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CANADA

MEDICAL & SURGICAL JOURNAL

DECEMBER, 1881.

Original Communications.

OVARIOTOMY.

By HAMNETT HILL, M.R.C.S., Honorary Surgeon to the General Hospital and Consulting Surgeon to the County of Carleton Protestant Hospital at Ottawa.

About the middle of May, 1881, I was consulted by Miss G., aged 30, in consequence of an abdominal tumour, which she described had given her much uneasiness for some length of time, tracing back, as well as she could recollect, to a period of nearly four years. She was of a spare habit of body, nervo-bilious temperament, and evidently suffering from impaired health and defective nutrition, whilst her unwieldy appearance would indicate almost that she was in the eighth month of pregnancy.

On examination in the posture of decubitus, the abdomen was found much enlarged, soft and fluctuating, giving the usual wave-like feel on percussion; this softness was modified somewhat on the right side from the inguinal region upwards over a space of about 4 inches in diameter, which space gave a decided feeling of hardness. The diagnosis was "cystic ovarian tumour," with, perhaps, fibroma, corresponding with the locality where the hardness existed. This opinion, *quo ad* ovarian dropsy, was strengthened by my discovering a cicatrix below the umbilicus, for which I sought an explanation, when I learnt that she had actually been tapped so lately as the month of February, when a large quantity of glairy, sticky fluid had been drawn off, but the swelling had quickly returned, and, although painless, her existence had

become miserable and wretched in the extreme. The usual treatment for such cases was explained, and she consented to put herself under my care for operation. On the 2nd of June, immediately after her menstrual period, the operation of ovariectomy was performed under chloroform at the private residence of the patient. Prior to this date I had read with much interest the valuable practical remarks on this subject quoted by Dr. Gardner of Montreal in the May No. of the CANADA MEDICAL & SURGICAL JOURNAL from a paper by Dr. Nœggerath, introducing a novelty of detail in the operation of a most useful character, namely, the evacuation of the contents of the sac by a trocar *before opening the peritoneal cavity*, a practice which cannot be too highly recommended, and of which I availed myself in the present case. The ovarian sac was found so tough and tense, that very considerable force was necessary, accompanied by a rotatory movement similar to drilling, before the trocar could be made to enter. The escaping fluid was of a peculiar character, very unlike that which I had seen in similar cases before, being usually of a dark straw colour, whereas this resembled "thickish arrowroot prepared with water"; from this cause it took at least twenty minutes to discharge itself, in quantity about three gallons. The sac was found entirely free from adhesions, arising from the right ovary, the pedicle was easily reached and secured by clamp, which was retained in position outside the wound at its inferior angle. After removal of the sac, the incision was brought together by five carbolized silk sutures, and covered with carbolized pledgets of lint. The operating table had been so arranged as to fulfil all the purposes of a bed, on which she was left for some days; 40 minims of laudanum were given as soon as she was put to rights; it was very shortly rejected by vomiting, and the same result took place on repetition of the dose; an enema of a teaspoonful of laudanum with a wine-glass of water thrown into the rectum was retained, and no more vomiting or unpleasant symptoms occurred. The urine was drawn off towards night, and at my morning visit I found she had slept comfortably and was progressing most favourably; no pain, no thirst; pulse 82, temperature about 99°. A daily record of the case would be tedious.

These favourable indications continued. Catheterism was used twice daily; the sedative enema was administered for a few nights, and then gradually discontinued. The bowels were relieved by emollient enema on the fifth day, after which the wound was dressed with carbolized pledget of lint and the patient placed on a more comfortable bed. Up to this time milk diet and gruel was the only nutriment allowed, but a more generous diet was now permitted. The pedicle sloughed away on the 14th day, and convalescence might be said to be perfected about the fourth week. The sac was found to be bilocular, without any fibroid degeneration, the hardness above referred to having been caused by a second cyst lying, as it were, on the surface of the main sac covered by a very dense membrane of about the diameter of four or five inches and about one inch in depth, and contained a fluid such as has been described above; it added so little to the size of the emptied sac, it was not found necessary to evacuate its contents prior to removal.

On visiting my patient in September, soon after my return from attending the Canada Medical Association at Halifax, I found her free from complaint and much improved in flesh and general appearance. There is, however, a most singular fact to record. On the return of the catamenial period, a very small blister, of a dark colour, appears over the cicatrix just where the pedicle was secured, and which has been perfectly healed long since; the skin gives way and enough blood oozes therefrom to stain her linen to the size of a quarter dollar or English shilling. It causes no further inconvenience, and quickly heals up again. The circumstance itself is very singular and unique, as far as my knowledge goes. Whether it will continue or increase, possibly, is a matter for future observation, and I shall endeavour to keep posted on the matter.

