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Original Papers.

CASE OF RECOVERY FROM EXTENSIVE FRACTURE OF THE SKULL.

BY E. L. BURNHAM, M. B.

HILLSBERG.

July 14, 1870.

Editor Dominion Medical Journal.

SIR,—I send you the enclosed report of a case of "Fracture of the Skull" recently under my care, thinking you might consider it worthy of publication. I should like to see a larger number of "Original Communications" in your Journal, but when the *great quus* of the city hold back, as they seem to do, you cannot blame the country practitioners for being backward also. Hoping that the time will soon come when an interchange of opinions or experiences through the medium of the JOURNAL will become more general,

I remain, yours, &c.,

E. L. BURNHAM.

On the 7th of May last, Mr. B——, a man of spare habits, *æt.* 42, a farmer by occupation, while riding on a heavy land-roller, drawn by a yoke of young, wild oxen, was thrown off, owing to the oxen running away, and the roller, which weighs from 800 to 1,000 lbs. passed over his head, inflicting the injuries I am about to describe. I saw him a few minutes after the accident, and found him insensible, pale, surface of body cold, pulse weak and fluttering and bleeding profusely from both ears; the blood was evidently arterial, issuing in jets, and in a large full stream, so freely, indeed, that in a very short time his own person and the road—which, by the way, is a hard gravel one—for a considerable distance around was covered with it. On the left side of his head, about an inch from the median line above, there was a wound

in the integuments fully two inches and a half long, through which could plainly be seen an extensive fracture of the skull, with depression. On seeing the dangerous character of the injury, I had him conveyed into a neighboring house, and immediately sent for Dr. McNaughton, of Erin, who shortly arrived, when we made a close examination of the injured parts, together. We found, by tracing the line of depression, that the fracture extended from a point about three-quarters of an inch posterior to the external angular process of the frontal bone, in a semi-circular direction, upwards and backwards to within an inch of the median line above, and then downwards and backwards to the lambdoidal suture, and approaching to the mastoid process of the temporal bone behind. There was also very strong evidence of a fracture of the base of the skull as well, viz: copious bleeding from the ears, a free discharge of serum after the hæmorrhage ceased, and partial paralysis of the face. This discharge of serum was most observable from the *right* ear; the paralysis of the face was also on the *right* side. The patient still remained almost completely insensible. During the night I allowed him to have a little whisky and water occasionally, and applied hot flannels to his feet and legs. On Sunday morning, the 8th of May, Dr. McNaughton and myself, with Riddell, of Alton, saw him, and as he had now recovered in a great measure from the shock which his system had received at the time of the accident, we determined that trephining was necessary to afford him any chance of recovery, although, of his recovery we had very little hopes. He was now in a partially comatose condition, breathing heavily, pulse slow and full, one pupil, the *right*, dilated, and the other contracted; he could be roused when spoken to

loudly, and would answer any question put to him, sensibly enough, but would immediately go to sleep again, skin warm; the blood would still flow freely from the left ear on his making any exertion, while serum was oozing from the right one in considerable quantities. On our representing to his friends the necessity for an operation, they would not agree to have it performed, preferring, as they said, to let him die in peace, because we could not assure them that it would save his life. On receiving their refusal we separated, much against our inclination, as we considered the case called for the operation. On Sunday night the friends reconsidered their opinion and sent me word that they were willing we should do whatever we thought proper. Immediately, I sent word to the other medical gentlemen, and on Monday morning, the second day after the accident, we met again, and proceeded to perform the operation of trephining, using for the purpose a medium sized trephine, and removing a disc from the sound bone above the depressed portion, when, by means of an elevator the depressed bone was quickly raised into its normal position. I may here mention that we had previously endeavored, by means of the elevator alone, to raise the displaced part, but had been unable to do so. On removing the disc loosened by the trephine, fully 3ij. of dark-colored but fluid blood escaped. When the edges of the fractured portions of bone were examined, it was seen that the bone broke with a bevel, the inner table of the skull breaking about $\frac{3}{4}$ of an inch in advance of the outer table. The overlapping of the two portions was more than $\frac{1}{2}$ an inch, owing to this. After the operation Mr. B. was put to bed, cold cloths and pounded ice was applied to his head, and a brisk cathartic was administered after an interval of 3 or 4 hours. His bowels moved freely several times; in a few hours the symptoms of compression nearly all disappeared, and he became quite sensible. He rested well during the night and the next day was, and expressed himself as being very much better. The after treatment consisted in keeping him mildly under the influence of hyd. submur for about four weeks, administering ol. croton tig. and ext. coloc. co. in sufficient quantity to keep [the bowels freely

open, perfect quietness in a cool, dark room enjoined, diet rather low, and applying cold cloths and pounded ice to the head. As the weather became warmer a little carbolic acid was added to the water applied to his head for the purpose of keeping the flies away. Under this treatment he steadily improved. On the 21st day he had a sharp attack of fever, with pain, heat and throbbing in the region of the fracture, but on giving him a few doses of a mixture containing tr. verat. vir., in combination with ant. tart, and liq. ammon. acet. these symptoms soon disappeared. He has had no medicine now for the last month, and is, I may say, almost well. Of course I have ordered him to abstain from any severe manual labor, but he goes around and oversees his farm, and performs light jobs at times. His pulse is strong and regular, his appetite is good, he has no pain or uneasiness in his head, and the external wound is nearly healed up. There is, however, a slight inclination of his mouth towards the left side when he speaks, and slight paralysis of the right eyelid. With these exceptions nothing is observable to show that he has so lately passed through such a severe ordeal.

That recovery should take place from such an extensive fracture, extending, as it did, nearly entirely across one side of the skull, is a matter of astonishment to all of us who saw the frightful nature of the injury, and I publish the case in the hope that its recital may be of benefit to some brother practitioner, who may be called upon to take charge of a similar, apparently almost hopelessly injured patient. It is, of course, impossible for us to tell the extent of the fracture at the base of the skull, but the symptoms above-mentioned certainly seem to show that such a fracture did exist there.

ON THE KATIPO, A POISONOUS SPIDER OF NEW ZEALAND.

BY F. W. WRIGHT, L.M.B., TORONTO,
L.M.P. NEW ZEALAND.

(Read before the Medical Section of the Auckland Institute,
October 20th, 1869.)

I have presumed to offer for the consideration of the Medical Section of the Auckland Institute the following memorial on the Katipo, a

poisonous spider of New Zealand, with a case that occurred in my own practice, believing that the subject deserves a general notice, as it certainly requires investigation at the hands of the medical profession.

In the month of December, 1868, a person of the name of John Huff, living near my residence, came into the surgery complaining that he had been bitten on the shoulder by a spider. He was in the employment of Messrs. Archard and Brown, of Stanley-street, Mechanics' Bay. He was occupied, at the time, in carrying fire-wood, to supply the furnaces of a brick-kiln; the wood was stacked near the kiln in sedge or coarse grass; this happened between the hours of eleven and twelve o'clock, a.m. At noon he came home to dinner, sat down to table, but upon attempting to eat, found he could not open his mouth, or was scarcely able to articulate, in consequence of stiffness about the jaws. He was alarmed and came into the surgery, when it was difficult to understand what he had to say; all I could learn from him was that he had been bitten by a spider, on the shoulder, in the Bay. Upon examining the spot, I found the surface raised, to an extent as large round as a tea-cup; this elevated surface was white, and was surrounded by a halo of red, not unlike an exaggerated wheel of the nettlerash. He complained of considerable pain in the part, and during the examination became faint, and soon almost pulseless. His pulse was unusually slow, scarcely counting more than twelve or fourteen beats in the minute. His countenance and the general surface of the body assumed a hue of extreme pallor, which gradually turned to a blue tint. His extremities were cold and flaccid; his respiration almost ceased, and indeed I had fears that he was about to expire. Dr. Pinching being in my house at the time, I called for his assistance. He was astonished at the feebleness and prostration of the patient, from such an apparently trifling cause.

From his extreme faintness it was necessary to lay him on the floor, when I applied spirits of ammonia to the wound, which had the effect of lessening the swelling and abating the pain. I also administered ammonia and water, afterwards combined with brandy, in considerable doses;

under this treatment his pulse gradually improved, his circulation and respiration became more natural, as was evidenced by his return to a more natural colour. Although a stout strong man, this state of depression remained for upwards of two hours before he was able to return home. In the evening I found him considerably improved, having taken a slight dose of medicine. For several days he could not return to his work, but complained of great lassitude and nervous depression, which he was sensible of for many days after. * * * *

In corroboration of the nature of this accident, I append the following very graphic description of the bite of the Katipo, furnished by the Rev. Mr. Chapman, whose long residence as a Missionary to the Maori race, in the interior of New Zealand, renders his observations and opinions of peculiar importance.

"In the course of my sojourn in New Zealand, I have had three rather remarkable proofs of the violently poisonous nature of the bite of the Katipo.

"Some twenty years ago a party of natives had taken up a temporary residence at Waihi, near Maketu; their resting place being near the sea-beach. During the period of their morning's meal, a girl was bitten by a Katipo, in the region of the abdomen. She did not seem at first to suffer much pain, but towards noon, inflammation set in, and some native remedies were used. As these had no effect her friends decided to convey her to my residence, and they reached my house about one p.m. I discovered on first seeing her, indications of severe pain; and on examining the wound, found a swelling of the size and shape of the obtuse end of a hen's egg. I immediately rubbed the part with strong ammonia. This had no other effect than of lessening the severity of the pain, but failed to decrease the swelling. I gave the girl also medicine, which was probably salts and tincture of henbane. After this, I saw her nearly every day, for a fortnight, using such means as appeared to me suitable. She seemed at this stage to be gradually recovering, but suddenly became faint and pallid, lost all desire for food, and though offered whatever my house afforded, would only take a little bread and tea, and

sometimes a little wine. She lingered in this way for about six weeks and then died.

