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THE
CANADIAN PRACTITIONER

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THE SURGICAL TREATMENT OF INSANITY.

BY ERNEST HALL,

Fellow B.C. Gyn. Society, Victoria, B.C.

IN THE CANADIAN PRACTITIONER of April I made a preliminary report upon a case of insanity of two years and ten months' duration which was relieved by removing diseased appendages. It is satisfactory to report at this period, more than nine months since the operation, a continued physical improvement, the patient having gained thirty-five pounds in weight, and what is still better she has been completely restored mentally and is again a useful member of society.

Since treating this case I have examined eleven insane women with the result of finding abnormal conditions of the pelvic organs in nine instances. In six of these cases surgical

measures were adopted with results upon the whole satisfactory. One case of exceptional interest is here given.

PRELIMINARY REPORT.

Mrs. R., aged 52 years, married 29 years, never been pregnant, husband healthy, mother melancholic; one brother committed suicide at the age of 45 after the death of his wife; brother suffered from religious mania and upon two occasions endeavored to take his own life, but for the last twenty years has manifested no indications of insanity. Two uncles of the patient died in Bodmore Asylum, Cornwall.

The patient had been healthy until fourteen years ago, when she suffered from an attack of so-called ovaritis upon the right side. She was considered very sick, and was confined to her bed for six weeks. She had complained of continual pains in the right side. Bowels sluggish.

HISTORY OF THE INSANITY.

Eight years ago the patient first manifested indications of mental disturbance, after reading some religious works on the doctrine (?) of sanctification. As she did not feel as the writer described, she was not "sanctified," and in order to be good she must experience these peculiar sensations. After a few months she became rational again, remaining so until three years ago last February, when she again shewed symptoms of insanity, with similar characteristics. She considered it was her duty to give up everything for the "Lord." She gave away a certain amount of her jewellery. Then the "Holy Ghost" told her she must give up that which was dearest to her; that being her husband, she was asked to give him up and unless she did so she had not reached the desideratum. She told her husband repeatedly that there was a danger of her killing him, as the "Holy Ghost" had told her that since she had made her husband her idol she must kill him. She also attempted suicide, and wandered away from her friend's house and was found near the seashore.

At this time she came under my observation, and upon this finding she was admitted to the Provincial Insane Asylum on June 19th, 1896, where she remained until October 5th, 1898.

Her asylum life was characterized by an intensification of religious delusions, with melancholia. She refused to recognize her husband, and said she was not married, that his wife was dead, etc. She also suffered greatly from insomnia.

One year ago, while visiting the asylum, through the courtesy of the medical superintendent, Dr. Boddington, and with the consent of the husband, I made a pelvic examination under anaesthesia, finding the uterus retroverted, with dense adhesions. I could not determine either right or left ovary.

Upon the result of this examination, I recommended operative measures, but on account of conditions unnecessary to here state I was not allowed to operate until October 5th, 1898.

The patient offered no objections to taking anaesthetic, and the last words she said as I commenced it were: "You look like a preacher; I have no need for you, I have no soul." After commencing the anaesthesia, I gave place to an assistant and prepared for the operation.

Conditions found :

Adhesion of the clitoris with retention of smegma as large as a small pea. Dilated and curretted without finding any abnormality. Abdomen was then opened, and the omentum was found adherent to the parietal peritoneum for about six inches along the median line. The pelvis was one mass of adhesions, and it was with the utmost difficulty I succeeded in freeing the uterus from the sacrum and the bowels. The left ovary and tube were found in a mass of adhesions, and with difficulty were removed. Upon the right side the adhesions were so dense that I was unable even to find the right ovary.

The uterus was brought forward and ventrofixed, and the abdomen closed without any drainage. Convalescence normal; stitches removed on the twelfth day.

RESULTS.

Physical :

Patient rested well after operation; slept a few hours the first night. Second day satisfactory; somewhat restless upon the third day. Sixth day she passed several large concretions of faecal matter which appeared to have been lodged for some time in the bowel. Ten days after she experienced uneasiness in the bowel, and an examination revealed the presence of several additional concretions—one so large that it required to be forcibly broken before removal.

Patient sat up in bed beginning of third week. Physical condition rapidly improving under tonics.

Mental :

There appeared to be a marked change in the mental condition immediately upon awakening from the anaesthetic. During

the first two weeks her mind would wander for a moment only each day, when she would be instantly checked by the nurse, who could easily get the mental operations back to the realm of reason. Only rarely did she return to her religious delusions. She recognized her husband and discussed plans for the future, and since the beginning of the third week she has exhibited no indications of mental abnormality.

It is a matter of the utmost importance in these cases that the nurse possess mental power sufficiently strong to cope with, conquer, and dispel the slightest indication of any reversion to former abnormal habits of thought and expression. From a very limited observation of these cases I am led to conclude that a vicious mental habit is a factor of no small importance in these cases, and, again, the importance of nutrition must not be overlooked. The best of food, daintily prepared with the most vigorous hæmatinic tonics, should be given. Patients have complained at the Asylum of the fare being not of the most tempting description, and not calculated to whet the appetite and stimulate digestion, but I fail to see how it could be otherwise in a large public institution. Regular evacuations and blood rich in hemoglobin are the best eliminators of ptomaines with which the tissues may have been saturated during years of impaired function and organic agony. In the nine months following the operation upon my first case the patient was transformed from a spare anemic woman to rosy robustness, with an increase of thirty-five pounds' bodily weight.

Let it not be forgotten that surgery is but a part of the treatment in these cases, but the most important part.

IMPRESSIONS RECEIVED ON RECENT EUROPEAN TRIP.*

BY DR. NEU.
London.

To ask one who has been born in this country, who has received his education for the practice of medicine in a small school like the Western University, who has obtained his clinical instruction in a hospital with scarcely a hundred beds, and who has engaged in a limited private practice for three years, what impressions were received when he found himself where hospitals were as numerous as the beds in the one he received his teaching, where one meets with every disease in every degree and stage, is indeed a question which can be approached in many ways.

But as this society has for its object the advancement and improvement of their knowledge and skill in the healing art, only those ideas arising from association with institutions pertaining to that art will occupy our attention.

In Heidelberg an operation for enlargement of cervical glands was interesting as regarded the result, as the enlargement was said to be lymphadenoma. In order to remove all glands affected it was found necessary to divide the right mastoid and dissect up beneath the parotid gland, posteriorly beneath the trapezius, and downwards along the great vessels into the thorax. The internal jugular vein was so intimately connected with and incorporated by part of the enlargement that about two inches of it had to be ligatured off and removed. It was found impossible to reach through the thorax, and as the respiration suddenly ceased about this time the operation was stopped, and after performing artificial respiration about ten minutes the breathing was re-established, the wound was closed, the patient removed from the room more dead than alive, while the complimentary remarks concerning the difficult-feat of the operation were numerous, but the autopsy followed in the morning.

*Paper read at the November meeting of the London Medical Association.

In Vienna, which can without doubt lay claim to having the largest hospital in existence, the eager desire to determine the exact pathological condition of every disease is the paramount consideration. The patients are fully utilized for the purpose of demonstration, instruction and education of those interested in whatever conditions exist.

The thoroughness which the individual investigators display in determining each and every condition which will assist in eliminating a possible, or confirming a probable disease is one great practical lesson. Their enormous, unlimited facilities for observing the exact pathological condition of every fatality, the scope of which is limited only to the facial outline, is the great factor in making Vienna so prominent a headquarter in the study of medicine. No wonder the great and renowned Bilroth acquired here a reputation which, as yet, has not been excelled. No clinician is satisfied without a complete thorough report of the autopsy in which he takes as much if not more interest than in the methods employed to assist nature in repelling the attack, and throwing off the effects of the existing diseased condition. The frequency with which the clinicians refer to and make comparisons with cases presenting certain points of similarity which shewed certain definite pathological conditions is a good, reliable indication of the benefit to be derived from observing the conditions of every necropsy. How often they prove a factor in clearing up an otherwise doubtful case is known only to those who have access to these opportunities.

No matter how simple the case may seem before death one cannot help but notice how complex may be the condition at the autopsy. Is it not important, then, that we, as guardians of health, should instruct and educate the public mind to look upon an autopsy as an important factor in the promotion of health and happiness for the people by assisting in our education and instruction?

In Berlin, through the kindness of the first assistant, I was shewn through the various branches of scientific research under the management of him who a few years ago aroused the whole world by his supposed cure of tuberculosis. I mean Koch. Although his discovery to a considerable extent proved a failure, yet it has proven beneficial in opening new fields for investigations in the line of treatment. All must admit the benefit to mankind of Pasteur's treatment of hydrophobia and the usefulness of antitoxine in the treatment of diphtheria,

which indirectly followed the discovery. At present experiments are in progress to determine some method of serum treatment for almost every disease, but so far no very satisfactory results have been attained. In typhoid the results have not been satisfactory. In streptococcus serum some success has been attained in the treatment of septicæmic conditions and sarcomatous growths.

The marked degree of failure as a cure for tuberculosis by Koch's tuberculin has not altogether disheartened its originator, nor has it altogether proven useless. At present it is being utilized to a great extent as an agent in establishing a tuberculous affection in animals. Reference to this will be made a little later. It is still used in early tubercular affections and in leprosy, if not curing, at least tending to aid the healing process and to limit the extension of the diseased process.

In London and Edinburgh one cannot help but notice the enthusiasm shown and the work done in the science of bacteriology. No clinical report is looked upon as complete without its bacteriological examination. Although there may be an exaggerated tendency to attribute every disease to some organism, yet in some diseases the bacteriological examination is of itself sufficient to establish a diagnosis. All must admit that there are cases of malaria, tuberculosis, gonorrhœal affections, diphtheria and tonsillitis, etc., in which it is impossible to state a definite diagnosis, and which can, if their respective micro organisms be found, be proven to exist with absolute certainty. Not only is it important as a means of diagnosis to confirm a possible disease by a bacteriological examination, but as a guide in the line of treatment.

As an instance of its importance attention need only be drawn to two rather common diseases, but differing greatly in their nature and effects, viz.: diphtheria and tonsillitis. It is acknowledged by all who have given special attention and study to these diseases that there are cases of tonsillitis resembling diphtheria and cases of diphtheria resemble tonsillitis so closely that it is impossible to make a diagnosis certain without a bacteriological examination.

The disease most occupying the attention of the medical minds at present is tuberculosis. Not only are the fields of medicine and surgery agitated, but also those of veterinary and sanitary science. Admitting the possibility of heredity transmitting only a predisposition to the disease, no evidence, as yet, being found

that the disease itself is inherited, the question of its acquirement for some time after birth occupied their attention. It was shown that the three situations most liable to infection were the tonsils which affected the cervical glands, the intestines affecting the mesenteric glands and the air passages affecting the bronchial glands. Taking this as a basis, it has been shown that in the great majority of children under five years of age dying of tuberculosis the disease is contracted by intestinal infection, and milk, forming the basis of food for children, was looked to as a probable source of infection.

