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CANADA

# MEDICAL & SURGICAL JOURNAL

**JUNE, 1879.**

## Original Communications.

## THREE CASES OF MALIGNANT DISEASE.

BY RICHARD MACDONNELL, B.A., M.D., M.R.C.S., Eng.

Assistant Demonstrator of Anatomy, McGill University, Montreal.

(Read before the Medico-Chirurgical Society of Montreal.)

I propose to read to you this evening the histories of three cases of scirrhus cancer, and I hope by them to illustrate three points in the clinical history of malignant disease.

1. The insidious progress of cancer of the upper part of the rectum and sigmoid flexure.

2. The irregular course of symptoms of cancer of the stomach.

3. The rare co-existence of pregnancy and malignant disease of the breast.

Case I.—Mary B., exact age unknown, apparently about 70 years of age: for many years a widow; of fair complexion, thin but not emaciated. Has been an inmate of the Church Home for many years.

I was sent for on the 28th June, 1878, to visit her. A slight cough, to which she had been subject for many years, was rather worse than usual, and for the first time she noticed the sputa tinged with blood. She had a fairly strong pulse and did not feel ill at all. The hæmoptysis was very trifling. I prescribed rest, cold food, and a mustard poultice to the chest. She was to take a pill of acetate of lead and opium every four hours until I saw her again.

The next day there was no return of the hæmorrhage. There was increase resonance on percussion. Large moist râles over chest generally. Heart sounds normal.

On the third day of the illness there was a slight return of the hæmorrhage. Altogether she had taken three lead and opium pills, for I gave her ergot.

She complained to me that day that her bowels were confined, and I ordered a enema of soap and water.

On the following day she was thought to be quite well, and she resumed her ordinary occupation.

Two days after she was apparently in the best of health, and was doing her daily work in the institution.

Five days after her recovery I received a message to hurry to see Mrs. B. I was out at the time the messenger arrived, and did not get to the Church Home for two hours afterwards. Mrs. B. was just dying; insensible; extremities cold. She died within a few minutes of my arrival.

I was told that that morning she had been uneasy in her bowels, and complained of distension with gradually increasing pain, and that her abdomen had become distended. Turpentine stripes had given momentary relief.

*Post-mortem appearances.* — Abdomen much distended with gas. The colon was very large, as large as a quart bottle, and dark in colour from congestion. Beginning at the sigmoid flexure and involving the upper part of the rectum was an indurated stricture which almost occluded it. The gut itself was much thickened, and was constricted on the outside.

The colon above contained a large quantity of semi-fluid fæces. There were no other lesions except those found in the old cases of bronchitis with emphysema.

The site of the disease affords a definite reason for the absence of pain. Those who have read Mr. Hilton's admirable lectures on "Rest and Pain," will perhaps remember his remarks on this very point.

"Little sensibility and easy dilatibility are the physiological characteristics of the rectum, except at the lowest part, where

great sensibility, difficult dilatation, and enduring power of contraction are the normal physiological features."

As practitioners you have no doubt noticed the extreme degree to which this part of the bowel can be distended without even causing inconvenience to the patient, and Mr. Hilton mentions the almost painless operation of tapping the bladder through the rectum, and of applying nitric acid to prolapsed gut. It is still very remarkable that this woman should have been the subject of such serious disease without the existence of premonitory symptoms.

CASE II.—Maria B., æt. about 70. For many years a widow. No family constitutional disease. One sister died of hypertrophy of heart. Two sisters living.

Always enjoyed excellent health. On February 18th, 1878, she first came under my care. She was suffering then from constipation for which the usual remedies were prescribed.

On the 18th of April she complained of pain and distension of the abdomen, constipation and loss of appetite.

On that day I thoroughly examined the chest and abdomen, and beyond noticing that the latter was slightly tympanitic, I could find nothing to account for the symptoms. She was greatly relieved by a pidophyllin pill, and by the application of stupes of turpentine to the abdomen.

In the first week of May this pain in the left hypochondrium was very troublesome. It was more a sense of distension, I think, than actual pain. The patient could not localize it; it was not increased by pressure, nor was it influenced by posture. It was not constant, and it had a tendency to become worse at certain hours of the day. It was certainly unconnected with the taking of food, or with its quantity or quality.

There were then only two symptoms, tympanites and pain.

The general health was tolerably good. At this time I repeatedly examined the chest and abdomen. The urine neither contained sugar nor albumen. Bowels generally confined. I thought then that the symptoms were due to flatulent distension of the colon.

On the 12th of May I had the benefit of a consultation with Dr. Craik. At his suggestion salicylic acid in small doses was used, with a view to assist fermentation. A great improvement in the symptoms followed, but it was merely temporary.

One day in the latter end of May she caught cold, and during the week ending 1st June, 1878, she suffered from lung symptoms, which were thought by Dr. Craik and myself to arise from a slight pneumonia.

After this attack the old symptoms returned, and then I began to suspect malignant disease. In the middle of June Dr. Howard did me the honour of examining the case with me. We examined the chest, abdomen, rectum, vagina, and urine, but still no light was thrown on the diagnosis.

The pain and typanites continued as obstinate as ever until the 14th of September, when she went under homœopathic treatment. On the 14th of October I resumed charge of the case again. Much emaciated. Pulse very weak. For the next month she improved rapidly and was soon able to spend her day in a chair. The treatment consisted of anodynes, food and stimulants. The abdomen being now very flaccid, it afforded us (for I had benefit of frequent consultations with Dr. Howard) abundant opportunities for careful examination.

We became day by day more convinced that we had malignant disease of the colon, or of part of the intestine to deal with. For my own part, I did not even suspect the stomach until I had seen, through Dr. Howard's kindness, the autopsy of a patient of his, whose symptoms were all referred to in the intestines, and in whom, after death, the seat of the disease was found to be entirely confined to the stomach, the fatal event being caused by perforation of the pericardium.

The consideration of this case prevented me excluding from my list of possibilities, the existence of extensive organic disease of the stomach.

From the 14th of October to the 26th of November, she was entirely free from pain, but suffered from weakness and constipation. In fact the bowels now never acted spontaneously.

On the 28th of November she had a sharp attack of diarrhœa,

brought on by an overdose of mineral water. It was noticed that the stools were black. They continued so until the 2nd of December. Dr. Howard was of the opinion that the dark colour was due to blood. The pulse was frequent, and she became very anæmic. The pain in the left hypochondrium not so severe as it used to be, but more periodic, generally occurring at 4 P.M. Appetite very capricious. Occasionally slight vomiting, but merely the contents of the stomach were ejected. Never vomited blood. Diarrhœa and tenesmus were present in the month of December. The pulse gradually weakened as the disease advanced, being always regular. Tongue is now dry, brown and fissured.

On the 26th of December, Dr. Howard detected in the left hypochondrium a small movable tumour which was smooth and rolled under the fingers. Throughout the whole course of the disease this tumour afforded us ground for conjecture, but from the fact that at times it could not be found, we hesitated at giving a decided opinion.

At this time pain was very severe, but in the course of a month or so it wore away. She complained greatly of an uneasy sinking sensation in the left hypochondriac region. In March, 1879, hiccough appeared, and refused to yield to treatment.

In the beginning of April œdema, firstly of the feet, and subsequently of the hands, set in. The asthemia became more and more marked, and she died worn out.

*Post-mortem Appearances.*—Extreme emaciation, œdema of the ankles and hands. Abdomen shrunken and flattened; no tumour could be felt.

On opening the abdomen the lesser curve of the stomach appeared to be puckered and red. An ulcer as large as, and the shape of, the human ear, was found encircling the lesser curve, about ½ an inch from the pylorus. The edges of the ulcer were raised, thickened, and much indurated. The centre of it was very thin, so thin that on slight manipulation a rent was made in it.

Dr. Howard, who was present at the autopsy, thought that it was a large gastric ulcer which had taken on malignant action. We found no other lesion in the body except senile changes.

The ulcer was examined microscopically by Dr. Ritchie, who has kindly provided us with the slides we have this evening.

The treatment consisted in, at first, the use of remedies said to be of service in dyspepsia and constipation, afterwards opiates internally, as well as many anodyne applications. Of the latter, the best one, was a mixture of 7 parts of Lin Bellad., and 1 part of Chloroform, sprinkled on spongiopiline. The last ten weeks of her illness, she was fed almost entirely by the rectum.

A few remarks on the diagnosis of this case. As you perceive, the early symptoms were misleading. From their persistence and from the progressive cachexia, one was forced into the conviction that there was malignant disease in some part of the alimentary canal. But in what part? Examining the symptoms one by one we shall find that scarcely any of them point to the stomach.

1. Pain was not of its usual character, nor did it occupy its usual site. Only at times severe, it was absent during the latter part of the patient's illness.

Habershon regards pain in such cases as being due to exposure of the vagus to the irritating contents of the stomach. The pain ceases when the branches are divided by the progress of the disease.

2. Vomiting, though occasionally present, was never urgent.
3. Hæmatemesis was entirely absent.
4. No tumour could be felt.

The probabilities of the disease being in the colon were very great.

1. The colon is a favorite site.
2. Tympanites was an urgent symptom, inclining one to think that there was some obstruction in the course of the gut.
3. Pain was complained of in the left hypochondrium, and in the left lumbar region.
4. There was obstinate constipation. The bowels were emptied about every 4th or 5th day, by an enema of soap and water. This day was looked forward to with dread. Great relief followed the removal of an accumulation of fæces.

5. Tenesmus accompanied the diarrhœa and the passage of bloody stools, and was at times present throughout the course of the disease. She often strained for hours without effect.

6. A small tumour in the left hypochondrium could at times be felt. This afterwards was proved to be fæcal, yet at the time it was very deceptive.

7. The presence of blood in the evacuations.

CASE III.—M. B., æt. 36, came to the Montreal Dispensary on the 18th of March, 1879. Her father had died from an unknown cause. Her mother and several brothers and sisters were alive, and in good health. Married eleven years. Four healthy children. No miscarriages. Labours always uncomplicated.

From early girlhood has had a small tumour on right side of chest. This commenced as a little wart, increased to the size of a walnut, and gradually acquired a pedicle. It was never painful, but it used to catch in her dress and she found this very inconvenient.

