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**Original Communications.**

THE MANAGEMENT OF THE THIRD  
STAGE OF LABOR.\*

BY A. H. WRIGHT, B.A., M.D., M.R.C.S. ENG.,  
Professor of Obstetrics in the University of Toronto.

A paper on this subject was read before a meeting of this Association in Hamilton eight years ago by the late Dr. George A. Tye, of Chatham. I was very much impressed by the views at that time enunciated, although I differed from the reader in many, if not most, of his conclusions. It was my pleasure to have an intimate acquaintance with Dr. Tye; and I am thoroughly convinced that he was one of the most conscientious workers, one of the most careful observers, and one of the grandest physicians that this country has ever produced. On the occasion referred to, he took a strong stand against Credé's method of expressing the placenta, and warmly advocated the expectant or do-nothing method. He stated that he had practised this plan of forcible expression for ten years, with bad results, inasmuch as he had a large number of hemorrhages. He had observed during a portion of that time that when called to cases which had been attended by midwives, who left the expulsion of the placenta to nature, that flooding seldom occurred, although the placenta was frequently retained a long time. He then abandoned the method, and pursued the expectant plan for seven years with good re-

sults. He thought that it not only tended to prevent the occurrence of hemorrhage, but also assisted in the prevention of puerperal fever.

With due respect for one whose opinions were always worthy of careful consideration, I will refer to some of his statements at a later stage.

On consulting Tyler Smith's work on obstetrics, which was the first I read in my student days, I find the following directions with reference to the management of the third stage of labor: "When the pains recur (after the birth of the child) gentle traction should be exerted upon the cord. . . . If there should be no pain, the finger should be introduced into the vagina, and the stringy insertion of the cord will generally be felt. . . . In extracting the placenta slow and gentle traction only should be used, as by this means the whole of the membranes . . . are likely to come away with the placenta." Other British obstetricians, and especially those of the Dublin school, at that time advised pressure on the uterus after the birth of the child as the best method of expelling the placenta, and preventing post-partum hemorrhage. To Credé, however, is due the credit of giving the most complete description of expelling the placenta by force applied externally to the uterus, as opposed to the method of extraction by pulling on the cord.

What, then, is Credé's method? I know of no procedure in midwifery which has given rise to more confusion than this same method. This has arisen from the fact that Credé in later years made an important change in the plan he

\*Read before the Ontario Medical Association, June 1, 1892.

first adopted and described. After the expulsion of the child he applied friction to the fundus, and when the first uterine contraction occurred he grasped the fundus in his hand, with the thumb on the anterior wall and the four fingers on the posterior wall, and thus squeezed out the placenta—"as the seed from a ripe cherry compressed between the thumb and fingers." His aim appeared to be to complete the operation as soon as possible, and, according to some of his earlier statistics, the average duration by expression was  $4\frac{1}{2}$  minutes. This method was popular for years, although many opposed it. After a time the opposition grew stronger, and a reaction set in. It was then condemned as harsh and unscientific. I think there can be no doubt that the adverse criticisms which became so common at this time were essentially correct. In the hands of many, if not the majority, it was extremely harsh, and caused much unnecessary pain. Too much attention was given to a rapid expulsion of the placenta, and too little to the expulsion or extraction of the membranes. As a consequence, large portions of the latter were frequently left in the uterus. The rapid expression of the placenta partially emptied the uterus before retraction and contraction were properly established. Under such circumstances accoucheurs were likely to meet with two conditions—inertia of the uterus and retention of membranes—which together were always likely to favor post-partum hemorrhage. And yet Credé's chief aim was to prevent such hemorrhage.

It is somewhat remarkable that results so varied should follow any one plan of treatment. I think that in the hands of Credé and his assistants the results were generally satisfactory; but it was soon discovered that the dangers to which I have alluded were very serious in the practice of many who were either unskilled or improperly taught. Without going too minutely into details, I may say that Credé himself, after practising his method some years, recognized these defects, and accepted the rule that no one should endeavor to squeeze out the placenta until at least fifteen minutes had expired after the expulsion of the child. This extremely important modification of Credé's original method is a great improvement, and, while it makes the plan almost perfect in the opinion of the great majority, will account for the many misconceptions

which have appeared in the numerous discussions which have taken place on this subject.

I have no doubt that the bad results which Dr. Tye noticed in his practice were entirely due to the faulty features in Credé's earlier efforts, together with the very defective descriptions of his work. When results so disastrous followed the obstetric efforts of so able and careful a practitioner as Dr. Tye, it is difficult to have any idea of the injuries which might follow such defective methods in the hands of the rank and file of the profession in this and other countries. In discussing the subject, I shall consider the modified Credé method and that of the Dublin school as practically the same, and actually the best known; but I think that many of the details are worthy of a critical discussion.

My description of my conception of the method need not be long. While the child is being expelled keep the left hand on the uterus, and endeavor to keep it contracted. In my own practice, my aim is to keep this hand on the uterus for at least half an hour after the expulsion of the child. I use the right hand to place the child in a proper position, or get the assistance of the nurse for the same purpose. I object to the practice of asking the nurse to press on the uterus while the accoucheur ties the cord. In my experience, I have not met one nurse in ten who is able to perform this duty effectually; and I make it a rule, on that account, to ask the nurse to tie the cord. If I am not satisfied with the way the ligature has been applied, I retie the cord after I consider it safe to remove my hand from the mother. Harsh friction or rough kneading is quite unnecessary. I would like to emphasize this point, because I have seen methods unnecessarily rough employed by competent practitioners. It frequently happens that a slight friction with one or two finger tips is quite sufficient to keep the uterus well contracted. Wait 15 to 30 minutes before making any active efforts to express the placenta. If possible, choose the acme of a pain, or, more correctly speaking, of a uterine contraction. Endeavor then to squeeze out the placenta either with one hand in the manner before referred to as described by Credé, or grasp the fundus with both hands, taking care to squeeze and press in the direction of the axis of the uterus. When you are confident that the placenta has left the

uterine cavity, I think traction on the cord, as practised by those of the Dublin school, will often afford material assistance.

After the expulsion of the placenta, we have to consider the extraction of the membranes. I say extraction, as distinguished from expulsion, advisedly; and I think the directions usually given in our text-books on this point are exceedingly defective. It is a very common practice to continue squeezing the uterus, and at once commence turning the placenta so as to twist the membranes into a cord. I believe the result of this method is frequently to tear through the membranes, while a considerable portion of the same is retained in the uterus, which is being squeezed so tightly. We are so thoroughly imbued with the *vis a tergo* idea in connection with the delivery of the child and placenta that we are apt to forget that the extraction of the membranes should be effected by an entirely different process. My advice in connection with this procedure is to take plenty of time—not less than 5 to 10 minutes. Don't drag away the membranes rapidly, but support the placenta in such a way that it will not pull forcibly on them; watch for slight relaxations or dilatations of the uterus, and during such coax them away. If you detect a slight tearing on one side, pull gently on the other. A little judicious twisting may assist sometimes, but remember the dangers connected therewith, and beware.

If no abnormal condition be present, it is quite unnecessary to introduce the fingers or hand into the vagina or uterus during the third stage of labor. In speaking to my class of students, or in giving directions for my cases in the lying-in hospital, I insist strongly that the finger shall not be introduced into the vagina after the delivery of the child if it be possible to avoid it; and, in the great majority of cases, such procedure is entirely useless. My objections, however, are not based on mere inutility, but on the fact that this is the period when there is the greatest danger of introducing septic matter into the system. The passage of the child has produced tears of greater or lesser extent in the cervix, vagina, or perineum, or perhaps in all three combined; and the open-mouthed blood vessels and lymphatics are ever ready to absorb and distribute through the body any poison that comes within their reach. If you

happen to be in doubt as to whether small portions of membranes are retained, don't investigate too carefully; leave them alone; if no septic matter be introduced, they are not likely to do any harm. If you have reason to believe that large portions of membranes or placenta are retained, it will be necessary to introduce the fingers or hand and remove them; but be careful to use the best methods of cleaning your hand and arm which science and art have placed at your disposal. Wash and disinfect them as carefully as if you were going to perform an abdominal section.

Many discussions have taken place recently with reference to the physiology of placental expulsion. I have not time to discuss this question in detail, but I will give briefly the views which prevail with the majority. Detachment of the placenta is caused by a contraction in the area of its insertion, in which contraction the placenta itself cannot share. Separation occurs in different ways, varying according to the position of the placental insertion. When inserted at the fundus it begins to separate at the centre, forming a cavity in which a certain amount of blood accumulates. When separation is completed the foetal surface of the placenta falls towards the cervical canal, and the membranes follow, being turned inside out and containing a certain amount of blood. The placenta and membranes emerge in the same order from the vulva. When the placenta is inserted in the anterior or posterior wall the separation begins either at the upper or lower edge, and, as it descends, may appear at the vulva either by its foetal or maternal surface. The lower the insertion, the more apt is the maternal surface to present at the vulva. The views herein expressed do not coincide with those of Matthews, Duncan, and others, who thought that when there was no interference the common method of separation was such that the edge of the placenta presented at the cervix. The practical point to bear in mind in this connection is that when traction on the cord is employed before the placenta is dislodged from its place of insertion, the initial separation is central; a partial vacuum is thereby produced, which sucks the blood from the large uterine vessels, or tends to invert the weak and flaccid uterine walls. This generally admitted fact

furnishes the strongest and most convincing argument against the pernicious practice of early traction on the cord.

There are three objects gained by the modern Credé method :

(1) By maintaining retraction and contraction of the uterus, it prevents hemorrhage.

(2) By causing rapid expulsion, it tends to prevent the dangers accruing from retention.

(3) By thoroughly emptying the uterus, without introducing the fingers into the genital canal, it tends to prevent septicæmia.

I think it quite unlikely that the puerperal fever observed by Dr. Tye was caused by the faulty Credé method, but rather by the introduction of septic matter from without by unclean fingers. The fact that puerperal septicæmia is nearly always due to such causes is generally admitted ; and yet, I am sorry to say, it is not even now properly appreciated. I have seen, during the last few years, some very absurd specimens of so-called antiseptic methods in the hands of men who acknowledged the necessity for antisepticism or asepticism in midwifery, but scarcely had the first idea of the proper methods of carrying out the principles or practice involved. It is not my place here to describe such methods, but I wish to state very emphatically that no system of procedure (whether Credé, expectant, or otherwise) gets anything like fair play in the hands of one who has not correct and positive ideas about asepticism. The statistics or general results of any one who is indifferent about such matters are simply not worth considering.

This brings me to the question, What shall we do after the placenta and membranes are delivered? As I have before indicated, it is frequently necessary to watch the condition of the uterus for some time to prevent, as far as possible, relaxation and dilatation. I wish to refer now, however, more especially to the treatment of the bruised and wounded genital tract. Nature's efforts at repair are magnificent and effective, if we give her anything like a fair chance. The internal wounds of cervix and vagina are, as a rule, healed with wondrous rapidity, notwithstanding the continuous passage of the uterine discharges over them, if you simply refrain from poisoning them. My advice is: Wash thoroughly the vulva and adja-

cent portions ; use what are technically known as antiseptics or not, just as you please. However, as soap and hot water are always indispensable, and as they are at the same time antiseptic, I can scarcely recognize the correctness of the term "aseptic midwifery." As to the tear of the fourchette or perineum, treat it as you would any ordinary wound on approved surgical principles. If it be of considerable extent, introduce sutures as a matter of course, and dress it carefully. On account of the ordinary discharges, you will require to change the dressings frequently. Whether you use antiseptic pads or ordinary diapers, see to it that they are perfectly clean, and changed as often as is necessary. In a general way I may say : Keep the vulvar surface perfectly clean and free from smells ; prevent the ingress of germs into the genital canal ; leave the internal wounds to the care of themselves ; avoid the routine use of vaginal or intra-uterine douches.