The following suggestions occur to me, a "Septuagenarian," which may be of some benefit to my younger *confrères*:—

1stly, I consider a private residence for this operation is much to be preferred to a hospital, as there is a largely diminished risk of septic influences in the former case, provided the locality is healthy in character, and cleanliness and comfort is the order

of the day. Another important feature exists in the fact that only a limited number of assistants should be present, which again reduces to a minimum the chance of septic influence; whereas in hospitals the whole staff has a right to be present, frequently very large in number, to say nothing of students and pupils attending the surgical practice, all which *pro tanto* must increase the risk of septic contamination. In my humble opinion, four assistants—at the most, five—besides the operator are all that are required or should be allowed to be present.

2ndly, In reference to the procedure of treating the pedicle, it appears to be a matter of doubt just at present whether it is more judicious to return it well and securely ligatured into the abdomen, or leave it clamped on the outside in the wound. *Theoretically*, the latter plan would unquestionably be far superior, as sloughing must occur in either case, and this destructive process must entail the production of septic matter, which is surely better outside the peritoneal cavity; of course drainage tubes can be left in and irrigation adopted, still, it must be borne in mind that these are all foreign bodies, and not at all unlikely by their presence to produce peritoneal mischief. *Practically*, however, these unfavorable results do not appear to occur, and the latest operators seem rather in favour of returning the pedicle into the abdomen; there is yet another important matter to bear in mind, namely, the possibility of hæmorrhage from the stump, which has occurred, I believe, in some instances, and has terminated fatally.

3rdly. With respect to the new method of operating introduced by Dr. Noeggerath, namely, the introduction of the trocar into the sac prior to opening the peritoneal cavity, I think it will be considered on all hands to be a most valuable addition to surgery. It reduces the exposure of the contents of the abdomen to a minimum, entirely prevents any septic matter from the sac entering the abdomen, and also prevents cooling abnormally the contents of this important cavity, the importance of which precautionary measure has been so much dwelt on by writers on this subject. The re-inserted trocar into the canula supplies the place of vulsellum, tenaculum, hook and forceps, reducing the

number of instruments very considerably, and at the same time makes a most efficient director on which the peritoneum can be opened to any extent desired, and the reduced sac immediately drawn out by simply depressing the handle towards the pubis.

4thly. Use of antiseptics. Before the operation is commenced every instrument likely to be required, sutures, needles, &c., &c., should be thoroughly anointed with carbolic oil, as also the hands of each assistant, whether his services are likely to be required or not, and each should be interrogated as to whether he is actually in attendance on any erysipelatous case, puerperal fever or any zymotic disease, in which case his absence would be most desirable. If operation takes place in hospital, carbolic acid solution should be copiously sprinkled on the floor and walls, and spray should be used; but if at a private residence, these precautions are not so imperatively necessary; probably the removal of all furniture, carpets, curtains, wearing apparel, pictures, &c., &c., with liberal use of scrubbing brush, and opened windows for a day or two before operation, may be all that is required.

5thly. Quietude of mind and body are essential matters of detail after operation. None but the nurse and one friend should be allowed in the room at one time for several days, and each should refrain from talking either with the patient or each other; no other visitor should be allowed in on any pretence. As a general rule the patient would be better if left on the operating table (properly prepared before-hand) in the same apartment as that used for operation for several days. Every act like straining should be most carefully avoided; the urine should be drawn off twice or thrice each twenty-four hours, and the bowels relieved by enema after four or five days. Milk diet, with oatmeal water if desired, as a drink. No circular bandages should ever be used, as their application and removal necessarily entail a great amount of disturbance; a many-tailed bandage is permissible just to keep in position the antiseptic dressing over the wound, and the longer this is left undisturbed the better for the patient.

6thly. Sutures.—As to selection of material, I much prefer

silk; they are removed with little difficulty, whereas the removal of silver sutures causes much unnecessary pain, and not unfrequently a good deal of excitement. I consider it a matter of importance to have your sutures previously prepared by carbolization and 12 inches in length; insert them by transfixing the peritoneum and integuments, and extend each free end on the surface of the abdomen, but do not tie until each has been properly placed. The object of this little manoeuvre is to lessen the difficulty of transfixing the peritoneum, for as the opening of the incision becomes contracted by tying each in succession, it is almost impossible to be sure that the last one or perhaps two have been properly adjusted as regards transfixing the peritoneum.

