at the rate of one thousand francs per hundred kilos. Finally, a law has been proposed prohibiting the importation or manufacture of saccharine, or substances containing saccharine, permitting, however, a restricted importation for pharmaceutical purposes. The importation into Portugal, France, and Spain, is forbidden. Great Britain has prohibited the use of saccharine in beer brewing, mainly for financial reasons. Holland, looking upon it as a drug, subjects it to a tax of five per cent. *ad valorem*, but now proposes to increase it to 60 gulden per kilo. Russia classes it with pharmaceutical and chemical preparations, and places a low tax upon it. Belgium collects

an import tax of 140 francs per kilo, and the same for all articles containing as much as one-half per cent. of it. The United States impose a tax of twenty-five per cent.

It is mainly as a substitute for sugar that its introduction and manufacture are antagonized. And yet, this industry, if it continues to grow, will have to be looked into from a sanitary standpoint. The danger is from two directions. An increased demand for the saccharine, with consequent hurry in the manufacture and temptation to adulterate, would most probably lead to the sale of a much impurer article than is now placed on the market. Again, the glucose, or starch sugar, with which the saccharine is mixed to substitute cane-sugar, is very often carelessly manufactured and injurious to health. Careful government supervision would be necessary to secure a harmless article. With impure saccharine and vile glucose largely used in confectionery, and as a general substitute for cane-sugar with the poorer classes of the community, the danger to public health would be great indeed. Saccharine and its utilization will have to be watched in the future.—*F. P. Venable in North Carolina Med. Jour.*

WE would call the attention of our readers to a very complete physician's battery, with current regulator, now being advertised in THE PRACTITIONER by the manufacturers, the Law Telephone Company of New York. In a communication, which our publishers have just received from them, the manufacturers state that since January 1st of this year they have sent eight of their "Galvanic Outfits" to Europe; three going to Paris, one to Boulogne, one to Berlin, two to London, and the last to Dr. Lawson Tait, of Birmingham. In his order for the battery Dr. Tait says: "It seems to me that your arrangements are more compact and less likely to get into disorder than any I have ever seen. I desire one of your fullest outfits. The arrangement seems to be extremely ingenious."

A CURIOUS VERDICT.—An embankment in Pennsylvania recently caved in on some railroad laborers, causing death. The verdict of the coroner's jury was: "Death of gravel."

THE
Canadian Practitioner

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

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

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TORONTO, MAY 16, 1890.

MEDICAL EDUCATION IN THE
UNITED STATES AND CANADA.

The report of Dr. Rauch, Secretary of the Illinois State Board of Health, on medical education in the United States and Canada, which we have just received, gives much valuable and interesting information. It shows that there are altogether 139 colleges in existence, of which there are 126 in the United States, and thirteen in Canada. The total number of colleges requiring attendance on three or more courses is sixty-four. There are still sixty-two colleges in the United States that only require attendance on two courses. It is certainly remarkable that in this great country, containing such institutions as Harvard, Johns Hopkins, Universities of Michigan and Pennsylvania, etc., this condition of things should exist. But that there is a great improvement in this respect is shown by the fact that in 1882 there were only twenty-two colleges requiring the three years' course. The total number of colleges exclusively for women is eight, of which two are in Canada. The total number of students attending lectures during the session of 1888-9 was 13,714 in the United States, and 1,491 in Canada.

The following is a list of the medical colleges in Canada, with the number in attendance during session 1888-9, as reported by the authorities of the various schools: Trinity Medical College, 289; Medical Faculty, University of Toronto, 258; Medical Faculty, McGill University, 233; Ecole de Medicine et de Chirurgie, of Montreal, 202; Royal College of Physicians and Surgeons, of Kingston, 150; Laval University, Medical Depart-

ments of Quebec and Montreal, 149; Medical Department of the Western University, London, 64; Medical Faculty of Bishops College, Montreal, 39; Manitoba Medical College, Winnipeg, 30; Halifax Medical College, 19; Woman's Medical College, Toronto, 35; Woman's Medical College, Kingston, 23. It will be seen from these figures that about forty per cent. of all the medical students in Canada are being educated in Toronto, and about the same proportion (including the French students) in Montreal.

It is stated that no less than eight new medical Colleges were opened during the past year in the United States. We find the following sensible comments on this fact: "In this connection it becomes a serious question to consider in regard to any new school, whether it is properly equipped from a teaching, a laboratory, and a clinical, standpoint. Can it be said with truth that there is any necessity for additions to the present large number of medical schools, some of which are not now properly provided for, and therefore hold out inducements, with results which tend so much to cast a stigma upon medical training and medical diplomas in the United States? More attention should be paid to securing endowments for medical institutions now existing, giving them more and better facilities to instruct, than to the creation of new schools inadequately endowed." One of the foot notes tells us: "The craze for establishing medical colleges, commenced in the United States about 1840, and continued uninterruptedly until 1880, when there was a lull, but it seems again to have broken out. The chances of survival of new colleges will be better appreciated when it is borne in mind that since 1850 there has been a mortality of over three per year, and that, at this time, more is required of the graduates of such institutions than at any period in the history of medical education in this country."

THE TORONTO SCHOOL OF MEDICINE.