I cannot pursue this aspect of the subject any further, but will recapitulate and epitomize with reference to the essential features of Credé's modified method of completing the third stage of labor as follows :

After following down the uterus during the expulsion of the child, keep the hand on the fundus, using gentle friction, if required, to prevent relaxation of uterine walls for a period of 15 to 30 minutes (usually 15 to 20 minutes).

During the acme of the first strong uterine contraction, squeeze the fundus and upper walls with one or both hands, pressing in the direction of the axis of the uterus. Do not use too much force, and repeat, if necessary, during subsequent pains.

When you feel certain that the placenta is forced out of the uterine cavity, slight traction on the cord is allowable, and may assist a delivery.

After the expulsion of the placenta, take plenty of time for the extraction of the membranes ; do not pull forcibly on them, but coax carefully during uterine dilatations.

After the extraction of the membranes, wash carefully, dress, and treat according to sound surgical principles.

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PROF. HARE said that next to cocaine, the best local anæsthetic that we have is menthol. —*College and Clinical Record.*

## THE SURGICAL TREATMENT OF HERNIA.

Remarks made before the Ontario Medical Association  
BY DR. H. O. MARCY, OF BOSTON,  
President of the American Medical Association.

Dr. Marcy regretted his inability to exhibit to the association a series of screen pictures illustrative of the anatomy and pathology of hernia, and consequently devoted the time at his disposal to the discussion of the methods best adapted to its cure. After referring to the exceptional history of operative measures which in preceding centuries had been advocated, only to fall into disuse and be forgotten, Dr. Marcy briefly sketched his own personal experience. Fortunately his first cases were operations for strangulated inguinal hernia in woman, and he used buried catgut sutures as an expedient for the retention of the abdominal contents and closure of the wound. He did this as an induction, based upon the experimental studies of Professor Lister in the ligation of arteries, from whose clinic he had just returned to America in 1870. He instituted a long series of histological researches upon the changes which supervene when aseptic animal tissues are buried aseptically in healthy animals, and demonstrated that a remarkable series of proliferative cell-changes ensue about the buried foreign material; *pari passu*, as the connective tissue cells of the implanted structures are absorbed, the exudative cells are transformed into newly-developed connective tissue, which replaces the dead material, and thus forms a living band marking the site of the buried suture, enclosing and re-enforcing the parts. Although this proved a discovery of fundamental importance in the coaptation and closure of all aseptic wounds, its value is especially apparent when applied for the re-enforcement of the parts involved in the cure of hernia.

The *bête noir* in the cure of hernia for the centuries has very naturally been the inguinal variety in the male, and too much emphasis cannot be made upon the wise distribution of nature in the arrangement of the structures for the retention of the abdominal contents and the allowing of the escape of the spermatic cord and vessels without pressure or interference of function. This fact has been singularly overlooked by the authorities, and its importance will be

readily appreciated in the attempt at restoration of the parts. The obliquity of the canal is very similar to the entrance of the ureter into the urinary bladder, and, in the normal condition, the intra-abdominal pressure is ever maintained at a right angle to the line of the canal.

This is of fundamental importance in the attempt at restoration of the parts in order to effect a permanent cure, a procedure impossible without the use of buried sutures, since in no other way can the internal ring be closed, the cord lifted to a higher point of escape, the obliquity of the canal reformed, and the underlying parts re-enforced.

Although a seeming heroic measure, in the hands of an experienced surgeon the operation is not essentially severe or difficult. The section is freely made until the canal is opened, the cord gently lifted until its exit from the abdominal cavity is plainly apparent. The peritoneal sac is usually resected after having been sutured to its very base, in order that its internal surface may no longer afford lodgment for an abdominal viscus. The posterior structures are carefully approximated with a deep double buried tendon suture, and the internal ring is closed quite upon the cord; thereby, as in no other way, reforming the obliquity of the canal. The cord is replaced, and the external tissues are rejoined by uniting in a similar manner Poupart's ligament to the conjoined tendon, closing the parts evenly in apposition upon the cord. A third and sometimes a fourth layer of buried continuous sutures are applied for the more careful coaptation of the divided structures. The skin itself is coapted by a layer of fine tendon sutures, taken in a blind running stitch through its deeper portion only, without the addition of a single external suture.

The incision through the skin having thus been reduced to the dimensions of only a line is hermetically sealed with iodoform collodion, reinforced by a few fibres of cotton, and this is the only dressing applied. It is needless to remark that Dr. Marcy is one of the most careful of aseptic operators, since upon these conditions alone, most rigidly enforced, is it safe to apply buried sutures. "An aseptic suture aseptically applied in aseptic structures." . . . "Scrotal œdema and tenderness of the wound is almost entirely wanting; the patient is con-

fined to the bed only a few days, and at the end of a month may safely undertake light duties." It is emphasized that a truss should not be applied after recovery.

Dr. Marcy has now operated about two hundred times, and reports that so far as he has been able to follow his cases, which is the greater majority of those operated upon, quite ninety per cent. have remained permanently cured. In no instance has he seen a patient approach what seemed to be the danger line where the intestine itself had not been involved. He has often removed large pieces of deformed omentum with seeming impunity. A modification of the above method is applied to the other varieties of hernia, and in umbilical and ventral hernia for a long period he has put into effect a method which might be denominated a flap-splitting of the abdominal wall for the purpose of inverting and everting of the coapted edges, thereby greatly strengthening and re-enforcing the parts involved.

#### PRIMARY CARCINOMA OF LIVER, WITH DILATED STOMACH.\*

BY J. T. FOTHERINGHAM, B.A., M.B.

*Gentlemen:* The specimens that I have the pleasure of presenting this evening were obtained at a *post mortem* in which I assisted Dr. W. H. B. Aikins about ten days ago. They have been kept in strong brine until 24 hours ago, when I transferred them to methyl-alcohol. The body from which they were removed was that of a man of 31 years or so, who had been ailing since last December with stomach symptoms, and had placed himself in the care of some Christian Science healers. The death certificate was filled in by one of the oldest practitioners in the west end of the city, and the cause of death assigned was chronic indigestion. A correct history of the case cannot be obtained, as his physicians do not hold a diagnosis to be necessary in order to a cure. The liver was plainly visible through the thin abdominal parietes as an irregular nodular tumor in the epigastric and upper umbilical regions. On opening the abdominal cavity the organ was found quite adherent to the anterior

parietes, about the median line of the epigastrium. There were no adhesions to the stomach or any of the underlying organs, and no ascites. Jaundice seemed not to have existed, so far as one could judge from appearance after death; at any rate it was very slight. The distribution of the neoplasm in the specimen will explain the absence of ascites and jaundice. Fagge says that there are two causes, usually, for ascites in cancer of the liver; first, the involvement of the portal veins by extension of the growth along the channels of a large number of its branches; or, secondly, the chronic peritonitis which starts from the serous surface of the organ. Of course a broad distinction must be made between true cancer of the liver and cancer of the structures entering the portal fissure, the latter only acting mechanically, and producing possibly both ascites and jaundice. Fagge says also that, with the exception of cirrhosis, the only disease in which these symptoms are often found together is cancer of the lesser omentum or of the structures entering the portal fissures.

I should submit some reasons for calling this a primary carcinoma. First, perhaps, though it is not according to the precepts of the rhetoricians, I may give my strongest one, that there was no sign of cancer at the pylorus, or in any other organ or part of the body. The rectum was free, as also the gall-bladder, and the whole intestinal tract. Cases are on record in which carcinoma had been called primary when it was in reality secondary to disease of the vertebræ or os innominatum, the lesion in the liver being the only one detected clinically. In this case the examination for metastatic growths was also fruitless.

So far as the history is known it bears out the view that the liver was the first and only seat of the trouble, as the sense of illness had been of only short duration. The weight of the organ was 6 lbs. 10 ozs. The much greater weights on record, 18 lbs., 19½ lbs., and one case of 24 lbs., with a final record of 25 lbs. in another case, are, so far as I am aware, all secondary cancers. I should like to hear the opinion of pathologists of greater experience than myself on the question, whether in a man of ordinary strength of constitution, and with ordinary conservation of failing strength

\* Read before the Pathological Society of Toronto, April 30th, 1892, with specimens, gross and microscopical.

by food and treatment, death should have occurred while there was still so large a portion of the liver acting normally and no metastasis? The whole right lobe, or nearly all of it, is apparently uninvaded by the new growth.

The microscopic specimens submitted are not nearly so good as I could wish, but show atrophy and pigmentation of the small amount of liver tissue persisting, with dilatation and thickening of the interlobular vessels (cirrhosis). The new tissue shows the characteristics of great malignity, the fibrous tissue being small in amount, and the invading cells being very large, and round in prevailing shape, while there are no signs of degeneration or change in cancerous cells, which from their position in the centre of a large focus of growth would show such change if they were not still young and growth rapid.

*The Stomach:* Apart from moderate dilatation and slight catarrh, it was normal. It may be that death was due to simple inanition; this, again, being caused by the weight of the overlying tumor causing obstruction and compelling vomiting. The latter was the symptom on which, mainly, the death certificate was given. There was nothing in the condition of the stomach *per se* to cause vomiting. One can at least advance the theory that whereas in partial obstruction by cancer of the pylorus vomiting occurs regularly after a varying length of time, during which food enough could pass on into the intestine to make death by starvation a very slow process, there might still be in this case sufficient mechanical obstruction to prevent the passage of almost any food through an otherwise normal pylorus, and so cause vomiting at so early a stage of digestion as to prevent nutrition almost altogether.

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## Selections.

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ALARMING ATTACKS OF DYSPNEA POSSIBLY DUE TO TEA—DIAPHRAGMATIC ANGINA?—I saw with Mr. Hewer, of Highgate, and in consultation with Dr. Gowers, a gentleman who had suffered from some peculiar and very alarming attacks allied to angina. He was a rather delicate man of nervous organization, and with a history of gout in his family. He had recently suffered from rheumatic stiffening of

his right shoulder-joint with secondary atrophy of the deltoid, and for this he had been under treatment by massage just before the attacks which I have to record occurred. Both of the attacks referred to had happened after breakfast. He had taken for breakfast eggs and bacon and tea. Mr. Hewer, who lived near to him, had seen him in both attacks, and had relieved him very speedily by the injection of morphia, and after the attack had passed off Mr. M—— had appeared tolerably well again, though weak. The attacks had occurred on each occasion whilst in bed. Mr. Hewer described the attacks as very alarming, and said that the patient had a corpse-like pallor, and was apparently quite unable to make an inspiration on account of the severe pain caused by it. He said that it appeared to him that the diaphragm and chest muscles were fixed. He did not consider that the attacks were ordinary angina, since the pain was referred more to the epigastrium and lower part of chest than to the shoulder, and inability to inspire seemed to be the prominent condition. The pulse during the attacks was very feeble, and the patient was only able to speak in a whisper. On the first occasion he expressed his belief that he was dying. On each occasion the attack had lasted, as I understood, about an hour, and was terminated by the use of morphia. On asking the patient himself how the attacks came on, he said that on each occasion he had thought that his breakfast had disagreed and given him flatulence, his first feeling being a sensation of distension of the stomach, which soon increased to great discomfort and then to great pain. With the latter came a sense of inability to draw breath, and of impending death.

Dr. Gowers made a careful examination of the chest and heart, with, for the most part, a negative result; at any rate, it did not reveal any organic disease of a nature to explain the attacks. The heart's action was feeble. The patient was admittedly a very nervous man, and one in whom all sorts of pain produced exaggerated results. Making, however, all allowance for this, there was no doubt that his attacks had been very alarming; for his wife and all who saw him, Mr. Hewer included, thought that he was dying. I was interested in noting that both the attacks had occurred just after eat-



ing a good breakfast in bed, and just after having partaken freely of tea, and, amongst other suggestions as to treatment, I advised strongly that he should not take any more tea at present. He was not a smoker, and was accustomed to take tea freely. I have known a cup of strong tea taken inadvertently in the afternoon produce attacks of breathlessness very similar, though not nearly so severe as those that he had experienced, and one of the ordinary symptoms produced by the disagreement of strong tea is, I believe, a sense of tightness behind the sternum, with some feeling of difficulty of breathing.