In the beginning of last autumn, her left breast began to get hard. There was not much pain in it at first. So she postponed from day to day seeking advice about it. She is five months pregnant. Cannot say which began first, the pregnancy or the hard breast.

*Present Condition.*—A pendulous lipoma grows from a thin pedicle on the right side of the chest, under the axilla at the level of the eighth rib. Complains of pain in the left breast, which is uniformly enlarged. The skin is tightly drawn over it and has a glazed appearance. The nipple is not retracted. There is no puckering of the mammæ. The whole breast is extremely hard throughout. On the surface the skin a firmly adherent to subjacent tissue. There is no adhesion to the ribs. The margins of the breast are hard, and cease abruptly in healthy tissue. Two small glands in the axilla are enlarged and hard.

I cut off the lipoma, and sent her up to Dr. Roddick, to show to his class, and also in order that I might have the benefit of his advice.

On the 10th April she was complaining of pain and debility. About four weeks after that I went to see her but found that she had moved. I found a sister of hers, and from her I obtained the following history. The debility had greatly increased. The axillary glands in the left side had become enlarged. The other breast had become similarly affected. At the seventh month of pregnancy labour set in. Both mother and child died about twelve hours afterwards.

Cancer of the breast occurring in pregnancy, is I think, a rarity, though I cannot understand why such should be the case. Very little mention of pregnancy is made in the many work srelating to disease of the breast. Mr. Heath* in one of his clinical lectures states that two conditions are not incompatible, and mentions the case of such a patient who went the full time and gave birth to a healthy child. Mr. John Wood† records a case where scirrhus occurring after pregnancy became complicated with milk abscess.

Mr. Nuun in his synopsis of 50 cases of cancer of the breast, mentions a patient who in September noticed her tumour, had it removed in January, and in the following April was delivered of a healthy child. The next June the right breast was attacked.‡

* *Lancet*, Vol. 1, 71. p. 849.
† *Pathological Transactions*, Vol. xix.
‡ In the discussion which followed the reading of this paper, Dr. R. P. Howard and Dr. Hingston both mentioned cases where the two conditions co-existed.

## Hospital Reports.

MEDICAL AND SURGICAL CASES OCCURRING IN THE PRACTICE OF THE MONTREAL GENERAL HOSPITAL.*

*Strangulated, oblique Inguinal Hernia.—Congenital.—Operation.—Death.*—Under the care of G. E. FENWICK, M.D.

Reported by A. W. Imrie, M.D., Assistant House Surgeon.

R. M., a strongly-built machinist, aged 38 years, was admitted to the Hospital on Friday afternoon, June 6th, with the following symptoms and history:

*Symptoms.*—Excruciating pain, radiating from an elongated tense tumour in the right inguinal region—throughout the ab-

domen and down the thigh. Occasional vomiting, unattended by nausea, and obstinate constipation. Patient felt weak; extremites cold; countenance haggard and inanimate. Pulse regular and full, at 85 to the minute. Temperature 99°.

*History.*—On the Wednesday evening previous, while working with an axe, he felt his rupture (present since childhood) suddenly grow unusually large and painful, and experiencing a sensation of faintness, he took to his bed, and so soon as he felt somewhat recovered from the shock, endeavoured by manipulation to return the intestine to the abdomen. Failing on this he soon had violent pain in his abdomen and thighs, and began to vomit, and these symptoms (vomiting and pain) he states persisted. On Thursday he sent for surgical aid, and the same evening an attempt was made to reduce the hernia under chloroform. A small portion of bowel appeared to slip back into the abdomen, and the tumour grew softer. Patient was advised to have himself removed to the Hospital where an operation would be done to relieve him. This he obstinately refused to do until this afternoon.

*Diary and Treatment.*—On admission the hernia was found to extend from anterior superior spinous process of the right ilium to the scrotum, to be uniformly smooth and tense. But one testicle could be felt, and that high up on the right side. The scrotum did not seem to be occupied by the bowel. Ice cloths were ordered to be kept constantly applied. Ice and milk in small quantities to be fed to the patient, and grain doses of opium administered every hour. On Saturday pain had subsided. Tumour felt softer; vomiting continued, and patient was somewhat exhausted. Hypodermic injections of morphia were substituted for the opium. On Sunday, the pulse (previously full and regular at 85 or 90 to the minute) had quickened and became somewhat easily compressible and irregular. Temperature 100°; pain slight. Tumour soft. Vomiting and constipation persistent. Extremities blue and cold. Patient, after much persuasion, consented to submitt to the operation.

At four P.M., Dr. Fenwick proceeded to the operation. After ether had been administered, he made a free incision cutting

through the structures, layer by layer, until he reached the sac. This was freely opened; it contained a large quantity of serum, and nearly two feet of small intestine. The stricture at the internal ring, was very tight and unyielding, and had to be freely incised. A portion of the intestine was drawn through the stricture and examined, when it was deemed sufficiently healthy to return into the peritoneal cavity. This was done without difficulty, a drainage tube was placed in the wound which was closed with cat-gut sutures and the patient returned to his bed. The operation was performed with antiseptic precautions, but the patient never rallied, sinking gradually until seven o'clock, when he died.

AUTOPSY BY DR. OSLER.

Body, that of a powerfully-built man; no hair on the face; only a few bristles on chin.

On opening the abdomen, omentum is injected and is attached in right inguinal canal. Lower coils of intestine injected, and toward the ileo-cacal valve dark-coloured, and at one point there is a definite constriction, immediately above which is seen a tiny orifice through which the contents of the bowel are escaping. On removal and careful inspection of this part of the bowel, it is seen that the nipping has taken place just three feet from the valve; at the point of constriction the tissues are soft and necrotic in a band extending round the gut and about three lines in width. For eight inches below this the bowel is dark-coloured, peritoneum opaque, and intestinal wall sodden, but scarcely looks gangrenous; the next twelve inches are not so dark. The perforation is just above the constriction and is not much larger than the head of a pin. The intestine beyond it is tolerably natural, walls relaxed, and here and there are a few ecchymoses. A few ounces of dirty semi-feculent fluid in pelvic cavity. Very little lymph. Right inguinal canal is large, readily admitting two fingers, and leads to a large scrotal sac.

On examination it was seen that the patient has been the subject of undescended testes, the right organ lay just at the

internal ring, the left high up on the postero-lateral wall of the pelvis. Both organs are very small, not larger than good-sized almonds. They were removed with the vasa-defferentia and bladder. On dissection the epidydimis is small and separated by a considerable interval from the body of the testis, the vasa efferentia being very distinct. On section the substance of the organs is yellowish in colour, and teased preparation show that there is entire absence of secreting structure, the seminal tubules are distinct and can be uncoiled, but they are filled with granular *debris* and fatty matter; no trace of either seminal vesicles or epithelium. The vasa defferentia are small but patent; the vesiculæ seminales are of normal size; some of the tubes contain fluid resembling semen, but on examination no spermatozoa are seen, only epithelial cells. In the larger coils there is a firm, inspissated matter like wax. Prostate is normal. The left inguinal canal admits the finger, and leads to a pouch of peritoneum which passes to the upper part of the scrotum, the middle finger passing down as far as the second joint from the internal ring. Nothing abnormal about the other organs.

Remarks by Dr. Fenwick:—There are some points of interest in this case which demand attention. Although neither testis had descended yet was the scrotum well-formed and normal in appearance. The absence of a scrotum in similar cases has been noticed and recorded by the late Mr. Poland. On both sides, in this case, the internal ring existed, and a process of peritoneum passed down, on the right side it extended into the right scrotum, and was filled with the intestinal protrusion, on the left a pouch existed quite large enough to admit the passage of a loop of intestine, but none had descended. The operation for the relief of the strangulated gut was not urgently necessary, until the Sunday morning, the day on which the operation was performed. The man, however, positively objected to submit to operative measures until the evening of that day. After opening the sac and relieving the stricture the intestine was examined carefully; the portion which had been constricted was drawn out through the opening, but although it was dark and congested, it presented a glistening

appearance, and was believed to be sufficiently healthy to return into the peritoneal cavity. The result in this case affords another proof of the danger of delay in operating for the relief of strangulation, and had the operation been performed a few hours earlier there can be little doubt the chances of a successful issue would have been much greater.

## MEDICAL CASES UNDER DR. OSLER.

### III. *Aphasia, with right-sided Hemiplegia, coming on fifteen days after delivery.*

Reported by D. Mignault, B.A.

Philomene A., æt. 35, admitted April 15th with hemiplegia and aphasia. Patient has always been a healthy woman. Married at 23 years of age, and has had five children, the last born on 25th of August, 1878. Has never had a miscarriage. After the birth of her third child she had a mammary abscess, which continued to discharge for five years, and has only healed since last confinement. During her last pregnancy she suffered from headache, vertigo, and a feeling of numbness and weakness in the right side. The patient's sister, an exceedingly intelligent woman, from whom most of these facts have been obtained, is quite positive about these facts. On the 9th of September, fifteen days after delivery, she became suddenly paralysed in the right side, and unconscious. For six months she remained in this state, never speaking or appearing to recognize any of her friends, and during the entire period passed fæces and urine in bed. At the latter end of February she began to recognise her friends, and soon after made attempts to speak, and began to recover the use of the right leg.

*Present condition.*—Patient is well-nourished, with a somewhat vacuous expression of countenance, and laughs at the slightest provocation. No facial paralysis. She walks with a paralytic gait. Right arm is moderately wasted, and is kept in a semi-flexed position, it can be moved from shoulder, movements at elbow less free. Fingers strongly flexed, firm, secondary contracture. No impairment of sensibility. She still com-

plains of headache, and when asked to point out the spot invariably places the hand on the right temporal region.

The aphasia still persists, and presents the following characteristics: on being asked her name, patient cogitates profoundly, and appears vexed and distressed at not knowing it, and finally shrugs her shoulders in despair. When told, she at once recognizes it, and repeats it quite well, and can do so for two or three times, and then forgets it. When asked her husband's name, she could not remember it, but when a long string of names were gone over and the right one mentioned, she at once recognized it and repeated it joyfully. It was the same with simple objects, she cannot tell her age, and repeats and appears to consent to almost any number suggested, but when the right figure is named she at once shows by her expression that she recognizes it as correct, and repeats it with great emphasis. During her short stay in Hospital she improved somewhat, and Mr. Mignault got her to retain the names of some familiar objects from day to day.