Some people appear to think that the old Toronto School of Medicine is now the Medical Faculty of the University, and as such controls all matters connected with this Faculty, with the result of increasing the incomes of the members of the former corporation. Such an idea is incorrect, and, as it is likely to

create some prejudice against the new order of things in the minds of many who favor advances in medical education, we think it desirable to state a few facts in connection therewith. The Senate of the University decided to establish a medical teaching faculty before consulting any school, and to have absolute control over such faculty. After arriving at such decision, it made offers to both schools then teaching in Toronto. Trinity refused to accept the proposals of the University. The Toronto School took a different stand, and the majority of its staff (not all, we regret to say) received positions in the new Faculty. There are now in the University staff seventeen out of the thirty-two teachers who had nothing to do with the Toronto School. Even among the remainder there was such a redistribution of the work as to alter very materially the complexion of the staff. This will probably show to the most sceptical that there is in reality a new staff. Supposing, however, for the sake of argument, that there is still too much Toronto School represented (although we do not admit it), time will, ere long, provide the remedy. A new system has been established, by which the Senate, a perfectly independent body, will have every opportunity to fill vacancies as they occur with the best available men. In this same connection it may be worthy of note that all appointments are made for a period not to exceed five years.

As far as emoluments are concerned, it so happens that the teachers, who formerly belonged to the Toronto School, receive smaller salaries from the University, than under the old regime. This means that they have actually lost money by their connection with the University. Not only are they required to work for less remuneration than that received by the teachers of any of the large medical colleges of Canada, or the United States, but they must, in addition, engage in the very laborious work of examining the students, without any remuneration. At the same time all examiners not connected with the staff are paid for their work according to a fixed scale.

It is only just to the Toronto School of Medicine to say that its record from its incorporation to the present time has been an admirable one. This is, perhaps, not as highly appreciated as it ought to be. It is probably pretty generally

recognized that the establishment of the Ontario Medical Council has done a great deal to raise the standard of medical education. Members of the Toronto Faculty did much to bring it into existence. We think it right to point specially to the indefatigable and untiring exertions of Drs. H. H. Wright and W. T. Aikins, who worked so faithfully and so effectually in this direction. This was not, however, the commencement of their work in the interests of an elevation of the standard. For many long years the members of the Toronto School Faculty were true in their allegiance to the University of Toronto, while their pockets were suffering sadly from their fidelity. Without going too much into details, we may say that their loyalty received no encouragement from the Senate.

The Toronto School was placed on the same basis as medical schools largely in sympathy with other Universities. It was expected that the "double affiliation" regulations would soon bring many, if not all, the Provincial schools into sympathy with the University. We need hardly add that such anticipations were never realized. In self-defence the Toronto School had to adopt the same principle for herself, and obtain further affiliation. With a choice of Universities thus procured, her numbers of students were growing rapidly, and in the spring of 1887 her prospects were brighter than ever before. This was the position when Toronto and Trinity Schools were asked by the Senate of the University to assist in the formation of the Medical Faculty. Both were in a very prosperous condition. The University's high standard had been ahead of the times, and had never been well supported. The Toronto school had already lost too much through the University. The older members of its Faculty had had to struggle hard for many years without any remuneration, sometimes with considerable loss in building up their school. In the climax of their success they were asked to surrender all their powers, give up their name, sink their identity, work for smaller remuneration, and give up a certainty for an uncertainty—all in the interest of higher medical education. Their sister's answer was short, sharp, and decisive—No! Toronto's answer was—Yes! Her decision was a noble and generous one, and we are pleased to know that her unbounded confidence in the sense of justice of the Senate, and

her hopes of success for advanced and scientific methods of teaching, are not likely to meet with any disappointment.

NOTES.

THE BRITISH COLUMBIA MEDICAL COUNCIL.—The election for the Medical Council of British Columbia was held last month, the vote being counted April 29th, with the following result: Dr. G. L. Milne, of Victoria; Dr. W. J. McGuigan, of Vancouver; Drs. E. B. C. Harrington and J. C. Davie, of Victoria; Dr. Tunstall, of Kamloops; Dr. Le Fevre, of Vancouver; Dr. Smith, of New Westminster. Of these, six were members of the former council, while the seventh, Dr. Smith, takes the place of Dr. Trew of New Westminster.

ONTARIO MEDICAL ASSOCIATION.—The next meeting of the Ontario Medical Association, which, as we announced in our last issue, will be held June 11 and 12, is likely to be one of the most successful that the society has known. The President, Dr. Temple, of Toronto, has exhibited his usual ability and energy in his efforts to complete all the arrangements in a satisfactory manner. He has been well supported by the worthy and industrious secretary, Dr. Wishart, whose labors in this connection have not been light. Among the distinguished visitors will be Drs. T. A. Emmet and Andrew Smith, of New York; Dr. Goodell of Philadelphia, and a few representatives from State associations. The meeting will be held in the new building of the Ontario Medical Council, on the corner of Bay and Richmond streets; the regular sessions in the large examination hall, the meetings of sections in the smaller rooms. The building is not specially adapted for such a meeting, but it is considered the most suitable place for an association composed of physicians of Ontario.