The above notes were taken in 1888. In April of the present year (1891) I wrote to Mr. Hewer to ask if he could tell me anything as to the sequel of the case. In his reply he has informed me that the patient now enjoys good health, and has never had any return of the angina symptoms. He expresses his belief that in attributing them to tea we were probably right. It is, of course, easy to suggest several fallacies. The attacks may have been due simply to flatulence, and not directly to the influence of tea. They may possibly have had some connection with the fact that the patient kept in the recumbent posture after a rather liberal meal. Neither of these suggestions is, however, very probable. I am rather inclined to suspect the tea itself, because, as already said, I have known other instances of somewhat similar effects, in which the sources of fallacy were fewer. A medical man described to me attacks which he felt tolerably certain had been caused by the incautious use of strong tea. On one occasion when going a railway journey he visited a patient very near to the station and gladly accepted the offered cup of afternoon tea. The tea was very much stronger than he was accustomed to, and he took it without eating. Having driven straight to the railway station he got into his carriage without any hurry, but just as the train was starting he was seized with a most distressing sensation at the region of the heart, and felt as if he would be unable to breathe. He was obliged to open the window and lean forward with his head half out and his arms uplifted, and holding to the sides of the door. After half an hour in this position, with most dis-

trressing dyspnoea, the attack passed off. Its recurrence, though not with such great severity, but under very similar circumstances, made so strong an impression on his mind as to the cause of the attacks that for a long time he never ventured to drink tea except in his own house, where he knew its quality and strength.

The attacks described in Mr. Hewer's patient were not very dissimilar from those from which John Hunter suffered, and which he has himself so graphically described. To whatever cause we may incline to attribute them, they certainly afford examples of very alarming attacks for which no adequate organic explanation can be given.—*Jonathan Hutchinson in Archives of Surgery.*

A PLEA FOR THE TOOTH-BRUSH AND DISINFECTIO OF THE MOUTH IN CHILDREN, ETC.—It is only recently that the study of bacteria of the human mouth has been zealously pursued by various investigators, and much has been accomplished toward bringing to light the causes of the various affections of the mouth and its associate parts. Prof. Muller, of Berlin, has repeatedly said that the human mouth was the abode of numerous microscopic organisms. But it is only within the last five years, really, that the more exact methods of bacteriological investigation have come into use, and thus a more definite knowledge acquired as to their form and life. There is no part of the human body which furnishes better spots for their cultivation than that of the mouth and teeth. There are now known nineteen different pathogenic micro-organisms, which have been experimented with, and there are found many of those organisms of the character called non-pathogenic, which means that they do not produce a certain specified disease, but may become, under favorable conditions, pathogenic in the development of certain diseases which, up to the present time, we know nothing of. These organisms of the non-disease-producing kind—or non-pathogenic—live and propagate upon the various organic substances in the secretions of the mouth—particles of food which have been allowed to remain after meals between and in cavities of carious teeth and neighboring parts. So far these last-named organisms act deleterious on the teeth only. These organisms have a chemical power of

changing the secretions left in the mouth into certain acids and ferments. It is within a short time only that the decay has been shown to be caused by the decalcification of the tooth substance, followed by a solution of the decalcified base substance. This is brought about by these acids, among them chiefly lactic acid. These acids are principally formed by these organisms. Leyden and Jaffe found that the leptothrix buccalis bacteria, which also inhabits the mouth under certain causes, has given rise to severe lung troubles. Also, that from a class of bacteria found in bad teeth, abscess of the neck, abscesses at the root of teeth, chronic disturbance of digestion, both of stomach and intestinal, abscess of the tonsils, diphtheria, all kinds of pharyngeal inflammation, and other parts closely associated.

That there exists in the human mouth such bacteria that produce malignant forms of disease is now proved beyond a doubt.

These bacteria may remain there latent until such a cause presents itself for cultivating in a medium suitable for their existence, as, for instance, in the drawing a tooth, where a fresh wound is left, and also the fact that it has proved dangerous to scratch one's finger on a sharp tooth in an unclean mouth, etc.

Now, how should we prevent these bacteria and micro-organisms from developing? What is the course to be pursued?

Above all, every carious tooth must either be sealed by a filling or extracted. Diseased tissues, such as enlarged tonsils, catarrhal affections, post-nasal vegetations, etc., should be attended to. The tooth-brush, above everything, must be used vigorously by all children and adults after each meal. These are the first rules to be observed.

In order to destroy these organisms, a powerful antiseptic must be used, and such a one must be strong enough and possess a non-poisonous quality; also by its use be able to destroy these organisms which breed in the mouth. We know that children always swallow some of the liquids used during the act of either gargling, rinsing, or douching of the mouth.

The zymocide is the newest of the non-poisonous antiseptics. It is entirely free from poisonous vegetable or mineral chemicals, and therefore no danger can arise from absorption

through the mouth, wounds, or stomach, etc. Ready for use as a mouth-wash, dilute from ten to twenty parts to that of water. This new antiseptic and detergent preparation represents the latest advancement in chemical sciences and pharmaceutical skill. It is composed of extract golden seal, extract calendula, stone root, sulphocarbonate of zinc, extract witch-hazel, boric acid, thymolate of soda, and menthol. It is manufactured by Reed & Carnick, whose preparations are already known to the profession as reliable.

Another very important antiseptic is the peroxide of hydrogen (medicinal—Marchand's), which is already known to us. This is to be used in the mouth, diluted one to three of water. Such substances as carbolic acid, chlorate of potash, salicylic acid, corrosive sublimate, creolin, etc.—these are all poisonous substances and deleterious to the teeth; besides taking into consideration the great possibility of poisoning by long-continued use of these chemicals.—*J. Mount Bleyer, M.D., in the Archives of Pediatrics.*

THE VITALINE CRAZE.—To call it consternation is not too strong a term; for although we do not accredit the statement that ten thousand people in Russia have received injections of the stuff "vitaline," there is without a doubt a panic on the subject of this injection—this most absurd so-styled "rejuvenator" of old idiots and antidotal preserver of young ones. The story of the "discovery" of this "new remedy" is an old story revived. A wanderer from his native land, this time one Gatchkowsky, an engineer, was sent on his own business into the Trans-Caspian territory, and there, amongst a primitive people, he heard of a new specific. "A Chinese savant" revealed to him the particulars of a miraculous compound medicine which, being instilled into the blood of a man, would cure everything: it was more than a mere panacea; it was a "rejuvenator," a curer of such fatal diseases as consumption of the lungs without fail. All previous wonders were to be surpassed by it, and the scientific world was once more to be set in commotion by a discovery that should show how natural law in disease could be overthrown in wholesale fashion. For a time—happily short, yet long enough—the new

practice made its way, and we are told the regular practitioners of medicine in St. Petersburg were dumbfounded by the presence of the "tide of fashion and favor" that set in. To some invalids, real or supposed, the "vitaline" was administered by injection subcutaneously; to others it was administered externally. Prices for the medicine and its application varied; the rich paid the largest fees, but the poor also paid, and some of them also largely. The Czar himself was counselled—by whom is not known, but we should suppose not by any authorized medical adviser—to let his son, the Grand Duke George, undergo the treatment. At last a somewhat less important man, but still one of great importance, was subjected to the remedy, and he, General Gresser, the Prefect of St. Petersburg, and one of the firmest and shrewdest of the guardians of the imperial power, was led to submit himself to the operation, and by the submission sacrificed his life. How, precisely, the sacrifice was brought about, we have as yet no satisfactory details. The discoverer of "vitaline" turned round in his defence from the sublime to the ridiculous. The omnipotent remedy at once diminished from its potency into a mere mixture of borax and glycerine—a harmless mixture for good or for evil. If death resulted from the use of it, a dirty syringe used for the injection must have been the true cause; but M. Gatchkowsky, having made a clean breast of his discovery, will practise the art of cure no more; and if he be not, in the panic, charged with political offence and of systematically poisoning the Prefect, he is fortunate. The history of this latest blast of quackery recalls some of olden times which it has been the duty of *The Lancet* to expose and trample out. The case of the notorious St. John Long comes at once to mind. In this case the results which followed the practice of the astute quack were practically the same as those we have just witnessed. What is more, the secret, which Long sold, as was reported, for £3000 to a lady of fashion, turned out, in the end, to be no secret at all. The element of the treatment was counter-irritation, and the vaunted composition employed as a liniment was nothing more and nothing less than spirit of turpentine and strong acetic acid. One day the famous nostrum went wrong in its action; it caused, or was accused of

causing, a diffuse cellulitis in an unfortunate victim, and then not only was its fate sealed, but in defence the secret was exploded in the proof of its harmlessness and its perfect simplicity. Against this specimen of quackery the founder of *The Lancet* fought tooth and nail. He neither hesitated nor paused until the mischievous practice was expelled for good. In this fight, moreover, he had not the whole voice of the profession with him. On the contrary, one man in the profession stood by the delusion to the last, and vainly maintained his advocacy of it after the bubble had burst and its inventor with it. It is our business still to expose and protest against these frauds on humanity, exploited, as they are, at the risk of human suffering and death.—*Lancet*.

OBSTETRICS AND GYNECOLOGY IN MOSCOW.—The report of the lying-in department of the Golitsinski Hospital in Moscow for 1891, by Dr. Inoieffs, has just been published, and in addition to its statistics contains several interesting papers. The total number of labors conducted in the department during the year was 713. Very nearly equal numbers of these were concluded during each of the four quarters of the day, the slight difference existing being in favor of the evening quarter—namely, from 6 p.m. to midnight. Detailed tabular observations are given of the 17 cases of twins and of the 24 cases of contracted pelvis, that is to say, where the external conjugate diameter was below 18 centimetres. There were 4 fatal cases—1 from croupous pneumonia, 2 from anæmia, and 1 from septic endometritis and parametritis. The antiseptic employed was corrosive sublimate. The use of the forceps was required in 15 cases, laceration of the peritoneum occurred in 14 cases, and rupture in 17. There were 7 cases of craniotomy, and one of evisceration. With regard to the puerperal period, there was no fever—*i.e.*, temperature above 38° C.—or other complication in 599, or 84.1 per cent., of the cases. There were only 8 cases of true puerperal diseases—*i.e.*, 2 of colpitis with endometritis, 4 of endometritis, one (fatal) of septic parametritis with endometritis, and one of mania. In the 8285 cases attended in the department since 1868, there have been 309 cases of true puerperal diseases and 64 deaths, 20 of which are

attributed to non-puerperal affections. In all this number the employment of the forceps was required only in 189 cases, craniotomy was performed 33 times, and evisceration once only. There is no mention of the Cæsarean operation. Amongst the reports of the gynecological sections there is one dealing with electrical treatment by Dr. Dyski, a tabular view of twenty-eight cases being given. The best result was obtained in parametritis, a lesser degree of success being secured in oophoritis, and still less in salpingitis. With regard to fibromata, some degree of subjective improvement was always obtained, but the tumor did not in any case appear to become reduced in size. This agrees with the experience of most other Russian writers on the subject—Massen, Himmelfarb, and Kholmogoroff—though Neêloff, who reported twenty cases to the Kieff Obstetrical Society in 1890, had succeeded in reducing the tumor in seven instances to some small extent. Dr. Dyski calls attention to two cases of gonorrhœal endometritis which had been treated unsuccessfully by various ordinary methods, and which only yielded to repeated electrical applications, the anode being introduced into the cavity of the uterus. In one case the discharge so nearly ceased that the patient considered herself cured, and did not return after eighteen sittings; the other, which was complicated with salpingitis and perisalpingitis, was quite cured after twelve applications of the induced and six of the constant current. Dr. Dyski remarks that the antiseptic properties of the anode of a galvanic current render it a peculiarly suitable agent in obstinate gonorrhœa of the internal genital organs in the female. It is of course advisable in all gynecological cases where electricity is employed not to depend upon it entirely, but to make use of other local and general treatment simultaneously with it. In several of the cases described in the table, the induced current was used for the earlier sittings and the constant current in the later ones.—*Lancet*.