Heart, lungs and kidneys appear healthy, appetite is good, bowels regular. After remaining about ten days in hospital her husband removed her.

IV. *Acute Rheumatism treated with Salicylate of Soda. Delirium apparently caused by the remedy.*

Reported by B. E. Mackenzie, B.A.

Margaret H., æt. 35, admitted April, 16th, with acute rheumatism. Two years ago, had a mild attack of the same. On the evening of the 12th she was seized with pain in the right knee and became feverish; had been scrubbing during the day and was exposed to a draught. The following day the pain was very severe, and on the 14th and 15th the other knee and the shoulders became affected. On admission the wrists and ankles were also swollen, red and tender. Temperature 100·5°. Ordered salicylate of soda, 15 grs. every five hours. Systolic murmur at apex. Has a troublesome cough. During 17th and 18th, pain continued. Temperature in evening reached 101°

19*th.*—Knees better, and can be freely moved. Complains of a buzzing sound in the ears.

20*th.*—Temperature normal, joints much better. Noticed by the nurse that she talks incoherently, and requires watching.

21*st.*—Temperature 98°; joints better. Still rambles and talks all sorts of nonsense, is with difficulty kept in bed.

22*nd.*—Incoherence more marked. Does not appear to know where she is. Slept badly and gave great trouble in the ward. Systolic murmur distinct. Albumen in urine. Temperature, 98°. Pulse 108. Salicylate of soda stopped, and a mixture of pot. bromide and chloral ordered.

23*rd.*—Pain has disappeared from joints. Delirium not so marked. Slept well. Complaining of sore-throat, and on examination the uvula is seen enlarged and swollen, dark in colour, at the tip, and for a distance of nearly one quarter of an inch it is in a state of hæmorrhagic infiltration. The soft palate is somewhat injected.

24*th.*—Delirium has disappeared. Throat very sore; the tip of the uvula is greyish-white in colour, and greatly swollen at elongated. Palate and pillars of fauces also swollen. Temperature 99·5°.

25*th.*—The portion of uvula which was at first hæmorrhagic and subsequently of a greyish-white colour, appears to be separating, a distinct line can be seen between the healthy and diseased parts. Complains of pains in shoulders and knees; ordered the salicylate of soda again, 15 grains four times a day,

26*th.*—Slough has separated from uvula, leaving a rough red base.

30*th.*—Patient convalescent.

# Proceedings of Societies.

## MEDICO-CHIRURGICAL SOCIETY.

MONTREAL, MAY 16, 1879.

A regular meeting of the above society was held this evening, the President, Dr. Henry Howard, in the chair.

Dr. Osler exhibited a kidney which had undergone amyloid degeneration in a patient who also had syphilitic disease of the rectum. The patient had been in the Montreal General Hospital under the care of Dr. Reddy. The chief symptoms during life were albuminuria and profound anæmia, with slight œdema of the ankles. On post-mortem examination the kidneys were found enlarged and in a condition of advanced amyloid degeneration. The liver was in a similar condition, but neither the liver nor the spleen were enlarged. No deposits of pus were seen in any of these organs. The uterus, vagina, and bladder were healthy. The rectum, however, had the characteristic appearance of syphilis; namely, great thickening of its lower third, stenosed, and the mucus membrane for three inches above the anus was gone, and replaced by firm, fibroid tissue. Extending from the posterior wall were several sinuses passing into pockets of pus. The only other evidence of syphilis was a suspicious ulceration of the throat. Dr. Osler remarked that the majority of these cases occur in women.

Dr. A. Lapthorn Smith then read a paper on "Chorea," giving a detailed account of several cases and expressing his belief that this disease is due to a defective nutrition of the motor ganglia of the brain.

Dr. F. W. Campbell mentioned that he had three years ago a case of Chorea, so severe that he had to keep the child for a whole week under the influence of chloral. The treatment he adopted was iron before meals, and arsenic after.

Dr. Roddick said that he had attended a lady in February for pneumonia, and on visiting her to-day decided choreic movements of the left side were noticed. He ordered in this case 30 min. doses of dialysed iron three times a day.

Dr. Henry Howard looked on chorea as a functional and not an organic disease. His treatment was arsenic and nux-vomica.

A vote of thanks to Dr. Smith was moved by Dr. Roddick, seconded by Dr. Hingston, and carried.

Dr. Hingston exhibited to the society a pen-holder which he extracted from the urethra of a young man, it having unintentionally got lodged there. Urethral forceps were used. They are so constructed as to facilitate the removal of foreign bodies from the urethra.

Dr. F. W. Campbell saw a case some years ago in the General Hospital under the care of the late Dr. Jones, in which a pencil had been passed into the urethra. Lithotomy was performed in order to extract it. He also stated the facts of a second case, where through envy an individual was forcibly held while two shawl pins were inserted and pushed down his urethra. Finding it impossible to withdraw them, as their points became, in every effort, caught in the urethral walls, the points were pressed forward, cut down on and extracted through the wounds. He was assisted in this case by Dr. Drake.

Dr. Campbell also related a case of cancer of the bladder.

Dr. Hingston mentioned a case of atresia of the vagina, in which he had dilated and subsequently directed a medical man to continue the dilation. At his next visit, (the patient residing out of town), he found that the urethra had been dilated instead of the partially closed vagina.

MONTREAL, May 30, 1879.

A regular meeting was held this evening, the President Dr. Henry Howard, in the chair.

Dr. Osler exhibited two pathological specimens. The first was a monstrosity. It was a foundling brought into the Grey Nunnery, and lived for three days after admission. It is devoid of cerebellum and cerebrum. Projecting from the top of the head are some peculiar convolutions. The frontal and parietal bones are wanting; the occipital is wanting. The head is buried in the shoulders, and there is a peculiar idiotic appearance. Dr. Fenwick asked if the child fed and swallowed. Dr. Schmidt

replied that it swallowed very well, and was fed from a spoon. Dr. Smith asked if the child could move its limbs freely. Dr. Schmidt replied that it did not move its left arm. Dr. Osler further added: that an interesting fact in these cases is, that the cranial nerves are developed and perfect.

The second case was one of post-partum endo-metritis, death having taken place on the 9th day preceded by symptoms of septic poisoning. There is a coating like a diphtheritic membrane over about one-third of the uterus. The uterine veins are not filled with thrombi, the right ovarian, however, is large, firm, hard and filled with a thrombus. This was traced up to the inferior vena cava, and where it enters the cava it was of natural size, and through this opening the thrombus extended, and was attached to the wall of the cava. There was diphtheritic endo-metritis. According to some writers, there is a difference between this and true diphtheria. Herschfeld says that if this be inoculated in the throat of a rabbit it will not induce genuine diphtheria.

Dr. Rodger then read a paper on "Softening of the Brain." Some discussion followed, and a vote of thanks was moved by Dr. Kennedy, seconded by Dr. Ross, and carried.

Under the head of "Cases in Practice" Dr. Hingston mentioned that on Sunday last a child was brought to him suffering very great pain in the rectum. On passing his finger into the rectum, he found a needle, which was removed. The child had swallowed it.

Dr. Ross asked what was the experience of members of the Society in regard to Ague occurring within the city of Montreal. He said he knew of it occurring in the neighbourhood of the city, but had never seen a case originating within the city. He had lately a case from Hochelaga, and had seen two cases in the General Hospital, the disease having attacked the men while working in the Lachine Canal. Dr. Fenwick said he had seen cases originating within the city, especially on the line of Ontario street. Dr. Armstrong had seen one case, and Dr. Rodger two at the Point.

The meeting then adjourned.

O. C. EDWARDS,
*Secretary.*

## Reviews and Notices of Books.

*A Practical Treatise on Surgical Diagnosis.* Designed as a Manual for Practitioners and Students.—By AMBROSE L. RANNEY, A.M., M.D., &c. 8vo. pp. 386. New York: WILLIAM WOOD & Company, 27, Great Jones Street.

This is a very excellent manual. The author in publishing it as a text-book for students trusts that it may be an aid to memory by presenting the symptoms of any given diseases in contrast with those of other diseases that they may resemble. Considerable care has been devoted to the preparation of this work. All questions of ætiology, pathology and treatment have been excluded, the author confining himself to the symptomatology of disease, showing the differences in this respect between different affections which often resemble one another, and which may be mistaken the one for the other. The table of contents sets forth a division of the subject into eight parts. In part I Disease of the blood-vessels are given. In the classification we have diseases of the arterial coats, as atheroma and fatty degeneration. Disease affecting the calibre of the vessels, as aneurism, occlusion of arteries from pressure, from emboli, from thrombi, and from foreign bodies. Diseases of veins, as hypertrophy of the coats, atrophy of venous coats, adhesive phlebitis, diffuse phlebitis, varicose tumours, obstruction from plugging, or outside pressure, and parasites of veins.

The author is forced to admit that many of these affections are obscure, and that in some a positive and decided opinion cannot be given, based on the rational aymptoms, or physical signs observed.

In speaking of aneurism, the author points out the difficulties of diagnosis, more especially in the thoracic and abdominal varieties. He enumerates some thirteen other affections with which aneurism may be confounded. The differential symptoms of each are given, side by side, so that the reader is enabled to grasp the subject more readily.

In part II. Diseases of joints are treated in the same manner.

These the author classifies under the headings, inflammatory diseases, anchyloses, dropsy of joints, articular neuralgia, loose cartilages, and congenital and acquired malformations. In part III. we have the subject of diseases of bones. Part IV. dislocations, and part V. fractures. Part VI. is devoted to diseases of the male genitals. Part VII. to diseases of the abdominal cavity, and Part VIII. to diseases of the tissues. In this last part will be found inflammatory conditions of the tissues, tumefactions, indurations, suppurations, gangrene, the formation of abscess, tumors, both benign and malignant, and the differential diagnosis, between various conditions of the uterus, uterine fibroids, and ovarian cysts. This is a very practical book and will be found of great use to the surgical teacher, more especially those engaged in bed-side instruction. The arrangement of the subjects is concise, and the differentiation so placed that the symptoms of each disease can be reviewed separately by reading from above downwards, and by reading across the page the points of contrast become at once apparent, while at the foot of each page will be found an enumeration of symptoms common to the disease under discussion, and that with which it might be confounded.