In the performance of the above operation, I must refer to the kind assistance of my *confrères*, Drs. Grant, Horsey, Leggatt, Henderson and S. Wright.

REPORT ON THERAPEUTICS AND PHARMACOLOGY.

By JAMES STEWART, M.D., BRUCEFIELD, ONT.

(Read before the Canada Medical Association, at Halifax, August, 1881.)

(Continued from page 225.)

JABORANDI.

It is now several years since this drug has been employed by physicians, and although much yet remains to be discovered as to its physiological actions and uses, we are in a position to estimate in a great measure where benefit can be obtained from it. That this drug, or rather its alkaloids, are likely to come into general use as powerful therapeutic agents seems undoubted.

Harnack and Meyer* have published the results of observations which they made in Prof. Schmiedeberg's laboratory in Strasbourg on jaborandi and its alkaloids. They have found that jaborandi leaves contained not only the alkaloid pilocarpin, but also another similar body which they named *jaborin*, which was to a great extent antagonistic to pilocarpin in its action. Jaborin

* *Arch. fur Exper. Path. and Pharma.*, Vol. XII., page 366.

dilates the pupil, and has an action on the heart, salivary glands, the intestines and central nervous system exactly like atropine, and which is found also, like it, to antagonize the action of muscarine. Sidney Ringer* has shown that jaborandi and pilocarpin paralyze the frog's ventricle separated from the auricles, and as the ventricle contains no inhibitory ganglia, the paralyzing effect must be induced by the influence of the drug over the excito-motor ganglia or the muscular tissue, or both. In all probability the action of jaborandi on the heart is two-fold—for a heart arrested by this drug will at first contract on mechanical stimulation, but soon ceases to contract either on mechanical or electrical stimulation. As atropia antagonizes the action of jaborandi on the ventricle, it cannot act by paralyzing the inhibitory apparatus, but from its effects in the excito-motor ganglia and muscular substance, and he has suggested that this antagonism is due to chemical displacement.

The greatest value of pilocarpin appears to consist in its power of causing rapid elimination of effete material in cases of scarlatinal nephritis. It has been frequently administered in such cases, and with much benefit; and it appears likely that, if it be given with proper precaution, it may frequently be the means of saving life. It is frequently observed that œdema and uræmic phenomena are neither proportionate to one another nor to the quantity of urine passed. In some cases, uræmia occurs when a normal quantity of urine is excreted, while in others no uræmic symptoms follow several days of anuria. In the former cases, the urine contains little urea; and in the latter, the urea passes from the blood into the œdemic fluid and hence becomes harmless for a time. When, however, at the beginning of convalescence, the excrementitious materials pass back into the blood, uræmia may come on, and obviously the more rapidly they pass back, the more danger there is. In virtue of its power of producing prompt and energetic increase of the sweat, salivary and other glandular secretions, pilocarpin causes a very rapid reabsorption of the transudation, and therefore its administration

* *Practitioner*, January, 1881.

may give rise to uræmic phenomena, which, though transient, may be highly dangerous. There is another danger in the administration of this drug in this disease. We know that it produces a great increase in the bronchial mucus, and if the child, who is lying on his back, is too weak to cough, a catarrhal pneumonia is very apt to be induced. It therefore should be immediately stopped if there are any symptoms of pneumonia present. If pilocarpin is given with a due heed to the above precautions, it will be the means of rescuing some apparently hopeless cases of both acute and chronic nephritis.

From the observation of the fact that sufferers from prurigo feel relief when the secretion of the sweat glands is active, as, for example, in summer, O. Simon* has been led to try the preparations of pilocarpin and jaborandi itself in this distressing condition. The effects of this mode of treatment were: abatement of the accustomed sense of pruritus, softening of the skin and diminished tendency to relapse. In Hebra and Neumann's Kliniks (1879), excellent results were obtained in the treatment of prurigo by pilocarpin. Against psoriasis it was found valueless. It was found beneficial in the chronic stage, but injurious in the acute stage of an eczema. Just† says that he has found it to act better as a pupil contracter than eserine, being free from any irritating qualities. Prokop Rokitansky‡ has employed the muriate of pilocarpin in uncomplicated serous pleurisy with excellent results. The effusion was quickly absorbed. The patients were kept on a dry diet.