MEDICAL ALUMNI ASSOCIATION OF THE UNIVERSITY OF TORONTO.—The annual meeting of this association was held in the Medical Council building, on Friday, September 9th, at 4 p.m., with the President, Dr. Thorburn, of Toronto, in the chair. After the ordinary routine business, a number of new members were

elected. The following were elected as officers for the ensuing year: President, Dr. Geo. Shaw, Hamilton. Vice-Presidents, Dr. Spencer, Toronto; Dr. Henry, Orangeville; Dr. Horace Bascom, Uxbridge; Dr. Clarke, Kingston; Dr. McConnell, Toronto. Treasurer, Dr. Riordan, Toronto. Secretary, Dr. Harley Smith, Toronto. Council, Drs. Acheson, J. F. W. Ross, McPhedran, Canie, Machell, Ellis, and R. B. Orr, Toronto; Dr. Olmstead, Hamilton; Dr. Moore, Brampton; Dr. Bennett, Jarvis. In the evening the annual dinner was held in the Queen's Hotel. In the absence of the newly elected president, Dr. Shaw, the chair was occupied by Vice-President Dr. Spencer. The proceedings were altogether informal in character, there being practically no set speechifying or toasting. An exceedingly pleasant hour was spent after the manner of a large and happy family gathering.

Meeting of Medical Societies.

THE PATHOLOGICAL SOCIETY OF TORONTO.

February 22nd, 1890.

The president, Dr. R. H. Reeve, in the chair.

CASE OF BRAIN DISEASE.

Section of the brain, the clinical history of which was given by Dr. McPhedran at the last meeting, showed suppurative of the corpus callosum extending through the lateral lobes into the posterior lobes. This was more marked on the left, although present on both sides. There was also a small patch of softening in the centre of the cerebellum. A thrombus was found in the left cerebral artery.

Dr. I. H. Cameron argued from the symptoms that the lesion in the cerebellum was probably primary. The case was hardly regular, for the plugging of the left cerebral artery should have caused complete hemiplegia.

Dr. J. E. Graham had seen a case in which the symptoms were the same, with the exception of the peculiar gait. In that case there was softening of one of the hemispheres down into the crus. Lesions of the corpus callosum are rare. Irregularity of gait is a symptom of tumor of the corpus callosum. The lesion in cerebellum seemed so much farther advanced than that in the cerebellum, that the cerebellar dis-

ease could not account for the peculiar gait. There was no thickening of the arteries to be found.

Dr. W. P. Caven thought that disease in the vessels must have caused the embolism.

MORBUS COXÆ.

Dr. I. H. Cameron exhibited the left femur from a case of morbus coxæ. The patient, a girl of three, was admitted into the Hospital for Sick Children with hip-joint disease in the third stage. There were several sinuses opening above Poupert's ligament. Extension was applied and every effort made to feed the child up. An operation was not thought advisable, because the acetabulum was, to all appearances, affected. The girl was in the hospital for three years, during which period abscesses developed from time to time.

Post mortem examination showed amyloid disease of the liver, which was so enormously enlarged that there was scarcely a half inch of space between the edge of the liver and the crest of the ilium. The os innominatum was greatly thickened, but there was no perforation of the acetabulum. The cartilage lining the acetabulum had disappeared, as had the head and part of the neck of the femur. The posterior surface of the neck was united to the body of the ischium by fibrous tissue. The medullary cavity of the shaft was much enlarged, so that only a very thin stratum—two lines in thickness—of compact bone remained. The remains of the capsule and other fibrous tissue about the joint was very much thickened, especially over the upper part of the great trochanter, where an incision in this region opened into a somewhat large abscess cavity, about the size of a sparrow's egg. The fibrous tissue was closely adherent to the periosteum, which was apparently quite healthy where it still remained. Microscopic examination showed amyloid disease of the liver, spleen and kidney.

From the light thrown by the *post mortem* upon the condition of the femur and joint, it was to be regretted that excision had not been done.

Dr. Thistle saw in the fibrous, thick, walled cyst surrounding the head of the bone, an effort at reconstruction on the part of the periosteum. It extended too far down the shaft to be a part of the capsule.

ANEURISM OF AORTA.

Dr. Cameron said that this case was interesting, not only on account of the seeming acute development of the aneurism, but also because the patient was commonly reported to have died of la grippe. The patient was a man of 35, banker by occupation, very tall and thin. He was a great oarsman, one of the Argonaut eight, and spent most of his leisure time either rowing or canoeing. He had never had any illness, save some slight attacks of dyspepsia. Nothing had ever occurred to indicate any heart lesion.

Dr. Scadding, who had attended the patient for Dr. Cameron, had found him dressed for dinner. Whilst dressing, he had been suddenly seized with great pain, referred to the pit of the stomach and abdomen, passing up into the throat, which he described by saying that he felt as if he would burst asunder. There was no heart murmur or noticeable dullness; pulse 50. He was put to bed and morphia given hypodermically, with but little relief of the pain. Morphia granules, gr. $\frac{1}{4}$, were given, to be taken every 3 or 4 hours if needed. On the following day the pulse was 90, on the third day pulse was 116. The pain persisted, but was localised more in the region of the umbilicus. That evening he had a spasm and died. *Post mortem* examination showed, at the base of the aorta, a dissecting aneurism, which had ruptured. There was no laminated clot in the sac. The blood in the pericardium was clotted; on the visceral pericardium a few milk patches. Heart was dilated, but not hypertrophied.

It was supposed that on the first night the internal coat had given way. The pain had been kept up by the dissecting blood. The aneurism was evidently of very recent date, as shown by the fact that there was no hypertrophy of the heart, and by the absence of a laminated clot in the sac.

CEREBRAL HEMORRHAGE, CANCER OF PANCREAS.