"The next case was the son of a trader resident at Maketu; three of his boys went up the river on a ramble, and lingered at the Tumu, resting themselves by sitting on the tufts of sedge growing on the sand hills just above the reach of the tide. These tufts are the principal haunts of the Katipo. While so resting, one of them was bitten by this insect, on the fleshy part of the thigh, it having crawled unperceived up his trowsers. The boys were at this time about two miles from home. They returned immediately, but not thinking the bite of any consequence, delayed applying to me until towards evening, at which time the sufferer became ill, and the place bitten inflamed. I attended him, using the same remedies as in the other case; but he suffered long, wasting, and losing all energy, soon having the appearance of one going into a decline. If I recollect correctly, he was three months before he rallied, and probably another three before he fully recovered.

"The next case occurred to that remarkable man Toke, the chief of Maketu. We were travelling together up the coast from Whakataane, and halting to dine, he seated himself upon a large tuft of sedge. He had not been resting many minutes before he sprang upon his feet, saying, 'I am badly bitten by a Katipo.' He was bitten on the upper part of the thigh. I directed him to lie down; I then dissolved some carbonate of soda in a very small quantity of water, and adding to this some brandy from my flask, I quickly made a crucial incision over the part bitten, and squeezed out forcibly, the blood, and then rubbed in this antacid solution, keeping up this action alternately for some ten minutes, when he said he no longer felt the pain. He remarked on rising, 'Had you not been with me I should have had a long illness.' Only two or three minutes could have elapsed after the bite, before a spot about the size of the top of the little finger appeared, and of a peculiar white colour, in strong contrast with the dusky shade of Toke's skin. He was very careful to secure all the blood I had forced out of the wound I had made, by absorbing it in a piece of rag torn from his shirt; this relic, now so doubly sacred

he carried into the middle of a swamp close by, and I saw him stamping it down into the ground very violently, to preserve it from possible desecration.

"The natives generally avoid sleeping on the sea-beach, but have no fear of the Katipo half a stone's throw inland of the sea-beach line. I never knew them (of themselves) use any other remedy than rubbing and applying hot, half-scalded leaves to the part, and as soon as convenient taking the bitten one to the priest, to receive the benefit of his incantations, as they then believed in the efficacy of prayers, made to their gods of the hills and valleys."

The Katipo are said to be of two kinds,—one having a dark glossy back, with a marked red spot on the back: the other, of about the same size, having a similar round black and shining body, but without the spot.

Mr. Taylor, in his book, "A Leaf of the Natural History of New Zealand," writes thus: "The Katipo—venomous spider—one kind red and one black with a red spot upon its back. Their bite appears to be very poisonous, occasioning a violent swelling of the part." Major Heaphy is inclined to believe that Mr. Taylor is mistaken in describing a red Katipo; but agrees with him that the one with the black body and red-vermillion spot upon its back, is the most poisonous.

A difference in the habit of the Katipo would seem to point to a variety, the one inhabiting the sandy beaches of the sea-shore, taking refuge among the drift wood and roots of sedge or rushes found there, while the other one, with the black body without the red spot, may be discovered in the garden, or among the rafters of any old building.

Major Heaphy says, "I saw one, with the red vermillion spot upon its back, at Massacre Bay, near Nelson, in the Middle Island; a native there obtaining it for me, after a few minutes' search, for a small reward. It was found among the roots of the Wiwi, or rush, around some dry drift wood, on the sandy beach. The natives were very careful not to allow it to touch them, they said it would kill them; but on close enquiry they admitted they never knew of a case of the bite ending fatally, although the bite from

them was not uncommon. Great suffering, however, they said ensued, the part swelling considerably."

The other variety, with the black body without the red spot, is of about the same size as the other, of a dark glossy brown or black color. This, as well as the preceding, is a very beautifully shaped insect, the abdomen is perfectly spherical, like a "number one" shot, very glossy. The legs are compact, not straggling. It is found amongst dead wood, in a garden, and, with a slight web, amongst the rafters of an out-building or loft. The natives have no distinguishing name for either variety, they are both called Katipo, to distinguish them from the Punga-were-were, or common Spider.

I have never heard of a case of bite from one of this kind, but the natives say that they are equally venomous with the spotted variety. I am convinced that the one with the red spot, indicates a different variety, and is not the result of age or sex, as among hundreds of the black kind I never saw a spotted one. * * *

Selected Papers.

The Prognosis in Chronic Diseases of the Heart.

BY AUSTIN FLINT, M.D.

Read at a meeting of the New York County Medical Society,
March 7, 1870.

(Continued.)

The difference in the tolerance of chronic affections of the heart is to be considered with reference to prognosis. What is true of most chronic diseases, namely, that the same lesions are tolerated very differently in different cases, is especially exemplified by the structural affections of the heart. It is truly astonishing how well borne, in some cases, are cardiac lesions of unusual magnitude. A case which recently came under my observation afforded a striking illustration of this fact. The patient, a man of middle age, was suffering greatly from dyspnoea in paroxysms, together with loss of appetite and general prostration, and the case ended fatally within a few weeks after the occurrence of the symptoms just named. I saw the patient a few days before his death, and the heart enormously enlarged. The apex-beat was in the eighth intercostal space several inches without the *linea mammalis*; and dulness on percussion over

the *præcordia* was proportionately increased both in area and degree. Here was truly a *cor bovinum*. There were present murmurs, indicating both aortic and mitral lesions. There occurred an attack of acute articular rheumatism fifteen years ago. Now, prior to a few weeks before death, this patient had seemed to be in excellent health, and he declared that he was so. He was a man of very active habits, engaged in a business (that of wool merchant in the country) which required much travelling. He had, on one occasion, an attack of hemiplegia, of very brief duration, which was probably attributable to embolism. With this exception, he had not for many years been a patient, considering himself a healthy man. He was a man of temperate habits, but a good liver as regards diet, eating very heartily, and digesting his abundant meals without difficulty; yet, it is certain that for several years there must have been very great enlargement of the heart, resulting from the valvular lesions. For some time before the occurrence of grave symptoms referrible to the heart, he had had an unusual amount of mental and physical work, accompanied with much excitement; nervous asthenia and impaired appetite ensued, and, under these circumstances, he began to suffer from dyspnoea. He was compelled to keep the bed; he became despondent; the existence of disease of the heart was forced upon his attention, and he failed rapidly. The history of this case represents what I have repeatedly been led to observe in other cases, to wit, the tolerance of disease of the heart, while it was advancing, more or less slowly, until it had attained to a great amount, the person affected, in the mean time, not considering himself an invalid, taking no remedies, living freely, and engaged in pursuits involving activity of mind, or of body, or of both. The case also represents a fact which I have repeatedly observed, namely, that from the time when persons with disease of the heart become patients, that is when they become impressed with a knowledge of the existence of the disease, and are obliged to give up their usual pursuits and habits, they are apt to fail rapidly. It is a *facilis descensus* from that time. The latter fact, as well as the remarkable tolerance of the disease under the circumstance stated, teaches an instructive practical lesson.

In speaking now of the tolerance of cardiac lesions, I do not, of course, have any reference to those which have already been referred to as innocuous. I refer to lesions which are more or less serious, that is, involving either obstruction to the free passage of blood through the orifices of the heart, or regurgitation, or both these immediate effects combined, together with enlargement by

hypertrophy or dilatation separately or in combination.

All clinical observers who have seen much of disease of the heart must have been struck with the fact that the inconvenience and suffering attendant on lesions the same in character and extent, differ widely in different cases.

What are the circumstances on which this variation as regards tolerance depends? This question not only has a bearing on the prognosis, but it is of great importance in relation to management. I will devote to it a few remarks.

In general terms, chronic diseases of the heart, as of other organs, are tolerated in proportion as the functions of the body, exclusive of the part diseased, are healthfully performed. The internal conditions of general health and constitutional strength relate especially to the series of functions which begin with ingestion and end with nutrition. Other things being equal, the toleration is best and longest when, *first*, of all, the ingesta are ample; *second*, when digestion is active; *third*, when, owing to adequate assimilation, the constituents of the blood are in normal proportion; *fourth*, when the nutritive supplies in the blood are well appropriated; and, *lastly*, when the secretory and excretory organs do their proper work. Now, a healthful performance of these functions is not incompatible with considerable damage of the central organ of the circulation; and, in so far as it is practicable to maintain these functions at, or near to, the state of health, the toleration of diseases of the heart will approximate to completeness. *Per contra*, the toleration will be incomplete in proportion as the functions of the body, exclusive of the heart, are feebly or imperfectly performed; in other words, in so far as the conditions just named of general health and constitutional strength are deficient. The blood may be considered as representing the healthful performance, or otherwise, of the functions of nutritive and destructive assimilation; so that the simple phrase, *healthy blood*, comprehends the grand requirements for toleration.

In these few remarks on the circumstances on which the variation, as regards tolerance in different cases, depends, I have opened up the governing principle in the management of chronic diseases of the heart. The great object of management in all incurable affections is to prolong and to render as complete as possible the tolerance of them. The prognosis in individual cases will be much affected by a full appreciation of this object, and of the means for its promotion. Here, once more, we are obliged to admit that the knowledge of the ex-

istence of cardiac disease is sometimes a calamity. Take the case of which I have given an account, in connection with the topic under consideration, suppose the patient, whose heart doubtless for a long period was greatly enlarged, had been assured of this fact years before his death; and, with this assurance, it had been enjoined upon him to be abstemious in diet, to watch carefully his digestion, to avoid physical and mental exertion as much as possible, and to await quietly a fatal termination—it is probable that the tolerance, which was such a marked feature of the case up to a short time before death, would have given way long before, that his comfort and usefulness would have been impaired, and his life shortened. It is a rational conclusion that these effects would have resulted from the depressing influence on the mind, insufficiency of alimentation, disordered digestion, and, owing to mental and physical inactivity, defective nutrition, secretion, and excretion. It would be easy to enlarge upon the object of management which has thus incidentally suggested itself, but I must not forget that the subject of this paper is the *prognosis* in cases of chronic diseases of the heart. It is evident, however, that, if I do not overestimate the importance of tolerance, as an object of management, and of the means which have been alluded to, for the promotion of this object, the prognosis is in no small degree affected by the practice pursued in individual cases. Here, as in other points of view, treatment is an element in prognosis by no means to be overlooked.