A royal commission made quite extensive investigations and found that in Wales one half the cows were tubercular, that the milk of two-thirds of the dairymen in Birmingham contained tubercle bacilli, and that calves fed upon the milk contracted the disease even when no abrasions were present, and they drew the conclusion that all cases of tuberculosis in infants, whether pulmonary, intestinal or tonsillar, were due to the milk. In the treatment of the milk itself there is always one agent at hand to destroy its infective property and render it sterile, but this is not all that is required. One must not lose sight of the fact that cream, butter, cheese, and even the meat of the slaughtered animal are just as capable to convey the micro-organism. In this, however, as well as all other diseases, prevention is better than cure. The destruction of all animals affected is a safer and more effective means of combatting its aggressions than any treatment of the affected material. This, of course, necessitates the discovery of the disease in the animal, a process as you may readily comprehend is none too easy. It is claimed, however, that by injecting an affected animal with a certain amount of tuberculin a condition is produced quite characteristic—an injection of thirty to forty grams, causing in twelve to fifteen hours, a rise of temperature from one to three degrees.

In Britain laws are being enacted compelling the slaughter of all animals not standing the test, and providing for compensation for their loss. Besides this they are thoroughly renovating their sanitary conditions, not only as regards the source of milk, but also in the treatment of people afflicted.

If our medical brethren across the water have deemed it wise and found it necessary to agitate such procedures in the interests of humanity, is it not our duty to do likewise? In this country it is doubtful if the disease exists to so great an extent as there, but even here there are hundreds who succumb annually to its fatal ravages, and if anything lies within our power to lessen its power it is certainly our duty to do it.

PLEURISY.*

BY GEORGE HODGE, M.D.

London.

James L., aged about thirty years, married, came to my office on Sabbath, May 19th, 1895, complaining that for the last six weeks he had not felt well, during which time he suffered from a slight hacking cough, loss of appetite, and weakness. His temperature was 101° F., but as my office was uncomfortably cold, I did not strip him for examination. On the following day he called at my office; temperature about the same as on the previous day as were also his other symptoms. I asked him to go home and go to bed and to remain there till I visited and examined him. This I did on the following morning and found evidence of considerable effusion into right pleura. No pain in chest, nor had there been any. Morning temperature 101° F., evening 102° F. Urine normal.

Patient's condition remained much the same till the 29th inst., when I aspirated from right side of chest 60 oz. clear serous fluid. Temperature remained for the most part 101° F. in morning and 102° F. in evening. On June 1st there were signs of effusion in left pleura, followed in a couple of days by a very distinct pericardial rub, which continued for a few days and then disappeared.

On June 4th.—I again removed from the right side, by aspiration, 60 oz. clear fluid.

On June 10th.—I removed from left side 35 oz. of clear fluid. After this the patient was much more comfortable, the temperature became normal in the morning, although it continued to rise a couple of degrees in the evening. Appetite increased. Patient slept much better.

On June 13th.—Removed from right side 60 oz.

June 22nd.—60 oz. from right side. Serum tinged with blood.

*Paper read at the November meeting of the London Medical Association.

July 9th.—Removed 32 oz. of clear serum from left side. After this temperature dropped to normal in the evening. Appetite improved. Patient now gets up and dresses and goes down stairs—feels better in every way.

July 15th.—Removed sixty ounces of blood-stained serum from the right side.

July 29th.—Removed sixty ounces of clear serum from right side. I now applied the following over the right side: \mathcal{R} Guaiacoli \mathfrak{z} ii. tinct. iodi ad. \mathfrak{z} i. m. Urine normal. Patient now suffered from external piles which gave much annoyance and interfered with his sleep and appetite.

August 5th.—Slight swelling of feet and legs which in the course of a few days increased very much, loins were also much swollen. Urine greatly diminished in quantity; sp. gr. 1023, no albumen, no casts. Urine was after this repeatedly examined and never showed albumen or casts.

August 12th.—Removed 80 ozs. blood-colored fluid from right side which in a short time coagulated to a jelly in the vessel. Soon after the aspiration the patient began to cough violently and to expectorate large quantities of frothy serous fluid, which continued till I gave a hypodermic of morphia. Temperature this p.m. 100° and pulse 96.

August 13th.—Did not pass a comfortable night. At 9 a.m. temperature $98\frac{1}{2}^{\circ}$, pulse 104; was coughing, breathless, feet and legs greatly swollen. Gave a seidlitz powder which produced several watery stools. Urine 12 ozs. in 24 hours. Breathlessness worse in p.m., unable to lie down.

August 14th.—Slept fairly well, but was unable to lie down. Temperature $98\frac{1}{2}$, pulse 102. Removed 60 ozs. of clear fluid from left side. Urine increased in quantity; sp. gr. 1032, acid, no albumen, no casts.

August 15th.—Rested well last night, swelling in feet and legs less, passing more urine. Temperature $98\frac{1}{2}$, pulse 112. Gave tinct. digitalis, min. x., every three hours.

August 17th.—Temperature, 9.30 a.m., $99\frac{1}{2}$, pulse 100. Pulse intermits, missed every third beat, coughing a great deal.

August 21st.—Has been quite comfortable since the 17th inst. 9 a.m. temperature 98, pulse 96, regular, breathless. Removed 70 ozs. of straw-colored fluid from right side. \mathcal{R} Pil. triplex, i.e., hydrarg. mass. 1 gr., aloes 2 gr., podophyllum resin $\frac{1}{4}$.

August 23rd.—Removed 45 oz. clear fluid from left side. Legs and face swollen; bowels loose.

September 2nd.—General œdema. Temperature, 98½. Removed 50 oz. of clear fluid from right side.

September 11th.—Urine still very scanty; patient has persevered with pil. triplex, notwithstanding that it produces a great many watery stools daily; œdema very considerable. Fluid in peritoneum. Removed 65 oz. of yellowish fluid from right side of chest.

September 21st.—Patient has continued much the same. Temperature usually normal, never elevated more than 1° F. Urine still scanty; very frequent watery stools; appetite good; sleeps well; not much cough. Removed 70 oz. clear fluid from right side. œdema not so marked. Peritoneal fluid increased.

September 26th.—Feels much better, appetite good. Urine still very scanty. Large amount of fluid in peritoneal cavity. Anasarca less. Removed 45 oz. from left side.

October 7th.—Has improved very much, anasarca much less, so also is fluid in peritoneal cavity. Urine increased in quantity; sleeps well, eats well, very little cough. Removed 60 oz. of fluid from right side.

October 19th.—Patient much improved, œdema quite gone, still considerable fluid in peritoneal cavity. Removed 60 oz. from right side.

October 31st.—Much improved. Removed 20 oz. from left side.

November 13th.—Much improved. Removed 12 oz. from right side; evidently more fluid present, but aspirator would not remove it. Still considerable fluid in peritoneal cavity.

January 4th, 1895.—Patient steadily improved, till about one week ago, when he had an attack of indigestion. Urine more scanty, no albumin, rather breathless. Aspirated 10 oz. of deep colored fluid from the left side; still fluid in peritoneum. No swelling of feet or legs.

Patient now continued to improve steadily till early in June; he could walk four or five miles without fatigue. All swelling was completely gone, no evidence of any fluid in peritoneum, some dullness over the lower lobes of lungs on both sides, however the breath sounds could be heard over every part of both lungs. Patient now left for the West and I learn from his friends that his health has been unusually good during the last two years.

I aspirated this patient's chest 21 times, 14 times the right side and 7 times the left, removing altogether 1054 ounces, or over 25 quarts.

That the pleuritic effusion was inflammatory in origin, I have no doubt. A question at the time was, "Is the inflammation tubercular in origin?" I had a bacteriological examination of the effusion made, but with negative results.

Unfortunately the injection of the pleural effusion into the peritoneal cavity of a guinea-pig was not carried out.

What is the pathogenesis of the anasarca and ascites? There was neither cardiac nor renal disease.

Dr. Gee in his article on pleurisy in Allbutt's System of Medicine says: "Dropsy, that is to say, anasarca and ascites, sometimes occurs even in acute pleurisy with effusion on one side only, there being no evidence of nephritis or of disease of the heart, and the patient recovering completely in about three months. In such cases the dropsy must be due to stagnation of blood in the right side of the heart."

If as stated by Gee acute pleurisy on one side may cause dropsy, how much more would a chronic pleurisy of both sides be likely to do so, inasmuch as the long continued interference with the circulation would bring about such changes in the capillaries as would lead to their greater permeability and thus we would have not only diminished absorption but also increased transudation of lymph.

Clinical Notes.

CEREBRAL TUMOR IN THE LEFT FRONTAL LOBE.

A CLINICAL OBSERVATION BY DR. GIOVANNI VIVIANI, OF THE HOSPITAL OF CREMA.

Clinical history. Pandani Stefano, 48 years of age, a farmer of Moscazzano. Nothing worthy of note in the family history. Has never had any serious diseases; has never had syphilis; has used wine somewhat excessively. Married at twenty-nine, he has had four children, one of whom was an idiot. Of robust constitution, he has always been industrious, of a frank, jovial disposition. About May 1st, 1897, without apparent cause, he became gloomy and taciturn, complaining at the same time of continuous intense headache, which resisted every remedy. He began to forget the most common things of life and had to stop his work, both on account of the headache and his forgetfulness. Meanwhile the headache became more intense and the patient acquired a kind of reeling in his walk. By the 1st of June the disease had reached the climax of its ascending phase. At this time the patient is markedly emaciated. In his gait there is a wavering, with a tendency to fall in various directions; he does not, however, present Romberg's sign. There is no contraction, paralysis or paresis in the limbs or face. The face is slightly congested, the gaze uncertain; pupils contracted, only slightly sensitive to light and accommodation, but equal. The speech is free and well articulated. All the other senses are normal. Reflexes slightly weakened. Also a slight diminution of the sensibility to pain and touch. General muscular tone somewhat weak. No change in the respiratory or cardiac organs, none in the abdominal organs. Urine abundant, normal in color, density and components; no trace of albumen or sugar.

Asked about his previous history, the cause of his trouble,

the time when it began, or about his present condition, he either does not answer, or answers in monosyllables, confusing dates and persons, things and places. The blanks in his memory are such that he does not remember his age or the time of his birth, or the chief events of his life. He often strangely confuses the recollections of the past with the happenings of the present. There is present a true confusion of ideas. He takes no notice of the children whom he used to be so fond of. He has insomnia. Left to himself, he asks for neither food nor drink. When food is offered to him, he eats, but like an automaton, as if his mind were upon other things. At times he has varying hallucinations; and at pretty long intervals he manifests a tranquil, but chaotic, delirium; at times I perceived slight and disconnected tremors, giving to the arms rapid and quick movements, which would vanish, without any particular attention.