Dr. Cameron: The patient, a man of 70, was a shoemaker by trade. Eight years ago he came for advice concerning attacks of vomiting blood, and of pain referred to the stomach. It was thought that thickening could be detected in the epigastric region, and therefore a diagnosis of cancer was made. This diagnosis was rather shaken by the fact that ordinary treatment for dyspepsia relieved him, and by the duration of life.

I was sent for one afternoon to see him, but found him so well and jolly that I concluded there was not much the matter with him. That evening, at 8 o'clock, he complained of feeling a little sick and of pain in the head; no paralytic symptoms at any time. An hour and a half later he was dead. I had never known death to occur from cerebral hæmorrhage in less than 8 hours.

Dr. Cameron said that the condition of the stools could never be ascertained. The patient was not a drinker. There had not been a hæmatemesis of late. The hæmatemesis must have been due to obstruction of the vessels of the stomach by the growth.

Dr. Peters, who performed the autopsy, said that there was found an extensive hæmorrhage into the meninges of four or five ounces of blood. This came from a rupture in the basilar artery. The arteries at the base of the brain were markedly atheromatous. There was no interstitial hæmorrhage.

There was a hard, nodular tumor, involving the whole head of the pancreas, surrounding the pylorus, but not involving it, for it was still patent. The stomach was but little dilated. The growth had surrounded and caused the disappearance of the gall bladder and cystic duct. The common duct was found. The liver was slightly shrunken. There were adhesions to the transverse colon, hepatic flexure, and omentum. There was a cystic condition of the left suprarenal capsule, while the right was unaffected.

CHYLOUS URINE.

Dr. Graham exhibited a specimen of chylous urine, obtained from a patient of Dr. Todd's, who had typhoid fever complicated by pneumonia.

A. B. Macallum :

NORMAL PROCESSES OF DEGENERATION IN THE UTERINE MUCOSA OF THE PLACENTAL SITE IN THE CAT.

The greatly enlarged endothelial elements and the glandular cells of the placental mucosa in the cat, present many points of interest in connection with the studies on the degeneration of cells in epithelial neoplasms. That they are of great physiological importance to the embryo, my studies, I think, have shown unmistakably.

The ordinary endothelial cells of the mater

nal bloodvessels, increase in size simultaneously with the widening of the latter till each capillary appears like a gland tubule lined by large irregular cells, with a tortuous lumen in the centre. The edge of the cells next the lumen have a granular border, and they are separated from the syncytium of the foetal ectoderm by thin strands of fibrillar tissue. The latter is seen with difficulty in some places, where the endothelial cells appear to abut directly on the syncytium. This is especially the case in the stage where the embryo measures less than an inch in length. At this stage, also, the endothelial cells frequently exhibit indirect division, the amount of chromatin present in such cases being remarkably small in comparison with the amount of the cytoplasm. The latter condition recalls a common peculiarity in epithelial neoplasms. At this stage in the placental history, the division of the nucleus, apparently, usually is followed by division of the cell, but in the placenta at later stages (when *e. g.* the embryo is nearly 3 inches in length) the division of the nucleus is rarely followed by division of the cell, so that in the latter we frequently see two or more nuclei, each larger than the single nucleus of the earlier stages. This condition is accompanied by certain changes in the cell body, which becomes vacuolated, especially towards the periphery, and the cytoplasm becomes fibrillar, the fibrillæ radiating towards the cell boundaries. These cells are separated from the lumen of the bloodvessel by a new endothelial lining composed of small endothelial cells and a hyaline membrane, the cells and the membrane appearing perforated by canals like those in the peripheral border of the epithelial cells of the intestine. The older endothelial cells exhibit plasmolysis either in one of their nuclei or in the whole cell. The nuclear contents in some cases appear to undergo chromatolysis. When a whole cell degenerates, the mass acquires an eosinophilous character, fragments, the pieces are taken up by the protoplasm of the syncytium of the foetal villi, passed through the cellular layer and thrown into the lymphatic spaces of the villi. On their passage the fragments become more numerous and smaller, till finally they are of granular size. In earlier stages (when the embryo measured less than one inch in length), similar yolk-like masses are seen

n the syncytium of the villi, but they apparently come from the absorbed and degenerated tissues in the path of growth of the villi.

Here we see that the degenerated cells serve for the nutrition of the embryo. The chromatin and protoplasm of the endothelial cells pass directly into foetal tissues, when they can readily be detected with staining reagents.

The glands at the base of the placental layer of the mucosa also degenerate, but the process is somewhat different. At points in the epithelial wall of the gland the cells increase in number; they elongate by pressure, and the mass so formed projects into the lumen of the gland for a distance two or three times the height of the original epithelial layer. The nuclei of some of these cells become homogeneous or plasmolysed, and both nucleus and cell are set free in the lumen. Here further degeneration occurs, accompanied by gradual diffusion of the chromatin through the mass, which now fragments. Sometimes the protoplasm of degenerated cell disappears as if through digestion; leaving the chromatin in small masses, which run together, forming deeply colored spherules in the centre of the lumen. The fate of this chromatin was not observed distinctly, but it was inferred where a villus had broken through and projected into the lumen of a gland tubule, that epithelial cells covering the lower end of the villus were irregular in shape, with long, pseudopodial processes stretching out into the granular debris of the lumen, and apparently functioning as absorptive organs. In the substance of the process one can see granules similar in character to those found amongst the debris. One can, furthermore, find in the axial part of this end of the villus, an elongated mass of chromatin, apparently derived from the chromatin of the broken down gland cells. In the later stages of gestation the greater part of this chromatin, which persists, owing to slow assimilation, becomes mucinoid.