FIFTEEN YEARS OF IMMUNITY AFTER REMOVAL OF CANCER OF THE LIP FOR A THIRD RECURRENCE.—In reference to the non-recurrence of cancer of the lip after removal, the case of a Mr. R—, who is now aged 73, is of some interest and value. This gentleman had had a

sore twice cut from the left part of his lower prolabium. He came to me with a third recurrence. The sore had extended rather widely, but not deeply. For this reason I did not employ the usual V-shaped incision, but destroyed it very liberally indeed by means of the actual cautery. I find it described in my notes of March 12, 1874, as "an ulcer with hard edges, but without papillary growth." In August, 1889, that is, fifteen years later, Mr. R— came to me again for another disease, and I had the satisfaction of finding that his lip had remained quite sound, and that no gland disease had developed. There are doubtless many cases in which after excision of epithelial cancer of the lower lip no local return is ever witnessed. I fear, however, that it is exceptional to escape subsequent implication of the lymphatic glands. On the rarity of permanent immunity, Sir James Paget has expressed a strong opinion. In the present instance a third recurrence after excision well proved the local tendency. As regards the mode of operating, I believe that in certain forms of cancer of the lip which extend widely, but not deeply, and in which sometimes it is not easy to assign the limits of the disease, that the actual cautery, if very freely used, is more efficient than the knife.—*Jonathan Hutchinson in Archives of Surgery*.

BARBIER: CONCERNING CERTAIN MICROBIC ASSOCIATIONS IN DIPHTHERIA (*Rev. Mens. des Mal. de l'Enf.*, September, 1891).—In diphtheritic membrane one finds, in addition to the Klebs-Löffler bacillus, certain organisms, of which some are constant, but without influence upon the form of the disease, while others are inconstant, but pathogenic, and give a particular physiognomy to the disease. Three of these are described as follows: (1) *Streptococcus (a)*, which is found at certain periods of the year. (2) *Streptococcus (b)*, which resembles the *streptococcus pyogenes*, and is found in the pharynx when the mucous membrane is red and swollen, covered with thick and diffuent membrane, associated with adenopathy; it is also found in the blood of the heart. This form is very virulent for guinea pigs, whether injected alone or with the bacillus of diphtheria. This association may occur clinically as follows: The bacillus is installed after

the streptococcus, this being a primary infectious form, or the two infections may be simultaneous, the form which is infectious from the beginning. The streptococcus may be engrafted upon the diphtheria, this being the secondary infectious form. (3) The *coccus y*, which is found in cases of modern intensity, in which there is an abundant muco-purulent excretion, or glandular engorgement. With these facts in view, one may distinguish two principal forms of diphtheritic angina. One pure or toxic diphtheritic angina, which is without general microbic infection, and has the following characteristics, there may be no pharyngeal disease nor general disturbance at first, typical membranes appearing in layers, the mucous membrane is almost normal, and there is no adenopathy, croup is frequently present, with tubular bronchial membranes, and no muco-purulent secretion. When death occurs, it results from nasal and bronchial asphyxia, or from syncope and paralysis.

Streptococcal diphtheritic angina, which is infectious, and corresponds to the hypertoxic or classical forms, and may be due to the streptococcus rather than to the bacillus. It is present in the membranes, the glands, the pus of the canula, the lungs, and the blood. In this variety the head is swollen, and has a leaden hue, a discharge from the nose excoriates the lip, the breath is fetid, pain is severe, there is swelling, redness, and hemorrhage of the mucous membrane. The membranes are thin or putriliginous, there is intense adenopathy, and death occurs in from one to three days. There is purulent bronchitis, without false membrane, and albuminuria. Should the patient recover, ulceration of the pharynx and nose persist for a long time.—*Archives of Pediatrics.*

PRIMARY NASAL SYPHILIS.—At the British Laryngological and Rhinological Association meeting, held Friday, March 25th, Dr. W. Milligan read the following case:—Patient, a married man, æt. 32, experienced pain and discomfort in the right nostril four weeks after exposure to possible syphilitic infection. Towards the latter part of 1884, he had what was diagnosed to be a poisoned wound at the root of the nail of the right index finger. This subsequently proved to be a syphilitic chancre, and was followed by the usual glandular enlargement and

cutaneous manifestations, for which he underwent treatment. His wife became syphilitized and consulted the same surgeon, being treated by him during the greater part of 1885. The first child was born in July, 1886, the second in January, 1888, and the third in February, 1890. These children appeared to enjoy good health. In consequence of subsequent "reminders," he underwent another course of treatment in 1889, since which time he had remained in fairly good health till the present affection. On examination an oval indurated sore was seen just within the margin of the right ala on its septal aspect which had all the appearances of true Hunterian chancre. No enlarged glands, however, were detected. In spite of local and general treatment, a characteristic roseolar eruption made its appearance at the seventh week. The chancre healed under treatment in about three weeks, and at the present time the condition of the patient was fairly satisfactory. He brought this case forward as a well-marked instance of reinfection after seven years.—*Medical Press and Circular.*

CONGENITAL ABSENCE OF RADIUS.—I wish (Warfield in Johns Hopkins Hospital Bulletin) to report a case of congenital absence of radius in a boy, aged fourteen. He is a well-grown boy, five feet two inches in height, and otherwise well formed. Both radii and both thumbs are wanting. The ulnæ are curved inward and are quite short, the right one being six inches long, and the left one five and three-quarter inches. The humeri are twelve inches long. The hands are bent inwards, making almost a right angle with the ulnæ. The pisiform bones are present, but most of the other bones of the wrist appear to be wanting. The biceps muscle seems to be absent. No pulse can be made out at the wrist. Motion at the elbow is good, but at the wrist pronation and supination are wanting. In spite of his deformity, the boy can write, play ball, fight with other boys, and amuse himself as other boys of his age do.—*Nashville Journ. of Med. and Surg.*

PROF. HARE said that in the treatment of gout and rheumatism the combination of the iodides with colchicum increases the activity and efficiency of both drugs.—*College and Clinical Rec.*

THE  
Canadian Practitioner

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

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

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TORONTO, JUNE 16, 1892.

MEDICAL FACULTY OF THE UNIVERSITY OF TORONTO.

The Faculty of Medicine in our Provincial University has been in existence only a few years, and its recent reorganization (as it has been termed) has created considerable interest. The report of the committee of the Senate on the Medical Faculty, which was prepared after the expenditure of a great deal of time and labor, has been approved and adopted by the Senate. The contents of that report have been made public, and have caused considerable comment, favorable and otherwise, a good deal of surprise, and a certain amount of consternation. The editor of THE PRACTITIONER wishes to place on record the fact that he does not approve of the action of the committee in ignoring to such a large extent the vested rights of the members of the corporation of the Toronto School of Medicine. Beyond this simple statement, it is unlikely that this journal will make any further reference to such features of the report which are largely personal in character.

The questions which will interest the professional, as well as the general public, are these: Will the reorganized faculty command the confidence of the friends of higher medical education? Will it prove a source of strength to the University? Will it work zealously and honestly by methods that will strengthen the hands of those who are endeavoring to raise the standard of medical education in Ontario? Without any hesitation or mental reservation, we answer—yes. It is strong, well balanced, and possesses a great teaching capacity; its members are fully impressed with the responsibility which they are called upon to assume; its

teachers in all departments will endeavor to work faithfully and well; its efforts in all directions are likely to be crowned with success.

Many vague and dark rumors have been in the air during the last few weeks. We have been told that the other faculties, especially the Arts, were opposed to the existence of the Medical Faculty, and would use their influence to have it destroyed. Perhaps the learned Chancellor had such rumors in view when he used the following words in his powerful address delivered on Commencement Day:

"I plead for harmony and good will, for cordial concert and co-operation, between our several related faculties and institutions, and our various bodies of graduates and undergraduates. Each duly maintaining the special interests of which it feels itself the guardian, let each give generous consideration to the claims of others; above all, let each remember that it is a part of a whole, that the whole is greater than the part, and that the general interests should in all things prevail. Animated by this spirit, we may, aye, and we shall, overcome all difficulties, remove all defects, dissipate all doubts, and cause an honorable and worthy past to culminate in a yet more glorious and transcendent future. May these things be."

As a happy sequel to the deliverance of such golden words, we have much pleasure in referring to the fact that, at the meeting of the Alumni Association of University College, Mr. Dale moved and Mr. Squair seconded a resolution, which was carried unanimously, expressing "the hope that the greatest harmony would continue to subsist between the Arts and the Medical Faculties." Under the circumstances nothing could be more satisfactory to the Medical Faculty, and further comment in this connection is needless.

ONTARIO MEDICAL ASSOCIATION.

The twelfth annual meeting of the Ontario Medical Association, which was held June 1st and 2nd, was quite as successful as any that preceded it. This society has been so uniformly prosperous, its meetings have always been so largely attended, its proceedings have been so well conducted, its officers have ever been so indefatigable in the performance of their duties, that nothing like a reverse has

been encountered since its organization. In a general way a description of one meeting will apply to all.

The president, Dr. Reeve, of Toronto, is one whom all classes of physicians in this province ever delight to honor, and was found on this occasion to be eminently the right man in the right place. It frequently happens that a president simply presides, and lets his secretary and other officers and members of committees do all the work, while he reaps the major portion of the glory. Dr. Reeve, however, had no ambition to be merely an ornamental wielder of the gavel, and showed himself to be something far more substantial than a figurehead. It is well known that he worked continuously and faithfully for a whole year to make the meeting a success; and the cordial and hearty vote of thanks tendered at the last session came from the deepest regions of the hearts of the members present.

It has been our pleasant duty on three former occasions to speak in the highest terms respecting the work of our secretary, Dr. Wishart. This year he appeared to excel himself, if such a thing be possible. In saying that, we can give him no higher praise. The quiet work done by committees may not generally be fully appreciated, but it is frequently all-important; and, during the last year, was certainly very creditable to all concerned, and contributed materially to the success of the meeting.

Our visitors were few, consisting only of H. O. Marcy, of Boston, the president of the American Medical Association; and Dr. Laphorn Smith, of Montreal. Dr. Vander Veer, of Albany; Dr. W. W. Potter, of Buffalo, and others, were expected, but were prevented from coming—much to the disappointment of their friends.

Upon the whole the papers were good, and the discussions interesting. The committee on "Papers and Business," following a custom which has recently been introduced into many societies, arranged for a symposium on the "Pneumonias of Children," and another on "Hip-joint Disease." The papers and discussions connected therewith were highly appreciated.

The next meeting will be held in Toronto, under the presidency of Dr. Hillary, of Aurora, whose election was evidently popular with all parties.

## AMERICAN MEDICAL ASSOCIATION.

The annual meeting of this Association was held in Detroit, June 7 to 10, and is said to have been a successful one. It is well known that the society has been subjected to a number of reverses in the past, but it is hoped by its friends that it is now on the high road to that proud position which it ought to occupy as the best medical association of the continent. Among the Canadians in attendance were Dr. Bray, of Chatham; Drs. Moorehouse and Meek, of London; Drs. Howitt, Cormack, and Lett, of Guelph; Drs. Reeve, Ross, Price Brown, and O'Reilly, of Toronto; Dr. Cotton, of Lambton Mills; Dr. Bruce Smith, of Seaforth; Dr. Gunn, of Clinton; and Dr. Laphorn Smith, of Montreal. An important feature of the meeting, as far as Canada is concerned, was the introduction of a resolution to so amend the constitution as to allow the admission to membership of all Canadian physicians in good standing. The next meeting of the Association will be held in Milwaukee, under the presidency of Dr. Hunter McGuire, of Richmond, Va.

## Meeting of Medical Societies.

### ONTARIO MEDICAL ASSOCIATION.

The twelfth annual meeting of the Ontario Medical Association was called to order at 10 o'clock a.m. on Wednesday, June 1st, 1892, the president, Dr. R. A. Reeve, Toronto, in the chair. The secretary read the minutes of the last meeting.

Dr. A. H. Wright, Toronto, opened the discussion in Obstetrics by a paper entitled

#### THE THIRD STAGE OF LABOR.

which appears on page 269 of this issue of THE CANADIAN PRACTITIONER.