A few words respecting fatty degeneration of the heart. The remarks having reference especially to valvular lesions and enlargement are in the main applicable to this affection. But it is to be remarked that there is a notable difference, as regards diagnosis, between the former and the latter. Not only the existence, but the extent, of the valvular lesions and enlargement, may be determined with great precision by means of physical signs. It is not so with respect to fatty degeneration of the heart. This affection has no definite signs. The diagnosis is inferential, being deduced from the evidence of permanent weakness of the heart, taken in connection with the symptoms, age, and other circumstances. It is fair always to give the patient the benefit of doubt or difficulty in diagnosis. If the experience of those whom I address accord with mine, they will be able to recall cases in which fatty degeneration was inferred, and the subsequent history showed the inference to have been incorrect. This is a point to be considered in respect of prognosis, the more because, as will presently be seen, fatty degeneration of the heart belongs among

the cardiac lesions which involve a liability to sudden death.

Assuming correctness of the diagnosis, encouragement in the prognosis may be derived from cases in which the lesion existing in a considerable degree is remarkably tolerated. Some years since, a specimen showing rupture of the heart was exhibited at a meeting of a medical society, the rupture arising from fatty degeneration which was great and extensive. The rupture occurred during an attack which resembled *angina pectoris*. Up to this attack the patient had considered himself well, and took active exercise without inconvenience. He had no symptoms leading to the suspicion of any disease of the heart. It is not uncommon in autopsies to find more or less fatty degeneration of the heart when it had not been suspected, death having taken place from some intercurrent affection. These facts warrant hopefulness, as regards the prolongation of life, with a certain measure of health, for an indefinite period, even when symptoms and signs denote much fatty degeneration.

In treating of the prognosis in chronic diseases of the heart, some consideration of the liability to sudden death, should not be omitted; and my concluding remarks will relate to this topic.

In a very large majority of the cases in which the heart is the seat of organic disease, the cardiac lesions are not exclusively or directly, the cause of death. Most patients perish from superadded or intercurrent affections which may be either incidental to, and dependent upon, the disease of the heart, or accidentally associated with it. Of the cases in which cardiac lesions are fatal of themselves, that is, in consequence solely of their pathological effects, sudden death occurs in a very small proportion. As already stated, the popular impression is quite the reverse of this; and it is certain that many physicians participate, to a certain extent, in the common belief. The error is sustained by the frequency with which sudden death is attributed to disease of the heart on medical testimony, and after *post-mortem* examinations. It is too much the custom to refer the death to the heart whenever there is cardiac lesion, either from signs during life, or the appearances in the cadaver. But diseases of the heart, in a certain proportion of cases, do destroy life suddenly. What, then, are the lesions and the circumstances which render patients liable to sudden death?

The affection just noticed, namely, fatty degeneration, may be first mentioned. This affection involves a certain amount of liability to sudden death, rupture being the immediate cause in some cases, but oftener paralysis of the heart from over-

dilatation. Other things being equal, the liability is, of course, proportionate to the degree and extent of the degenerate change; and the amount of the disease can only be determined approximately by symptoms and signs denoting permanent weakness of the heart's action.

Of the valvular lesions, those which occasion free aortic regurgitation involve by far the greater liability to sudden death. The *rationale* is intelligible. The immediate cause of death is paralysis of the left ventricle from overdistention. The interesting fact that mitral regurgitant lesions are conservative, as regards the liability to sudden death from aortic regurgitation, has been stated in another connection. The fact of aortic regurgitation is determined by a diagnostic murmur; but the danger has relation, not to the existence of regurgitation, but to its amount. The latter is estimated by the increased size of the heart, the feebleness or extinction of the aortic second sound, and by the movements of the arteries which, together with certain characters of the pulse, denote that the regurgitation is considerable. It is rare for sudden death to be caused by aortic regurgitation so long as the heart is enlarged by predominant hypertrophy; generally, the weakness due to dilatation is a causative element.

A French writer, Mauriac, has offered an explanation of sudden death, in cases of aortic insufficiency, which is, perhaps, worthy of being considered. It is claimed, as preliminary to this explanation, that the blood is forced into the coronary arteries, not by the direct action of the left ventricle during the systole, but by the recoil action of the aorta directly after the ventricular contraction. The state of contraction of the muscular walls during the systole is supposed to constitute a mechanical obstacle sufficient to prevent, at this time, the entrance of the blood into the arteries of the heart. Now, assuming this, if there be much aortic insufficiency, a regurgitant current, caused by the recoil of the arterial coats, takes place, and, owing to the defect of that resistance which is afforded by the semilunar valves in health, the current into the coronary arteries is diminished. In this way, aortic regurgitation involves, in proportion as it is free and abundant, a diminished supply of the arterial blood to the walls of the heart; and, of course, the supply becomes more and more diminished in proportion as the systole of the ventricle is weakened by overdistention or other causes the arterial recoil being weakened in a corresponding degree. Mauriac would ascribe the sudden death to the want of arterial blood in the muscular walls, rather than to paralysis of the ventricle from

overdistention. The latter is the *rationale* which I have given, and it is, I believe, correct; but it seems very probable that Mauriac has called attention to a condition which is important as contributing to the occurrence of sudden death. Mauriac's explanation has relation to a topic to be presently noticed, namely, occlusion of the coronary arteries as a cause of sudden death.

Dilatation of the right ventricle resulting from mitral obstructive, or regurgitant lesions, involves some, but a very small, liability to sudden death. The explanation is paralysis from overdistention. Probably the so-called "safety-valve function," at the tricuspid orifice, is a conservative provision against an accumulation of blood in the right ventricle sufficient to destroy life suddenly. It is hardly necessary to say that fatty degeneration of the heart, coexisting with valvular lesions and dilatation, increases the liability to sudden death; but it is not easy to determine this combination during life.

There is danger of sudden death whenever paroxysms of angina pectoris are associated with organic disease of the heart. Other things being equal, the danger is especially great when the angina is associated with aortic lesions which occasion free regurgitation, the mitral valves being sound; and angina is oftener associated with aortic than with mitral lesions. The association with fatty degeneration is also especially dangerous. These facts are easily understood when it is considered that aortic regurgitant lesions and fatty degeneration of the heart involve a liability to sudden death irrespective of angina. What causative agency is exerted by angina in addition to the lesions with which it may be associated? This question can perhaps now be answered satisfactorily, with our knowledge of the effect upon the movements of the heart of galvanism transmitted through the pneumogastric nerves.

Facts appear to show that the force and regularity of the cardiac movements depend on an innervation received through the pneumogastrics. The division of these nerves is followed by notable perturbation of the action of the heart, its movements becoming rapid and feeble. A feeble galvanic current suffices to arrest its action, producing in effect paralysis. Without entering into any discussion of the explanation of these facts, they lead to the rational supposition that, in certain cases of angina, there is superadded to the neuralgic pain a morbid innervation exerted through the pneumogastrics, producing the perturbation of the heart's action which is of frequent occurrence, and sometimes

arresting the movements of the heart like the galvanic current.

I have heretofore held the opinion that paroxysms of angina pectoris involved a liability to sudden death, only where there are lesions, more or less serious, of the heart or aorta; and hence, wherever from the absence of physical signs organic diseases could be excluded, we are warranted in giving positive assurance of the absence of danger. As a rule, I believe still that this opinion is well founded; but within a short time I have learned by experience that there may be exceptions to the rule, and that the opinion is therefore, in individual cases, to be expressed with a certain amount of reserve. Not long since I saw, with a member of this society, Robert F. Weir, a patient who suffered from angina pectoris. A physical examination revealed no signs of disease of the heart or aorta. The patient, however, died suddenly in a paroxysm. On an examination, *post mortem*, there were found some dilatation of the aorta, and some calcareous deposit; but the valves were sufficient, and the heart was neither enlarged or fatty. It was evident that the lesions had nothing to do with the sudden death, except, perhaps, as entering into the causation of the angina. This case would seem to show that angina may destroy life suddenly, by an inhibitory or paralyzing effect upon the heart, irrespective of cardiac lesions.

The inquiry arises, What are the symptoms during a paroxysm of angina which denote danger of sudden death? In answer, it may be said that there is absence of danger so long as the action of the heart is but little or not at all disturbed, whatever lesions exist, or whatever lesions are absent or present. There is little or no danger if the patient *have not a sense of impending death*, and if the necessity of perfect quietude be not felt. On the other hand, the danger is great in proportion as the action of the heart is rapid, feeble, irregular, or notably retarded.