Thus, in the placenta of the cat, are to be seen many processes which find their parallel in conditions occurring in neoplasms, etc. The parallel is not surprising, since the embryo is, from one point of view, a foreign body, a parasite, which irritates, though physiologically, the structures of the uterine mucosa, and calls forth in its cells changes such as those des-

cribed above. In fact, the growth and changes in the placenta belong to the class of phenomena which concerns the border-land between pathology and physiology.

TORONTO MEDICAL SOCIETY.

April 22nd, 1890.

The President, Dr. Atherton, in the chair.

CONVENIENT METHOD OF RETAINING DRESSINGS.

Dr. W. B. Nesbitt attaches to a piece of rubber adhesive plaster, a piece of tape on which hooks are sewn at intervals of one inch. Such a tape may be bought at any dry goods store. One of these strips of plaster is fixed to the skin on each side of the wound, and the dressing is held in place by a lace passing backwards and forwards through the hooks. The principle is very much the same as that of the Farny suture, which, however, it is superior to in the ease of threading. This dressing had been found specially useful in cases of empyema, and spinal abscesses. It does away with the necessity of a bandage, and the dressing can be readily changed without removing the plaster.

ACUTE PERITONITIS.

Dr. J. F. W. Ross related the history of a case in which laparotomy had been performed. There was extreme distension with both gas and fluid, and the patient was "in extremis." When the abdomen was opened, there was found on the one side a suppurating ovarian cyst, and on the other a suppurating hæmatocele of the broad ligament. The peritoneal cavity contained a large amount of serous fluid, but no pus; whilst the whole peritoneum was studded with fibrinous deposits. There was pretty free hæmorrhage. The pulse dropped to 100; the temperature also came down, but the septic trouble was too much for the patient, and, in ten hours the temperature and pulse went up, and death ensued. Dr. Ross has not much faith in the occurrence of "idiopathic" peritonitis; in all cases some local cause may be found, and the proper treatment is early abdominal incision.

Dr. Atherton thought that such cases were often let go too far before surgical interference was had recourse to. In women there may be many cases due to local causes, yet in men such local causes were not always to be found, and such cases were really idiopathic, and should be

treated not by cathartics or by abdominal section, but by opiates.

April 29th, 1890.

FRACTURE OF ZYGOMA.

Dr. Cuthbertson presented a patient—a young man—with a depression over the zygomatic arch. He had been, that morning, struck a blow by a fist. There was no swelling or bruising of the soft parts, and scarcely any pain. He thought that there was a fracture of the zygoma, with displacement of the fragments.

In the discussion, the majority of the members expressed an opinion that there was no fracture, but that the depression in the bone was probably congenital, the attention of the patient having never been attracted to it before the blow.

Dr. McKenzie agreed with Dr. Cuthbertson that the bone was fractured, and related a case where a similar injury was due to a blow from a cricket ball, the man being unconscious, and blood coming from the nose and ear.

DIPHTHERIA.

Dr. Price Brown related the history of a case of diphtheria in a child of fourteen months, whom he saw in consultation. Patient was greatly cyanosed, but there was no membrane visible in the throat. Vesicular murmur was absent over the chest, and there was bronchial respiration. Resonance was unimpaired. He performed tracheotomy, and there was instant relief, and consciousness returned. Though blood and mucus passed freely from the tube, no membrane came away. The child sat up and took milk greedily, and respiration was almost normal. Next day the child had a convulsion, and gradually sank. Death was not due to stenosis, pneumonia, or bronchitis. He was in doubt as to the cause.

Intensity of the septic trouble, cerebral thrombosis and overloading of the stomach were suggested as possible causes of the convulsion.

Dr. Brown, in reply, said that it was quite possible that the large amount of milk taken, and also the administration, by the mother, of a dose of iron, contrary to instructions, forming a coagulum in the stomach, had caused a reflex convulsion. He could not fall in with the idea that death was due to cerebral thrombosis, or to septicæmia.

HERNIOTOMY.

Dr. J. A. Watson presented a specimen of irreducible left inguinal hernia. The hernia had existed for many years, and was apparently chiefly omental. The patient had frequently reduced it and wore a truss. On the last occasion taxis, ice, etc., had been tried in vain. Bowels had moved, and flatus was passed with difficulty. Patient was removed to the General Hospital. Dr. Nevitt operated, making an incision over the tumor down to the sac, dividing the ring freely, but the hernia could not be reduced. The sac was then opened, but, on account of numerous firm adhesions, the gut, now seen to be the large intestine with the appendices epiploicæ, could not be returned. The bowel had also the appearance of becoming gangrenous. A median abdominal incision was then made, and the attempt at reduction by pulling on the gut from above was unsuccessful. The adhesions were then ligated and divided, and the bowel, thus freed, was returned, and the wound sutured. The operation lasted five hours. The patient rallied well, but died about forty hours after the operation.

They were led astray in this case by the patient's positive statement that he had completely reduced the hernia a day or two before.

Dr. Gullen asked why, when the hernia was found to be irreducible, but not strangulated, it had not been left alone.

Dr. Atherton said the general practice now was to open the sac at once, and, if the bowel is not reducible, to divide the neck of the sac and leave it.

Dr. Watson replied that it was impossible to leave this after opening the sac, as the large mass of the large intestine with the attached fat could not be returned to the scrotum.