Dr. H. S. Griffin said he felt a certain regret that he was unable to oppose, for purposes of discussion, those points which had been put forward. Haste in removing the placenta was usually disastrous if practised in any other manner than the method proposed by Credé. The expectant plan should be, to a certain extent, always associated with Credé's method. Expulsion of the placenta from the uterus was a definite

procedure, and, as a rule, should not be hastened; while the expulsion from the vagina was indefinite and should generally be assisted. The best means, he said, was by firm pressure with the hand upon the fundus, directed almost directly backwards. The placenta should then be rolled several times, the membranes twisted into a rope and gently coaxed out. The parturient canal was practically aseptic, unless sepsis were introduced from without. Intra-uterine douches were to be deprecated unless the time should come that symptoms of sepsis presented themselves, when they should immediately and thoroughly be made use of. In conclusion, Dr. Griffin stated that perfect cleanliness and coaptation of the external parts formed the total local treatment called for after the delivery of the placenta.

Dr. Preston, of Newboro, remarked that he differed from Dr. Griffin with regard to the time allowed to elapse before the removal of the placenta from the vagina after its expulsion from the uterus. He (Dr. Preston) thought it should be removed at once, and not be allowed to remain plugging up the vagina.

Dr. Geikie, of Toronto, emphasized the desirability of neither being in too great a hurry to remove the placenta after delivery, on the one hand, nor allowing it to remain too long in the vagina, on the other. Allowing it to remain too long, as well as removing it too speedily, tend to post-partum hemorrhage. The application of the broad bandage around the abdomen, with compresses over the contracted womb, Dr. Geikie held to be of great value; and as soon as this has been done, Dr. Geikie held it to be of great value in preventing post-partum hemorrhage to remove all clots from the vagina and os uteri.

Dr. Moore, of Brockville, said: "I am in favor of antiseptic douches, no matter whether we have a rise in temperature or not, always beginning on the second day; not later than the third. I do not remove the placenta immediately, but rather wait, carefully keeping fairly firm pressure over the uterus until I find the placenta coming away. If I find an adherent placenta I remove it, using all the antiseptic precautions possible. I think that douches should be used both before and after the labor. The parturial canal should be rendered aseptic, and

kept so. All clots should be removed from the vagina and a firm bandage applied. No traction should be made on the cord. The douche should be given gently, not forcibly. I use bichloride of mercury, one to four thousand, and never had any rise of temperature amounting to anything, and no blood poisoning. I never use carbolic acid."

Dr. Laphorn Smith, of Montreal, said that he was in favor of allowing nature a little time to enable the uterus to expel the placenta. He used Credé's method, but did not approve of pulling hard upon the cord; but he always gave a dram of the best fluid extract of ergot. He used douches of hot water in every case because it made the woman comfortable. He never used bichloride of mercury because he had seen cases of poisoning from it.

Dr. J. D. Macdonald, of Hamilton, said: "I do not venture to instruct where so many experts have spoken, but I wish to say that the old methods of managing this stage were not so different from those at present recommended. We did not know the value of antiseptics until lately, but we always knew the virtue of soap and water, and I believe that if we do not ourselves introduce impurities on our fingers or on our instruments there is little fear of the passages becoming septic. The placenta may be gently drawn upon as soon as the child is separated and handed to the nurse, but a touch will be sufficient to let the physician know whether it is separated or not. If it is not, let it alone for half an hour; generally by that time it is in the vagina. Avoid force, and do not introduce the hand unless there is urgent need. The poor woman has had enough without that experience. I never had the experience of Dr. Smith, of leaving the placenta for hours. I do not think I have had more fatality than other men."

Dr. A. H. Wright, in closing the discussion, said: "I am quite in accord with Dr. Geikie in urging the necessity for the avoidance of undue haste, and also agree with him in thinking that the ordinary obstetric binder adds to the comfort and safety of the patient, but I believe that a pad in the majority of cases is worse than useless, because as ordinarily used it generally becomes dislodged, and that simply displaces the uterus. While I agree with much that Dr. Laphorn Smith has told us, I desire to ex-



press a very positive opinion that it is never safe to leave a patient before the expulsion of the placenta. We know from the observations of Schroeder and others that the placenta, in the great majority of cases, is expelled from the cavity of the uterus within 15 to 20 minutes. It may lie in the vagina for a long time if we do not assist expulsion, but I consider it absolutely necessary under such circumstances to watch the patient carefully whether we adopt the Credé or the expectant plan of treatment. I object to the use of ergot before the termination of the third stage, or at least before the placenta has left the cavity of the uterus; I have seen it produce tetanic spasm of the uterus, which causes severe pain to the patient, but no expulsive efforts. I was much interested in the remarks of Drs. Griffin and Moore with reference to asepsis, antiseptics, and douches. Our ideal method would probably be as nearly aseptic as possible, but in actual practice I think it well to have antiseptics for external use, especially for the hands and instruments. The use of such antiseptic agents as bichloride of mercury for douches is attended by grave dangers. I have very strong objections to what may be called fussy antiseptic methods, such as those advocated by Thomas and others some years ago. I object also to the routine use of douches after labor. They disturb that physiological rest which is so necessary for the repair of such wounds as those of the cervix. They frequently cause much pain; and they become possible vehicles for the introduction of septic matters."

It being 12 o'clock, the Association adjourned.

At 1 o'clock many of the members availed themselves of the invitation by the Hospital Trust to inspect the Victoria Hospital for Sick Children. The Association reassembled in general session at 2 o'clock, the president in the chair. The minutes of the morning session were read and approved. Dr. R. A. Reeve, president, read his address, at the conclusion of which the discussion in medicine was opened by Dr. A. S. Fraser, of Sarnia, with a paper on "The Diagnosis of Diphtheria." He was followed by Dr. W. Britton, of Toronto, on the treatment, and Dr. Harrison, of Selkirk, on the etiology. As Dr. Wright, of Ottawa, was absent, the discussion here closed.

Dr. J. A. Williams, of Ingersoll, president of

the Ontario Medical Council, addressed the Association in an able manner upon recent medical legislation and its effects. At the conclusion, Dr. A. A. MacDonald, Toronto, seconded by Dr. A. B. Welford, Woodstock, moved that a cordial vote of thanks be accorded Dr. J. A. Williams for his clear, able, and eloquent address, and that we, the members of the Ontario Medical Association, cordially endorse the sentiments he expressed, and heartily support the action of the Ontario Medical Council. This was carried unanimously. The Association then divided into sections.

#### MEDICAL SECTION.

Dr. Arnott, of London, was elected president, and Dr. Clouse, of Toronto, secretary. A paper on

#### PUERPERAL ECLAMPSIA

was read by Dr. Raikes, of Midland. In the discussion which followed, Dr. Rice, of Woodstock, said: "I have had two cases in eight years. The first case occurred at five months. She had two convulsions before I saw her. I at once gave chloroform and bled, taking away twelve ounces of blood. No convulsions occurred after that. I produced an abortion. The woman recovered completely. The second case was that of a woman *æt.* 40. First child. I was called at the ninth month. Convulsions ensued. I gave morphia, chloroform, castor oil, and pilocarpine. The patient never regained consciousness. If the patient be full-blooded, I would bleed and give morphia sufficient to keep patient quiet."

Dr. Arnott, of London, said: There are two principal causes for puerperal eclampsia—albuminuria and nervous irritation. This sufficiently indicates the treatment. As soon as albumen is discovered in the urine of a pregnant woman, diaphoresis should be induced as rapidly as possible, and for this purpose I would very much prefer the steam bath. At the same time the bowels should be moved freely by some such agent as *pulv. jalapæ co.* In the cases which depend upon nervous irritation a hypodermic injection of morphia, chloroform, etc., should be used. If this simple line of treatment be adopted, a very large proportion of cases will recover, and many of the children be saved.

Dr. I. Olmsted, of Hamilton, read a paper on

## BRAIN INJURIES.

This paper will appear in a future issue of THE CANADIAN PRACTITIONER.

In the discussion which followed, Dr. J. E. Graham, of Toronto, said that Dr. Olmsted deserved the thanks of the meeting for the clear and lucid description of his case; he quite agreed with him in the diagnosis he had made. He spoke of the benefit obtained by the administration of iodide of potassium in large doses in tumors not syphilitic. This beneficial effect, however, was not permanent. Sooner or later, the unfavorable symptoms returned. He spoke of a case which he had under observation for seven or eight years, in whom he had at first suspected tumor of the cerebellum. That suspicion had, however, disappeared until a few weeks ago, when the patient returned with even more decided brain symptoms. He had observed three or four cases of cerebellar tumor which were verified by *post mortem* examinations. In one the symptoms were very similar to those of the patient under discussion.

Dr. Olmsted replied, and closed the discussion.

Owing to the absence of Dr. Greig, Toronto, through illness, his paper on "Disinfection after Infectious Diseases" was not read.

Dr. J. Duncan, Toronto, then read a paper on

WHOOPIING COUGH TREATED BY ONE OF THE NEWER METHODS.

This paper was discussed by Dr. J. D. McDonald, Hamilton. (It will appear in a future number of THE CANADIAN PRACTITIONER.)

## SURGICAL SECTION.

This section met in the examiners' room. Dr. T. K. Holmes, of Chatham, and Dr. Primrose, of Toronto, were appointed respectively chairman and secretary of the section.

Dr. A. B. Atherton, Toronto, read a paper on SUTURING OF EXTERNAL POPLITEAL NERVE, and presented the patient. Sensation had returned, but there was considerable rigidity in the knee joint.

Dr. B. E. McKenzie, Toronto, who had assisted Dr. Atherton at the operation, said that he had not seen the patient for some time, and now noticed considerable improvement in the

circulation. He also stated that there was great difficulty in recognizing the ends of the divided nerve during operation, but that so far the result of this case was eminently satisfactory.

Dr. Powell, of Ottawa, congratulated Dr. Atherton on the result so far, and said that he thought further improvement might now be made before further contracture takes place.

Dr. Whiteman, of Shakespeare, said that judging from similar cases and results he would keep up continual rubbing and passive movement rather than forcible bending, which has been advised.

Dr. Holmes, of Chatham, said that when we consider the importance of the functions of the joint in maintaining the nutrition of the limb, we would conclude that massage is of little use in a long standing case of ankylosis.

Dr. Atherton, in reply, stated that, in his opinion, it would be dangerous to try forcible means because of the risk of interfering with the union of the nerve, which was in the first instance bound down in cicatricial tissue. He would rather favor massage and passive motion in the meantime.

Dr. MacCallum, of London, then read his paper on

## CHLOROFORM INHALATION.

It was discussed by Dr. Moore, who reported a case of non-narcosis and inability to produce insensibility. Voluntarily stoppage of breathing occurred, and artificial respiration was resorted to. This condition continued for some time; finally the administration of chloroform was stopped, and the patient, after half an hour, began to breathe naturally.

Dr. Mullin, of Hamilton, asked why the tongue be not drawn forward. He thought the tongue should be drawn forward somewhat forcibly, as it excited respiration. He again thought that the tongue should be kept all the time well forward. He referred to a case of a drinking patient who was taking chloroform quickly. Patient suddenly became pale, pulseless, and respiration ceased. Result, death. In the case referred to by Dr. Moore, he would by pushing the ribs forcibly cause the patient to breathe.

Dr. MacCallum stated that, in his opinion, one should inject morphia in cases of spasmodic respiration. In Edinburgh they push the drug.

The Association met in general session at 8.30 p.m.

Dr. R. B. Nevitt opened the discussion in surgery, taking for his subject the

#### PRESENT STATUS OF ANTISEPTICS.

He was followed by Dr. T. K. Holmes, Chatham, who devoted his remarks to the sterilization of the field of operation—the hands of the surgeon and his assistants and of the instruments and dressings which come in contact with the wound. He pointed out the advantage of steam as a sterilizing agent, and showed how by means of Arnold's Steam Sterilizer it can be utilized to the best advantage. He also pointed out the best method at present known of disinfecting the hands by the use of permanganate of potash and oxalic acid after they have been thoroughly cleansed with soap and water. Recent experiments have proved the inefficiency of carbolic acid and mercuric chloride to destroy pathogenic germs on the hands when applied of a strength compatible with comfort, so that their use for this purpose must be abandoned, and the plan recommended adopted in preference to all others.