Is sudden death ever attributable to either embolism or thrombosis of the coronary arteries? It was considered that this might have been the explanation of the sudden death of the late Prof. Enos, of Brooklyn. In that case both coronary arteries were obstructed by calcareous masses, and it was conjectured that, the obstruction taking place suddenly, an arrest of the circulation in these vessels caused paralysis of the heart. It may be assumed that defective nutrition and consequent weakness resulting from obstruction of the coronary arteries, whether due to an embolus, or a thrombus, or the encroachment of calcareous deposit upon the mouths of the vessels, contributes to sudden death,

when other causes exist; but it may be doubted whether sudden death is ever attributable exclusively to the occlusion of these vessels. The occlusion of both coronary vessels simultaneously by thrombi or emboli must be an extremely improbable event; but, admitting its occurrence, and a fatal result, the death would probably not be sudden, although it might be speedy. Contractions of the heart may be produced for some time after its removal from the chest, even in cold-blooded animals. If death took place at the heart, in the case of the late Prof. Enos (which is open to doubt, inasmuch as the head was not opened at the autopsy), it seems more rational to suppose the occurrence of an attack of angina pectoris, the arrest of the heart's action being the effect of a morbid agency through the pneumogastric nerves.*

Finally, sudden death may be incident to the coagulation of blood in either of the heart-cavities, occurring in cases of weakness from either dilatation or fatty degeneration. The presence of an *ante-mortem* clot, even of considerable size, in either of the cavities, in connection with the lesions just stated, would not be proof that the sudden death was caused by the clot; it would be more likely to be caused by paralysis, from a sudden increase of the accumulation of blood which led to the coagulation. A heart-clot, as shown in certain fatal cases of pneumonia destroys life speedily, but not suddenly. The accident incidental to heart-clot, which causes sudden death, is embolism of either the aorta or the pulmonary artery. This accident is to be reckoned among the causes of sudden death in chronic diseases of the heart; but it is proper to add that I have not met with a case in which sudden death was attributable to this cause.

The few remarks submitted in this paper have related, for the most part, to points from which encouragement is to be derived as regards the prognosis in cases of chronic diseases of the heart. I have considered the subject more especially in this aspect because, in the first place, it is desirable that popular impressions, alluded to at the outset, namely, that all cardiac lesions are of necessity

fatal, and that all alike involve a liability to sudden death, should be so modified as to be more consistent with our present knowledge of this class of affections; and here as in other matters relating to medicine, popular impressions having been derived primarily from the medical profession, must receive their modifications from the same source. I trust that I have not done the profession injustice by saying, as I have done already, that the impressions just stated pervade, more or less, the views of physicians as well as the popular mind. In the second place, it is a principle, applicable to all diseases, that patients are entitled to the comfort and advantage of all the encouragement which, in the existing state of our knowledge, can be conscientiously given, on the basis of diagnosis and clinical experience. The duty of communicating the full extent of danger may be sometimes questionable; but there can hardly be a question concerning, not only the propriety, but the obligation, on the part of the physician, not to withhold whatever is favorable in respect of the prognosis.

If, as has been seen in the course of these remarks, the facility with which diseases of the heart are now recognized, by means of physical signs, be sometimes a disadvantage, what an advantage is it, on the other hand, to have derived from the study of these diseases the lessons which it has been the chief object of this paper to set forth respecting the innocuousness of certain lesions, the provisions for compensation, the tolerance of lesions which are more or less serious, and the circumstances which occasion, in a very small proportion of cases, a liability to sudden death.—*New York Medical Journal*.

Therapeutic Uses of Chloral.

BY M. M. Pallen, M.D.,

Professor of Obstetrics, &c., St. Louis Medical College.

The use of Chloral becoming more extended every day, I propose to give a short account of its effects, as far as I have witnessed them. * *

A lady labored under a certain form of monomania. She could not rest at night at all, but wandered (if not prevented) about the house. Chloral, in doses of thirty grains, one or two at night, composed her completely; and although she has now recovered her reason, she yet continues the use of the remedy.

Another lady, troubled with endometritis, could not rest at all. Opium in any form had a most unhappy effect. At first bromide of potassium in large doses, combined with lactucarium, procured some sleep at night, but it lost its good effects.

*As bearing on the question whether sudden death is ever attributable to occlusion of the coronary arteries, a specimen recently exhibited by Prof. Loomis, at the New York Pathological Society, possesses much interest. The specimen was from a case in which sudden death occurred during convalescence from pneumonia. Both coronary arteries were plugged with cylinders of fibrin, each of which was connected with a fibrinous mass (a thrombus, not attached) as large as a filbert. The heart was sound, and there was nothing else discovered which would account for the sudden death. The left ventricle was not distended, so that paralysis from overdistention was to be excluded. This case, perhaps, demonstrates that the coronary arteries may be simultaneously occluded; and I am free to admit that it renders this explanation of sudden death, in some very rare instances, less improbable than I supposed, when my remarks in relation to this topic were written.

She was given chloral in forty grain doses, and she sleeps well at night. Her daughter, a young girl of keen observation, tells me that any noise, or the slightest touch from her (she shares the bed with her mother), will arouse her parent, but she falls again to sleep.

To sum up, then, I think it a valuable agent to procure sleep, particularly in feeble individuals. I have given it with the happiest effects, after depletion, in puerperal convulsions. To prevent convulsions, if such do not demand depletion, the same having been used, or never required, I have used it somewhat extensively, and have given it, in some instances, in doses as high as a drachm; to children in doses from six to twenty grains, according to age.

There are diseases in early childhood in which the use of chloral is indicated. I refer to some of the nervous affections. Dr. Parrish described a species of colic, to which was due an attack of convulsions resembling epileptic fits. Dr. Parrish, who described the phenomena well, was mistaken in the order of antecedent and sequence. The disease arose primarily from irritation in the nervous centres, and the spasm in the bowels is the consequence. Moreover, it is the opinion of Dr. Parrish, that if the child survive the period of dentition, it is usually safe. If the convulsive attacks continue during the period of dentition, and cease, they are apt to recur at the age of puberty, or later, and the sufferer becomes an epileptic. Such children are apt to be sleepless, particularly on the eve of an attack. It is here that chloral is valuable. It induces a quiet sleep, and if there be spasm in the muscular coat of the intestine, it produces muscular relaxation.

So, too, in that form of affection known as night terrors. The child sleepless, or even when it sleeps, slumber is disturbed, and it moans or it grinds the teeth. All this should be overcome, or else the child in after-years will be an epileptic. Physicians ought to be aware of this. The great rules of hygiene as to diet, exercise, etc., should be strongly urged on the parent, and to procure rest (a most important point), chloral is the remedy, opium the poison.

The dose to children will vary from four to twelve or more grains, according to age. I always use as the vehicle with which to mix the chloral, the syrup of tolu.—*St. Louis Medical Journal.*

A Physician recently advertised for a partner who could "stand a confinement." He received an answer from six widows with sixteen children each.—*Ec.*

Extirpation of a Kidney in Man.

BY PROF. G. SIMON,

OF HEIDELBERG.

In some English and French journals I find communications regarding the extirpation of a human kidney which I performed in August last at the surgical clinique of Heidelberg. These communications are due to medical men who, on their journey through Heidelberg, have seen and examined the patient. As, however, the said communications contain several inexact and erroneous statements, and as the publication of a full description of the case may most likely not take place for some time, I may as well give the following short abstract. I feel the more justified in so doing, as a sufficiently long space of time has elapsed since the operation, to enable us to judge fully of its results.

Our patient (a labourer's wife, æt. 46) was operated upon by Dr. Walther of Offenbach, on account of a cystoid tumour of the ovary, one year and a half previous to her admission into the Heidelberg Surgical Clinique.

After the abdominal incision was made, it was discovered that the ovarian tumour was so intimately connected with the very enlarged uterus, that that organ had to be removed at the same time as the degenerated ovary—i.e., that ovariectomy had to be combined with hysterectomy. But the ovarian tumour was not alone connected with the uterus, but also with the left ureter so that, at the removal, the ureter was severed in its whole circumference.

The patient recovered, but an abdominal-urethral fistula remained, through which all the urine which was produced by the left kidney involuntarily escaped. I attempted to cure this intolerable state by trying to make a communication between the ureter and the bladder, and by a subsequent occlusion of the abnormal passage, which opened through the abdominal walls and into the vagina. But after many unsuccessful attempts, during which even the life of the patient was several times at stake, we had ultimately to give up this plan of cure. Attempts to produce artificial occlusion of the ureter (and by that means obliteration of the kidney) had also to be abandoned on account of very dangerous symptoms, which made a favourable result most doubtful.

Ultimately I contemplated extirpation of the kidney. By perusing the literature of the day, by experimenting on dogs, by anatomical researches, and by comparing this operation with other some

what similar operations which have been introduced into surgery, I had convinced myself that, in our case, nephrotomy was not only justified but even indicated. Consequently, I performed extra-peritoneal nephrotomy in presence of a great number of medical practitioners and students, after having stated the reasons which, in my opinion, urged me to perform the operation. The patient stood the operation pretty well, and, after six weeks, was so far advanced towards recovery that she could leave her bed. The ligatures of the pedicle did not show any sign of detachment, so I did not try to remove them forcibly, because there was increased suppuration and pain whenever strong traction was made. After six months the ligatures came away with comparatively slight traction. Two days afterwards, the sinus in which they were embedded was closed, and thus the whole wound was cicatrized.

After the ovario-hysterotomy there remained a contraction of the muscles of the calf of the right leg, which took a long time to cure. The patient, whose health, as may well be imagined, had been seriously impaired in consequence of all the operations which she had undergone within three years, is now in a most satisfactory state of health. She is engaged all day in needlework, and sometimes takes long walks in the environs of Heidelberg. The reason that she has not been long ago discharged is, that we wish to have her as long as possible under observation, and because we knew that she must, on going home, return to very reduced circumstances.

These are the chief points of our operation, which hitherto has not been attempted in man. In a pamphlet on the case, which will be published in a couple of months, I shall enlarge on the admissibility of nephrotomy in my case; then I shall give the history of the case, and describe the operation, and shall discuss the bearing of my case on the operative treatment of some diseases of the kidney; concluding with observations at the bedside, and the relation of the experiments on animals, which I have deemed necessary for the decision of some physiological and pathological questions no less interesting than important.—*Edin. Med. Jour.*

Increase of the Physical Power of the Uterus, by the Application of Physical Force to the Fundus Uteri.

By J. H. GRANT, M. D.