Continuing in this condition, the patient came on the 3rd of June to the Asylum of Crema, where, through the great kindness of the Superintendent, Dr. Ernesto Dergami (to whom I am deeply thankful), I was enabled to follow the progress of the obscure affection. The symptoms remained almost unchanged, only twice there was added vomiting, spontaneous, not attributable to gastric disorders. But on the 14th day of the same month, at 9 p.m., the patient had a stroke of apoplexy, with general paralysis of the limbs and face, followed by very high temperature and profound coma, with complete unconsciousness, during which death took place at 11.30 of the 15th.

It seemed to me not easy to make an exact diagnosis of the above case. If on the one hand the psychical disturbances pointed to a mental affection, on the other hand, the peculiarities of gait, the headache, the slight tremors, pointed rather to an organic cerebral affection, upon which would depend the marked psychical, as well as the other, symptoms. Having granted that, the reasons are obvious for which it seemed nearer the truth to think either of a cerebral abscess or tumor. The intense and persistent headache, as a phenomenon of augmented intra-cranial pressure, was as much an argument for abscess as for a neoplasm. The psychical disorders, the reeling, the tremors, would likewise appear in both. But if, in favor of abscess, there was the rapid rise and fall of the disease, nothing in his history was obtainable to show how it had been produced, no injury to the head, no foci of suppuration, no otitis, no

ocular or nasal affections. Hence it was to cerebral neoplasm that the mind turned, although, on account of the patient's condition, it was not possible to examine the fundus of the eye.

The problem became still more intricate when a search was made for the seat of the trouble. The only guide was the tottering gait. This suggested a lesion of the cerebellum or of the corpora quadrigemina. But, against a lesion of the corpora quadrigemina, there was the want of paresis or paralysis of the ocular muscles, which, according to Nothnagel, generally accompanies the reeling gait in such a lesion. Against the cerebellar seat there was both the want of a true vertigo and the very character of the reeling, which was not the true cerebellar ataxia; also the want of amblyopia or amaurosis, so frequent according to Luys. On the other hand, amid the opinions of neurologists, not entirely unanimous, I could not decide to fix the seat of the disease by the psychical facts alone. In the midst of my doubts the sudden death of the patient took place, and the autopsy enabled me to solve the problem.

Autopsy.—We shall note only the most prominent points. A normal cranium. Dura mater slightly hyperæmic as is also the pia; both of normal thickness. No change in the apparent origin or in the early part of the course of the cranial nerves. A large hæmorrhagic softening in the internal portion of the two cerebral peduncles and the upper portion of the pons. On a closer examination of the upper surface of the frontal lobe on the left side, the convolutions are seen to be slightly flattened. There is, however, no inflammatory process which could make the pia adhere to the brain substance. No ventricular dropsy, no atheroma of the cerebral arteries. Systematic incisions being made into the cerebral substance, the white and grey portions are seen to be somewhat hyperæmic and œdematous. The white matter of the frontal lobe on the left side is occupied by a hard body, of a reddish-yellow color, easily enucleated. When enucleated it appears as an ovoidal tumor, 3 cm. in the longer diameter and 2 cm. in the shorter, occupying the central portion of the præ-frontal lobes in such a manner, however, that its posterior pole does not pass beyond the third frontal convolution. It is slightly adherent to the nerve-tissue round about. The tumor on examination is found to be of almost fibrous consistency, externally of a reddish-yellow color, furrowed by numerous reddish streaks, internally of a yellowish hue, with small blood extravasations. The microscope shows it to be a fibro-glioma.

The psychical symptoms in the patient were certainly due to the presence of the neoplasm in the brain. If we should say then that they were due to the changes in the white and grey matters of the præ-frontal lobe, and not rather to the altered circulation and the increased pressure, we should pre-suppose as solved the problem of the localization of the higher psychical functions—a problem so much discussed and around which great minds are struggling, without being perfectly in accord. From Munck, who avers that the intelligence has its seat diffused over the whole cerebral surface and in no particular region, we come to Pitres, who, in the Congress of Medicine at Nancy in 1896, did not show himself at all favorable to the idea of an exact localization of the intelligence. From Ferrier, who states that the faculty of intelligent and exact observation is situated in the frontal lobes, we come to Bianchi, who, studying the problem for years, maintains that the præ-frontal lobes are the seat of the intelligence.

If we can admit with most of the authorities that psychical symptoms are often served in tumors of the other parts of the brain, we must, however, also admit that they have not great intensity, and appear almost always late when the tumor has already produced other symptoms which prevail throughout the course of the trouble, while in the cases of tumors occupying the frontal lobes, and especially the præ-frontal, such symptoms (psychical) are early and notable, and are prominent throughout the whole duration of the affection.—*Translated from "La Clinica Medica Italiana" by Harley Smith.*

(To be Continued.)

Progress of Medicine.

OBSTETRICS

IN CHARGE OF

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H. T. MACHELL, M.D.,

Surgeon St. John's Hospital and Physician to Victoria Hospital for Sick Children.

L. D., aged twenty-eight, 2-para. Admitted 7th February, 1897. Patient suffering from tertiary syphilis, ulcers on both legs, with extensive sloughing ulceration of labia majora. Scrupulous cleanliness was observed, as far as possible, previous to delivery. No vaginal examinations were made. Delivered next day. Eighteen hours in labor, child still-born; third stage 35 minutes, placenta and membranes came away entire. The vulva was dusted with iodoform. On the morning of the second day her temperature rose to 101° F. The lochia was slightly foetid, a vaginal douche was given, but the evening temperature was 102.6° F.; the uterus was douched, but nothing abnormal was noticed. R. Quin. Sulph. gr. v., every fourth hour. After this the temperature fell for three days. On the sixth morning the temperature rose to 103° F., and pulse to 115, and in the evening to 105° F., pulse 120. The uterus was curetted with Rheinstadter's spoon, but very little came away; the lower part of the vagina was of a greyish color, covered with a large puerperal ulcer, which was dusted with iodoform. The temperature dropped two degrees for 48 hours, but then rose and fluctuated between 103° F. and 105° F.; the pulse varied from 115 to 146, until the time of her death.

All through the lochia was scanty, except when the uterus was douched, which was done daily. Patient was on from $\bar{\text{v}}\text{vii}$.j. to $\bar{\text{v}}\text{xx}$. whiskey daily, but it had little or no effect on the pulse-rate. She became exhausted and died on the 13th day.

Post-mortem examination showed the uterus slightly enlarged,

and covered by a grey, sloughing membrane, which extended into the vagina. Other organs healthy.

From the *post-mortem* examination of this case we think that, in addition to curetting and douching, it might have been beneficial had the uterus been plugged with iodoform gauze, as recommended by Duhrssen.—*Rotunda Hospital Clinical Reports, 1898.*

EFFECT OF AN ABDOMINAL BLOW.

A diagnosis of rupture of some viscus may be said to be sufficiently certain to justify immediate exploratory incision when a train of symptoms such as the following is presented: excessive amount of shock; extreme depression and weak pulse; nausea, growing considerably worse and leading to vomiting; deep-seated pain in the intestines that is never absent, but shows violent paroxysms of increased intensity; abdominal distension rapidly becoming tympanitic, and a temperature but little above normal, or even at first below it.

J. Whitridge Williams, Associate Professor of Obstetrics, Johns Hopkins University, in an elaborate paper, "The bacteria of the vagina and their practical significance, based upon the bacteriological examination of the vaginal secretion of ninety-two pregnant women," arrives at the following conclusions:

(1) That the vaginal secretion of pregnant women does not contain the usual pyogenic cocci, having found the staphylococcus epidermidis albus only twice in ninety-two cases, but never the streptococcus pyogenes or the staphylococcus aureus or albus.

(2) The discrepancy in the results of the various investigators is due to the technique by which the secretion is obtained.

(3) As the vagina does not contain pyogenic cocci, autoinfection with them is impossible; and when they are found in the puerperal uterus they have been introduced from without.

(4) The gonococcus is occasionally found in the vaginal secretion, and during the puerperium may extend from the cervix into the uterus and tubes.

(5) It is possible, but not yet demonstrated, in very rare instances, that the vagina may contain bacteria, which may give rise to sapremia and putrefactive endometritis by autoinfection.

(6) Death from puerperal infection is always due to infection from without, and is usually due to neglect of aseptic precautions on the part of the physician and nurse.

(7) Puerperal infection is to be avoided by limiting vaginal examinations as much as possible and cultivating external palpitation when vaginal examinations are to be made. The external genitalia should be carefully cleansed and disinfected and the hands rendered as aseptic as if for a laparotomy. Vaginal douches are not necessary and are probably harmful.—*Am. Jour. Obs., Oct., 1898.*

At Edinburgh, Dr. A. Martin (Berlin) commented on the tendency to neglect the teaching and practice of midwifery in favor of gynæcology.

CLAMP AND LIGATURE IN VAGINAL HYSTERECTOMY.

I believe that a judicious combination of clamp and ligature will ultimately become the usual method adopted.

F. J. McCANN,
Samaritan Hospital.

ABORTIONS.

There were sixty-two cases of abortion admitted during the year. Some of these required no special treatment; only those in which the hæmorrhage was severe, or in which any part of the ovum was still retained, were interfered with. In all these cases the treatment adopted was the emptying of the uterus—if possible by expression of the contents. This failing, and the os being sufficiently dilated, the ovum was removed by the finger, or, if the latter condition was not fulfilled, by Rheinstadter's curette.

In one case the cervix was cicatricial owing to a previously performed Schroder's amputation, and as a result there was stenosis of the external os; it was dilated with Hegar's dilators, and a four months' foetus extracted by means of Schultze's spoon-forceps. The patient's temperature rose on the evening of the sixth day to 104.6°, and after a uterine douche fell to normal, and remained so.

In another case the patient was admitted with hæmorrhage, which had been constant for two months previously. The uterus was up to the umbilicus, and she stated that she was three and a half months pregnant; no foetal parts could be felt. The os was dilated by means of laminaria tents, a large quantity of clots escaped, and the patient coming into labor was delivered of a four months' foetus. Convalescence normal.

In another case the patient was admitted in the fourth month of pregnancy, with a foetid discharge. The membranes were ruptured,

and the foetus could be felt lying partially in the dilated cervical canal. As the os externum was only the size of a threepenny piece it was divided bilaterally, and the foetus extracted by Schultze's spoon-forceps. Free hæmorrhage followed its removal; the uterus was curetted and plugged with iodoform gauze. Convalescence normal.