May 6, 1890.

CRUTCH PARALYSIS.

Dr. B. E. McKenzie related the case of a boy twelve years of age, under his care for hip joint disease, who, wearing a Thomas' posterior splint, was going about with the aid of a crutch. The other day there was noticed a condition of wrist drop of the left side; paresis of the muscles of the hand, but not of the forearm. The boy was ordered not to use the crutch on that side, but did not obey orders. He also got electrical treatment. The paresis becoming more marked

he was ordered positively to quit the crutch. The trouble began by a numbness down the back of the hand.

GASTRALGIA.

Dr. J. E. Graham related the history of a physician in the asylum service, who had attacks of gastralgia, which began four or five years ago, with periodical severe pain in the stomach and vomiting; not influenced by food. The vomited matter usually contained a large amount of mucus. The attacks became more frequent, occurring several times a day, and there was great emaciation. He went to the old country and consulted Gairdner, McAll Anderson, and others. Before going away it was thought that he had carcinoma, but the general opinion there was against this, though no definite diagnosis was made. There was no evidence of tumor by physical examination. He came home and got quite well, and continued so for a year. He then had some worry about a new building, and the excitement of a fire in the asylum caused a return of the symptoms, and he got worse and worse.

Dieting, quinine, arsenic, and massage were tried, but without effect. He then gave up the asylum. Being thus freed from all strain and worry, he became quite well, and has remained so now for two years.

During his second bad attack he had an outbreak of Herpes Zoster on both sides.

REFLEX GASTRALGIA.

Dr. W. Britton related the case of a young lady, who consulted him some two years ago, for pain in the stomach, at first not very severe; no vomiting or tenderness. Gastralgia was diagnosed, and various remedies used without effect. One day he asked if she had any bearing down. She said that she had had for several months. Examination revealed complete retroversion of the uterus. This was reduced, and the gastralgia, evidently reflex, disappeared.

Pathology.

THE PASSAGE OF BACTERIA THROUGH THE INTACT SKIN, AS A RESULT OF RUBBING.—Machnoff. (*Russkaje Medicina*) has shown: (1) That it is possible by rubbing to cause bacteria to pass through the unbroken skin. (2) That

the corneous layer of the skin is a reliable safeguard against the transmission of germs, but that the hair follicles afford a ready passage to the lower layers of the corium.

Hospital Reports.

INTESTINAL OBSTRUCTION—LAPAROTOMY—RECOVERY.

UNDER THE CARE OF J. ALGERNON TEMPLE,
M.D., M.R.C.S., ENG., IN THE TORONTO
GENERAL HOSPITAL.

Mrs. C., aged 36, a widow with two children, had always enjoyed good health, had always been free from headaches and constipation. For the past three months she had constantly been complaining of feeling tired and worn out; this she attributed to close confinement at her work, sewing furs. She was first seen by Dr. Parker on March 8th, suffering from pain in the stomach, in the small of the back, and in the left side just below the region of the spleen. These symptoms had existed for a week, and at first there had been slight vomiting; the temperature was slightly elevated; she exhibited marked distaste for food, and the pain in the stomach was increased by the ingestion of food. There was no abdominal tenderness. The temperature became normal after a few doses of quinine had been administered, and remained so; the pain in the back soon disappeared; the pain in the side lingered for a week or more, but subsequently disappeared also.

Poultices were applied to the epigastrium, and the diet restricted to milk with lime water, and the following pill prescribed:

R.—Res. Podophyl.	gr. $\frac{1}{4}$.
Ext. Hyoscyam.	gr. $\frac{1}{2}$.
Ext. Colocynth. Co.	gr. $\frac{1}{2}$.
Ext. Nuc. Vom.	gr. $\frac{1}{2}$.

She took one of these pills three nights in succession, then one each alternate night, and the bowels acted satisfactorily each day without pain. She gradually began to take a less restricted diet, and at the end of two weeks was able to leave her bed, and to go about her house. At the end of another week she took a walk out of doors, and the next day she complained of griping pains; the bowels had been

regular up to this time, but on the day on which these pains occurred there was no motion. On the following day the pains were more severe, were paroxysmal and accompanied by contractions along the colon; the course of the peristaltic movement could be seen on inspecting the abdominal parietes. A large enema of soap and water was administered, and a powder containing calomel, grs. iv., pulv jalap, grs. viii., but no evacuation followed. Enemata of soap and water, containing castor oil and turpentine, were then given, with calomel, castor oil and turpentine by the mouth, but nothing whatever passed through the bowel. She continued to take small quantities of buttermilk, and there was no vomiting. Upon the fifth day after the abdominal pain and constipation commenced, Dr. Temple was called in consultation. A copious enema was administered with the foot of the bed raised; she complained of the stomach being "pressed upwards," and vomiting occurred and persisted for several hours. The vomited matter was, as far as could be ascertained, all fluid, and had a very foul odour. The temperature for several days had been about 100°.

She was admitted into the Toronto General Hospital under the care of Dr. Temple, April 6th. Bowels were very much distended with flatus, and she complained of a considerable amount of pain, with a constant desire to have the bowels moved. Ordered her to have a copious hot soap and water enema, with the hips raised and the head lowered. Only a small quantity of water, however, could be inserted, as it returned almost immediately without any faecal matter.