There are some defects which are of importance, as for instance, in the subspinous dislocation of the humerus, it is stated that it is frequent in all ages. This is manifestly an error, as this form of dislocation is very rare. Frank Hamilton testifies to the rarity of this accident. In the 5th edition of his valuable treatise on dislocations and fractures, he mentions one case only as having come under his observation; again, in reference to this dislocation, the author states the reduction is permanent when accomplished. This is certainly not always the case. Hamilton mentions the fact of one case in which the bone would not remain in place when reduced, and accounts for that result from disruption of the subscapularis muscle, an accident which is mentioned as occurring by Sir Astley Cooper. There are some other defects which in a careful revision of the work will, we doubt not, be amended in a future edition. Altogether the work is most creditable, and will be found of great use to both practitioner and student.

*Modern Surgical Therapeutics.*—A Compendium of Current Formulæ, approved Dressings and Specific Methods for Treatment of Surgical Diseases and Injuries.—By GEO. H. NAPHEYS, A.M., M.D. Sixth edition. Revised to the most recent date. 8vo. pp. 420. Philadelphia: D. G. BRINTON, 115 South Seventh Street.

This is an old friend with a new face, another edition of a very popular compilation of the various modes of treatment adopted by surgeons in all parts of the world. We are pleased to see that the author gives credit to Canada for some of the plans of treatment he enumerates.

Prof. Fuller's treatment of shock by opium (*Medical Record*, February, 1877) is mentioned.

Three pages and a half are devoted to synopsis of Dr. Rosebrugh's (Toronto) treatment of Conjunctivitis. The work is an exceedingly useful one, and quite up to the practice of the present day.

*A Treatise on the Diseases of Infancy and Childhood.*—By J. LEWIS SMITH, M.D., Clinical Professor of Diseases of Children in Bellevue Hospital, New York. Fourth edition, thoroughly revised, with illustrations. 8vo. pp. 740. Philadelphia: HENRY C. LEA, publisher, 1879.

The fact that the author has been called upon to produce a fourth edition of this work demonstrates conclusively that it supplies a want keenly felt by American practitioners. Either from his own neglect, in many more instances from the neglect of the authorities of his college, the student goes into practice knowing little or nothing about the diseases of children. On the day he graduates, though he may know all about tying the third part of the subclavian, diagnosing spinal sclerosis, or the best method of performing Cæsarian section, yet his examiners would puzzle him were they to ask how an enema ought to be given to a baby, or how to prescribe for a case of infantile diarrhœa.

Many a young practitioner, aware of his ignorance in this branch of medicine, commences his reading in that long dreary period before the patients come to him, by careful application to

some treatise on diseases of childhood. Dr. Smith's work would suit such readers most admirably.

In being written by one whose experience is American, it possesses a great advantage; for, as we all know, the climate of a country alters in a great measure the type of a disease, and many diseases of childhood are almost absent, or, at all events, not so prevalent in England as they are in America. The summer diarrhœa of children affords an example of one of these.

The earlier chapters are connected with the bringing up, the feeding, the clothing, etc. of children. Of the artificial feeding of infants, Dr. Smith's statistics are alarming.

"Thus, on the continent, in Lyons and Parthenay, where foundlings are wet-nursed, the deaths are 33.7 and 35 per cent. On the other hand, in Paris, Rheims, and Aix, where the foundlings are wholly dry-nursed, their deaths are 50.3, 63.9, and 80 per cent. In this city, (New York) the foundlings, amounting to several hundred a year, were formerly dry-nursed; and incredible as it may appear, their mortality with this mode of alimentation nearly reached 100 per cent."

The subject of systolic brain murmur in children, which Professor Osler brought before the Medico-Chirurgical Society of Montreal some time ago, is referred to by the author in connection with rickets. "Later observations have established the fact, that this murmur possesses little diagnostic value. It is heard in healthy as well as diseased infants. Dr. Wirthgen detected it 22 times in 52 children, all of whom, except four, were in good health. I have auscultated the anterior fontanelle in 29 infants who were, with two exceptions, between the ages of three and thirty months. Most of them were well, or with trivial ailments, which would not affect the cerebral circulation. In most infants with a patent fontanelle, a murmur can be distinctly heard, synchronous with the respiratory act, and in 15 out of the 39 cases, no other bruit could be detected, while in the remainder, namely 14, a bruit synchronous with the pulse was heard at the fontanelle."

Dr. Smith ignores the ingenious theory of Jurasz, that these brain murmurs are due to want of correspondence in size between

the internal carotid artery and the bony canal through which it passes in the base of the skull. The researches of his own countrymen, Drs. Fisher and Whitney, deserve recognition.

In the treatment of whooping-cough the remedies found most useful and which are most employed in the New York institutions, are belladonna, quinine, the bromides, and the hydrate of chloral.

"The use of quinine as a remedy for pertussis, was first strongly recommended by Binz, who embraced the theory of Letzerich, that this disease is produced by a fungus upon which the quinine acts injuriously."

Fungus or no fungus, the remedy is an old one. The use of Peruvian bark in whooping-cough was recognized long ago. We quote from Cullen's "First Lines," chap. vii. paragraph mccccxxv:

"Of the tonics, I consider the cup moss formerly celebrated, as of this kind; as also the bark of the mistletoe, but I have had no experience of either, as I have always trusted to the Peruvian bark. I consider the use of this medicine as the most certain means of curing the disease in its second stage; and when there has been little fever present, and a sufficient quantity of the bark has been given, it has seldom failed of soon putting an end to the disease."

The chapters on cerebro-spinal meningitis deserve special commendation, the author from his official connection, with so many institutions for children in New York, being able to give valuable information about this terrible disease.

Apropos of the relationship between rheumatism and chorea, which is thought by some pathologists to exist, attention is drawn to the somewhat remarkble difference in the statistics of different countries.

"In England and France, so large a proportion of choric patients present the history of rheumatism either in themselves or family, that certain physicians of these countries believe that rheumatism is the most common cause of the disease. In Germany, on the other hand, according to Romberg, in the majority of cases no relation can be traced between chorea and

rheumatism, and the statistics of this city (New York), and I think of this country, correspond with those in Germany."

The best part of the whole book is that relating to the intestinal catarrh of infancy. Dr. Smith is a strong believer in the benefit of country air, and his opinion, will no doubt be endorsed by practitioners in Canada. He thinks the high temperature of summer is not directly the cause.

"But the state of the atmosphere which is most favourable for the development of intestinal catarrh, is found only in the cities. The filthy streets containing more or less decaying animal and vegetable matter, the crowded and unclean tenement houses, the neglected privies, the slaughter-houses, pig-pens, bone-boiling establishments and the like, are so many sources of the most deleterious effluvia, which, inspired by the infant, produce diarrhœa, and intestinal inflammation. Those squares of the city, where sanitary regulations are most neglected are the very ones where the mortality from this cause is largest."

Such is the experience of the profession in Montreal, we venture to say.

The perusal of Dr. Smiths's work has afforded us much pleasure and still more instruction. Its place is amongst the first of American medical works. There is no work on the subject we can more conscientiously recommend to our readers.

*Clinical Diagnosis.*—A Hand-book for Students and Practitioners of Medicine. Edited by JAMES FINLAYSON, M.D., Physician and Lecturer on Clinical Medicine in the Glasgow Western Infirmary. Examiner in Clinical Medicine to the Faculty of Physicians and Surgeons, Glasgow, &c., &c. with eighty-five illustrations. 8vo. pp. 548. Philadelphia: HENRY C. LEA.

There are a great many manuals of Clinical Medicine,—hand-books of physicians,—and others with different titles, but a similar end in view, already published. Of course many of these are valuable to students, and those beginning the practical observation of cases of diseases at the bedside of the sick in a hospital ward. One great fault of several of them, it has ap-

peared to us, lies in the stray, harsh, dogmatic lines that are drawn in establishing different diagnoses between complaints apt to resemble each other. This every experienced physician knows does not exist in nature and it is therefore incorrect to start a student with the idea that that is what he is to expect to find. It is a fault which is quite inseparable from the plan of endeavoring to give very short and concise lectures for the distinctive systematic diagnosis of most of the important diseases. This procedure is not followed at all in this little book, but, on the contrary, it aims at, and succeeds in, being rather an assistant of personal observation, whilst at the same time it contains much that is eminently instructive, there is more which is suggestive. It does not make any attempt to cover the ground of diagnosis—which is so manifestly impossible—but it discusses in a brief, terse manner, all the important symptoms of each class of diseases, pointing at their connections with each other and with those of other classes, attention being directed to all collateral circumstances which assist in the careful observation of a case as a whole, and in comprehension of such as are governed by definite pathological laws. The method and arrangement is, we think, especially adapted for the wants of students, and we would earnestly recommend it to all such, for constant reference whilst reporting cases in the Hospital. To give some idea of the scope of the work (premising that each section has a fair amount of space allotted to it) we give the list of contributors and their subjects. For a special feature of this book is that it is the joint work of several of the prominent physicians of Great Britain—each one, as in the cyclopœdias of medicine, writing that part pertaining to the branch with which he himself is most familar. Dr. Gardner on the physiognomy of Disease. Dr. Finlayson, On Case-taking, and On Symptoms of Disorders in the Venous Systems. Dr. Wm. Stephenson, On the Disorders of the Female Organs. Dr. Alexander Robertson, On Insanity. Dr. Samson Gemmill, On the Sphygmograph, and On the Examination of the chest and abdomen. Dr. Joseph Coats. On the Examination of the Fauces, Larynx and Nose, and on the Method of Performing Post-mortem Examinations.

*Epitome of Skin Diseases with Formulæ.*—For Students and Practitioners.—By TILBURY FOX, M.D., F.R.C.P., and T. C. FOX, M.B., B.A. (Cantab). Second American edition, enlarged and revised by the authors. Philadelphia: HENRY C. LEA, 1879.

We have much pleasure in strongly recommending for the careful study of our readers this excellent little book. The study of skin diseases is enveloped in far too much mystery in this age of specialism. There is nothing whatever in the diagnosis and treatment of skin diseases which is outside the province of the general practitioner. It is for him and for students that this little book is written. This, the second American, is a decided improvement on the English edition, for it contains an excellent summary on the difference in skin diseases found in America and those found in England. The most useful part of the book to the every-day practitioner will, doubtless, be the Cutaneous Pharmacopeia appended. The last chapter on "Diet in Skin Diseases," demands very careful attention.