In another case the remains of an incomplete abortion were removed from one horn of a bicornuate uterus.

PSYCHIATRY AND NEUROLOGY

IN CHARGE OF

R. W. BRUCE SMITH M.D.,

Resident Physician at Orchard House, Asylum for Insane,
HAMILTON.

THE SYPHILITIC ETIOLOGY OF LOCOMOTOR ATAXIA.

Dr. Harrison Mettler, Chicago, in the *Alienist and Neurologist* demonstrates the untenability of the view that all cases of locomotor ataxia are the result of syphilitic infection. Marie, of Paris, goes too far, he thinks, when declaring that tabes is nothing more or less than a sequel of syphilis. It is admitted, and it is easily demonstrated, that spinal syphilis and locomotor ataxia are widely different affections. Even the ataxia of spinal syphilis differs from the ataxia of tabes. All the other symptoms are sufficiently unlike in the two affections to indicate clinically their pathological differences. This being so obviously the case, the advocates of the syphilitic etiology of tabes have had to fall back upon the statement that the degenerative process of the disease is merely the result, more or less remote, of the action of the specific virus upon the delicate nerve structures. They say the toxæmia of the syphilitic diathesis somehow affects the histological elements of the nervous apparatus, especially the sensory apparatus, so that their nutrition is impaired and they undergo degeneration.

This explanation of the post-syphilitic nature of tabes proves, the writer asserts, too much, for the advocates of this view must demonstrate that the syphilitic toxæmia is the only blood dyscrasia that can cause the degenerative process observed in tabes. Does syphilis set up any other degenerative process beside that of locomotor ataxia, and if so, why does it not do it as often as the advocates of its etiologic importance declare it does in locomotor ataxia? Why does it select the sensory apparatus, as it seems to do in this disease? If the syphilitic poison is always the cause of locomotor ataxia, wherein does it differ so much

from other severe toxæmias, such as ergotism for instance, that it and not any other form of blood poisoning should produce the degeneration of locomotor ataxia? Or, on the other hand, what is it in the nervous elements that should induce them to yield always to the syphilitic and not to any other form of toxæmia? These are some of the questions that the advocates of the syphilitic etiology have left unanswered. They tell us that the degeneration of the nerveelements is produced by the specifically poisoned blood; some of them declare that this poisoned state of the blood operates by lowering the nutrition of the nervous structures; but none of them so far have informed us how the syphilitic toxæmia *alone* is capable of doing all this. To uphold syphilis as the *sole* etiologic factor of tabes, they must demonstrate that the syphilitic is the only virus that can directly light up a degeneration of the nervous elements or indirectly affect their nutrition so as to bring about their ultimate degeneration. Until they can do this positively and clearly, and in view of the fact that statistics from reliable sources show that locomotor ataxia is due to specific infection in from five per cent. to ninety-five per cent. of cases, I do not think we are yet justified in stigmatizing a tabetic patient who may be dealing honestly with us in denying infection, with the charge of having so foul a disease whether acquired knowingly or unknowingly. The *syphilitic* origin of *all* cases of locomotor ataxia has not yet been sufficiently established to warrant us in making so dogmatic an assertion.

The newer histology of the nervous system and the newer pathology of tabes dorsalis seem to Mettler to upset the theory, on *a priori* grounds of the syphilitic origin of *all* cases of the disease. A knowledge of the sensory neuron, its anatomy and its physiology, is essential to the conception of the pathology of tabes. This particular form of neuron consists of a central body with two long processes extending out from the body in opposite directions and terminating in brush like arborizations in the skin and posterior columns of the cord respectively. The body of the neuron situated in the posterior spinal ganglion is supposed to subserve somehow a nutritive purpose to the neuron, and, in view of the fact that the newer pathology makes of locomotor ataxia essentially a disease of mal-nutrition, a confirmation is thus afforded of the theory of Marie, Deferine, Obersteiner, Redlich and others who long ago located the primary source of the disease in the posterior ganglia. The nutrition of the

neuron being thus affected, it naturally follows that its delicate, distal extremities, the cutaneous and medullary arborizations, should reveal the strain first and undergo degeneration. This explains the peripheral character of many of the symptoms of tabes such as the ataxic gait, the anæsthesia, the pains, on the one hand, and the central character of many other symptoms, such as the ptosis, cranial nerve disturbances, myosis, optic atrophy, etc., on the other. The crises are probably peripheral manifestations, though they may be of a central origin through implication of the medullary nuclei.

This peripheral character of the pathology of locomotor ataxia—peripheral in relation to the central neuron body—is receiving stronger recognition day by day. The degeneration travels along the neuraxons and is centripetal in relation to the neuron bodies. Its simultaneous appearance in the peripheral arborizations of the sensory neurons gives to the disease its hitherto unexplained peculiarity of manifesting simultaneously cutaneous and cordal pathological changes. The old idea of an upward degeneration in the cord must be abandoned, and the more or less simultaneous degeneration of mal-nutrition in the neuron terminals of skin and cord be accepted.

Though this nutritional disturbance is probably dependent upon some disturbance of function in the neuron body, located in the posterior spinal ganglion, it is primarily due to one of three factors, viz., (a) toxæmia (including syphilis); (b) exhaustion (overwork); and (c) traumatism (including such factors as cold, damp, etc.). To these causes must be added also heredity, for the neuron body must have inherited a normal structure ere it could have performed its functions normally. Freidreich's disease is thus accounted for, as well as its close relationship to ordinary locomotor ataxia.

The whole question presents itself somewhat thus: Given a normal nervous system in a healthy individual without hereditary taint. In such an individual a progressive degenerative process may be started up (1) by direct injury (traumatism) including such factors as cold, damp, etc., (2) by overwork of the nervous elements (exhaustion) and (3) by certain blood states (toxæmia) including syphilitic and other forms of infection such as alcoholism, ergotism, etc. Of the toxæmic and in fact of all the three sets of causes enumerated, the syphilitic is without doubt the most common; because probably under these circumstances the highest degree of blood poisoning,

acting for a long period of time, is brought in relation with the sensory, the most delicate and highly organized part of the nervous apparatus. In other words the muscular sense being the last acquisition in the evolution of the sensory functions of the race and therefore the first that would be liable to succumb to any unusual strain, the power of resistance is probably less in the sensory neurons than in the other neurons, to the prolonged action of the syphilitic virus. On the other hand there is probably a higher degree of virulence in the syphilitic virus towards the nervous elements than there is in most of the other varieties of toxæmias. That some syphilitics do not acquire tabes is explained on the ground that either the virus in their case is not sufficiently active, or if it be sufficiently active the inherited vitality of the nervous elements is so vigorous as to be able to resist the action of the syphilitic poison.

The above explanation, Dr. Mettler thinks, is the true one of the so-called selective action of the syphilitic and other poisons in locomotor ataxia. Upon no other ground can he understand how in this disease the nerve terminals within the muscle-spindles are always found to be degenerated, while the intervening nerve trunk lying between the muscle-spindle and its corresponding posterior ganglion remains normal. These muscle-spindles which Sherrington, Battin, Ruffini, and others have proved to be of a sensorial character, to be closely related to the posterior ganglia and to be probably subservient in some way to the very elaborate and highly specialized function of the muscular sense and sense of position, and which are always degenerated in locomotor ataxia, but not in any other disease with the same regularity, are in all likelihood the most delicate and most readily injured part of the entire nervous system. Upon these delicate structures the syphilitic and occasionally other toxæmias act harmfully; they yield and undergo degeneration, and so seem as though they were *selected* by the poison. The selective action is not in the poison but in the lessened power of resistance on the part of the sensory elements.

But do toxæmic conditions, other than syphilis, start the degenerative processes of locomotor ataxia? They certainly may do so, if the above explanation of the pathology of the disease be correct, and if the toxæmia be sufficiently virulent, and the sensory neurons sufficiently debilitated by heredity or other cause. Not only *may* they do so, but, in the writer's opinion, they most certainly *do* sometimes do so. And here is where we

are to classify those cases which, in the absence of a syphilitic history, can only be attributed to such manifest, general cachexias as malaria, rheumatism, alcoholism, ergotism, arsenic-ism, etc.—especially when these are conjoined with such exciting causes as cold, damp, muscular exertion, etc.

To summarize: Those who believe that syphilis is *always* the cause of locomotor ataxia depend largely upon hospital statistics, but hospital cases would, for obvious reasons, give a large percentage of syphilitic cases.

Those who believe that syphilis is *always* the cause of locomotor ataxia must, in order to maintain their thesis, present a large number of consecutive cases in which syphilis has been positively established. The simple fact that percentages of syphilitic locomotor ataxia vary amongst authorities from five to ninety-five shows that there is no uniform method of tabulation among them, or that their observations must have been made upon very different classes of patients.

Those who believe that syphilis is *always* the cause of locomotor ataxia must prove the reason for and nature of the so-called selective action of the syphilitic virus on the sensory apparatus. They must show why it does not affect in a similar way the other parts of the nervous system. If, in their explanation, they fall back upon the extreme virulence of the syphilitic toxin and the readier susceptibility of the sensory system, they must show why any other extremely virulent toxæmia may not similarly affect a vitiated nervous system, and set up in the sensory apparatus the same sort of degeneration that syphilis does in tabes. In a word they must deny, and at the same time show cause for their denial, that any form of toxæmia other than the syphilitic *can* accomplish what they so dogmatically declare the syphilitic toxæmia accomplishes in *all* cases of locomotor ataxia. When a man with locomotor ataxia, for instance, denies having had syphilis, but gives a clear history of chronic alcoholism with exposure to damp and cold, they must not only prove absolutely the presence of the syphilitic taint, but they must or should demonstrate, upon some histological or chemical basis in connection with the so-called selective action of the virus, why they prefer to believe in the denied syphilitic etiology rather than in the confessed alcoholic etiology. More than this, they must prove the presence of syphilis and its selective action in a reasonably large number of consecutive cases.

Until they do this they are not justified in attributing *all* cases of locomotor ataxia to specific infection. Nay, more, in view of the newer pathology of locomotor ataxia, we may safely say that *not all* cases of locomotor ataxia are due to syphilis.