April 7th—temperature, 100°; pulse, 110; face flushed and anxious, restless and uneasy; bowels greatly distended, especially the colon which stood out prominently. Some dulness in the flank. Dr. Macfarlane saw her, and it was agreed not to do anything more than to keep her quiet. Dr. Temple carefully explored the rectum but could detect nothing, it was simply contracted.

April 8th, 10 a.m., temp., 97°; pulse, quiet and small; face, pinched and anxious; bowels had not moved. This was now the eleventh day without any evacuation from the bowels, and it was deemed expedient to wait no longer. 11 a.m., patient was put under chloroform, and,

assisted by Dr. McFarlane, Dr. Temple made an exploratory opening in the abdomen. The large intestines from the cæcum to the rectum were enormously distended with flatus, probably to three times or more their normal size, very red and congested. The small intestines were red, congested, and triflingly distended. The whole length of the colon was explored for faecal accumulation or any obstruction, several times, without, however, finding anything, and after searching in vain, the abdominal cavity was washed out with hot water. The incision was five inches in length, and it was very difficult to keep the bowels in on account of their great distention; they were kept carefully covered up in cloths wrung out of hot water. The abdominal wound was closed with silk suture and powdered iodoform with iodoform gauze, and patient put to bed in a very collapsed condition. She, however, rallied quickly, and six hours after the operation passed a large quantity of flatus, and twelve hours after the bowels moved freely; within twenty-four hours she had three large stools, and on the fourth day diarrhoea set in. Her progress towards recovery has been steady and uninterrupted. Stitches removed on the sixth day; wound quite healed, and the patient convalescent.

Remarks by Dr. Temple: It is plainly evident from the distention of the colon and cæcum the obstruction was at or near the sigmoid flexure, and that the obstruction was probably volvulus, and that in the examination of the bowels the twist had become loosened. This is a case certainly in favor of exploring for cases of obstruction where ordinary measures fail to give relief.

Correspondence.

Editor of CANADIAN PRACTITIONER.

SIR,—In the PRACTITIONER for April 16th, Dr. McGuigan, of Vancouver, writes in the hope of obtaining from the profession a more favorable opinion of the B. C. Medical Council than would be the case were your editorial of March 17th allowed to go unchallenged.

While conceding that my pamphlet "had good effect in some quarters," he most decidedly objects to the idea that the Council "was very apathetic in this matter."

As Dr. McGuigan writes as president of the Council, you feel in duty bound to accept his statements, and accordingly you withdraw your previous remarks anent that body.

But, sir, permit me to say that the *ex parte* statement of the president is not so unreservedly correct as you appear to imagine. So "quietly" did the registrar and president work that not a soul knew anything was being done—not even the registrar himself, if I may judge from his own words on the occasion of an interview I had with him last November, when he said, with a degree of vagueness remarkable in one who was working "so sincerely," "something ought to be done"! I accuse the Council of apathy, not only in reference to the unjust sections of the Medical Acts, but also in permitting the medical laws, which it is empowered to enforce, to be broken with impunity. One medical gentleman thus wrote to me a few weeks ago: "Dr. Milne and other members of the Council know just as well as I do that there are several men, some not qualified, others qualified, but not registered, who are practising in defiance of the Act; then why should I pay fees for that protection which I, in common with others, do not receive?"

Two other correspondents refer to instances in Vancouver where the Medical Act is openly set at naught. There are over seventy names on the medical register of B. C., and only forty have paid their fees. And why? In most cases because of the apathy of the Council; they don't feel inclined to pay for what they do not get, *i.e.*, protection.

I venture to assert that had I not written my pamphlet, I doubt whether the obnoxious sections would have been repealed this session. The Attorney-general introduced a bill to repeal one of the unjust provisions *shortly after I issued the "notes,"* and Dr. Milne told me that Dr. Davie, the Attorney-general's brother, declared he had *no knowledge* of his brother's action. Of course Dr. Davie may, at a later stage, have given his brother some assistance; that I know nothing about, and it does not concern the question. Besides all this, not until Mr. Davie had, *unaided*, introduced his bill, did the Council's executive prepare *their* draft bill (if they care to recollect, they will remember that they intended asking Mr. Grant, M.P.P., to

introduce their bill). Mr. Grant did not do so; on the contrary, he spoke against the bill re-introduced, amended, by the Attorney-general. Mr. Davie was *not* inspired to take the first step by the Council, nor any of its members, and they all know that perfectly well.

Of course, the Council members do not like being twitted on the score of lack of interest in their duties; few people relish being "hauled over the coals," and however diligently the president of the B. C. Medical Council may strive to lead you and your readers to believe that the Council did the lion's share in bringing about the recent reforms, he will utterly fail to convince the practitioners of this province. I ask you, sir, is it possible for a medical council to work incessantly and yet no one know of it? The Medical Council is not a secret society, that its work should be done with such profound secrecy. To amend the Medical Acts some public action was necessary; this they did not do, but I did. I flatly deny the president's statement that the Council members did their duty "faithfully and well." On the contrary, they were, and are, *afraid* to take any spirited action, lest they should offend and perchance lose some patients!

Your editorial of 17th March was substantially correct, and I regret that you have considered it advisable to withdraw it. The fact of the president's attempting to secure for the Council all the credit for the repeal of the section admitting British graduates for a \$10.00 fee, does not prove that his claim is a just one. The "we succeeded" is very misleading. Had Dr. McGuigan said Dr. Wade succeeded, it would have been nearer the mark. The Council did absolutely nothing *until after I had issued my pamphlet.* That woke them up; "we must do something;" said they. I paved the way, they followed, and now they want all the credit!