* * * * *

The mode of practice I now lay before the profession, has for its object the direct increase of the power of the uterus by the application of physical force to the fundus uteri, in the form of pressure to or upon that part during the pains.

I shall now adduce reasoning and an array of facts to prove that this mode of practice is the most natural, convenient, and effective now known to the profession; requiring not the use of ergot, forceps, or turning, except in cases of mal-position of the fœtus, and will banish craniotomy from obstetric practice, except in cases where it is impossible for the head to pass without mutilation.* *

No. 2. Mrs. J.—n has had several children. Her labors have been extremely hard—the last she had was the severest of all. She was in labor two days, and had several attacks of eclampsia, though she never had anything of the kind before in her life, nor was she in the slightest degree predisposed to such attacks. She was scarcely able to leave her bed at the end of four months, and then could not attend to her ordinary domestic duties. She became pregnant again, and it was her opinion, as well as that of her husband and friends, that she could not survive such another time.

Under the circumstances, I was requested to attend her. The time having arrived, I was summoned to her: when I arrived, she had been in labor about twenty-four hours. She described her feelings as dreadfully distressing, and premonitory symptoms of eclampsia had made their appearance. The os uteri fully dilated; the presentation correct (vertex); no advancement of the fœtus. The membranes did not protrude in the slightest degree. I administered ergot, but fearing it might increase the distress in the head and accelerate the eclampsia, I requested her sister, a stout, strong woman, accustomed to farm labor, to spread out her hands over the fundus uteri, and to press firmly but moderately, gradually increasing by my direction, I myself frequently pressing on the same part with considerable force. In a short time the pains began to increase; the membranes protruded, and I ruptured them. The head symptoms, which were very severe and distressing, now diminished, but the labor progressed very slowly. Finding the labor did not progress to my satisfaction, I directed her husband, who is a very strong man, to place his hands over the woman's, and directed them to press down with all their might. The child now began to advance, and not many pains were required to effect its expulsion. During the process I frequently asked the woman if such pressure gave her any pain or inconvenience, and she invariably replied it did not.

I have also, in similar cases, put the same interrogatories, and have in general received negative answers. The woman was able next morning to sit upon a chair until her bed was adjusted, and in one week was able to be up and about, and declared

she never felt so well, and never recovered so rapidly before in her life. The child weighed twelve pounds, and was very large—the head particularly was excessively developed. * * * *

No. 4. Called to Mrs. A—n; had been in labor with her third child about forty-eight hours. Midwife said the child did not advance, though the pains were severe. Found os uteri dilated to its full capacity; membranes not in the least protruded; entire; presentation natural. Commenced pressing on the fundus uteri; woman cried out, "Oh, don't press there!"—"You'll kill me!"—"I shall faint!" etc. Continued to press, at first moderately, during the pains; after a while pains began to increase. Upon pressing, could feel the fundus uteri harden under the hand, and the tensibility at first complained of soon subsided.

I now requested the midwife to spread her hands over the fundus, and press down with all her strength. The head advanced, and the child was soon born. The after-birth came away in good time, without any trouble. * * * *

I shall not lengthen out this paper by citing any more cases for the present, as I think those given are sufficient to illustrate the mode of practice I have pursued for several years past.

I claim that this mode is, as before stated, the most natural, convenient, and effective known to the profession; equally as safe for the child and mother as any mode of delivery now known in the practice of midwifery. Of all the cases subjected to this treatment, not the slightest injury or inconvenience has happened to the mother. Only two children have been born dead, and one of these was known to have been dead before the operation was commenced.

And I assert, without the possibility of successful controversy, that if the fœtus is born dead under this mode of treatment, it could not have been born alive under any other of equal safety to the mother.

I shall now endeavor to define more clearly the mode of treatment mentioned above.

With regard to the quantum of pressure to be applied, it will of course depend on the resistance to be overcome. Upon applying my hands to the hook or scale of a spring steelyard, I found that I could, with tolerable ease, bring or press it down to the point of twenty pounds; two persons then might press down to the amount of forty pounds, without any great exertion; and indeed it is generally difficult to get assistants to press with all their might, as they are apprehensive of doing mischief, or injuring the woman in some way. * * *

It must be remembered that the conditions necessary for delivery, in all cases, must obtain in these; or in other words, the fœtus must be right, the os uteri dilated, or dilatable. The practitioner must draw the line of distinction between the cases to which this practice is applicable and those in which it is impossible for the head to pass without mutilation, and rendering it necessary to resort to craniotomy or the Cæsarian section. I will make some remark in reference to supra-uterine pressure, as I shall call it, illustrating its utility and modus operandi. The hands of one or two assistants are to be spread over the fundus uteri, and any degree of pressure necessary to enable the uterus to move forward its contents should be applied. It will be found that as soon as this pressure is commenced, the pains rapidly augment in intensity, and return with great regularity, that in cases where the ergot fails to produce the desired effect, and even where it often does mischief, the pressure assists nature, as it were, to do her work in her own way.

The character of the pains is entirely different from those excited by ergot; for the latter excites the uterine fibre, rendering the uterus extremely irritable, so that if it does not speedily follow, great mischief may accrue, and even rupture of the uterus may result. On the other hand, the pains are natural, the uterus not forced to propel its contents, but is kindly and gently assisted to do so. Again, this supra-uterine pressure is conservative in its action and influence, for if it be applied so as to embrace a considerable portion of the body of the organ, there can be no doubt it has a tendency to support that organ and preserve it from rupture, in the same way that pressure on the perineum preserves that part from similar accident. * * *

ARGUMENT.

That labor is a physical process, and that when the power of the organs concerned in the expulsion is inadequate to the performance of this duty, they can be exalted to any desirable extent by the application of physical force to the fundus uteri.

And that this increase of power is more natural and effectual than that produced by the use of medicinal agents; and that the increase of power is in accordance with the operation of the laws of nature, and safety to the mother and child.

The judicious application of such force will entirely supersede the use of obstetrical instruments in cases in which they are now used.—*New Orleans Journal of Medicine.*

The question of the origin of the white corpuscles of the blood is one to which it is by no means easy to give a satisfactory reply. A communication, however, has lately been made by Dr. Klein to Virchow's *Archiv*, which goes far to show that they result from the fission of pre-existing corpuscles.—*London Lancet.*

Injuries of the Ankle Joint.

By W. W. DAWSON, M.D.,

From Section on Surgery, Cincinnati Academy of Medicine.

Injuries of the ankle joint, fractures in its neighborhood, fractures within the joint or its dislocation, always give the physician trouble in the treatment, and great solicitude as to the result. It is one of the largest and most exposed joints, and one of the most frequently injured, yet the bones of which it is constructed are so arranged as to give great security to the articulation, and being bound together by powerful ligaments, it is seldom that we have merely a simple dislocation; in the great majority of cases where the integrity of the joint is interfered with, there is fracture of some portion of the bones entering into its formation.

I intend in this brief paper to refer to some of those lesions of the ankle in which a good result may be confidently expected, and to some in which deformity is inevitable.

Simple dislocation, as I have already said, from the peculiar conformation of the joint, is rare and the result is almost always good; but occasionally, although no violence is done to the skin or to the bones, yet ligaments are so damaged that it requires the closest attention on the part of the surgeon to prevent eversion or inversion of the foot. Such a case must be treated as if it were a fracture: splints must be applied and the foot retained in position until the divided ligaments have united sufficiently to hold the parts in their normal positions. Sometimes, however, this cannot be accomplished; the broken ligaments make an improper union; they are too long or too short in their new estates, and the foot is either inverted or everted. We saw a case of this kind during the past summer, the external lateral ligament had been torn loose from the malleolus in a simple dislocation, it united with the bone below its normal place of attachment. Inversion of the foot resulted.

In one form of *Pott's fracture* a symmetrical limb usually follows, but before describing the accident, I may be allowed to refer to that peculiar lesion to which the name of Pott is attached. Most writers when they speak of "*Pott's fracture*," mean a fracture of the fibula near the ankle and a fracture of the internal malleolus, and yet Percival Pott, in his work on surgery, does not refer to this damage to both bones; he discusses and shows by engraving, fracture of the fibula two or three inches above the joint and accompanying this injury to the fibula, and almost necessarily associated with it, rupture of the deltoid ligament, and a separation of the tibia from its proper position upon the astragalus.

But to return to that form of *Pott's fracture* in which an undeformed limb may be expected. I refer to those cases where the integrity of the anterior and posterior ligaments is not interfered with. In such the tibia will be held in its median position, the separated portion of the internal malleolus will regain its place, the broken fibula will solidify, and scarcely a trace of the accident will remain. A case of this variety was treated by me during the past spring in the Cincinnati Hospital, and is reported in the *Cincinnati Lancet and Observer* for October, 1869. Colles means this species of *Pott's fracture* when he says: "Sometimes we find no distortion of the foot, or anything else remarkable, except a swelling about the ankle, such as might be caused by a sprain."

In fracture of the fibula near the ankle, without accompanying dislocation, the repair is almost always satisfactory.

Simple dislocation of the astragalus, where reduction is complete and unattended with much difficulty, produces no deformity, and if the inflammatory action be not high the normal actions of the joint are preserved.

Simple fracture of the tibia, or of the tibia and fibula near, but not involving the joint, gives the surgeon little trouble in the treatment, and he is generally gratified by a symmetrical limb.

Nelaton reports the only case which has ever been observed of a *simple dislocation of the inferior peroneo-tibial articulation*. The patient was not seen until the thirty-ninth day, the fibula was thrown backward, and was on a line with the border of the tendo Achillis, the "abandoned astragalus" could be clearly defined. The foot was in its natural position, and the patient walked fairly. The dislocation could no doubt have been reduced, and an undeformed limb made had it been seen at an early period.