A Case of Cerebral Ataxia, affecting chiefly the right upper extremity with marked involvement of the Stenognostic Sense.—Dr. Ingersoll Olmsted, Hamilton, Ont., reports a highly interesting case in November *Journal of Nervous and Mental Disease*, N.Y. The patient, a clerk, aged twenty-seven years, had previously history free from disease. He is a well-developed man of medium size and intelligent, but slightly nervous. Parents had been both troubled with rheumatism during life. One ancestor said to have been insane. One brother died at thirteen from paralysis, following measles. One sister living, aged thirty-three, is very nervous. Patient denies ever having had syphilis. Three years ago, while riding a bicycle, he had a collision with another rider going an opposite direction, was thrown from his wheel, partly stunned, and received a contusion of one eye, but does not remember which one. He was sore for a few days, but felt no effect from his accident. Has used alcohol very moderately, but tobacco in excess at times. Since July 15th he has felt numbness in right thumb and fingers. Sensation in right side of face, described as a flash, and says it is a prickly, warmish feeling, beginning at the upper lip and extending to eye and ear. It passes off in a few seconds to return in four or five minutes. While his attention is drawn to it, he thinks, this sensation comes more frequently. Has never felt anything similar in right leg. Has been treated by Dr. Osborne for diplopia, which disappeared, but returned again the day before the prickling sensation was noticed in face. Owing to numbness in fingers found difficulty in writing. Skin is normal and no evidence of syphilitic lesion to be found. No tenderness over the nerves of the face or of the extremities; no affection of hearing. Tongue is protruded in median line. No affection of taste. Examination of heart, lungs, abdominal organs and cranium is negative. Urine contains neither albumen nor sugar. Eye movements in all directions are good except slight lateral nystagmus on either side. Pupils are equal and respond normally to light and accommodation. The facial and masticatory muscles act normally, jaw jerk present. Touch, pain, heat and cold sensation are normal on both sides of face. The muscles of upper and lower extremities had free movement. In

upper extremity the sensations of touch, pain, heat and cold were unimpaired except to very slight degree in thumb, index, and middle fingers of the right hand. The scapular, epigastric, abdominal and cremasteric reflexes are markedly exaggerated on the right side. There also appeared some hyperæsthesia of the right face, arm, and trunk. Knee jerk on left side was present, but on right side was very much diminished and could only be produced very slightly with motor reinforcement. No Romberg symptom, gait and sensation in both legs normal. The patient gradually grew worse; hand and arm felt much stiffer. The numbness affected the whole hand. Says his right leg tires much more quickly than the left. Electric examination showed ready response of all the muscles to faradic current. The condition of his eyes varied; at times there was diplopia, but at others none. The flash or paræsthesia of right side of face became more marked and extended down the right side of neck to right shoulder and arm. There was well-marked ataxia of right arm and hand. When he brings his index fingers together there is difficulty in getting them to touch. When asked to touch his nose with his right forefinger he made the attempt with a certain stiffness and uncertainty, and usually touched the face at a point some distance to the right of the nose; with the fingers of his left hand, however, he was able to execute that movement with precision. When asked to write he took the pen very awkwardly, and had to use the left hand to fix it properly between the fingers of his right hand. The writing was done with slow irregular movements. The letters were tremulously and irregularly formed and quite unlike his former handwriting. The movements of the right shoulder, arm and hand are all carried out with much less dexterity than those of the left.

Sensation to touch, heat and cold is perfect on both sides of the body, while that of pain is dulled in right arm and right side of trunk. The face, neck and leg on the right side are as sensitive to pain as on the opposite side. The most interesting feature of the case is the fact that the stereognostic sense is very much disturbed in the right hand. He cannot recognize a key, piece of money or pen when placed in his right hand, although they were recognized at once when placed in the left. He cannot button on or unbutton his clothes with the right hand. The farado-cutaneous sensibility was already diminished in the right arm, hand, and on the right side of trunk.

He remained (Aug. 17th) in much the same condition except that the stereognostic sense was even more involved—almost completely lost in the right hand. This loss, not associated with actual paralysis, but with a pronounced ataxia, manifested by an inability to carry out accurately finer movements, such as those concerned in writing, buttoning and the like. Disturbance of the stereognostic sense, by no means uncommon in cases of hemiplegia, is an extremely rare occurrence in the manner here reported. As a matter of fact, says the writer, there has thus far been no case to my knowledge reported in which a symptom-complex identical with that of the patient herein described, and with a similar mode of onset (absence of recent trauma), has been observed. Dr. Olmsted reserves his judgment as to the exact localization of the lesion and the exact nature of the disease.

The only cases resembling this one are those reported by Wernicke, VonMonakow, and Burr. Each of those, however, had a history of trauma.

SUICIDE AND SEX.—Dr. Alexander Haig (*British Medical Journal*) treats of "Suicide as a result of error of diet." He believes that mental depression and melancholia are due to defective circulation in the brain, and that this is due to the blood being rendered impure by the presence of uric acid, and that this uric acidæmia, or collæmia, is the result of error in diet, and can be controlled or removed by altering it. He says the great preponderance of suicides in males may be due to several factors: (1) Men are more exposed to weather than women, and exposure may be equivalent to living in a colder climate. (2) Men eat more meat than women. (3) Women excrete large quantities of uric acid every month or just after the menstrual period, so that other things being equal they will have less retention and accumulation than men; this monthly plus excretion accounts for the fact that when they do commit suicide it is often just before the monthly period. Again, women suffer much less than men from gout on the one hand and stone and gravel on the other. The uric acid, stored or retained in the rapid nutrition of girls about thirteen or fourteen years, which comes to an end about sixteen or seventeen years, passes through the blood about and after these latter ages and accounts for the blood and circulation changes which may end in chlorosis, headaches, depression, epilepsy, or suicide. The opposite side of this picture is the rapid nutrition and retention of

uric acid at thirteen years, with the acute rheumatism it produces; in such girls we often get a complete alternation of rheumatism and anæmia, with headache, epilepsy, depression and suicide as more occasional co-results.

Das Echo, in an article drawing attention to the statistics of German schools for the ten years from 1887 to 1896, shows that 407 school children committed suicide. All these cases occurred in State schools; 331 were boys and 76 were girls, each under 15 years of age. Whether or not Germany is more productive than other nations of this horrible modern symptom of child-suicide, it certainly, as *Das Echo* remarks, may be regarded as one of the saddest and most startling of the phenomena of modern social life.

Editorials.

ONTARIO MEDICAL LIBRARY.

THE following incomplete list will give the profession some idea of the works to be found in the Library :

Weekly journals regularly received : British and Foreign—*La Semaine Medicale*, *Deutsche Med. Wochenschrift*, *British Medical Journal*, *Lancet*. United States—*Medical Record*, N.Y., *Medical News*, N.Y., *New York Medical Journal*, *Boston Medical and Surgical Journal*.

Monthly and semi-monthly : British—*Edinburgh Medical Journal*. United States—*American Journal Obstetrics*, *Archives of Pediatrics*, *American Journal Medical Sciences*, *Alienist and Neurologist*, *American Journal Insanity*, *American Journal Physiology*, *Annals of Surgery*, *Charlotte Medical and Surgical Journal*, *Northwestern Lancet*, *Index Medicus*.

Besides fairly complete files of : *Birmingham Medical Review*, *Glasgow Medical Journal*, *International Magazine*, *International Journal of Surgery*, *Brooklyn Medical Journal* and others.

Reports and Transactions such as : *Johns Hopkins Bulletins and Reports*, *Trans-Ass'n American Physicians*, *Trans-Am. Orthopædic Association*, *Trans-Obstetrical Society*, *Edinburgh*, *Guy's Hospital Reports*, *Trans-London Pathological Society*.

Reference Hand-books as : *Sajous' Medical Annual*, *Medical Annual*, *International Clinics*, etc.

Systems of Medicine and Surgery like *Treves*, *Wyeth*, *Gross*, *Holmes*, *Erichsen*, *Ashurst*, *Pepper*, *Fagge*, *Loomis-Thompson*, *Albutt*, *Osler* and *Twentieth Century Practice of Medicine*.

Up-to-date Editions of Works on Special Subjects, as : *Kelly's Operative Gynæcology*, *Hermann's Diseases of Women*, *Albutt & Playfair's Gynæcology*, *Pozzi's Gynæcology*, *Holt's Diseases of Children*, *Rotch's Pediatrics*, *Bosworth on Nose*

and Throat, Thompson's Dietetics, Foster's Therapeutics, Phelps on Traumatic Injuries to the Brain, Fowler & Godlee on Diseases of the Lungs, Maylard's Surgery of Alimentary Canal, Lawson Tait's Perineal Operations, Greig-Smith's Abdominal Surgery, Jacobson's Surgical Operations, Allingham on Diseases of the Rectum, Deaver on Appendicitis, Hawkins on Diseases of Vermiform Appendix, Osler on Angina Pectoris, Osler on Diagnosis of Abdominal Tumors, Naunyn on Cholelithiasis, Zeigler on Pathological Anatomy, Thoma on General Pathology, Balfour on Senile Heart, and Keating on Diseases of Children.

MEDICAL COUNCIL ELECTIONS.

A GOOD deal of interest was taken in the election in Division 8; and much to the surprise of many, Dr. Armour was defeated by a small majority from one to three, by Dr. Glasgow, of Welland. Dr. Armour is a man of ability and prominence, and his friends will seriously regret his absence from the annual council meetings. Dr. McCrimmon, of Palermo, and Dr. Stuart, of Milton, were both good men. We believe the contest between them largely turned on local issues. As intimated in our last issue, these were the only contests for territorial representation. In addition to Drs. Glasgow and Stuart there will be four new territorial representatives: Dr. J. A. Robertson, of Stratford; Dr. A. A. Macdonald, of Toronto; Dr. Lane, of Mallorytown, and Dr. Powell, of Ottawa. We often had occasion to differ from Dr. Rogers; but we desire to say now, that, by the retirement of this gentleman, the Council has lost one of its most able and independent members. At the same time we feel certain that his successor, Dr. Powell, will prove a most worthy representative of the Ottawa district. The contest between Dr. Britton, of Toronto, and Dr. Ville, of St. Catharines, for the position of representative of the Senate of the University of Toronto caused a ripple of excitement. The former, on account of his unimpeachable record as a representative of eight years' standing, was elected by a good majority. Under other circumstances, Dr. Ville would have made a better showing, as it is generally recognized that he is not only a distinguished graduate of the University in two departments—Arts and Medicine—but also a man of marked ability and influence in the Niagara peninsula. There is also

a certain feeling abroad, which is strong enough to make it worthy of recognition by the authorities of the University, that graduates living outside of Toronto should have a larger voice in the governance of that institution than they have at present.

ST. JOHN'S AMBULANCE ASSOCIATION.

THE members of the Toronto Centre of this association held their third annual meeting November 16th, 1898. Mr. John T. Small, the President, in his opening address, gave a brief history of the parent organization, which was originally established in Palestine, and did excellent work in the middle centuries. In 1888 a royal charter was granted to the association, and the Prince of Wales became the Grand Prior of the order. Although in Canada the association had not a historical reputation, there was much good work which it could do. The objects of the association were to instruct in rendering first aid in cases of accident or sudden illness, transporting the sick and injured, and teach elementary principles of nursing and sanitation.