I now charge the Council with neglecting its duties. Had the Council done its duty, would it not follow that there would be more satisfaction among the profession than is expressed? A good criterion is the coming election of the Council. There are 40 voters and 12 candidates (all of whom are included among the 40 voters), six of whom are in the field for the first time. A few good men will get in; some others not so good will also succeed; but, however the

poll may go, it is to be hoped that the new Council will endeavor to erase the blot made by the old one, *and do its duty*.

I trust Dr. McGuigan, whom I esteem, will understand that I make these remarks not at him, nor at the registrar, but at the Council as a body corporate, with duties to perform, and, in this instance, left undone.

MARK S. WADE, M.D., F.C.S.

Victoria, B. C., April 28th, 1890.

Book Notices.

Asthma, considered specially in relation to Nasal Disease. By E. Schmiegelow, M.D., consulting Physician in Laryngology to the Municipal Hospital, etc., Copenhagen. 8vo., pp. 90. London: H. K. Lewis, 1890.

That the author, though a specialist, has studied his subject in a broad spirit is indicated by the closing sentence of his book: "It must always be remembered that one has to do with a suffering person, who is not merely an appendix to his nose." He adopts Germain See's pathology of asthma, viz., that it is a neurosis in the respiratory centre in the medulla, caused by an elevated reflex irritability, native or acquired, in this organ. The attacks are due to irritations, originating in the vagus or other peripheral nerves, and show themselves in the motory nerves of the inspiratory muscles, especially the diaphragm, in which the contractions become tetaniform. At the same time the vaso-motor centre, also in the medulla, is irritated, causing reflex dilatation of the vessels in the bronchial mucosa, from which results the copious secretion. That the asthmatic attacks in many cases are due to irritation in the nasal cavities is shown by such facts as (1) that asthma may return when nasal disease gets worse, and be relieved by improving the nasal condition; (2) the aggravation of the symptoms in some cases by treatment of the nasal tract; (3) the relief of symptoms by tamponing the nose with wool containing cocaine or menthol. The author warns us against the error of ascribing all cases of asthma, in which nasal disease exists, to such disease, as in some, other causes, as bronchitis, are present also, while in others the nasal affection has no causation relative to the asthma.

Though not accepting wholly the author's pathology of asthma, we have read the work with much pleasure and profit, and heartily commend it to the profession generally as a work that will prove very helpful to the general practitioner in the treatment of a disease that too often defies our best efforts. The publisher's work, as usual, is excellent.

Personal.

Dr. Annie L. Pickering has returned home after a five months' visit to Birmingham, England.

SIR WILLIAM JENNER has left London and retired from active practice. He will live near Southampton. He is in good health and intends to do some literary work.

DR. G. L. MILNE, of Victoria, and Dr. H. Watt, of Barkerville, B.C. will receive the degree of M.D., *ad eundem*, from the University of Toronto at the next convocation.

PROFESSOR RAMSAY WRIGHT sailed for Europe the last of April. He will spend most of the summer on the Continent, where he will make a rather extensive university tour.

DR. J. E. GRAHAM left Toronto, May 10th, for Washington, where he attended the annual meeting of the American Association of Physicians. At the conclusion of the meeting he went to New York, and sailed for Great Britain, May 17th. He expects to go to the Continent, where he will remain some time, and will attend the Berlin Congress.

Births, Marriages and Deaths.

MARRIAGES.

GREIG—BURNS—On the 28th April, at the residence of the bride's father, 222 Simcoe St., Toronto, by the Rev. J. Alexander, uncle of the bride, assisted by the Rev. H. M. Parsons, D.D., Dr. W. J. Greig, Toronto, to Anne J. Burns, daughter of John Burns, Esq.

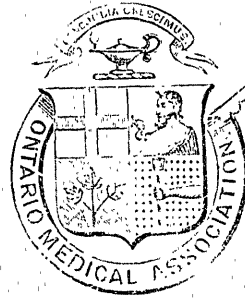
DEATHS.

At Toronto, April 30th, Sarah Bryant, at 83, mother of J. E. Bryant, M. A., of the J. E. Bryant Co.

RUSSELL.—At his residence, 172 Simcoe st., Wednesday, May 14th, at 6:30. John P. Russell, M.D., Edin., aged 69.

Obituary.

DR. JOHN PARTINGTON RUSSELL.—Dr. J. P. Russell was one of Toronto's best known physicians. He graduated in the University of Edinburgh in 1846. A few years after this he came to Canada, and after practicing in Quebec for a time, removed to Toronto, where he was engaged in a large practice up to the day before his death. He had been in poor health for some weeks, but, with his characteristic, indomitable energy, he stuck faithfully to his work. On the morning of May 14th he was found dead in his bed, from apoplexy. He was 69 years of age.



ONTARIO

Medical Association

SIXTH

Annual Meeting

June 11th and 12th, 1890.

The Tenth Annual Meeting of the Ontario Medical Association will be held in the City of Toronto on Wednesday and Thursday, the 11th and 12th of June.

Return tickets, at **One Fare and One-Third**, valid for seven days, will be issued to all properly qualified members of the profession. Physicians desirous of reading papers or presenting cases, before this meeting, are requested to notify the Secretary of the subjects of such papers or cases on or before the 1st of May.

Copies of the new By-laws and Code of Ethics may be obtained from the Secretary on application.

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