The foregoing are some of the accidents of the ankle and its neighborhood, in which the physician is master of the situation; but the following tax his patience, draft heavily upon all his resources, and often jeopardize his reputation. In these grave lesions some will be deformed; others will be both deformed and ankylosed.

Compound dislocations stand at the head of these injuries; in them, not only the limb, but the life of the patient is at hazard, and this is often as apparent to the friends as to the attending physician; they are generally satisfied if the life be saved with a comparatively useful limb.

Fracture of the tibia within the joint. In that form of fracture within the joint, where a portion of the external or fibula side of the tibia is sepa-

rated from the shaft of the bone, the fragment is held to the fibula by the tibio-fibular ligament, but the bone itself, no longer under control of this ligament, slips upon the smooth articular surface of the astragalus, puts the deltoid ligament on the stretch, and crowds the internal malleolus against the skin in the most threatening manner. The skin may slough from this pressing bone, and convert this into a case still more serious; but if this complication be escaped, there are no means within the range of surgery which can return and keep in position this damaged and displaced tibia. You may reduce such a fracture every hour in the day; there is no trouble in the reduction, the difficulty is in keeping the parts in their normal places. Bandages and splints are not well borne if you apply them with any degree of tightness; you, by promoting sloughing, increase the gravity of your already unpromising case, and place in jeopardy the life of your patient.

I have already referred to the simplest form of Pott's fracture; that is, to that form in which deformity may not be expected; but unfortunately the great majority of these accidents do not belong to this class. This fracture is by no means unfrequent. Of ninety-three cases given by Hamilton, of fracture of both bones of the lower third of the leg, the fibula and internal malleolus were broken in seventeen—about one in five and a half cases. The pathological anatomy of this form of injury, involving, as it always does, except in the cases I have already mentioned, a partial dislocation as well as fracture of both bones, is apparent. The fibula which gives external support to the articulation in its upright position, is broken and falls against the tibia, the internal malleolus to which is attached the deltoid ligament or the most powerful portion of that ligament separates from the tibia, hence this bone having literally lost its moorings, glides inward and projecting beneath the skin gives great width to the joint. In some cases it projects an inch beyond the articulating surface of the astragalus. An intensified specimen of this fracture, taken from a man who had died from alcoholism a few days after the injury, I had the honor of presenting to the Academy, in April of last year.

In the treatment of these cases the same difficulties are encountered as in fracture of the tibia within the joint before referred to. You may adjust the parts, but as soon as you remove your hands they resume their abnormal positions. You will be fortunate if the tibia does not press its way to the surface. Pott looked upon flexion of the limb as of the utmost importance in the treatment.

Others, by an elevated position, drain the blood from these as they do in all cases of fracture where it is practicable. It seems strange, and yet it is true that such a man as Dupuytren should have attempted, under such circumstances, to control a tibia by a tourniquet. His patient was not so fortunate as to lose only his limb,—he lost his life.

Fracture of the tibia within the joint, where, from the peculiarities of the case, reduction is impossible. This occurs where a fragment is broken loose from the tibia and thwarts the best efforts of the surgeon at replacement. Reduction in some such cases is impossible, and although this is one of the most humiliating of all the experiences which fall to the lot of the physician, yet it is a comfort to know that the wisest and most skilful have failed in accomplishing it. Hamilton, writing on a case of this kind, says: "Our efforts were prolonged in all more than an hour, when, as we had made no impression upon the bone, and the patient had repeatedly implored us to desist, the attempt was given over. The end of the tibia seemed to rest partly upon the astragalus, and the extension was plainly all that was demanded; but the obstacle was beyond doubt within the articulation, or rather between the tibia and fibula. * * * * * Not long since I had occasion to amputate a limb for a compound dislocation inward at the ankle joint, and the possibility of this fracture was confirmed by dissection. About one-third of the outer portion of the articular surface was broken off obliquely, and the fragment was lying so displaced that a reduction would have been rendered impossible. * * * * * Dr. Townsend, of Boston, has reported a case of compound dislocation in which amputation became necessary, and, with other injuries, the dissection showed a fragment from the outer margin of the tibia, one inch and a half long, and one inch thick at its widest part, with a very sharp point, displaced and lying almost transversely over the astragalus."

In this contribution to the report of the Section on Surgery, I have space left for but one more of the various lesions of the ankle joint; this space I shall devote to the astragalus. Situated above securely between the malleoli, resting below upon the os calcis, and in front braced against the scaphoid, the astragalus is seldom disturbed; but when it is, the most serious consequences generally follow. I have already discussed its simple dislocation and easy reduction. Unfortunately, this is seldom the case; usually the luxation is compound or complicated. When the dislocation is compound, resection or amputation should be resorted to. The former (resection), without there be very great in-

jury to the soft parts, should be preferred. It should be preferred also to reduction where the disturbance to the bone is great. It is remarkable how good a limb may be made after the loss of so large and important a bone as the astragalus. Turner gives eighteen cases of complete excision of this bone. In fourteen cases, these recoveries were good, and anchylosis followed in but one of the fourteen. I saw a case during the past summer of compound fracture and dislocation of the ankle joint in connection with Dr. McMehan, of this city. The astragalus was thrust from its bed through the skin, and removed by Dr. McMehan with a few touches of the knife. The ends of the tibia and fibula were injured; these were removed. The patient recovered with a useful limb, but stiff joint.

I have thus sketched some of the simplest and some of the gravest accidents to which the ankle is subject. There are no injuries in which the surgeon hazards so much as in some of those alluded to; they are a prolific source of litigation. Percival Pott, in speaking of one of these injuries—one in which the tibia has lost its inferior connections, says: "But in its most simple state, unaccompanied with any wound, it is extremely troublesome to put to rights, still more so to keep it in order, and unless managed with *address and skill*, is frequently productive of both lameness and deformity ever after." We may well ask who has sufficient "address and skill" to prevent "deformity and lameness" in many of these cases—in the large majority, I may, say, of just such cases as he was then describing? Such remarks as these—and unfortunately too many of them are to be found in our literature—lay the foundation of suits for malpractice, the lawyer quotes such assertions to show that his client would have had a good, a perfect leg, if the attending surgeon had had the requisite "address and skill."—*Med. and Surg. Report.*

Doctors and Teetotalers.

BY A PHYSICIAN.

The subject of alcohol is one of the most stirring of the present time in the domain of hygiene. Is there anything like orthodoxy to appeal to in this, as there is in some other medical questions? Are the members of the medical profession by any means so unanimous in their condemnation or in their approval of the habits of modern society in partaking of alcoholic drinks as they are on the question of vaccination as a preventive of small pox? The answer, we maintain, must be in the

negative. There is nothing like unanimity on this point amongst us. Such being the case, it behoves each of us to argue the question by the lights that are in us, without in any way appealing to authority. Well, as far as we ourselves can see, there can be no doubt that the teetotal party can make out an admirable case when they assert that a very large proportion of the disease and crime among us is traceable directly to the use of spiritous liquors in some form or other. Specialists, who devote their attention to diseases of the kidney, the eye, or the brain, will at once probably corroborate our assertion, that hosts of cases of disease in these organs are traceable to alcohol. The pallid and dull skin of the habitual drinker is well known to the hospital physician; the bronchitis and emphysema of old drinkers is one of his most common experiences. Gout, and dropsy, and disease of the heart are the usual terminations of the lives of the swillers in our large cities. What is there to be said on the other side? The doctors who advise us to use beer and wine daily at our chief meals say that we are living in "an artificial state of society," and hence require stimulation to get through the wear and tear of existence without breaking down. This looks well in theory but does not hold true in nature; at any rate in all cases. Those persons—and they are not a few—who have witnessed the practice of hydropathic institutions, know well that many persons who are accustomed to habitually partaking of a certain number of glasses of wine or pints of beer daily find the simple fare and unexciting beverage there obligatory more conducive, in most cases, to health than their ordinary more exciting regime. And persons who train for prize fights or for boat-racing are obliged, if they would quickly get rid of the softness of their tissues and attain to good wind, almost entirely to abandon all their beer and wine for a time. If such persons often become ill and die young, it is that they are often very idle and intemperate when not in training. Boerhaave said truly that water-drinkers live longer, have a better appetite, and preserve their sight longer than those who drink beer,—he might have added, or smoked tobacco, as he was, we think, a Dutchman. Our conviction is that alcohol is a medicine, just like opium, and should only be used for some temporary purpose, and steadfastly avoided by all persons as a daily part of diet. It is true that many persons can use opium daily, and seem to live pretty healthily notwithstanding; but the vast majority who do it are deeply injured and depraved by opium-eating or smoking; and, in the same way, the ingestion of alcoholic beverages cannot be defended, in our humble opinion, by any physician who has the facts in his recollection which we have alluded to above. There could not be many changes in civilized society to promise a greater improvement in human affairs than the abandonment of drinking of alcoholic liquors; and for more reasons than one.

Our concern, of course, is not with the moral aspects of the question, except in so far as the use of alcohol takes away from the amount of money which its habitual consumer, if poor, is able to expend on nutritious food; the economical argument is not fit for our pages; but we have no hesitation in saying that the habits of gin and beer drinking in London and elsewhere produce a callousness to questions of human suffering and disease which would be certainly lessened if drinking were nearly abandoned. Brains soddened with gin and beer are less able to take interest in the great questions of the hour, the removal of pauperism and ignorance, than those left clear by the use of simple beverages such as the aromatic infusion. We are not in the least anxious, by these remarks of ours, to seem to dogmatize on what is evidently a difficult question. Doubtless, numerous persons, especially among the well-fed classes, are but slightly injured by the moderate amount of wine and beer they consume, whilst they are rendered gay, and have more pleasures of a physical kind, from the moderate consumption of alcoholics. But, taking all things together, we are strongly of opinion that it would be much better for one and all of us to resort to aromatic infusions, such as tea and coffee, instead of using alcoholic beverages. Human life would be simpler, less costly, and more impressionable; besides which, hosts of cases of dropsy, of palsy, of atrophy, and degeneration would cease to sadden the physician's eye. Temperance in all things is good; abstinence from alcohol is one of the virtues which should be inculcated upon the young.—*Medical Press.*

The Medical Reform Crisis.