## Extracts from British and Foreign Journals.

Unless otherwise stated the translations are made specially for this Journal.

**The use of Eserine in Glaucoma**—(By W. SPENCER WATSON, F.R.S.)—In a communication to the *Medical Times and Gazette* in February last, I remarked that "sulphate of eserine in the form of collyrium was *said* to be useful either when, from any cause, the operation is delayed, or after the operation if the tension returns." Recent experience has convinced me that this reputed power of eserine is not a mere illusion. I can fully endorse the views expressed by De Wecker in his recently published work ("Thérapeutique Oculaire"), in which he lays down as a rule that eserine should always be employed before and after an operation for glaucoma, whether the operation chosen be iridectomy or sclerotomy. I have been agreeably surprised at the manifest advantages of employing it under these circumstances, and now find that operation may be safely postponed in certain cases for a week or ten

days, or even longer when eserine is used, whereas without it delay seemed almost fatal to the chances of saving or restoring sight. In hospital practice, and perhaps even more so in private, it is often difficult to convince patients of the extreme urgency of the symptoms; and even if convinced, the dread of the knife keeps back nervous patients from the necessary ordeal until it is perhaps too late. It is therefore a great advantage to have at hand a remedy the effect of which is to render delay less dangerous than it must otherwise be, and in eserine we possess such a remedy. The two following cases illustrate this point in a way which to me is very convincing:—

CASE 1—*Simple Glaucoma of both Eyes, with Excavated Discs and Pulsating Vessels—All the Symptoms relieved by the use of Eserine.*

Elizabeth C., aged 39 years, a small woman with dark hair and irides, married and with six children, came to the South London Ophthalmic Hospital on December 30th, 1878, with all the subjective and objective symptoms of simple glaucoma. She said she had been nursing a sick husband, and from various causes had very disturbed nights, and yet been obliged to work hard during the day. For the last eight months her sight had been failing, and she had noticed coloured haloes round the candle. She had never had any pain either in her eyes or in the surrounding bones. The tension was increased in both eyes. Vision of the right eye, letters of J. 20; vision of left, J. 10. Both pupils fixed and half dilated. Both anterior chambers shallow, especially that of the right, in which also the cornea and aqueous were very turbid. Both optic discs were excavated, that of the right eye being very much cupped and pale, as if from some degree of atrophic anæmia, while that of the left eye retained its normal colour, and was even hyperæmic. Venous pulsation was seen in the right eye, but not in the left. This was a clear case for iridectomy or sclerotomy. An operation was at once proposed, but, as might have been expected, the mother of six children, with a sick husband to nurse, was in no mood for sudden and active measures, even though threatened

with the possibility of losing her sight. She was, however, fully warned of the risks she was running by refusing operation, and told in the meanwhile to use the eserine drops twice a day.

January 3rd, 1879.—Patient declares that she has never had the coloured haloes before her eyes since she used the drops. Her vision has decidedly improved; right eye, T. 3, V. J. 10; left eye, temperature normal, V. J. 8. In both the anterior chamber is clear, and the plane of the iris normal.

17th.—The drops have been continued, and there is still further improvement of vision. It is doubtful whether there is now any tension, even of the worst eye.

An operation was again urged upon the woman, who is, however, so well satisfied with the improvement in her sight that she still declines, and is therefore directed to continue the use of the eserine drops and to take quinine.

The improvement in this case followed so closely upon the application of the eserine and its known action upon the pupil, that it is hardly possible to avoid the conclusion that the local application produced the improvement. As, however, in simple glaucoma, temporary ameliorations of all the symptoms are not uncommon apart from medical treatment, it is quite within the range of possibility that a temporary improvement, due to natural causes may have been accidentally contemporaneous with the use of eserine, and that the effect of the latter was simply *not detrimental*, though perhaps not actively beneficial.

In the following case the symptoms were more acute, and though the influence of the eserine was watched for a short time only, there was good evidence that during that period its effect was decidedly beneficial.

CASE 2.—*Acute Glaucoma—Relief of Pain, but no Effect on the Pupil by the use of Eserine—Iridectomy successful.*

Maria D., aged thirty-seven years had suffered for five weeks with well marked glaucoma of the right eye. There were chromopsiæ, severe pain, extreme tension ($T_3$), and great impairment of vision. She applied on January 20, 1879. The pupil of the right eye was then dilated and immovable, and the

cornea and anterior chamber very turbid. Vision = mere perception of light at the outer side of the field. With the ophthalmoscope only a dull-red reflex was obtainable when examining the pupil. Iridectomy was proposed, but the usual difficulty about the care of children at home (one being eight months old and sucking her mother's breast, and five others being dependent on her care, made it necessary to postpone the operation. Eserine was applied: it relieved the pain, but did not cause contraction of the pupil nor diminution of the tension.

On January 24, the daily use of eserine having no permanent effect beyond the slight relief of pain, iridectomy upwards was performed. On the 31st this patient could tell the time by the watch, the tension was normal, and only a slight amount of pain was complained of. She was directed to continue the use of eserine and to take quinine.

Here was a typical instance of acute glaucoma. The operation was unavoidably postponed, and the use of eserine appeared to delay the progress of the glaucoma during the interval so that eventually the operation was successfully performed. In several instances similar good effects have been obtained. It is therefore probable that in future the use of eserine in glaucoma will become very general. There is a danger, however, that its undoubtedly beneficial influence may be relied on as a substitute for iridectomy or sclerotomy. According to my experience hitherto, its action in the cases in which it has been used would not justify its employment with this view, and I hold that surgical measures must still occupy the first place in the treatment of glaucoma, while local medication, if used, must take the place of a handmaid or assistant to, not that of a substitute for, operative treatment.—*Medical Times.*

**Notes on Military Surgery.**—(By Surgeon J. LEWTAS, M.B., LOND., Guides Cavalry.)—A few notes of some of the injuries received in the cavalry affair near Futehabad, Afghanistan, on April 2nd, may perhaps interest some of the readers of *The Lancet*. The portion of the Guides Cavalry present on that occasion numbered about two hundred sabres,

and our casualties were five killed and twenty-eight wounded.

CASE 1. *Penetrating Gun-shot Wound of Frontal Bone.*—The subject of this injury, a Sikh trooper, was hit by a stray bullet before the cavalry came into action. The bullet entered just above and to the right of the root of the nose. At the same time, also, the right eye-ball projected prominently forwards and was painful. He did not lose consciousness but complained of pain in the head, and especially in the right eye. The eye-ball was uninjured, but the conjunctiva was injected, and there was a small quantity of blood between the lids. He thought that the ball had passed out through the right orbit—a not impossible hypothesis, since bullets were coming across from our left, where the enemy was outflanking us. The subsequent history of the case, too, gave support for a while to his idea, for it seemed to indicate but slight injury to the brain. During the first eleven days the only symptoms were diffused headache and drowsiness, while there was dilatation of the right pupil and ptosis of the right upper eye-lid the two latter symptoms being not impossible results of an injury to the orbit only.

Suddenly, however, on the eleventh day new symptoms developed themselves—viz., epileptiform convulsions followed by coma. The first fit occurred about midnight on April 13th. This passed off in half an hour, leaving a condition of extreme susceptibility to muscular spasm; so much so that the attempt to give him a drink brought on locking of the jaws, twitching of the facial muscles on the right side, and spasmodic movements of the limbs. About an hour later he had a second fit, and the convulsive stage of this was of such duration and attended by such exhaustion—his body being bathed in perspiration and his pulse rapid beyond counting—that I resorted to chloroform-inhalation to bring on the stage of coma at once. A subcutaneous injection of one-sixth of grain of morphia was given to him while under the influence of chloroform, and he then slept for four or five hours. The next day, April 14th, he had a third fit, which was similarly treated, and since then up to the present date April 23rd, there has been no return. Dilatation of the right pupil and ptosis persist. There is, however, no squint, nor are any of

the movements of the eyeball impaired. He is drowsy and somewhat irritable. There is also decided impairment of the memory, as he no longer remembers the occurrences of that day, or even that he was wounded. There is still an abundant discharge of yellowish-green pus from the opening in the frontal bone, and there is some prominence of the inner angle of the roof of the right orbit.

*Remarks.*—The course and symptoms have not, I think, confirmed the opinion of the man himself that the ball escaped by way of the right orbit; the injury to the contents of the latter would have been greater, whereas the protrusion of the eye-ball would be sufficiently accounted for by a depression of the roof of the orbit caused by the bullet in its passage backwards. There can, I think, be little doubt that the ball has lodged within the skull, but at what precise spot it is impossible to determine.

CASE 2. *Gun-shot Fracture of Great Trochanter of Femur; death on nineteenth day.*—The bullet in this case entered at the outer side of the left thigh, about two inches below the great trochanter, passed upwards and inwards, splintering that projection, and finally lodged superficially over the base of the sacrum, where it pointed. Its position, however, was not so superficial that the bullet could be grasped between the finger and thumb; it gave rise rather to a diffused swelling, in which the exact position of the bullet was uncertain. Hence, I did not feel justified in cutting into this prominence, and sent him as he was to the field hospital at Jelalabad, where a few days later the bullet worked towards the surface, and was extracted. The discharge from the track of the bullet was abundant and fetid; syringing the wound twice and sometimes oftener daily with carbolic lotion, and a free use of disinfecting powder (McDougall's) failed to keep down the fetor He was further weakened by obstinate diarrhœa, over which treatment of various kinds had little effect. He died on April 20th, nineteen days after receiving the injury.