The report of the Treasurer, Mrs. G. S. Ryerson, was submitted by Dr. Ryerson, who spoke of the progress made by the association in Toronto, which far exceeded the most sanguine expectations of those who promoted it. Thousands of textbooks had been sold, and the number of pupils who have attended the lectures was very large. The association is in a good financial position, with a cash balance on hand of \$140. Canada is not foremost in the work of disseminating knowledge, especially on "first aid to the injured," Australia and New Zealand being far ahead. In South Africa, also, the association had made great progress, and the reason was, perhaps, not far to seek. The many wars and the frequency with which large bodies of the residents of these countries found themselves shut up in laagers, surrounded by hordes of Matabele and other savage warriors, had demonstrated the practical advantages of the work of the association. In Great Britain a large number of centres of the association are working, and in the colliery districts the beneficial results of the operations of the association had been experienced, and the County and City Councils made generous grants in aid of the work. In Toronto the police force had received a systematic instruction in the work, and Dr. Ryerson strongly urged that it should be made compulsory upon members of the city fire

brigade to attend the lectures given under the auspices of the association. Dr. Ryerson mentioned the interesting fact that the plot of land in Jerusalem recently presented to the Emperor of Germany, Prior of the German Order of St. John, is the identical location upon which the original Knights of St. John erected their first "hospice."

The Hon. Secretary, Dr. Charles R. Dickson, reported that six first aid classes, with 137 pupils; three nursing classes, with 64 pupils; one first aid junior class, with 36 pupils; one medalion class, with 5 pupils, had been held in Toronto during the year. Of the 243 pupils, 188 completed the course of lectures and 145 passed the examinations. The record of work since the organization of the Toronto Centre in February, 1896, shows a total of 32 classes; 646 pupils completed the course, 473 of whom went up for examination and passed, and of this number 23 have succeeded in passing the second and third examinations and obtained the medallion of the association.

The employees of the street railway have formed a separate class, and a large number of the members of the Toronto Police Force, no fewer than 182 out of 250, have obtained certificates.

YUKON PHYSICIANS AND SURGEONS.

THE establishment of a College of Physicians and Surgeons and the election of a council for the same, have taken place. There were some twenty-five Canadian practitioners in Dawson and vicinity and a number of American physicians who were practising in spite of the N.W.T. Ordinance. The Canadians found it necessary to incorporate themselves into a legal body for the purpose of protection and mutual help.

At the election held on the 5th of October, 1898, the following gentlemen were elected members of the Council of the College of Physicians and Surgeons of the Yukon Territory :

President, E. D. Dunn; Vice-President, R. R. Macfarlane; Registrar, A. F. Edwards, and J. W. Good and H. H. Hurdman.

The first examination was announced for October 15th, 1898, and the following examiners were appointed :

Surgery, J. W. Good and E. L. Barratt; Medicine, R. R. Macfarlane and E. G. Scott; Midwifery and Gynecology, E. P. Thompson and W. G. Hepworth; Medical Jurisprudence and Sanitary Science, J. A. Sutherland and W. A. Richardson.

Since the Ordinance assented to by the Executive Council

an amendment has been added, which allows all bona fide medical practitioners practising in the Yukon Territory at the date of the establishment of the College of Physicians and Surgeons who were able to produce certificates of having attended a Medical College for three years and a diploma of qualification from the same, to be eligible for admission to the College of Physicians and Surgeons upon passing an examination and paying one hundred dollars to the Registrar. This amendment holds goods only until the close of the first examination.

As it now stands the regulation with reference to the practice of medicine in the Yukon Territory is, in brief, that (1) licentiates of Quebec, Manitoba, and the Northwest Territories are eligible to practise medicine in the Yukon Territory on the presentation of their licenses and the payment of a fee of one hundred dollars; (2) those who can present certificates of attendance for four years or a diploma of qualification from a recognized school of medicine are eligible to practise in the Yukon Territory upon passing the examination of the Medical Council of the Territory and the payment of one hundred dollars to the Registrar.

Correspondence.

NEEDLE IN THE HEART.

MONTREAL, Dec. 1, 1898.

To the Editor of THE CANADIAN PRACTITIONER:

DEAR SIR,—I was much interested in reading the account by Dr. Peters of a case of "needle in the liver." I was reminded of a case which I saw some years ago. A man aged about forty, the subject of suicidal mania, by some means or other escaped the vigilance of his keeper and managed to possess himself of a file and two darning needles, each two and a half inches long. The needles, he thrust, as he thought, into his heart and then drove them home with the end of the file so that they disappeared beneath the skin. This caused him great pain and, although he was not believed, he said he had driven two needles into his heart. I was sent for in the middle of the night and found the patient writhing in agony on the floor. On examining the heart region I saw two punctures in the region of the apex between the fifth and sixth ribs and an elevation of the skin took place near the one over the apex at every heart beat; feeling with my fingers I could make out distinctly the heads of the two needles, the outer one deeper in and not affected by the heart beats, the inner one apparently firmly fixed into the muscle of the heart near its apex and pushing up the skin at every beat. I immediately cut down on the needles, having to go through the intercostal muscles before reaching them and then extracted them with a small needle-holder I happened to have with me—the one fixed in the heart came away with difficulty, the other, which was in the lung, was easily removed. The patient experienced immediate relief, the wounds healed by primary union and in a couple of days the patient was as well as ever. The first needle introduced missed the heart and the second was firmly embedded in the left ventricle; fortunately for the patient it had not entered the cavity of the heart. Hoping you will not think I am growing old and reminiscent, I am,

Yours truly,

FRANCIS J. SHEPHERD.

SURGICAL OPERATIONS ON THE INSANE.

— — —

VICTORIA, B.C., Nov. 3, 1898.

To the Editor of THE CANADIAN PRACTITIONER:

In the October issue of THE PRACTITIONER appeared an article by Dr. Russell, Medical Superintendent of Hamilton Asylum, upon "The after effects of surgical procedure on the generative organs of females for the relief of insanity," which contained statements somewhat misleading, although, no doubt, wholly unintentional upon the part of the author. To some of these statements I wish to call attention, not in a spirit of unfriendliness towards anyone, but with the desire to determine the truth in regard to this most vital question.

In the first place, while apparently in opposition to the gynæcological treatment as adopted in the London Asylum* the author stands self-committed to the essential principles that underlie Dr. Hobbs' work. While he appears to ridicule and denounce the application of those principles, Dr. Russell states "while it (gynæcology) has a place among the insane just as it has among the sane for the relief of physical distress," "and I am free to admit that there may exist pathological conditions in the pelvic organs of lunatics which tend to intensify the mental disorder, and in that case the lunatic has the same right as the sane person to surgical aid for its relief." With these admissions he has conceded all that Drs. Hobbs and Burgess state. In Dr. Hobbs' report* these words are used referring to the surgical treatment in the London Asylum: "These operations were done primarily and specifically for the removal of physical disease and the promotion of bodily comfort." I can see no material disagreement between the statements of these two gentlemen.

Again Dr. Russell is not slow in expressing his disapproval of reckless and embryonic surgery as seen in the following quotations; "The specialist in surgical gynæcology . . . proceeds to restore to reason the unhappy victim by unsheathing his scalpel and removing the offending organ"; "he wages his most relentless surgery upon the ovaries." "It is high time for the profession to call a halt in its mad career of pelvic mutilation in order to extol the triumphs of surgery and build up a reputation for surgical skill by imposing upon the ignorance and credulity of the public." With this we all agree, but I fail to see any indi-

*See Dr. Hobbs' report in September PRACTITIONER.

cation of such illegitimate surgery in any of the reports published to date. Surely Dr. Russell does not question the judgment of Dr. Gardiner, of Montreal, who operated on Dr. Burgess' three patients, to say nothing of the work of others. Does not this resemble the proverbial man of straw which has been set up and satisfactorily demolished? While Dr. Hobbs' report gives his experiences to within a few months of the appearance of the report, Dr. Russell's paper is more than fifteen months old and without any additional material, an admission, possibly, that within the last year he has made no further investigations. In the development of any department of science direct effort and personal experience is to be preferred to the opinions of others of equal ability and opportunity; he who investigates further is more apt to be nearer the truth in his conclusions and his opinion will command greater deference. While Dr. Hobbs reports upon one hundred and thirty-six cases Dr. Russell reports upon but three, two of which, if not the third, were operated upon in direct violation of the principles clearly stated by Dr. Hobbs and repeated by Dr. Russell. Now, I ask, should anyone attempt to establish a precedent upon a basis which he himself repudiates? According to Dr. Russell's report two at least of his cases were operated upon "for insanity" without the diagnosed presence of distinct local disease, which is *sine qua non* of all operative procedure.

But the true genius of progress considers less the combating of the old than the development of the new. The makers of history have always struggled through marshes of stagnation and against the popular current. Opposition is an invigorating morsel and its universal result development. The application of modern surgery to the therapeutics of the asylum marks an epoch in Canadian medical history.

Theories may be attractive, but facts are substantial, and we have a few that may be made the basis of new generalizations, the nidus of more reasonable theories. In conclusion, let me ask for an explanation of this fact, that cases labelled "hopeless", "incurable," etc., by asylum superintendents have been restored to mental health within a few weeks from the removal of diseased pelvic structures.

ERNEST HALL,

Meetings of Medical Societies.

LONDON MEDICAL ASSOCIATION.

Minutes of the regular meeting of the London Medical Association, held on the 14th of November, 1898. Present: Dr. Eccles, the president, in the chair, and Drs. Moorhouse, Hodge, Meek, Roome, Wishart, Neu, Ovens, Stevenson, Bayly, Kingsmill, and English.

After the reading and approval of the minutes of the previous meeting, Dr. Neu read a most interesting paper on "Impressions received on a recent European trip." (See page 705).

Drs. Moorhouse, Ferguson, Roome, Kingsmill, and Eccles discussed the paper and urged that the Board of Aldermen of the city be approached early in the coming year and the matter of the appointment of a bacteriologist in connection with the Health Department of the city strongly urged.

Dr. Hodge gave notes of an interesting case. (See page 709.)

The paper was discussed by Dr. Moorhouse, who stated that after fifteen years of careful investigation he believed that the majority of the cases of idiopathic pleurisy were due to tubercle.

Dr. Ferguson thought that this might be a case of cholerae, as many of this characteristic occurred in '95.

Dr. Neu believed that the rapidity of onset, several cavities being rapidly affected, did not point to tubercle as the cause.

Dr. Roome had found that under twenty years of age pleurisy was not usually due to tubercle, but over forty years of age it was present in nearly every instance.

Dr. Bayly suggested liathiasis or oxaluria as the possible cause.

Dr. Eccles believed the case to be toxæmic—the line of

treatment accidentally adopted proved this to be a probable cause: renal inadequacy might be present without albuminuria.