The Government Bill has passed the House of Lords. Clause 18 has been restored, and some amendments withdrawn. This is the news of the week; and although clause 18 gives the Bill some slight value, it is by no means such a bill as will give satisfaction, or last a long time. It must, therefore, be attacked in the Commons. What does it effect? It sets up three portals into the profession, one for each of the kingdoms, as if medicine were a different science in London, Dublin, and Edinburgh. The profession cries out for a single portal. Let the three United Kingdoms be seen to be really united so far as medical licensing is concerned. A single imperial diploma, giving the right to practise every branch of the art of healing wherever the Queen's authority prevails, would be the best protection for the public, give the most satisfaction to the profession, and interfere least with the examining bodies.

The Universities and Corporations might then make what rules and regulations they pleased. They would only be forbidden to grant their honors to unlicensed persons. Justice would thus be done. Those Universities and Corporations whose diplomas were of real value would have plenty of applicants

for them; and if a few were really useless, they would quietly die out, or amalgamate. This is the great reform that all earnest men have for years demanded, and the Government Bill gives us only a feeble attempt at compromise—a wretched three-portal system, possessing the elements of competition downwards, and sowing the seeds of jealousy between the three "United" Kingdoms. What is to keep the three examining boards to the same level? If that were possible, what is to convince students or others that the level is the same? What is to prevent the licentiate of the Irish Board from sneering at his neighbor as the possessor of a "Scotch diploma," or the two trying to persuade the public that the English licentiate is more easily passed than the others? If we are to have a change, let us have a measure that shall effectually settle all such differences. Give us a single State license. Let that be the sole entrance into the profession, and we will decide for ourselves what other diplomas we will take as honors.—*Medical Press and Circular.*

Conservative Surgery.

Dr. Wayne Griswold, of Circleville, Ohio, sends the following case to the *Western Journal of Medicine*:

December 8th. 1868.—Was called to see Miss W. While holding a chicken for her brother to kill, a misdirected blow of his hatchet cut off the end of her thumb, taking the entire nail, about one-third of the first phalanx and the entire ball of the thumb. On asking for the piece of thumb they informed me that it was rolled up in a cloth out in a cold room, and that it had been one hour and three minutes (by the clock) since the accident. The mother was in great tribulation at the prospect of a deformed thumb for her youngest daughter, and the child was still more worried for fear she would not be able to play octaves on the piano. After washing the thumb in warm water till it bled freely, and warming the piece in the same manner, it was placed as near in position as possible and secured by adhesive straps. Left orders to wet the thumb (in a warm weak solution of carbolic acid in water) every few hours.

On the third day removed the dressing. The parts adhered, but the nail looked blue and the skin white and dead. Dressing continued.

On the sixth day, removed the skin and with it the phalangeal bone. The ball of the thumb looked like a piece of fresh beef covered with purulent matter. Found by examining with a glass, a new nail starting. Continued the carbolic acid dressing.

The old nail came off in fifteen days; a new one took its place, leaving the thumb perfectly natural, except a little flatness of ball from loss of bone. There is not a scar to mark the place where the thumb was injured. New skin formed from the stump up over the ball, smooth as it ever was. The mother was left to rejoice that her daughter had no thumb deformity and was again able to play the piano as well as she did before the injury.—*Medical and Surgical Reporter.*

The Dominion Medical Journal,

A MONTHLY RECORD OF

MEDICAL AND SURGICAL SCIENCE.

EDITORS:

UZZIEL OGDEN, M.D., L.M.B.

J. WIDMER ROLPH, M.D., L.R.C.P., LOND.

TORONTO, JULY, 1870.

OUR MEDICAL SCHOOLS.

For the last ten days our Journal, with the exception of this page, has been lying in type, but we have held it back until our Publisher's patience was exhausted, for the purpose of being able to announce to the profession the *personnel* of the staff of our Toronto Medical Schools. In Victoria University especially, we believe that at one time the resignations of quite a number of the staff were in the hands of the President, but as there is every probability that the greater portion of them will be withdrawn, we refrain from saying more. We can, however, authoritatively announce the entire resignation of the Dean, the Hon. Dr. Rolph, who withdraws from all connection with that Institution, and he will be followed by at least one other of the staff. Dr. Hodder has also vacated the chair of Obstetrics in the Toronto School of Medicine. More than this we are unable so say positively, as negotiations are still pending, the results of which are uncertain. We refer our readers to the advertisements.

CREAM OR SKIM-MILK.

We have been a good deal amused at the following paragraph, which appears in the Hamilton correspondence of the *Canada Medical Journal* for June, where the writer says, "We were glad to find Dr. Oldright (who with Drs. Agnew, Mostyn, C. B. Hall, and Bethune, and one or two others, really represent the feelings of the *cream* of the Profession at the Medical Council) doing good service," &c., &c.

Now the five gentlemen named are all "jolly good fellows every one," and we entertain for them a strong personal regard, but the "one or two others" we cannot vouch for. But let us see what the "cream of the profession" is like, as represented by the gentlemen named.

We find that Drs. Oldright, C. B. Hall, and Bethune, represent three Universities, not one of

which possesses an organized Medical Faculty, but as we think our readers would like to know who constitute the "*cream* of the Profession," we have taken some pains to ascertain how many medical men have positions in the Senates of the Institutions referred to, in order that we may form some idea of the *relative proportions* of cream and skim-milk, into which our author thus divides the Profession.

We confess we do not feel very highly flattered by the result of our analysis.

Dr. Parkes says, that good milk should contain 4 to 6 per cent. of cream, but the best French and American writers assert that the proportion should be 10 or 15 per cent., and we are bound to admit that the amount of professional cream represented at the Council Board, is very little more than the low estimate of Dr. Parkes would call for. Dr. Oldright was elected by the Senate of the University of Toronto, which contains *three* medical men, Drs. Hays, Herrick, and Aikins.

Trinity College elected Dr. C. B. Hall, and we find that Dr. Bovell is the only medical who has a seat on her Senate, and is in a position to vote for her representative to the Council, while there is *not one* medical man in the Governing Body of Queen's College, to cast his vote for Dr. Bethune, if the published lists be correct.

We therefore find that three of the five gentlemen, who are said to represent the "*cream* of the Profession," have been elected by *non-medical* bodies, containing, all told, just *four* medical men, two of whom have taken no part in medical politics or practice for many years.

Verily the percentage of cream appears rather low for a body supposed to be so rich.

Four men constituting the *cream* of the body represented by about one-sixth of the regular division of the Medical Council.

"Drs. Agnew and Mostyn, and one or two others," who represent territorial divisions, were elected by true medical votes, and may claim with a greater show of reason the position assumed for them by the writer in question, but we doubt whether it will be regarded generally as a very high compliment to be likened to so light and oily a thing: even as cream.

Cream is all very well in its place, either among the profession, or as an article of diet, to dance attendance on Vice-Regal Receptions, or to flavor our grandmother's tea, too large a proportion, however, conduces to corpulence and great sluggishness of mind and body, but we are able to congratulate the profession upon its comparative freedom, from all

danger arising out of an excessive development of its fatty elements.

After all, however, we believe in skim-milk to develop a sturdy manhood, and although we have the honor of living in one of the "cream" districts, yet we regard those who reside in the land of skim-milk, as worthy of quite as much respect, and capable of exhibiting quite as independent a judgment and intelligent an exercise of the franchise as those even, who constitute the "cream of the Profession."

CANADA MEDICAL ASSOCIATION.

We would remind our readers that this Association meets at Ottawa on the 14th of September next. We expect a large muster of the profession from all the Provinces, and trust that Ontario will not be behind. The opportunity of a trip at one fare to the Capital of our Dominion, there to meet the *cream* of the profession, is one that does not often offer itself; and we trust that medical men will, wherever it is possible, avail themselves of it. In order that the Association should really be the voice of the profession, a full attendance is necessary, and the numbers from all parts of the country should be as nearly as possible equal. We therefore make a special appeal to our Western brethren not to suffer their section to be unrepresented.

CLINICAL TEACHING.

The tendency of the medical mind seems to be more and more, every day, in favor of Clinical Instruction, and we believe, that the more our young men are made familiar with disease at the bedside, and are enabled to watch the practice of their seniors in the case of accident or disease, the better will it be for them, the better will it be for the people, the better will it be for the future of the profession, and the less likely will we be, to have those suits for malpractice, which every now and then create such dismay, annoyance, and expense among the whole body of the profession, and the less likely will we be to have that discrepant medical testimony, which is now so invariably given on these occasions, and is the cause of so many sneers and gibes at our expense. No greater mistake was ever made than when young men were sent out to contend with diseases and accidents, in districts far removed from counsel or assistance, without having had the most ample opportunity afforded them of studying diseases and accidents, as they actually present themselves, in the wards of a large hospital. But we hold that it is comparatively little

use, for a student to walk the wards of the best appointed hospital, unless some older head takes an interest in pointing out to him the various phases which the same disease is capable of presenting at different times, and instructing him how to discriminate between diseases which often resemble each other very closely in outward appearance, but differ very widely as to their essential character. This brings us back to the old question of clinical instruction, and the possibility of getting it more fully recognized in our own hospital, which after all, furnishes a fair amount of material for instruction, if it were only utilized.

When we look over the announcements of the American schools, we are struck with the prominence which they all justly give to this department of their courses, and the ample provision being made, even by the oldest and most conservative of them, for its efficient treatment. Even so old an institution as the University of Pennsylvania has been compelled to follow the popular current, and a few weeks ago appointed no less than six clinical lecturers.