Dr. N. A. Powell, of Toronto, said that in regard to hand and wound-area cleansing, both mechanical and chemical, he advised that, in accordance with Schimmelbusch's suggestion, nail brushes should be boiled for five minutes in a one per cent. solution of carbonate of soda, and kept in a one to one thousand bichloride solution. Such brushes, used freely with green soap, get the skin into excellent condition for the chemical sterilization by solutions made with the tablets which we all now carry, or with the more perfect method worked out by Dr. Howard Kelly, referred to by Dr. Holmes. In sterilizing instruments carbolic acid solutions are no longer required, and the damage they do to the hands of the operator can be avoided. When Davidsohnin, 1888, showed that boiling for five minutes under pressure—that is, in a closed vessel—would absolutely sterilize instruments if they were properly constructed, we all began to test the method, and soon had samples of rusted and ruined instruments on hand. Then came the happy suggestion of Schimmelbusch that a one per cent. solution of carbonate of soda would prevent rusting, and on this we now rely.

Saturating a piece of gauze with a one to ten solution of glycerine and water was equally efficient with the soda carbonate in the prevention of rusting. A good many Ontario physicians had obtained the sterilizer from the United States at a cost of from six to ten dollars, when they could be bought in Toronto, where the patent was owned, for half that outlay. In the preparation of silk, Dr. Powell advocated fractional sterilization as suggested by Halstead. The silk on glass spools is simply placed in strong glass tubes loosely plugged with cotton and steamed for half an hour on each of two days in the sterilizer, and no better or easier plan could be desired. As regards catgut, Dr. Powell prepares it by first scrubbing with green soap, then soaking in ether sulphate, then for twenty-four hours in a one to one thousand watery solution of bichloride and using it out of absolute alcohol. He never used large catgut but by this plan; the small sizes seemed to preserve their strength and aseptic condition indefinitely.

The Association was then addressed by Dr. H. O. Marcy, of Boston, president of the American Medical Association, on the "Anatomy and Surgical Treatment of Hernia," an address which was illustrated by blackboard sketches. (See page 273.)

Dr. Spencer, of Toronto, then gave a very interesting lantern demonstration of the newer bacteria.

The Association then adjourned.

*(To be continued.)*

#### PATHOLOGICAL SOCIETY OF TORONTO.

April 30th, 1892.

The society met in the Biological Department, the president, Dr. J. E. Graham, in the chair.

Dr. McKinnon, of Guelph, presented, through Dr. Peters, a tumor removed from the lumbar region, and the secretary read the following notes of the case :

#### SPINA BIFIDA.

Removed June, 1887. Boy then 6 years old. At birth the tumor appeared to be about an inch in diameter. When six years old, the boy appeared to be in perfect health, being able to play and romp about like any other boy of his age.

He had incontinence of urine, and very imperfect control of the action of his bowels. His limbs were well developed, and the only other inconvenience he suffered arose from the tumor, which now measured, from upper to lower margin, about fourteen inches, and, transversely, about twelve. He is bright and intelligent in appearance.

The excision was performed in June, 1887. The boy made a good recovery, and showed much better control over the bowels and bladder than before the operation. He attended school during the fall and winter till the following March. After an acute illness of ten days, he died from meningitis about the 30th March, nearly nine months after the operation.

Dr. Peters said this case was undoubtedly one of pure meningocele; the cord was not at all involved, and the pedicle was less than one inch in diameter. It was not very clear what was the cause of the trouble with the bladder and bowels. Perhaps it was due to interference with the circulation in the ano-vesical centre caused by the weight and shaking of such a large tumor. It was strange, too, that the patient should die nine months afterwards from meningitis, when the operation wound had completely healed.

#### EXTRA-UTERINE PREGNANCY.

Fœtus and placenta presented also by Dr. McKinnon. The secretary read the following notes:

Nov., 1890. A young married woman, the mother of one child about 6 years old, was suddenly seized with agonizing pain in left side of the lower abdomen. It became gradually worse, and had continued for six or seven hours before she was first seen by me. She was then pale in the face, in great agony, pulse about 112, very feeble, and the abdomen tender and tympanitic. Under large doses of morphia she seemed to improve, her color returned, her pulse became full and fell to 88; but within 12 hours the ghastly pallor returned, the pulse lost volume and rose to 120, 130, 140, and at times could scarcely be felt. The tympanites increased. It was now evident beyond the shadow of a doubt that there was an internal hemorrhage, as was at first suspected. A prompt operation, in which I had the valuable

assistance of my colleague, Dr. Howitt, disclosed the nature of the cause and controlled the hemorrhage. On opening the abdomen, a large quantity of blood, partly fluid and partly clotted, was found free in the peritoneal cavity.

After the operation the pulse was not perceptible for some hours, but the respiration was good. She made an uninterrupted recovery.

Dr. Howitt said that this case was remarkable from the large quantity of blood and large amount of clot contained in the peritoneal cavity, and also from the situation of the fœtus, which was in the fibrated extremity of the Fallopian tube, and so it might be called an ovarian gestation.

Dr. McPhedran asked what was the usual situation of the ovum in extra-uterine gestation, and what were the conditions of development outside of the uterus.

Dr. Graham asked if it was true that blood is always effused into the peritoneal cavity at the menstrual periods.

No reply was made.

#### PRIMARY CANCER OF THE LIVER, WITH DILATED STOMACH.

Dr. Fotheringham presented a specimen and read the following description (see page 274 in this issue).

Dr. John Caven questioned the correctness of calling this a primary cancer. He had examined the right lobe and found several small nodules which seemed to be of embolic origin, and they could hardly have been embolic from the large mass in the left lobe, but had more likely come from some small primary focus in some other organ. He asked if any explanation could be given why cancer of the liver was more commonly found in the right lobe than in the left, other than that the right lobe was the larger.

Dr. Peters also was doubtful if this was a primary tumor. There might be a very large secondary carcinoma from a very small primary focus, so that the primary tumor might easily be overlooked. He had seen a case which had been described as a primary cancer of a lymphatic gland, but in which afterwards a very small tumor was found in the breast. Of course there was no theoretical reason why cancer of the liver might not be primary, but it was very

rare. He would like to know the condition of the pancreas in this case, as the primary focus might have been in that organ.

Dr. Graham asked if pain had been a symptom in this case. The liver might be largely infiltrated with carcinoma without jaundice, but never, he thought, without pain.

Dr. McPhedran said the pain was due probably to implication of the structures outside of the liver substance.

Dr. Acheson said he had heard that pain was a prominent symptom in this case. In regard to this being a metastatic growth, might it not be possible for a primary carcinoma to undergo natural cure, leaving the secondary tumor as the only visible lesion?

Dr. J. Caven said he had seen such in a case of so-called "withering cancer" of the breast, where the tumor in the breast had been completely replaced by fibrous tissue, and the only carcinomatous nodules were the metastatic growths in the gland.

Dr. Fotheringham, in reply, said that he had looked carefully for any evidence of a primary cancer elsewhere, but had found none; there was, however, some slight abnormal condition of the pancreas; it had not yet been examined microscopically, but he did not think it was cancerous. Of the history of the case during life he knew very little.

#### TUBERCULOUS INTESTINE.

This specimen, with microscopical sections, was presented by Dr. Thistle, who gave the following history:

E. W., æt. 3 years. Admitted to Victoria Hospital, May, 1891. Condition, marasmus, together with conjunctivitis, corneal ulcer, impetigo, and purulent discharge from left ear.

*Previous History:* Healthy until mother died, when the child was improperly fed, and neglected in every way, suffering from diarrhoea and constant abdominal irritation.

*Family History:* Mother died of phthisis. Child did well in hospital and became quite plump, losing all trace of previous illness, and remained in good health until about the end of March, 1892, when she complained of abdominal pain, particularly at night. For some weeks prior to this had been losing flesh, had very little appetite, and was very subdued and

silent. The tongue was thickly coated, breath very offensive, gums swollen, and lips dry and sore. Skin became dry and rough, and had lost its normal elasticity. Bowels constipated throughout. No blood or mucus in stools. Abdomen slightly distended. Slight tenderness on pressure, but child objected very much to examination. Knees were flexed and drawn up on abdomen. On palpation nothing abnormal could be felt over belly. There was marked tenderness of femora—a condition noted in a case of intestinal tuberculosis which occurred in this hospital some time ago—so much so that the slightest pressure on gripping the thighs caused the child to scream out with pain. This tenderness was not found in other bones.

Chest examined. Nothing abnormal in lungs or heart.

*Temperature:* About 102° daily, with fall to normal or slightly above. Continued that way throughout.

*Diagnosis:* Intestinal tuberculosis. Child wasted rapidly. Pain became much more severe, and all the symptoms already noted became more marked. April 25th: Convulsion occurred. Irregular respiration and pulse. Contracted pupils. Coma, and death.

*Autopsy:* Very extensive ulceration of bowels, annular in several places. Large ulcer in cæcum, with much infiltration. Mesenteric glands were very much enlarged, forming masses. No breaking down. Loops of intestine were found adherent in several places. Nothing abnormal in brain, lungs, or in any other part of the body.

#### ENLARGED PROSTATE AND HYDRO-PYONEPHROSIS.

Dr. John Caven presented a bladder with hypertrophied prostate, ureters widely dilated, and kidneys showing pyonephrosis. The bladder was extremely small and its walls greatly hypertrophied; the capacity did not exceed four fluid ounces. The prostate presented a median nipple-shaped projection, which one would suppose from appearances to be large enough to cause obstruction to the outflow of urine. The ureters were dilated to the size of a man's middle finger, and contained urine mixed with mucus and pus, as did the bladder also. The pelves and calyces of both kidneys

were sufficiently dilated to cause considerable atrophy of the kidney substance, the cause apparently being pressure of retained urine and pus. There was no urethral strictures. The history of this case obtainable was very deficient, he being a vagrant and dying in gaol. His age was about 45 years. There was no *intra vitam* diagnosis of bladder and kidney disease, as far as could be ascertained. The exhibitor found difficulty in explaining the occurrence of dilatation of ureters and kidney pelves along with contraction of bladder and hypertrophy of its walls and the prostate. Apparently the urethral and renal damage was of long standing, although the obstruction caused by hypertrophied prostate had not been sufficient to give rise to distension of bladder.

Dr. Cameron thought that the contractile structure of the bladder had been hypertrophied from overuse; frequent micturition, due to reflex irritation from the diseased pelvis of the kidney, together with a certain amount of obstruction from the enlarged prostate, would naturally cause hypertrophy of the muscular coat of the bladder. Dilatation of ureters he thought due to sphincter action of muscle fibres around urethral orifices. Several members objected to this explanation, as they could not see how it was consistent with the dilated ureters, and they did not think that frequent micturition would produce hypertrophy.

Dr. Caven, in reply, said the dilatation of the ureters in this case could not have been due to over-distension of the bladder, since the bladder was thickened and contracted, but might have been caused by the strong contractions of the hypertrophied bladder obstructing their orifices. He thought Dr. Cameron's view best explained all the facts. He remarked further that there were no cardio-vascular changes, and the condition of the kidney was secondary.

MALIGNANT DISEASE OF THE VERTEBRAL COLUMN  
WITH SOFTENING OF THE CORD.