Dr. Hodge made reply.

After a discussion on arrangements for the new hospital, and also the use of the new ambulance in the transfer of typhoid fever cases, the meeting adjourned.

W. M. ENGLISH,
Rec.-Sec'y.

TORONTO PATHOLOGICAL SOCIETY.

(Continued from last issue.)

SECONDARY TUBERCULOSIS OF THE INTESTINE—DR. RUDOLF.

The case was that of a girl aged eleven years, who had been suffering from pulmonary phthisis for about a year, and during the last few months of life had very persistent diarrhoea with occasional passage of blood.

At the *post-mortem* examination the lungs and bronchial glands were found to be extensively affected with tuberculous disease.

The stomach and duodenum were free from lesions, as was also the jejunum.

The *caput carcum coli* was extensively ulcerated, so much so that no healthy mucous membrane remained, and the walls were much thickened and formed a mass which could easily have been felt through the abdominal wall. The lower part of the ileum was thickly studded with ulcers, and these became more scattered upward. Below the caecum, the ulcers also became more discrete, and the lowest one occupied the upper part of the rectum. It was a recent one, and had evidently been bleeding. The floors of the ulcers were rough and the margins were thickened and as a rule undermined. In the ileum they largely occupied the position of the Peyer's patches. There was no perforation of the intestine nor any adhesions to the surrounding structures. The mesenteric glands were extensively involved, as occurs in the majority of these cases. Tubercular ulceration of the intestine is a very common complication of chronic tuberculosis, occurring in 566 cases of this disease out of 1,000 examined at the Munich Pathological Institute. According to Clifford Allbutt, rather more than half of all cases dying of phthisis are complicated with the condition. The disease may occur in three ways: (1) Primary, (2) secondary, and (3) by

direct extension. Of these three varieties the secondary are by far the commonest. In the 1,000 Munich cases only one was primary, and Fagge says that probably tubercular ulceration of the intestines is never seen in the *post-mortem* room without the lungs being likewise affected with active tuberculosis. Woodhead points out, however, that it may occur in children, and there is much experimental proof that it may be the result of milk infection.

As regards the parts of the alimentary tract affected by the disease, the reason why the stomach and duodenum nearly always escape is probably because of the acid secretion of the former. Most commonly the ileum and colon are both affected, the most frequent site being about the ileo-caecal valve. Out of 250 cases collected by Frerich of chronic tuberculosis, 83 per cent. had the disease in the intestine. In these the ileum was affected in 200, the colon in 115, and the rectum in eighteen. Bristowe, however, states that it affects the large and small intestines with equal frequency.

In the specimen presented to-night a number of the ulcers had distinctly undermined edges. This condition is not infrequently seen, and yet most of the standard works on Pathology and Medicine describe the edges of tubercular ulcers of the intestine as never being undermined.

Discussed by Drs. Cameron and Anderson.

Dr. Amyot gave notes and *post-mortem* report of a case of malignant endocarditis with infarctions in the various organs.

Age 21. Admitted in February, 1898, with cardiac disease. Gave history of previous severe attacks of rheumatism. Had an attack whilst in the hospital and showed both mitral and aortic incompetency. Culture from blood during March negative. In July an abscess developed in one leg below the knee. Pure streptococcus culture. Blood showed same before opening abscess. Died about August 15th.

Post-mortem report: Abscess in legs extends up amongst muscles of thigh; part of femur bare; heart enlarged—all cavities much dilated; much hypertrophy, weight 28 ounces; infarct at apex, yellowish grey in colour; other small ones in smaller branches of the coronary artery; one over the right auricle muscle greyish, ill-defined elements; aortic orifice dilated; some thickening of the semi-lunar cusps; polypoid vegetation on edges, also on aortic side of mitral cusp; none in mitral blood surface; firmly adherent clot in endocardium of apex of left ventricle; retention band in right ventricle marked; spleen weight $14\frac{1}{2}$ ounces, and both kidneys show

irregular retracted scars and recent infarcts, anæmic, with well marked hemorrhagic borders.

A lengthy discussion followed on the pathology of infarction by Drs. Anderson, Cameron, Graham and Parsons.

The meeting then adjourned.

H. C. PARSONS,

Recording Secretary

Book Reviews.

A TEXT-BOOK OF PATHOLOGY. By Alfred Stengel, M.D., Instructor in Clinical Medicine in the University of Pennsylvania, etc., etc. Philadelphia : W. B. Saunders.

This is one of the text-books which we would rather had not been written and that chiefly for the sake of the author. Dr. Stengel is capable of something much better. The book has the appearance of having been put through by force of circumstances, within a period of time too short for such work. We cannot go into details, but would merely say that what is there is mainly good but that much is lacking for a volume of such a size and pretence. Can Messrs. Saunders not be persuaded to give Dr. Stengel a chance to do the thing properly? The make-up of the volume is what might be expected from so good a firm.

A MANUAL OF VENEREAL DISEASES. By James R. Hayden, M.D., Chief of Clinic and Instructor in Genito-Urinary and Venereal Diseases, College of Physicians and Surgeons, New York ; Professor of Genito-Urinary and Venereal Diseases in the Medical Department of the University of Vermont, etc. New (2nd) edition, revised and enlarged. In one 12mo. volume of 804 pages, with 54 engravings. Cloth, \$1.50, net. Lea Brothers & Co., publishers, Philadelphia and New York.

This little work is very concise, rather too much so we believe. It reviews the whole range of venereal disease and is undoubtedly popular. The new chapter added in this edition on "care of instruments" would be improved by mention of the use of formalin in vapor to sterilize sounds, catheters, both soft and metal. We can recommend the work to students and practitioners. The publishers have illustrated the work well and freely.

DOCTORS HARNEY AND DAVIDSON'S SYLLABUS OF MATERIA MEDICA. Revised in accordance with the "British Pharmacopœia," 1898, by William Martindale, F.L.S., F.C.S., member of the Council of Pharmaceutical Society, etc. Tenth edition. London : H. K. Lewis, 136 Gower Street. Toronto : Carveth & Co., Parliament Street. Price, \$1.00 nett.

This syllabus is a most useful book for the medical student in preparation for examination, used in conjunction with his materia medica and therapeutic treatise. It familiarizes one with the dosage, all the

official B. P. preparations and is revised absolutely up to date. There is no work that so concisely puts dose in both imperial and metric system.

CONSERVATIVE GYNÆCOLOGY AND ELECTRO-THERAPEUTICS. A Practical Treatise on the Diseases of Women and their Treatment by Electricity. By G. Bilton Massey, M.D., Physician to the Gynæcological Department of Howard Hospital, and late Electro-Therapeutist to the Infirmary for Nervous Diseases; Fellow and ex-President of the American Electro-Therapeutic Association; Member of Société Française d'Electro-Thérapie, American Medical Association, etc.

Third edition, revised, re-written and greatly enlarged. Illustrated with twelve original full-page chromo-lithographic plates and twelve full-page half-tone plates of photographs taken from nature, and numerous engravings in the text. Philadelphia, New York and Chicago: The F. A. Davis Co., publishers. 1898.

That Massey is a firm believer in the efficacy of electricity in gynæcology one has only to glance at the book to see. That he is an enthusiast or sees diseases of women through the spectacles of the specialist one has not to read far or ponder deeply to know.

Vaginal and intra-uterine galvanic and faradic applications and the apparatus necessary are considered. Menstrual derangements are taken up in Chapter VII., and it seems that electricity is equally useful in amenorrhœa, menorrhagia, metrorrhagia or dysmenorrhœa.

While we are willing to concede that chronic mitritis may be favorably influenced by electricity, we are loth to believe that it is the best or greatest method of treatment. "For a septic condition of the uterus the positive mercuric pole is the most satisfactory, owing to its distinct bactericidal powers, and, if the foul discharge comes from only small shreds of retained membrane or clots, it is quite unnecessary to resort to the risks and loss of blood attending the use of the curette." To such teaching we must enter a protest. Electricity is quite safe here, we admit, but the dull curette, guided by educated fingers, is just as safe and more effective. The author cites cases of pyosalpinx as cured by electricity, but here, too, surgery would be preferable we are convinced.

The diagnostic test treatment, indicated by Apostoli, for the purpose of deciding what cases of chronic ovaritis should be treated by electricity and what by operative procedures, is quite ingenious and well worth careful attention.

In regard to fibroid tumors the selection of suitable cases, the contra indications to the use of the remedy, the various methods and the result of treatment, are discussed. Of seventy-five cases in which a definite history is known, 85.33 per cent. of cures is claimed and 14.66 per cent. failures. He declares "if electricity does no good it can be relied on to do no harm in proper hands, leaving the tumors unchanged for the trial of other methods." We are scarcely prepared to agree to all of this. More than one death has occurred in this city as the result of electricity *per se*. In other cases a train of evils has been set up in-

finitely worse to bear and more dangerous than the original trouble. We repeat, it is not without danger, but in the hands of an electrician of the well-known ability of the author it is certainly robbed of some of its dangers.

Electricity is, of course, advised in extra-uterine gestation, and the author quotes eighty-six cases with only six deaths.

The book is the largest of its kind, contains 136 illustrations and 24 full-page plates. The motor points of the nerves and muscles are graphically shown on the person of a professional model photographed.

The typography, binding, cuts, photogravures, etc., reflect credit on the publishers.

A TEXT-BOOK ON PRACTICAL OBSTETRICS. By Egbert H. Grandin, M.D., Gynæcologist to the Columbus Hospital; Consulting Gynæcologist to the French Hospital; late Consulting Obstetric and Obstetric Surgeon of the New York Maternity Hospital; late Obstetrician of the New York Infant Asylum; Fellow of the American Gynæcological Society, of the New York Academy of Medicine, of the New York Obstetrical Society, etc.; with the collaboration of George W. Jarman, M.D., Gynæcologist to the Cancer Hospital, Instructor in Gynæcology in the Medical Department of the Columbia University; late Obstetric Surgeon of the New York Maternity Hospital; Fellow of the American Gynæcological Society, of the New York Academy of Medicine, of the New York Obstetrical Society, etc. Second edition, revised and enlarged; illustrated with sixty-four full-page photographic plates, and eighty-six illustrations in the text. The F. A. Davis Company, publishers, Philadelphia, New York, Chicago, 1898.

Two years ago the first edition appeared, and now the second comes revised and enlarged. The revision has resulted in the condensation of "two volumes in one" with a separate index for each volume—one in the middle, the other at the end of the work—into a single volume with one index, a matter of no little convenience on looking up a subject. The revision of the index has not been to the advantage of the reader; while pelvimetry and pelvimeters are considered in the text neither are mentioned in the index. This is one illustration of the result of revision. The publishers tell us the work is enlarged, as a matter of fact it is by two pages—a point hardly worth mentioning.