*Remarks.*—It is not the time yet to gather up the lessons upon gun-shot fracture of the thigh derived from the war. Five cases have now come under my notice, and they have all supported the received canons of military surgery; especially have

they shown the advisability of *immediate* amputation in fractures of even the upper third if, as is invariably the case in hill warfare, the patient has to be carried many miles to a permanent hospital, for on arrival at the latter he is so exhausted by the journey, and the limb is so much swollen, that an amputation then performed has most unfavorable results. In saying this I have two cases in particular in my mind, both of them gun-shot fractures of the upper half of the femur. One of these was carried from Ali Musjid to Jumrood, about ten miles, the other was carried for more than twelve hours in a dhooly, part of the time in darkness over rocks; and both of them died under the subsequent operation. The case of a man so injured is desperate, and justifies desperate measures: if, under the conditions supposed, his chance of life is increased by immediate operation, then the general rule of deferring all operations until arrival at a field hospital may surely be departed from, and advantage taken of the first halt to amputate the limb. The other plan has been tried, and with melancholy results; this, of imediate treatment (under the circumstances mentioned) has not yet had a trial.

Cases 3, 4, 5, and 6 were bayonet-wounds — two of them non-penetrating of the walls of the chest, and which soon got well; the third peculiar from its situation—viz., the right side of the fauces. The subject of it was leaning over in his saddle to make a cut, and received the bayonet in his mouth. The symptoms were only slight—some pain in swallowing, with slight swelling and tenderness of the neck.

The last case was a more serious one. The bayonet entered about two inches to the left of the navel and penetrated the peritoneum. Acute pain and collapse followed immediately, and some air seemed to have entered with the movements of respiration, for a few hours later the abdomen was tympanitic. Localised peritonitis followed, but the patient is now (April 23rd,) convalescent.

Case 7.—This is worth mention, as showing what terrible injuries a man will survive for a short time. The skull in this case, that of a non-commissioned officer, was cleft transversely

across the vertex, the sides of the cleft being separated in the widest part by an eighth of an inch, and the cleft extending from ear to ear. In addition to this another saber cut had raised the parietal portion of the temporal bone from its connections. Yet this man lived until the fifth day, and never lost consciousness until shortly before death.—*The Lancet.*

**Remarkable Operation.**—M. PEAN, the well-known surgeon of St. Louis Hospital has recently performed an operation which has considerably occupied the minds of the medical world in Paris. The patient was a man suffering from cancer in the pylorus, and was, at the time of the operation, in the last stage of cachexia, he not being able to retain any food in his stomach, and having to rely almost entirely on nutritive enamata for sustenance, which, as usual, were found to be insufficient. He accordingly applied to M. Péan to take some operative measures to relieve him, or, if nothing could be done, he was decided, he said, to put an end to his life. M. Péan, rather reluctantly, agreed to comply with the entreaties of the patient and his relatives, and decided to attempt an operation. An incision, about ten centimetres in length, was made on the left side of the umbilicus and parallel to the linea alba. When the peritoneum was opened the stomach was found to be considerably dilated, extending downwards as far as the pubic arch. Its walls were greatly hypertrophied. The peritoneum did not seem to be affected in any great degree. The pyloric portion of the stomach was then gently drawn forwards, when it was found that the growth measured six centimetres transeversely and four in a vertical direction. The whole of this mass was excised, as was also a portion of the epiploon, which was diseased. The two surfaces of section were then drawn into contact by means of catgut sutures. No liquid of any kind was allowed to enter the peritonal cavity during the operation. The abdominal wound was closed in the ordinary manner. The operation lasted two hours and a half. For the first two days after the operation the patient was fed by the rectum, but on the third day some food was allowed to be introduced into the stomach. During the

first three days the pulse remained alarmingly weak, consequently it was decided to perform transfusion. Fifty grammes of blood were introduced into the midian cephalic vein on a first occasion, and subsequently eighty more were injected. Unfortunately his condition did not improve, and he died on the night of the fourth day. He had shown no signs of peritonitis during these four days. It is much to be regretted that it was not possible to obtain permission to perform a necropsy, as it would have been highly interesting to see what had become of the catgut sutures, and to know whether the intestinal wound showed any signs of uniting.—*The Lancet.*

**Intravenous Injection of Ammonia.**—Dr. GASPAR GRISWOLD in the *New York Medical Record* uses for intravenous injection a drachm of a fluid containing equal parts of ordinary aqua ammoniæ and water. The vein is rapidly laid bare and the fluid injected. In the case of two moribund patients, he succeeded in making the vital flame flicker for a few hours longer than it would naturally.

The most interesting case he cites is that of a woman, aged 47, who came into Bellevue Hospital on the 29th April with ascites, supposed to be due to cirrhosis of the liver. The right pleural cavity was full of fluid. Seven quarts and fifteen pints were taken from the abdomen. The patient was nearly dying on the 4th May from dyspnœa. Thoracentesis was performed, and ninety ounces of clear serum withdrawn. She nearly died under the operation, but was kept up by fifteen or twenty half-drachm doses of whiskey administered hypodermically. Dr. Griswold's colleagues were of opinion that the woman was dying, and that further treatment was useless and even absurd. The Dr. injected ammonia, and in fifteen seconds there was marked increase in the force of pulsation.

In two minutes the pulse was plainly perceptible at the wrist, beating 100. Half an hour afterwards she was perfectly conscious and reported herself comfortable, though weak. To make a long story short. Dr. Griswold reports that on the 17th of May she sat up nearly all day, and was gaining strength.

**Cases in Surgical Practice.**—The following cases are reported in *The Lancet*, taken from Mr. Jonathan Hutchinson's Clinical Lectures, they are of interest because of their rarity :

*Paralysis of the Fifth and Third Nerves on the same side, probably from Syphilitic Gumma.*

The patient, a pallid man of middle age, had complete ptosis, dilated pupil and entire inability to use the three third nerve recti. In addition, he had numbness of the whole of the side of the face, not, however, amounting to absolute anæsthesia, with wasting of the temporal and masseter muscles and of the anterior belly of the digastric. Thus there was proof of implication of the trunk of the third and of both roots of the fifth. The condition had been increasing for some weeks, and was unattended by other indications of cerebral disorder. The demonstration of the paralytic atrophy of the three muscles was very definite and interesting; not the slightest action on the part of any of them could be detected. I drew attention to the fact that the buccinator had wholly escaped paralysis, as it almost always does in motor failure of the fifth. The eye was not in the least congested, and its being perfectly covered by the drooping lid was no doubt a valuable protection to it. The man was to be congratulated in one respect—that, having paralysis of the fifth, he had also paralysis of the third. There was the history, as is usual in these cases, of remote syphilis; and iodide of potassium, in ten-grain doses, was prescribed.

*Destructive Symmetrical Iritis without evident cause.*

A very important example of this affection was sent to me by Mr. Charles Palmer, of Yarmouth. The patient is a single young woman of about twenty-five. No cause—that is to say, neither syphilis, rheumatism, gout nor injury—can be made out, and the general health appears to be good. The iritis has been most severe, and has resulted in blindness with occlusion of pupils and disorganisation of the iris-tissue. It is remarkable that it has been almost wholly painless. An almost precisely similar case was that of a young man from Sheffield, who was also under care at the same time. In him the eyelashes had turned white. I suspect that these cases are neurotic in origin.

*Chancre of the Upper Lip.*

A young man was admitted six weeks ago with a large indurated sore on his lip. Its characters were most definite, and under the jaw were a number of enlarged glands. The skin was covered with a lichenoid and papular rash. He did not know how he had caught the sore. He first observed a little crack, then a month later it began to inflame and harden, and in another month the rash began to appear. Having remarked on the case as an example of non-venereal syphilis (*syphilis sine coitu*), or probably chancre from kissing, I drew attention to it as an illustration of the early stages of the disease. For practical purposes we may divide the early phenomena of syphilis into three periods of one month each. The first month is occupied by the incubation of the chancre, and during it there is either no sore at all, or a sore which is soft, suppurating and without definite character. At the end of this first month the process of induration will be commenced. Another month may be allowed for the full development of the chancre and for first appearance of the constitutional symptoms; and at the end of two months from the contagion the sore may be expected to be very hard, the bubo well characterised, and the skin mottled with a roseolous rash. If treatment be avoided, the rash will develop further, during another month, and at the end of three the chancre will still be in full vigour, and the skin covered with a multiform eruption. The disease will now be at its full height, and it is at this period that iritis and retinitis are most likely to occur. In this case the lad has now been one month under treatment by two-grain doses of grey powder three times a day; and, without ptyalism, and without any interference with general health, the induration has melted away, and the rash almost wholly disappeared.

*Case of Rapid Cure of Severe Syphilis by Profuse Ptyalism.*

In connection with the above, in which syphilis is being cured by small doses of mercury administered through a long period, salivation being avoided, I drew attention to another, which occurred a month ago, in which profuse salivation appeared to

be productive of the best results. A married woman of middle age was admitted with a most copious scaly and papular eruption. It covered her face, trunk and extremities, not any part escaping, and the profuse production of scale-crusts was a very remarkable feature. On the arms it might have been taken for common psoriasis, but on the face there could be no doubt as to the diagnosis. Mercurial baths were ordered, but after the third she became freely salivated. For a week or two she was confined to bed, and in a very feeble state from the profuse ptyalism. During this period the eruption vanished as if by magic. No more mercury was used in any form, and at the end of a month the woman left the hospital covered with stains, but having nothing whatever remaining but stains. She was charged to return in a month, that we might know if any relapse occurred.

I remarked in connection with this case that it was the most rapid cure of a severe secondary eruption which I had ever known. Although, on the whole, I prefer the long-continued treatment by small doses, yet it is well to bear in mind that in certain cases mercury appears to be far more efficient when pushed to its full physiological influence. We must avoid prejudging the question, and keep our minds open for the reception of all evidence that may be forthcoming. In some acute inflammatory affections, not syphilitic, benefit is observed immediately that salivation occurs, whilst none is witnessed before.

*Interstitial Keratitis, with Deafness.*

His deafness was symmetrical. It had come on during the last three months, and it had progressed to such an extent that the lad carried in his hand a slate and pencil for writing. He had not had any discharge or pain, but he complained bitterly of "such a ringing in my ears." I remarked that deafness of this kind and intensity, and at this age, was almost conclusive in itself as to inherited taint. We know of no other affection which in young persons can, without otorrhœa or any proof of inflammation, proceed in the course of a month or two to the entire loss of the function. Such cases are common enough in

those who inherit syphilis, and they occur in connection with no other cause. In this instance the lad suffers also from symmetrical keratitis, and of this disease precisely similar statements are true. Thus, although his physiognomy is scarcely peculiar, his teeth are well formed, and we know nothing of his family history, yet the simultaneous occurrence of two maladies, each of which is characteristically syphilitic, justifies us in a confident diagnosis.