Dr. J. E. Graham presented a case of Hodgkin's disease, lymphadenoma in the spinal canal and consequent central myelitis, and read the following history:

The patient, I. M., æt. 65, entered the Toronto Hospital, April 14, 1892. He enjoyed good health until the latter part of February. While

lifting timber his back pained him, and he was obliged to cease working on account of it. He did not strain himself, but he then first noticed a backache. The pain afterward extended towards the hips and down through the legs to the feet. It was of a sharp, cutting character, and the condition was diagnosed as double sciatica. This continued for about two weeks, when these symptoms suddenly ceased. He then noticed a weakness, more particularly of the lower extremities, which gradually increased until he lost control of the lower extremities, and the paralysis is still present. The patient is a tall man, six feet in height, and before his illness weighed 176 pounds. His face is much emaciated and has an anxious expression. The eyes are sunken, conjunctivæ jaundiced, and a very characteristic cancerous cachexia is present. He complains of dyspeptic symptoms, nausea, flatulence, etc. Bowels are regular; fæces of a light color, with no blood or other abnormal substance. Liver and spleen somewhat enlarged; prostate enlarged; inner surface of rectum healthy. A slight systolic bruit, of a hæmic character, was heard at the apex of the heart. Pulse 104, small and tense. On microscopical examination of the blood, the red corpuscles were found regular in shape and size and formed into rouleaux. 2,500,000 red corpuscles were found in the cubic mm., and the white to the red in the proportion of 1 to 50. Respiration is abdominal in type. Breathing and voice sounds normal. Skin hard and dry. The lymphatic glands throughout the body were indurated and somewhat enlarged. Urine pale in color; sp. gr. 1021, acid reaction. No albumen and no sugar. A urethritis appeared a few days after he came into the hospital. There is almost complete paralysis of the legs, and paralysis also of the bladder and rectum. Superficial and deep reflexes are absent in the lower extremities.

Patient feels at times a burning sensation along the inner sides of both legs. Sensation is lost on the soles of the feet, all the toes, and as far back on the dorsum of the foot as the metatarso-phalangeal joint. He has also lost sensation of heat and cold over the same surface, as well as over the inner sides of the legs. General tactile sensation is imperfect, and delayed over the latter surfaces. The pupils react imperfectly to light, and somewhat better to distance.

A few days after admission to the hospital, patient became much worse. He appeared to suffer from acute septicæmia, high temperature, frequent pulse, and a rapidly deepening typhoid state. He died about ten days after admission.

*Post mortem:* A small soft tumor was found on the anterior surface of the ninth dorsal vertebra. When cut into, the soft tissue was found to extend into the body of the vertebra and through to the spinal canal.

The bodies of the eighth and tenth vertebræ were also diseased. A soft lymphoid growth was discovered in the spinal canal on the outside of the dura mater, corresponding in situation with that found anterior to the body of the ninth dorsal. The lymphatic glands throughout the body were enlarged and indurated.

A central myelitis was found extending from the sixth vertebra downwards to the conus medullaris. The softening involved the gray matter leaving portions of the lateral and posterior columns intact. Above the sixth dorsal the cord was quite normal.

On microscopical examination, the growth on the anterior surface of the ninth dorsal vertebra was found to be made up of lymphoid tissue, as also was that in the spinal canal. No examination has yet been made of the inner portion of the vertebra.

Taking into consideration the clinical history and the *post mortem* examination of this case, we would conclude that it was essentially one of Hodgkin's disease, or pseudo-leukæmia. The peculiar course followed by the disease was due to the fact that one of the lymphoid deposits formed in the spinal canal pressed on the cord and produced central myelitis. It is difficult to understand why such a comparatively small tumor should be the cause of such severe myelitis. There was, however, a decided obstruction to the movement of the cerebral-spinal fluid, as the membranes in the lower part were much distended. The septicæmia, which was the immediate cause of death, might have arisen from urethritis, which followed catheterization.

(The following discussion took place under the impression that the tumor of the vertebral bodies was of a carcinomatous character, as was at first reported by Dr. Graham. After further microscopic examination, however, the neo-

plasm was determined to be lymphadenoma, and the author amended his report as above.)

Dr. Cameron said that from the history as related there should have been little or no doubt as to the diagnosis during life. Double sciatica was found in only three conditions: diabetes, spinal caries, and carcinoma. It was easy to exclude the first two. He thought the growth here must have originated outside the neural canal, and the condition of the cord was a secondary one, produced by pressure.

Dr. John Caven said if this was a primary cancer of the vertebral column, he could not see how it could arise unless we accepted Cohnheim's theory of the origin of neoplasms, for the structures of the column were all of mesoblastic origin.

Dr. Acheson thought that some embryologists now looked on the notochord as derived from the hypoblast.

Dr. Peters thought the growth might have originated in the central canal of the cord.

Dr. McPhedran said the existence of lymphadenomata and the condition of the blood rendered the diagnosis not quite so simple as Dr. Cameron was inclined to think it.

Dr. Graham replied briefly, and said he would have the tumor, cord, and membranes carefully examined by the microscope, and report further on the case at a future meeting.

#### CARD SPECIMENS.

By Dr. Graham, (1) Calculus in the spleen.

By Dr. Acheson, (2) Heart with vegetations on the aortic valve.

(3) Stomach and duodenum, showing a cicatrized duodenal ulcer and inflammatory thickening of the pylorus.

By Dr. Primrose, (4) Microscopical sections of villous growth of urinary bladder.

After nominations for the officers for next year, the society adjourned.

#### THE CLINICAL SOCIETY OF MARYLAND.

Baltimore, Md., April 1st, 1892.

The 265th regular meeting was called to order by the President, Dr. Robert W. Johnson.

Dr. Wm. S. Gardner read a paper upon

THE MECHANISM OF AXIS TRACTION FORCEPS.

A pair of forceps designed by the author were exhibited.

Dr. Frank Dyer Sanger read a paper on

## DEATH FOLLOWING SUPRAPUBIC ASPIRATION OF THE BLADDER.

The patient was seventy-five years of age, white, large, rather fleshy, full habit. Had had trouble passing his urine for some time, but never retention. For three days he had suffered much pain in the region of the bladder, and could only pass a small quantity of urine at a time. Examination showed the bladder to be moderately distended, its summit about two inches below the umbilicus. A hot bath gave no relief. A number of strictures were found in the urethra; nevertheless a long curve catheter was passed as far as the prostatic urethra. Nothing could be passed further. Seven hours after the patient was first seen, aspiration was determined upon, as I felt sure the bladder would suffer if not soon relieved. A double inguinal hernia and a rather thick accumulation of fat over the pubes decided me to insert the needle well up. Having used thorough antiseptic precautions, I felt that I could pass the needle through the peritoneum with safety. About one quart of urine was removed from the bladder. A drop of blood followed the removal of the needle; the point of the puncture was covered with a strip of adhesive plaster, and the patient went to sleep. Next day his bowels moved freely, and he passed considerable urine, a part of which escaped into the bed and could not be measured. The morning of the second day after the operation he complained of pain in the lower part of the abdomen and tenderness. Bladder could not be felt; pulse somewhat accelerated; temperature normal. Toward evening abdomen became tympanitic, pulse more rapid, temperature 98, expression anxious, urine passed in small quantities. Bladder could not be made out. Opium given to relieve pain and heat applied to abdomen. Patient died next morning, 62 hours after the aspiration.

*Post mortem:* Needle had entered the abdominal wall two inches above the upper border of the symphysis pubis. A line of light extravasation marked the track of the needle through the wall and parietal peritoneum fold; further than this its track could not be positively determined, as the pelvic cavity was filled with blood. Dense adhesions bound the bladder in all directions which required considerable force to be broken up. There was considerable redness of the parietal and visceral peritoneum in the vicinity of the bladder. No pus or urine apparently. In freeing the adhesions about the bladder that organ was ruptured, and about one-half pint of turbid urine escaped. I removed the bladder and urethra *en masse*, but was prevented from further examination by friends who came to claim the body. I regret that I did not at least secure one of the kidneys, as it might have thrown some light on the cause of death.

There have been a number of deaths reported from suprapubic puncture for the relief of a distended bladder. Deneffe and Van Wetter in 1877 collected 152 cases of suprapubic puncture, with six deaths; eighty-seven cases of rectal puncture, with eleven deaths. I have not been able to find another case of accident from aspiration in the literature, though my search has not been by any means exhaustive. Deneffe and Van Wetter report fifty-seven cases of aspiration, with no accident, showing the improvement upon puncture. The case here reported proves at least that aspira-

tion is not free from danger, and suggests greater circumspectness in its practice.

Dr. W. P. Chunn: In these cases of distended bladder by sticking close to the symphysis you can get into the bladder without striking the peritoneum at all, and this is what most operators attempt to do. In the case under consideration, some urine probably trickled out of the bladder and gave rise to peritonitis.

Dr. J. W. Chambers: I begin to look upon every case of greatly distended bladder in old men with enlarged prostate with a certain amount of apprehension. The condition is a dangerous one. The case in point is interesting from the amount of hemorrhage that followed a simple aspiration. The condition of the veins over the front of the bladder can be very aptly compared to the condition of the veins in front of the trachea, where we frequently meet irregular veins which give rise to considerable trouble in operations. In the present case, with an enlarged prostate interfering with the circulation, the veins on the anterior surface of the bladder were doubtless distended, and probably one of these varicose veins was punctured, giving rise to the hemorrhage. The peritoneum was probably infected by the needle, which became infected in the bladder. Ordinarily a puncture two inches above the symphysis, when the bladder is distended, would not strike the peritoneum, as there is then usually  $2\frac{1}{2}$  to 3 inches space between the symphysis and the peritoneal reflection.

Dr. S. K. Merrick read a paper on

## IDIOPATHIC PERICARDITIS,

with report of two cases. The term idiopathic pericarditis is used by authors to define an inflammation of the pericardium (which may be acute, subacute, or chronic) not the result of any discernible preceding or concomitant pathological process. To eliminate every etiological factor in any given case, and by exclusion arrive at a diagnosis of idiopathic pericarditis, requires no little pains on the part of the practitioner. Not a few authors are skeptical as to its existence. DaCosta, while admitting its extreme rarity, says he has seen several cases about which he has had no doubt as to the diagnosis. It may be that the paucity of cases of this affection reported depends in no small degree upon the obscurity of the symptoms and latency of the affection, which may possibly be characteristic of this form of pericarditis.

*Case 1:* Widow, aged sixty; came under observation at the North-Western Dispensary in early part of 1887. Complained of pain in the precordial region, of great weakness and faintness on exertion, and that her hands and feet were always cold. She had had no acute illness for years. Never had rheumatism, nor any of the diseases which stand in an etiological relation to cardiac diseases. Her urine was examined and was found normal. Careful auscultation discovered no valvular lesions. All the valvular sounds were clearly audible, but weak. The apex beat was in the normal position, but lacked force. The diagnosis made was weak heart from malnutrition, the latter being due to some unknown cause. She was slightly jaundiced, her skin being very much like parchment. She grew gradually weaker and progressively emaciated, the coldness of the extremities reaching up to the elbows and knees. To the touch she was more like a cold-blooded animal than the



*genus homo.* Her urine was repeatedly examined, and was always normal. She entered the Maryland General Hospital in the fall of 1887, and died about three months later. The autopsy was held by the late Dr. E. R. Walker. The heart and lungs were removed, the latter being sound and free from adhesions to the pleuræ or pericardium. The valves of the heart were perfectly sound, but the walls of the heart were atrophied and thin, and on close examination there was found a uniformly adherent pericardium which could be peeled off. The whole organ was firmly compressed by the adherent sac. All other organs were normal except the liver, which on close examination was found to contain small points of scar tissue here and there, the sites of former localized hepatitis, no doubt. The coronary artery had doubtless been compressed by the adherent sac, and thus the nutrition of the heart had suffered.

*Case 2:* Widower, aged forty-two, salesman in clothing house. Admitted to the Maryland General Hospital Nov. 10, 1891. His health had been good till three weeks previous, when he had considerable pain about the precordia. Said he had no fever at any time. Temperature was always normal while he was in the hospital. Urine normal. Man had never had rheumatism nor any disease to which pericarditis could be referred. No apex beat discovered by inspection or palpation. No friction fremitus on palpation. On percussion, an increased area of dullness over lower cardiac region. Auscultation revealed the to and fro new leather sound, heard with increasing loudness as the ear approached the base of the apex. A rather loud aortic regurgitant murmur was heard in the second right intercostal space, the blowing character of which was in sharp contrast to the pericardial friction sound. I pronounced it a case of pericarditis with effusion, complicated with endocarditis and aortic valvular lesions. Dr. Street, who also examined the patient, came independently to the same diagnosis. The patient, a few days after coming under my care, disobeyed certain rules of the hospital and was dismissed, much to my regret.