This edition, like the former, is profusely illustrated, a desideratum to the proper understanding of either theoretical or practical obstetrics. Two new illustrations in regard to symphysiotomy made the operation clearer than some of the articles in recent journals do. E. A. Ayres' method—the subcutaneous method—and his directions are so well and systematically arranged that they may with advantage be studied by any one who contemplates the operation. His apparatus for use after symphysiotomy is very ingenious. Eight new full-page plates are added to the present edition, four of which refer to axis-traction forceps, showing correct and faulty traction. These and the great majority of the plates and illustrations are all that can be

desired, and they help to clear up many a hazy point in the brain of the student or practitioner, who imbibed his obstetrics before the days of illustrations. But we do find fault with such plates as Nos. xxx., xxxi., xxxii., showing the finger in the rectum for the purpose of maintaining flexion and promoting extension. While this method may once in a long time be necessary, its routine use must certainly be conducive to septic infection. It is one thing for such men as the authors of the work—obstetric specialists—men who know how to take care of the hands, to practise flexion and extension by the finger in the rectum on rare occasions, but to teach it to students and advise it to general practitioners is quite another thing and very much to be deprecated. The following sentence shows that the finger inserted into the rectum is intended not as occasional but as routine practice: "The thumb applied to the head and, if need be, the index finger inserted into the rectum, in order to enable extension to be of the most gradual type, is the proper way to deliver the head, under normal circumstances." Such teaching is wrong in theory and worse in practice. The desired end may be obtained by other and safer means. We should be very sorry indeed to feed the newly-born infants, in even this bracing climate, on the food advised by the authors, where the mother is for any reason unable to nurse her baby. We had thought the days of French gelatine, arrow-root, and 50% milk were matters of ancient history. But it seemeth not. This portion of the work would serve a more useful purpose if omitted entirely in future editions. At least it would bear "revising" again.

Both type and paper are an improvement on the former edition.

DISEASES OF WOMEN. A Manual of Gynæcology designed especially for the use of Students and General Practitioners. By F. H. Davenport, A.B., M.D., Assistant Professor in Gynæcology, Harvard Medical School; Assistant Surgeon to the Free Hospital for Women, Boston. Third edition, revised and enlarged, with 156 illustrations. Lea Bros. & Co., Philadelphia and New York, 1898.

This little work of 388 pages contains an amount of information which is simply amazing. It is methodically arranged, very well adapted to the use of students, and so clear that the busiest general practitioner can see at a glance almost any disorder on which he wishes information. As the author states, it is not intended for the specialist, but, we believe the family physician will be able to get light on any point he elects to look up—certainly on any case which he should take charge of and treat throughout, without the advice or assistance of the specialist. We are particularly pleased with the advice as to when and where not to make an examination, and also the suggestions as to the examination of young girls. "Here an examination should be avoided, if possible." This sentiment, which, alas, too seldom appears in works on gynæcology, so corresponds with our own feelings that we quote the line.

The book is evidently the work of a teacher, is freely illustrated,

and may be profitably, though not exclusively, read by the busy physician, as well as the student.

The work is presented in the unusually good manner by the publishers.

ACCIDENT AND INJURY, THEIR RELATION TO DISEASES OF THE NERVOUS SYSTEM. By Pearce Bailey, A.M., M.D., Attending Physician to the Department of Correction, and to the Almshouse and Incurable Hospitals; Assistant in Neurology in Columbia University; Consulting Neurologist to St. Luke's Hospital. New York: D. Appleton & Company. Toronto: G. N. Morang.

This work will be welcomed as one that will undoubtedly fill a niche. It is clearly and concisely written, and reviews the nervous sequelæ following accidents in a most instructive manner. The chapters on Hysterical Joints and Traumatic Neurasthenia are very interesting. The greatest benefit from the work will, however, be to those practitioners who are called on to attend people injured and about to enter litigation. It is most important that the physician should be able to interpret the patient's condition, and not be carried away with sympathy nor allow his patient to mislead his legal adviser. Patients receiving injuries in railway accidents are always worse previous to and during any action, and, strange to relate, frequently recover from conditions supposedly and sworn to be permanent and incurable. It is rare to find physicians agree in the witness box on prognosis. It is also rare to find physicians who can speak with the authority of experience, and to meet these requisites this work will be most useful. The subject matter of this volume was, up to its appearance, not available except in widely-scattered monographs, and these largely in foreign languages. Here they are embodied and done by an able author. The work was needed, and is one that should be widely read and kept for reference. The publishers have carried out their share of the work in the usual elegant style that predominates in the house of Appleton. We highly recommend the volume.

Books received

- A. TEXT-BOOK OF OBSTETRICS. By Barton Cook Hirst, M.B., Professor of Obstetrics in the University of Pennsylvania; with 653 illustrations. Philadelphia: H. W. B. Saunders, 925 Walnut street. 1898.
- F. STEARNS & CO.'S PHARMACEUTICAL CATALOGUE.—This firm, which has been established fifteen years in Windsor, has issued a new catalogue, which is a most useful book to be possessed of. It gives one a very complete idea of the thoroughness with which the firm does its work. The work contains a Practical Scheme for Urinalysis, Poisons and Antidotes, Percentage in Solution, Doses, Rules for Proportioning Doses, etc., and will be sent free on application.

PARKE, DAVIS & CO.'S PRICE LIST.—We cannot deny that the highest praise is merited by the last edition of Parke, Davis & Co.'s Priced Catalogue. It was prepared in Canada, printed in Canada, and embodies an array of nearly five thousand preparations, every one of which is manufactured at the Walkerville Laboratory of this great house. Not alone does this list set forth formulæ and prices of each item in the twenty-nine extensive lines manufactured by Parke, Davis & Co., but it also contains in convenient form a vast fund of information which makes it permanently valuable for purposes of reference. Thirty-five pages are devoted to a most useful "property and dose list" of drugs from which Parke, Davis & Co. manufacture a fluid, solid, or powdered extract or concentration. Every paragraph in the eighteen pages on "Notes of Reference" is a valuable nugget of information. The list is compactly and handsomely printed, and is sent without charge to every physician who asks for a copy. Do not fail to write for one of these catalogues, and when you get it keep it within easy reach, for it will answer a thousand queries relating to drugs, their uses, doses, prices, and pharmaceutical preparations.

MULFORD'S NEW BROCHURE.—We are in receipt of a copy of Mulford Company's 1898 Antitoxin Brochure recently from the press. It is a great improvement on that of last year, for which there was an unexcelled demand, and is a valuable reference book for physicians. The subjects of antitoxin dosage, symptomatic treatment of cases seen later and immunization are the best and fullest ever given. There is a novel and valuable section on official reports on the use of antitoxin, which will be highly appreciated. The book is handsomely finished, and is easily without parallel in trade literature. It should be in every physician's office. The book will be mailed gratis upon receipt of request.

A TREATISE ON "UNRIPE" CATARACT. By William K. McKeown, M.D., M.Ch. Surgeon to the Ulster Eye, Ear and Throat Hospital, Belfast; member of the Senate of the Royal University of Ireland; Lecturer, etc., etc., Queen's College, Belfast. Illustrated with nine plates and sixty original drawings. 202 pages, 8vo. Price, 12s. 6d. net. London: H. K. Lewis, 136 Gower street, W.C.

We have received the AK. Skelton Calendar for 1899. It is another of those interesting series of Skeleton Sketches by the late Dr. L. Crusins. Any physician who has not received one will have one forwarded on request to the Antikamnia Chemical Co., St. Louis, Mo.

E. B. Treat & Co. announce that, with the January, 1899, number, they become the sole owners of *Archives of Pediatrics*, having purchased the interest of its founder and former owner, William Perry Watson, M.D. The *Archives* completes its XVth Volume with 1898, and is today the leading journal devoted to pediatrics.

Medical Items.

DR. J. M. JORY, of Bloomfield, has returned from a post-graduate course to New York.

DR. JOHN P. MORTON (Tor. '97) has recently returned from Vienna and commenced practice as a surgeon of the eye, ear, nose, and throat in Hamilton.

DR. THOMAS S. CULLEN (Tor. '90) is engaged in private practice in Baltimore. His monograph on Cancer of the Uterus will shortly appear, being published by Appleton & Co.

DR. W. T. CONNELL, Professor of Bacteriology, Queen's University, Kingston, had a serious septicæmia from post-mortem work last month. We are glad to be able to announce that he is recovering.

DR. THOMAS B. FLETCHER (Tor. '93) has been appointed first assistant in the medical clinic of St. John's Hospital, Baltimore: Dr. Thos. McCrae (Tor. 95) has been appointed second assistant: Dr. Norman B. Gwyn (Tor. '96) has taken charge of the clinical laboratory

A BACTERIOLOGICAL TRAGEDY.

A gay Bacillus, to gain him glory,
Once gave a ball in a laboratory.
The fete took place on a cover glass,
Where vulgar germs could not harass.
None but the cultured were invited,
(For microbe clicks are well united),
And tightly-closed the ball-room doors,
To all the germs containing spores.
The Staphylococci first arrived—
To stand in groups they all contrived—
The Streptococci took great pains
To seat themselves in graceful chains.
While somewhat late, and two by two,
The Diplococci came in view.
The Pneumococci, stern and haughty,
Declared the Gonococci naughty
And would not care to stay at all
If they were present at the ball.

The ball began, the mirth ran high,
 With not one thought of danger nigh.
 Each germ enjoyed himself that night,
 With never a fear of the Phagocyte.
 'Twas getting late (and some were "loaded,")
 When a jar of formaline exploded,
 And drenched the happy dancing mass
 Who swarmed the fatal cover glass.

Not one survived, but perished all
 At this Bacteriologic ball.

—*J. Lee Hagadorn, M.D., in Southern California Practitioner.*

OBITUARY.

SIR WILLIAM JENNER, K C.B.—Sir William Jenner, the distinguished pathologist and physician-in-ordinary to the Queen and Prince of Wales, died Dec. 12, 1898.

He was born at Chatham in 1815, and was president of the Royal College of Physicians from 1881 to 1889, when he retired from the practice of his profession. He was first to establish beyond dispute the difference in kind between typhus and typhoid fever.

On the death of Dr. Baly, in 1861, Jenner was appointed to succeed him as physician-extraordinary to the Queen, and the next year he was gazetted physician-in-ordinary to Her Majesty, receiving the same preferment in 1863 in the household of the Prince of Wales. It was in recognition of his services rendered during a severe illness of the Prince that he was made Knight Commander of the Bath. He wrote numerous papers on fever, the acute specific diseases, diphtheria, diseases of children, and diseases of the heart, lungs, and skin.

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