*Paralysis of both Six Nerves after Injury to the Head.*

The man in whom this lesion is present has, in all probability, suffered a fracture through the base of the skull. He bled at both ears and from the nose. His portio dura is paralysed on the right side, and he is deaf in both ears, though not absolutely so, and in the right he was, he says, deaf before his fall. Both six nerves are absolutely paralysed, and the eyes converge. The man is quite free from brain symptoms, and he is doing well. In anticipation of arachnitis he was put under the influence of mercury during the first week, but as he is now wholly without symptoms, excepting the paralysis, it has been discontinued.

What the precise lesion may be which has caused complete paralysis of both abducentes it is somewhat difficult to conjecture. In all probability, the fracture crosses the right petrous bone, and it may cross the sella turcica. I mentioned at the bedside that I had seen several cases of paralysis of one sixth nerve after injury to the head, but that I did not remember one in which it was double. During the same week I had seen with Dr. Macpherson of Midmay-park, a little girl who had been knocked down in the street by a horse, and in whom, without any other cerebral symptoms, the right sixth nerve was quite paralysed.

*Recovery from Paraplegia possibly of Syphilitic origin.*

We sometimes, in going over the past life-histories of our patients, come upon interesting fragments of evidence, always, however, to be taken with a certain amount of hesitation on account of the sources of fallacy. A gentleman who consulted me a few days ago for a syphilitic gumma in his tongue, told me that he

had formerly suffered from paralysis, and had wholly recovered. The facts were these. Fifteen years ago he had syphilis with eruption, &c., rather severely, and took mercury. Almost as soon as his treatment was over, he began rather suddenly to lose the use of his legs. The weakness began at his heels, and crept upwards, and his lower extremities wholly failed. He was on the couch for three or four months. His arms were weak, but not wholly paralysed. After four or five months' treatment he wholly recovered, and has never since had any reminder of it. He was married at the time, and married a second time some years afterwards. He has now enjoyed ten years of good health, and has, during that time had nothing of a specific character.

**Intercarpal Dislocation.**—(Under the care of Mr. C. E. RICHMOND, of the Warrington Infirmary and Dispensary).—Dennis S——, aged forty-seven, miner, a muscular subject, with well defined anatomical points, was admitted March 14th, 1879. He was working at a thrashing-machine when the strap of the fly-wheel caught his arm and dragged him up to the top of the wheel (the height of which was stated to be about nine or ten feet), from whence he fell on his hand. He could not state whether he fell on the back or palm of the hand. There were several skin lacerations (done by the strap) midway up the forearm, but no fracture of the radius and ulna was discoverable. There was, however, marked deformity at the left wrist. The length of the hand from the wrist to the knuckles was very noticeably shortened. There was a prominent transverse ridge on the dorsal aspect of the wrist beneath the ends of the radius and ulna; and below this ridge there was a marked depression. On the palmar aspect the base of the hand was unduly promiment, the general direction of the metacarpal bones being quite altered by their bases being pushed forward towards the palm. The diameter of the wrist, both laterally and antero-posteriorly, was much increased. There was not very much bruising or swelling of the soft tissues themselves, though the circumference of the wrist, taken round the extremities of the radius and ulna, was one inch and a quarter more on the injured

than on the sound hand, and below this point the difference was even more marked. He was unable to flex or extend his hand himself.

On examination the ends of the radius and ulna seemed separated from each other somewhat. The transverse dorsal ridge before mentioned could be demonstrated to be the first row of carpal bones, with the semilunar rather unduly prominent. Between this ridge and the ends of the radius and ulna the movements of flexion and extension, although restricted could be obtained with considerable ease and without any crepitus. Below the ridge the extensor tendons could be plainly felt stretching across the depression to the fingers.

The articulation between the thumb and the trapezium was not interfered with, nor had any of the articulations between the metacarpals and second row of carpals sustained any injury. On the palmar prominence before mentioned the trapezoid could be felt pushed more anteriorly than, and considerably above, the level of the trapezium, and nearer the ulnar side the head of the os magnum could be felt overlapping slightly the ends of the radius and ulna, which on the palmar surface were quite obscured; and on flexion and extension of the hand the os magnum could be felt to ride on their anterior surface. The displacement of the unciform, although distinct, was much less marked. Under no circumstances could any crepitus (other than that attributable to effusion) be detected, nor was there any sign of fracture whatever.

The result of examination showed that the second row of carpal bones was dislocated from the first forwards and upwards, the displacement was most marked in the case of the trapezoid and os magnum.—*The Lancet.*

**Movements of the Eyelids.**—A paper was read before the Royal Medical and Chirurgical Society on the "Movements of the Eyelids," by W. R. Gowers, M.D., of which the following is an abstract: Under normal conditions the lids leave the cornea approximately uncovered in all positions of the eye-ball moving with it. For these movements, and

for the voluntary closure and opening of the lids, there are only two muscles, the orbicularis and the levator. These will not expain all movements, and it is probable that the eyeball itself moves the lids, not by the conjunctival connection but by the pressure of the convexity of the sclerotic, and to a less extent of the cornea, the edges of the lids lying in or near the sclero-corneal sulcus. This effect is greatest on the upper lid, partly because the tarsal cartilages are attached, at their extremities below the transverse axis of the eye-ball. The eyelids are moulded on the globes, the shape of the palpebral fissure depending on the position of the eye-ball, and being curiously altered in some abnormal lateral positions. In closing the eye-lids gently the lower lid is raised by the palpebral orbicularis; in rotation up of the globe the lower lid is raised, not by the orbicularis, but by the pressure of the globe, and the movement is slight if the globe is very prominent. Depression of the lower lid in looking down is by pressure of the cornea. The upper lid is maintained in position by the balance of tone between the levator and the orbicularis. If the latter is paralysed, the lid is a little higher than normal. The descent of the upper lid in looking down is not by contraction of the orbicularis (for it is unaffected in facial palsy), but is by the pressure of the sclerotic against the tarsal cartilage. The lid is raised on upward rotation of the globe by the levator, the contraction of which, if sudden, is excessive. With this is associated a synergic action of the frontalis; the latter is sometimes habitual, and then is relaxed with the levator on looking down. The action of the levator, associated with that of the superior rectus, is beyond voluntary control, and, in the simulated ptosis of hysteria, necessitates a strong contraction of the orbicularis to keep the lid down, if the patient is made to look up. The associated relaxation on looking down prevents almost all voluntary contraction of the levator in that position. Gentle closure of the lids, as in sleep, is by the palpebral orbicularis; the levator being relaxed, the recti passive. Forcible closure is by the whole orbicularis, the levator being released and dissociated from the superior rectus, which contracts, rolling the globe up. Hence, probably,

the centre for strong closure of the eyelids is physiologically distinct from that for their gentle closure. If the orbicularis is paralysed the associated inhibition of the levator still occurs on an attempt to close the lids. But, if the inferior rectus is paralysed, a fruitless attempt to rotate the eyeball down is not attended with inhibition of the levator. This phenomenon (of which photographs were shown) is difficult to explain. Possibly this relaxation of the levator is not the result of a central mechanism, but is reflex from the commencing tension on the fibres, and so does not occur if the globe does not move. If so, the fact is of much interest in relation to the mechanism of other movements in the body. Lastly, it is pointed out that the eyelids commonly participate in the movements of the eyeballs in vertical nystagmus.

**Ophthalmoscopic appearances in Tubercular Meningitis.**—The following is an abstract of a paper on the "Ophthalmoscopic Appearances in the Tubercular Meningitis of Children," by GEORGE GARLICK, M.D.:—The ophthalmoscope discloses changes in the optic discs of about 80 per cent. of the children who die of tubercular meningitis. These changes fall under one of two heads—viz., optic neuritis or distension of the retinal veins alone. As the discs vary physiologically in different individuals and even in the same person, the two are often not alike; progressive change is better evidence than can be obtained from a single examination. In a small proportion of cases the optic changes occur very early in the course of the disease, and enable a diagnosis to be made when the symptoms are equivocal; this is the case when the meningitis is seated chiefly about the optic commissure. But the ophthalmoscopic changes are an important factor in the diagnosis in a much larger number of cases. The two forms of disc change—viz., optic neuritis and distension of the veins—appear related respectively to meningeal inflammation and pressure. The intracranial pressure may result from excess of ventricular or of subarachnoid fluid, and gives evidence of its presence in the anæmia of the cranial

contents. The palsy of the limbs is mostly found on the side opposite to that hemisphere of the brain which presents that greatest meningeal affection. No such definite relation exists with regard to the optic discs. In many cases of tubercular meningitis which run an indefinite course, especially those which are secondary to some other advanced disease, the optic changes share the indistinctness of the other symptoms. The ophthalmoscope countenances the idea that some cases of tubercular meningitis recover, and, even in fatal cases, a temporary improvement may occur in the discs. Tubercles of the choroid appear to be an uncommon complication.—*The Lancet.*

**Gas in Peritoneal Cavity in Typhoid Fever relieved by Puncture.**—Mr. George Brown read a paper before the Clinical Society of London on a case as above. The patient, a young man aged twenty-one, was under Mr. Brown's care for typhoid fever in October last. The temperature was high throughout, ranging from 102° to 105.2° during the height of the fever. The case was complicated with double pneumonia. In the third week of the fever tympanites developed, which was at first localized to the parts of the abdomen occupied by the intestines, but a few days later the physical signs indicated that gas had escaped from the intestines into the peritoneal cavity, or was being generated in the cavity itself. The distension of the abdominal wall gradually became more and more extreme, the tympanitic note entirely masking the hepatic and splenic dulness, and could be elicited over the sternum as high as the articulations of the fourth costal cartilages. Through the upward pressure on the diaphragm there was urgent dyspnœa, the respirations reaching as high as 50 per minute, and the heart was displaced upwards and outwards, so that the apex-beat was half an inch outside the nipple and in a line with it. Mr. Brown pierced the abdominal wall with a small aspirator trocar an inch below the umbilicus, and on withdrawing the cannula a rush of gas took place which continued for several seconds. The gas was odourless. The relief was immediate, the heart regained its normal situation, and in a few minutes the

respirations fell from 50 to 36 per minute. No ill effect followed the operation. The patient succumbed, however, from the lung complications thirty-six hours after. As to the source of the gas, Mr. Brown dismissed the idea of perforation of the intestine on the following grounds, viz. :—1. The gradual development of the gas in the peritoneal cavity. 2. Absence of symptoms of collapse which might have been expected had perforation taken place. 3. The fact that the tympanitic condition of the colon and small intestines was unrelieved by the operation. Had perforation existed, gas would probably have continued to escape into the peritoneal cavity after the operation, but of this there was no evidence, although the patient lived thirty-six hours afterwards. 4. The fact that the gas was odourless. Mr. Brown advanced two theories as probable sources of the gas; first, the gas might have passed by diffusion through the intestinal wall; or second, the gas might have been derived directly from the blood by exosmosis through the delicate wall of the peritoneal capillaries—and this was the more probable, from the fact that several days previous to the distension taking place the blood was highly charged with carbonic acid gas in consequence of imperfect aëration in the lungs. Mr. Brown said he was unable to decide this point, and preferred to merely record the case in the hope that other observers would be able to throw more light upon the subject should similar cases occur in their practices.—*Medical Times.*