Dr. W. T. Howard, jr., thought that the lesions described in the liver in the first case were suggestive of syphilis. If this case could be associated with syphilis it would be most interesting, as syphilis has never been set down as a cause of pericarditis.

Dr. Merrick: I could not exclude syphilis. There were no symptoms of syphilis as long as the case was under my care. The lesions were on the surface of the liver, and dipping down a quarter of an inch or so. Dr. Walker, who made the autopsy, thought they were the sites of hepatitis.

Dr. A. K. Bond: I have no doubt at all that Dr. Merrick's cases were cases of idiopathic pericarditis. One cause of pericarditis and endocarditis that might sometimes be mistaken for idiopathic is rheumatism where there is no associated joint pains. In a case under my observation this winter, I found signs of an old pericarditis. The patient told me that these signs had been present since childhood. She said she had never had rheumatism. As in infancy and childhood rheumatism sometimes manifests itself, not in joint pains, but by other symptoms, such as chorea, I asked the patient if she had ever had St. Vitus' dance. She replied that she had had several very obstinate attacks.

Dr. Charles O'Donovan quoted from Ziemsen, Loomis, Gowers, and others, to show the extreme infrequency of idiopathic pericarditis. In Dr. Merrick's first case very considerable trouble was found in and about the liver, and it seems hardly proper to record this as a case of acute idiopathic pericarditis. The second case was not the subject of autopsy, and is therefore incomplete. It is quite possible that some cause may have existed which was not detected. It is very plain, in my mind, that the first case was not one of idiopathic pericarditis.

Dr. J. F. Martenet: In ten years' special work in chest troubles, I have never come in contact with a case of idiopathic pericarditis. I should think that the first case of Dr. Merrick's was of syphilitic origin. I do not know that Dr. Merrick has eliminated chorea. We scarcely ever have a case of chorea persistent in character in which we do not have some trouble in the heart area. Dr. Osler says that one should look for troubles in the cardiac region associated with and following chorea. It seems to me that there must be some other affection, possibly early in life, that he has not traced out.

Dr. J. W. Chambers: It seems to me that the interest in Dr. Merrick's case is not so much the cause of pericarditis, but the fact that this woman died, and the principal lesion was in the pericardium. Lesions of the heart, endocardium, pleuræ, kidneys, and other organs, which are usually associated with pericarditis, were absent. "Idiopathic" is simply a waste-basket in which we throw things for convenience. Undoubtedly this trouble has a cause, but what the doctor means to say is that he could not find out the definite cause.

Dr. O'Donovan: I think Dr. Chambers' remarks are hardly *apropos*. The whole world is searching for a case of idiopathic peritonitis, and, as far as I know, they have not been able to find it. The same holds good as to pericarditis. It is hardly the thing to claim these cases as almost isolated cases of a very rare disease. Every case should be judged on its merits.

Dr. Norment: With Dr. Chambers and Dr. O'Donovan, I doubt if there is idiopathic anything, if by "idiopathic" is meant a disease without an underlying cause. The question of associating a previous illness with the case in hand is an interesting one. Dr. Howard said that he knew of no case in which syphilis has been recorded as a cause of pericarditis. If syphilis was likely to be a cause of pericarditis in the present case, it seems to me that it would have been the cause of it in a good many other cases as well, considering the prevalence of syphilis. If a man had syphilis twenty years ago, pneumonia ten years ago, typhoid or what not five years ago, and there is not a chain connecting these diseases with the disease that takes him off, it seems hardly fair to attribute lesions that are present to-day to something that happened long since. When we cannot say what is the matter, it is better to say that we do not know; and it is in this sense that the word idiopathic is used to-day rather than in a definite sense.

Dr. Merrick: With regard to syphilis, in searching over the authorities, I could not find syphilis as ever having been the cause of pericarditis. As to rheumatism in childhood, that is readily disposed of by the character of the adhesions, which

showed the trouble to be of recent date. I grant what the gentlemen have said of the extreme rarity, and perhaps the impossibility, of idiopathic pericarditis. All of Dr. O'Donovan's authorities acknowledge that such a thing may occur. DaCosta says there are cases in which the closest investigation has failed to show any assignable cause. In twenty years' practice, during twelve or fifteen of which I have had all the clinical material of the North-Western Dispensary, averaging four to six thousand cases in a year, I have had an opportunity of getting hold of such a case, if such a thing exists. Dr. Walker, who had made over three thousand *post mortems*, particularly noted this case in the hospital, and that was the reason an autopsy was held. The case was a unique one in Dr. Walker's experience.

## Correspondence.

Editor of THE CANADIAN PRACTITIONER :

SIR,—IN THE PRACTITIONER of the 16th of May a communication appears, signed "Juvenis" (from nowhere), *re* the opposition to the amendments of 1891 to the Ontario Medical Act.

As the communication was admitted to the columns of THE PRACTITIONER over an assumed name, more or less speculation has arisen as to its authorship. While some are inclined to think it not necessary to look outside the editorial management of THE PRACTITIONER for the author, others credit it to the "Ingersoll statistical pyrotechnist." As one of the many opposed to the medical legislation of 1891, I regard it a matter of very little consequence as to who may have been the author of the letter referred to, and also of very little consequence the views which its author expresses. However, this much I will say, if the object of "Juvenis" in making himself impudently offensive through sneering allusions to the Medical Defence Association was to obtain the applause of the dominant section of the Medical Council, he must have succeeded remarkably well. "Juvenis" appears to have intentionally ignored the fact that it is not so much to a "*mean* \$2.00" assessment the members of the Medical Defence Association object as to the manner in which the Council has taken to enforce its payment, to the way in which the funds of the College are expended, and especially to the management and expenditure of the College being controlled and directed by members of Council *outside the reach of the medical electorate*. If I understand

the feeling of the Medical Defence Association, it is not likely to be daunted by the sneering of "Juvenis," nor yet by any formal expression (however "unanimous") *engineered* by the *faithful* at the late meeting of the Ontario Medical Association.

"Juvenis" may rest assured that the Medical Defence Association is not likely to be extinguished by his shadow, that its list of membership has been greatly augmented on account of the shuffling tactics in the formation of the late committee of the Legislature on Dr. Meacham's bill, and that when the proper time comes the Defence Association will be found on the stand again to press for the repeal of the amendments complained of; failing which, a united effort will be made, the first opportunity, to effect through another source such changes as shall eventually redress the whole of the evils which a majority of the profession very justly and properly object to.

I happen to have a personal knowledge and a distinct recollection of the circumstances and conditions which led to the admission of the assessment clause into the Medical Act in 1874. At the time, the Council, through extravagance and bad management during the first few years of the operation of the Act, had got to the bottom of the treasury. Representations made to the late Hon. Adam Crooks in 1874, then Minister of Education, were that financial relief was an absolute necessity to carry on business and to secure examiners from the ranks of the profession, who could not be expected or induced to undertake the duties without some hope of reward, and that the necessity for the operation of the assessment clause would not be more than temporary. The profession, in return for willing and early assistance, was assured that quacks of all sexes, sizes, and conditions should be summarily suppressed; that a full report of the operations and expenditures of the Council should from time to time be furnished the members of the College; that the different territorial divisions should be fairly represented upon the Examining Board, etc., etc. To what extent have these promises been kept? Quackery is as rampant and flagrantly carried on now—even under the nose of the Council—as it has ever been; information respecting the speculative and other operations of the Council

has been carefully suppressed and concealed; and, so far as regards the territorial share in the examinations, the records will show what amount of fairness has been displayed. I have known the nominees of some of the territorial representatives objected to for no other reason than that they did not answer the purpose of the dominant section of the Council. At one time the domestic character of the candidate was at fault, at another want of qualification was put forth as an excuse, and so it went from the beginning. The territorial representatives in the Council are in the minority, in a measure powerless; and if a territorial man is not a pliant voter, and a sycophant to boot, he is not likely to be permitted, as the Council is now constituted, to do more than answer his name at the roll call and occupy his seat.

Can it be possible that a large majority of the profession will submit to being snubbed in this fashion, and at the same time pay an annual tax to be squandered at the will of the few? Time will tell.

W. COBURN.

Oshawa, June 10, 1892.

### Miscellaneous.

THE ASSOCIATION OF MEDICAL OFFICERS OF THE MILITIA OF CANADA.—The first annual meeting of this association was held in the Canadian Military Institute on Thursday, June 2nd, at 2 p.m., President Dr. F. W. Strange in the chair. Among those present were Drs. G. S. Ryerson, secretary; A. A. Dame, W. T. Stuart, Baldwin, Moore, Elliot, Orton, Preston, Osborne, Rennie, Leslie, Rice, McWilliam, Saunders, McCrimmon, Grasset, Warren, Raikes, King, and Clark. After the constitution and by-laws, which were submitted by the secretary, had been adopted, the president, Dr. F. W. Strange, delivered his address to the association. For the past twenty-six years, during which the militia of Canada as at present organized has existed, the medical officer of a battalion, he said, has been but a regimental unit, and one of the objects of the formation of this association was to draw these regimental units out of their retirement, and by binding them together to give them their proper position in the military history of the country, and impart an interest and increased efficiency in the work in which they were engaged. The status and rank of the regimental medical officer, he said, also needed some consideration. The medical officer should be an officer in the ranks the same as any other officer, and length of service should be considered in his promotion, as is done with the militia officers. "Let us have surgeon-captains, surgeon-majors, etc., and the officers promoted according to length of service and quali-

fication, and the injustice of chance will no longer assist the officer in obtaining his proper position in the militia." The most important object in the formation of the association, he said, was the purely professional aspect. The reading and discussion of papers on topics relating to military medicine, surgery, and hygiene has received no attention in Canada, and the contribution of papers on military matters will always be one of the main features of this association. Dr. Warren then read a paper on "Ambulance work during the Franco-Prussian war," and Dr. Daniel Clark, once Inspector of Surgeons in the United States army, contributed a very interesting paper on "Some brain wounds, with results."

In the evening a smoking concert was held at Dr. Ryerson's residence, when the officers of the Toronto Garrison were invited to meet the association. At the meeting following the secretary read, for Dr. Wm. Canniff, a very interesting paper on "Some Experiences of a Surgeon during the American War." Dr. Canniff was late assistant-surgeon in the Royal Artillery. The election of officers resulted as follows: Hon. President, Surgeon-General Bergin; President, Surgeon F. W. Strange; Vice-Presidents, Ontario, Surgeon V. H. Moore, 41st Brockville Rifles; Quebec, Surgeon Roddick, 1st P.W.O. Rifles, Montreal; New Brunswick, Surgeon-Major Connell, 67th Batt.; Nova Scotia, Surgeon D. A. MacGillivray, 94th Highlanders; P.E.I., Surgeon Jenkins, Garrison Artillery, P.E.I.; Manitoba, Surgeon G. T. Orton, 90th Winnipeg Rifles; British Columbia, Surgeon Duncan, R.C.A., Victoria; Treasurer, Surgeon Tracy, 49th Hastings Rifles; Secretary, Surgeon G. Sterling Ryerson, R.G., Toronto. It is likely that the association will hold a special general meeting at Ottawa in September, during the meeting of the Dominion Medical Association in that city. Ninety-one active members have joined the association.

PRIVATE HOSPITAL.—We are informed that Dr. Ryerson's Private Hospital for Eye and Ear Disease, to which attention is directed in our advertising columns, has been running satisfactorily for the last two years.

### GOOD OPENING FOR PRACTICE.

BEING about to retire from practice, I am prepared to sell or rent the premises in Trenton, in which town I have practised for thirty years. For further particulars, address

DR. HENRY W. DAY,  
Registry<sup>o</sup>Office, BELLEVILLE.

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