We think the present rather a favorable time for the inauguration of this new feature in connection with our Toronto schools, and that an effort should now be made to reorganize our existing medical schools, or to establish a new one altogether, on the recognized basis of clinical teaching, and we are fully persuaded that if this be done, that school, whichever it may be, that most fully carries out the principle, will occupy the foremost place among our educational institutions, and will receive the most hearty approval of the public, the profession, and the future medical students.

Correspondence.

FROM OUR NEW YORK CORRESPONDENT.

NEW YORK, July 5th, 1870.

The Medico-Legal Society, of this city, was organized a little more than three years ago, by a company of physicians, of which the writer was one. At first the meetings were held alternately at the houses of members, but lately it has been necessary, owing to the increasing attendance, to convene them in the hall of the College of Physicians and Surgeons. The society is composed of legal and medical men; the subjects discussed pertaining to the wide and comprehensive field of legal medicine, and requiring for elucidation the legal as well as the medical mind. I believe this great city has been the first to institute such a society, on this continent; and, though, I will not be

positive on this point, I think the Paris Medical-Legal Society, which is in regular communion with us, was founded after our experiment had proved successful. Be this as it may, however, the Medical-Legal of this city has already attained great prominence and popularity, and numbers on its list of membership some of the most distinguished physicians and lawyers of the community. There was a meeting of this association on the 9th ult., to listen to a paper, by Dr. O'Dea, on "The plea of insanity in criminal cases." He took for his text title vii, Section 2nd, of the Revised Statutes of the State of New York, defining the legal status of insane criminals. After characterising in strong terms the recklessness with which the plea of insanity is urged in our law courts, he sketched its history from the time of Lord Hale, one hundred years ago. He forcibly exposed the contradictions and inconsistencies of this criterion delivered to juries, as tests of the sane or insane character of a given act, and concluded by stating the reforms necessary to remove the abuses of which he spoke. They are as follows: the reform proposed by Governor Alcorn, of Mississippi, viz.: to have the question of insanity decided in the Chancery Court, before the trial of the alleged criminal act can proceed in the Circuit Court; and his own proposition, that in addition to this, the calling of medical testimony should be placed in the hands of the Court. The paper will be published, in full, in the *Psychological Journal* for October, a very able quarterly, under the editorial management of Professor Hammond. I hope to be able to send you a copy.

The question of admitting women students of medicine, to the clinics and operations attended by men, though for some time practically settled in many parts of this country, has been causing some animated discussion in Great Britain. I refer particularly to the debate at the recent half-yearly meeting of the General Council of the University of Edinburgh, in which Professor Masson championed the ladies, and Professor Laycock opposed them. With the merits of their arguments I wish to have nothing to do here. My object is to point out that both in the United States, and many European countries, the adoption of women to clinical instruction, and to operations attended by men, is an accomplished fact, from which no serious practical inconveniences have arisen. Thus, in our Bellevue Hospital, in the medical school of Wurzburg, Switzerland, in Paris, in Vienna, and, I think, in Moscow, females aspirants to a medical career are admitted to the clinics and demonstrations given to the men.

This leads me to say a few words on the system of clinical instruction adopted here. I will speak particularly of Bellevue Hospital. I may say, parenthetically, that this noble charity was established in the autumn of 1826, and it contains provision for *twelve hundred* patients. The maximum charge for admission to the sick is \$3.50 a week, which is only asked of those who are amply able to pay. The cost of conducting this institution is nearly \$90,000 a year. Well, the system of clinical instruction here in vogue is, I am informed, purely voluntary. Such members of the attending medical staff as feel competent to teach give, sometimes, informal expositions of disease at the bedside, sometimes, formal lectures on particular cases in the theatre. Such instruction is announced at the beginning of the season, and certain days during the week fixed for it. To these instructions all students who pay the entrance fee—three dollars, I think—are admitted. The system works admirably, and insures a quality and quantity of instruction not to be surpassed in any city I have ever visited.

Death has been busy of late in the ranks of celebrated British physicians. Simpson, Syme and Clarke, have followed in rapid succession to that mysterious hereafter, "whence no traveller returns." They were great lights, and all suddenly put out.

— "O proud death!
What feast is toward in thine eternal cell,
That thou so many princes, at a shoot,
So bloodily hast struck?"

To the Editors of the Dominion Medical Journal:

GENTLEMEN,—Could you inform me who are responsible for the following errors which appeared in the *Canada Medical Journal*, for June, 1870; the mistakes occur in an article entitled "Attempted Simulation of Disease," and are as follows:—

Pons Assinorum,.....	Blot No. I.
Echymosis,	" II.
Cheff d'ouvros,.....	" III & IV.
Nonchallance.....	" V.

Any information on the above would be gratefully received by

Your Obedient Servant,

19th July, 1870.

[We suppose the printers could explain the matter best, as a writer of the high classical attainments evidently possessed by the author never could make such *faux pas* as the above. When persons like ourselves, who do not belong to the "Cream of the Profession," trip in our orthography, the little *imp* of the galley is charitable enough to correct it for us, but he obviously either feared to meddle with the above, or doubted his own slender acquirements.]—ED. DOM. MED. JOURNAL.

Reviews and Notices of Books.

A PRACTICAL TREATISE ON THE DIAGNOSIS, PATHOLOGY, AND TREATMENT OF DISEASES OF THE HEART. By AUGUSTIN FLINT, M.D., Professor of Medicine and Clinical Medicine, Bellevue Hospital, New York. H. C. Lea, Philadelphia, 1870.

When we consider how important it is to be familiar with diseases of the heart, so that the functional disturbances may be distinguished readily from what are rightly termed organic affections of that organ, and how very frequently, in every-day practice, heart diseases occur, it is pleasing to be able to announce a new edition of a previous work by a very able writer, Prof. Austin Flint, of New York, devoted specially to that subject. Beginning with the various forms of enlargement of the heart and the affections of its walls, he goes on to the subject of valvular diseases, and describes congenital malformations. A chapter is devoted to such affections as are incidental to diseases of the heart; as for instance, coagulation of fibrine within the cavities of the heart, angina pectoris, and several other morbid states, more or less frequently associated with cardiac disease. Inflammatory diseases of the heart, as pericarditis and endocarditis, with myocarditis, receive their full share of attention, the various points connected with the diagnosis of these diseases being specially dwelt upon, and the treatment recommended being of a very practical and common-sense kind. Functional diseases are carefully and fully described, and the many points of similarity between functional and organic disease, which so often lead the ignorant and careless into sad blunders, are pointed out, and clear instructions given, so that errors in diagnosis and prognosis, so discreditably and often so injurious to those who make them, may be avoided. The volume before us closes with a chapter on aortic diseases, and gives much information as to thoracic aneurisms. Of course the bulk of this is to be found in other works on the subject; but Professor Flint has a practical way of treating every subject, which makes his writings of great value; and to any one who wishes to possess a full and accurate knowledge of the morbid affections of the heart, this work will be found of the greatest service.

Miscellaneous, &c.

The American Medical Association.

"We give the report of the proceedings of the National Medical Association, held in May last, at the National Capitol, as given in the New York *Medical Gazette*:

"Twenty-one years ago this Association was organized with the best wishes and highest hopes of the medical profession. What has it done in all that time? Year by year it has dwindled, until

the hopes of its founders have ended in shame and humiliation. No subject of higher consideration than the fee that should be charged for examination for life insurance companies, or the color of the skin requisite to membership to medical societies was definitely settled.

"The proceedings upon the whole would do credit to some Trade's Union Convention, and its objects seem to have been no higher. If the profession at large has been deteriorating as fast as this national association during the same time, may God have mercy on us!

"The Association did agree upon one other thing, which fills us with apprehension. It resolved upon the solicitation of some physician, who was at Washington on some lobby business connected with a hospital contract, who, it seems, had credentials sent to him by the so-called San Francisco Medical Society, to invite them—to meet next year in this city.

"We shall be glad to see them, we will show them the Seal Rock, Woodward's Gardens, our magnificent and unique City and County Hospital, and do the best we can to make their stay as pleasant as possible. The San Francisco Medical Society will furnish a steamer to take them about our beautiful harbor. The President of the San Francisco Medical Society will be delighted to take them to Yo-Semite Valley; his overflowing wine-cellar will make their hearts glad; but we hope the 'nigger question' will not be raised here, for we are not all white. Some Caucasian physicians, too, do attend African patients, and the question might be raised—but we will not borrow trouble, 'sufficient for the day is the evil thereof.'—*Cal. Med. Gazette.—Med. and Surg. Jour.*

Probable Duration of Pregnancy.

In the course of an action for damages for the seduction of a young woman, the question of the possibly protracted duration of gestation was raised. The alleged father had had no access to the mother of the child later than 301 days before its birth, and he naturally disputed his liability. Dr. Tanner deposed that the ordinary period was 270 to 280 days; but might be exceeded by 2, 3, or even 4 weeks. He thought there was no inconsistency in the present case (from April 15 to Feb. 9—that is, 301 days). He had not known any case himself in which the ordinary period had been exceeded by a week, but he had no doubt there were such cases. He had heard of such. Mr. James F. Clark deposed that there were on record cases extending over 310 days. Sir James Simpson had recorded a case of 310 days. Dr. Barnes deposed that the ordinary period was 271 days. He had known cases 290 and 285 days. He thought it very improbable, but did not like to say it was impossible, for gestation to extend over 301 days. It was so improbable that he did not believe it. Dr. Tyler Smith said that the longest period of excess he had known was a fortnight. Dr. Reid—a most accurate observer—has recorded forty-three cases of protraction, the longest of which was 300 days. Dr. Smith considered that case as reliable as any doubtful case could be. The verdict was for the plaintiff; damages, £200.—*British Medical Journal.—N. O. Jour. of Med.*