**Amussat's Operation in a case of Imperforate Rectum.**—Mr. Morrant Baker read notes of a case of imperforate rectum, for which Amussat's operation was performed, in a female infant, who, when nineteen days old, came under the care of Mr. Morrant Baker at St. Bartholomew's Hospital. When first seen, the abdomen was enormously distended; there was frequent vomiting, and the child was much exhausted. Chloroform having been administered, an attempt was made to find the lower end of the bowel, through the short *cul-de-sac* which represented the anus. The bowel, however, could not be found, notwithstanding very free

incisions, and in spite of the great distension of the abdomen, no bulging of the parts could be detected, even during the action of the abdominal muscles. It was decided, therefore, after a consultation, to desist from furthar operative procedures in the neighbourhood of the anus, and to perform colotomy by Amussat's operation in the left loin. This operation was accordingly performed. Meconium freely escaped, and within a few hours the infant was greatly relieved. An elastic tracheotomy-tube was inserted into the bowel through the wound in the loin, and had been worn continuously ever since. In this way all troubles which might have arisen from contraction on the one hand, or prolapse on the other, were avoided. A year after the operation it was noted that the child was well and wore the elastic tube; fæces passing only once or twice in the week. The abdomen was, however, not distended. Two years after the operation the note was the same, and the child, now nearly three years old, was shown to the Society, perfectly well in health, and still wearing the elastic tube in the loin. Instances of recovery, it was remarked, after the performance of colotomy for the relief of imperforate rectum were curiously rare, and probably the case shown to the Society was the only one now in this country. The question as to the best operation to be performed in cases of imperforate rectum, in which the bowel could not be found at the outlet of the pelvis, was discussed, and Mr. Baker thought that, on the whole, a preference should be given to Amussat's rather than to Littré's method of colotomy.—*Medical Times.*

WARNER'S PILLS OF QUININE.

We have received from Messrs. Warner & Co., a sample of their pills, containing gr. ii. of Quinine in each pill. These are thoroughly reliable preparations, and are beautifully put up, being coated over with sugar. The use of sugar as a coating for pills has been objected to, but there is nothing that in verity can be advanced against this method of coating these preparations. It is stated that in sugar-coated pills the drugs become dry and hard and soon loose their efficiency—not more so we should suppose than in drugs prepared in the ordinary way. But everything in nature is perishable, and will in time deteriorate. These pills, like others of Messrs. Warner & Co's. preparations, are made for use and not to be retained for any length of time in stock. We commend them as being reliable, and in being the most palatable form of taking medicine.

CANADA

# Medical and Surgical Journal.

MONTREAL, JUNE, 1879.

## REGISTRATION OF COLONIAL DEGREES.

There is a considerable amount of egotism in the sayings of some of our exchange journals of British heritage concerning this subject of the recognition of Colonial degrees. The Editor of *The Medical Times and Gazette*, in an article on "Colonial Medical Registration," informs us that he has been trying to establish reciprocity of Registration between the colonies and the mother country, and then quotes the Letter of Dr. Baldwin, a Registered Practitioner of the United Kingdom, to which we have already referred on a former occasion.

In the number of our Journal for December, 1878, we endeavoured to aid the understanding of our English contemporary touching our Canadian institutions, but it would appear that we were not sufficiently explicit. We fail to see in what particular *The Medical Times* has in any way advocated reciprocity of Registration between Canada and the mother country, and on referring to an article which was published by that periodical on the 16th November, 1878, the directly opposite inference must be drawn therefrom. But probably the Editor of *The Medical Times and Gazette* did not take the trouble to read our article, and he again falls into error as regards Canada and our Registration system. He states that "the Privy Council of Canada has omitted to notice that when the British Medical Act of 1858 passed, the Ontario College did not exist, and that for anything that appears, there may not have been at that date any Licensing Body in the British North American Provinces." Now the facts of the case are these: Medical legislation in this colony dates back to the 28th year of the reign of His late

Majesty King George the Third, which was shortly after the conquest of the country. The affairs of the profession were administered under that Act, which provided for the granting of a license, to entitle the holder to practice physic, surgery and midwifery in the then Province of Canada.

Having enlarged our borders, and several provinces having grown out of this single province, it was found expedient to seek for further legislation, and in 1847, the profession was incorporated under the name and style of the College of Physicians and Surgeons of Lower Canada. One of the provisions of this Act gave to holders of its license the privilege of legally practising in any part of what at that day constituted the Provinces of Upper and Lower Canada.

By the provisions of the Act of 1847, no person could obtain the license unless he could show that he had studied medicine, surgery and midwifery during four consecutive years, during which time he was required to attend two full courses of Lectures on the various branches of Medical science delivered at some university, college or incorporated school of medicine, and produce evidence of having attended the regular practice of a hospital of not less than fifty beds during a period of eighteen months. A candidate with the credentials above named could obtain his license by examination. If, however, he was the holder of a degree or of qualifications covering the ground of medicine, surgery and midwifery from any recognised British or Provincial university or college, he was entitled to receive his license on the payment of fees without examination. This, then, is the position in which we stand at the present day, and all British Graduates are admitted to license on what their papers show forth. We are in Canada General Practitioners. If a pure surgeon comes to us for a license he can only obtain such license on passing an examination in medicine and midwifery; if, however, these branches are covered by other qualifications, he is admitted to practise at once and the license issued on payment of fees. There can be no hardship in this. We simply think it preposterous of our British friends to remain in their pig-headed ignorance and attempt to write about our institutions, of

which they know nothing. It is lamentable to see *gaucheries* perpetrated almost in each issue of some of the British periodicals. Our friends on the other side of the Atlantic had better take notice and understand that we in this despised colony gave them the lead in medical legislation by our Act of 1847, and that the Ontario Legislature passed, some twelve years ago, an act enunciating and carrying out the central examining system, or the one door of entrace into the profession, a system that is being advocated at the present day before the British House of Commons.

## EXTRACT OF MALT.

There is probably no parallel, in the history of therapeutics, to the rapidity with which this most valuable agent has forced its way into universal favor with the profession. Until a year or two ago its use, in Canada especially, was of the most restricted character, now there are few practitioners who do not occasionally prescribe it. While no medicinal agent has achieved such favor, it may also be said there are few remedies possessing such well-founded claims for general favor, and none whose range of application is so wide. Its constituents are malt-sugar, dextrine, diastase, phosphates, the importance of which to the digestive process need not be discussed. The clinical evidence, too, which has sanctioned the physiological claims of Malt Extract is most abundant. Authorities, abroad (it is officinal in Germany) and at home emphatically recommend it. Niemeyer, Oppolzer, Werber, Bock, Hoppe-Seyler, Heimerdinger, Juergensen, Schrœder and Ziemssen, in Germany; Trousseau, Gosselin, Hardy, Mauduit and Pillois in France; Ramagalia, Testa and Tartaglia in Italy; Aitken, Anstie, Richardson, Chambers and Thompson, in England, are among the writers who speak in favorable terms of its use. In America the testimony is to the same effect. In Canada, as we have said, it has been received by the profession with the greatest favor, and a large number of the profession have already given formal, as well as practical, endorsation to this preparation.

Regarding Malt Extract, Dr. Niemeyer says:

"The class of diseases in which the chief, if indeed not the only task of the physician, is to maintain or restore the strength and nutrition of the patient, is very large. For several years past, to meet these indications, instead of prescribing cod liver oil, which I was formerly in the habit of doing, I have employed almost exclusively, Malt Extract, and with the very best effect. This substance must not be confounded with Hoff's and other so-called malt extracts, which are only a kind of beer containing a large proportion of carbonic acid and alcohol, which are often injurious to the patient. It is similar to other medicinal extracts, and consists of the soluble constituents of Barley Malt."

According to Professor Douglas, 1000 parts of the Trommer Extract of Malt contains: malt-sugar 46.1; dextrine, hop-bitter, extractive matter, 23.6; diastase, 2.469; ash-phosphates, 1.712; alkalies, .377; water, 25.7. In comparing this analysis with that of the Extract of Malt of the German Pharmacopœia, as given by Hager, he finds it to substantially agree with that article.

Malt Extract, with its combinations, is recommended in the following diseases: anæmia, chlorosis, marasmus, dyspepsia, neuralgia, insomnia, pulmonary and bronchial affections, dysentery, constipation, scrofula, convalescence from exhausting diseases, &c. We have used the Trommer Extract in some of these affections with satisfactory results, and have no hesitation in strongly recommending it.

[Mr. R. L. Gibson, agent for the Trommer Company, is desirous of securing reports from physicians of their experience in the use of Extract of Malt, and requests us to say that such courtesy would be very highly esteemed. He will also be glad to answer any enquiries, and to furnish samples on application. Address: P. O. Box 724, Montreal].

## Medical Item.

Charles H. Murray, B.A., M.D., C.M., McGill University of the Session of 1876, also M.R.C.S., Eng., passed the competitive examination for the Indian Medical Service, on February 17th last. There were fourteen vacancies and thirty-three candidates, and Dr. Murray stood eighth on the list of successful candidates. We believe Dr. Murray is at present serving at Netley.