A very marked antagonism exists between atropia and jaborandi. Atropia dilates the pupil, jaborandi contracts it; atropia dries the skin and mouth, whilst jaborandi induces salivation and perspiration. The hypodermic injection of atropia will immediately stop the perspiration and salivation of jaborandi. A few drops of jaborandi on the frog's heart will first retard and then stop it in diastole. If a drop or two of an atropia solution be

* *Berl. Klin. Wochenschrift*, No. 49, 1879.

† *Berl. Klin. Wochenschrift*, No. 30, 1879.

‡ Loebisch und Rokitansky: *Die Neueren Arzneimittel in ihrer Anwendung und Wirkung*, S. 15.

now applied, the action almost immediately recommences, and continues with unabated vigor. Falck* says that this is a complete physiological antagonism. From experiments performed by Ringer, † it is obvious that pilocarpin is not the chief ingredient in jaborandi which depresses the heart, for a grain of pilocarpin only slightly weakened and slowed the ventricle. On the other hand, twenty minims of the liquid extract of jaborandi, freed from spirit, stopped the heart in ten minutes. Ringer makes the following suggestion: "Pilocarpin paralyzes the heart by combining with the molecules of the excito-motor nervous apparatus and of the muscular tissue of the heart. Atropia antagonizes pilocarpin and muscaria, because it has a stronger affinity for the muscular and nervous structure of the heart than these substances, and displaces them, replacing their effect by its own."

QUEBRACHO.

First introduced by Penzoldt, ‡ it has been found to be a decided palliative in many cases of dyspnoea. It is especially valuable in the dyspnoea of emphysema and chronic bronchitis. In dyspnoea depending on valvular insufficiency, its value is questionable. § Penzoldt has lately experimented with an alkaloid obtained from this bark. It is called *aspidospermin*, and occurs in small, white, prismatic crystals. Ten milligrams of a 1 per cent solution of this alkaloid caused complete motor paralysis in frogs, with marked reduction of both pulse and respiration. Penzoldt administered it to eight patients suffering from dyspnoea due to various causes. In all there was considerable relief; in two this was very marked. According to Penzoldt, it has an undoubted influence over dyspnoea, especially that attending emphysema, but is inferior to the quebracho itself. Dr. Picot|| of Carlsruhe used a tincture of the quebracho bark while doing some mountain climbing, with the result that he

* *Der Antagonismus der Gifte, Volkmann's Sammlung, No. 159.*

† *Practitioner, January, 1881.*

‡ *Berl. Klin. Wochenschrift, No. 19, 1879.*

§ *Berl. Klin. Wochenschrift, No. 40, 1880.*

|| *Berl. Klin. Wochenschrift, No. 32, 1879.*

could climb with much greater ease and comfort. He has also used it in patients suffering from dyspnoea, and found it act well. In the same number of the *Ber. Klin. Woch.*, Berthold recommends it highly. Flint* has used it with success also.

HÆMATINICS.

Since the discovery of exact methods of estimating the number of corpuscles and the quantity of hæmoglobin, we have made some advance at least in knowing how it is that some drugs, as iron, arsenic, etc., act. We are able to estimate the changes that the blood cells and their colouring matter undergo in disease, and we can tell what our therapeutic agents are doing. Hoppe-Seyler and Preyer have shown that one atom of iron fixes two of oxygen. The following factors have to be considered: 1. The number of red cells contained in a unit of volume. 2. Quantity of hæmoglobin contained in the same unit. 3. Individual value of the corpuscles. 4. The number of white globules. 5. The number of hematoblasts.

Of all the hæmatinics, iron still maintains, as it has always maintained, the pre-eminence as a blood restorer. There are three hypotheses as to its mode of entrance into the blood: 1. Direct entrance of iron into the blood under the form of an inorganic salt and its combination with the albuminous substances of the blood. 2. Combination of the iron and the albuminates in the stomach and intestines before absorption. 3. Absorption, by these two methods combined.

E. Wild has recently shown that iron is absorbed from the stomach and intestines and then thrown out into the intestines. This explains the fact that sometimes as much iron can be found excreted through the fœces as was taken in altogether. According to Hayem† (*De la Médication Ferrugineuse*), there are two periods in the regeneration of blood by iron. During the first the iron appears to excite the formation of the globules. Then we have new globules, containing but little hæmoglobin;

* *Medical Record.*

† *Bulletin Général de Thérapeutique*, p. 289, 1881.

the globules are more altered than when the treatment commenced. Soon these young globules become physiological, the last being the most important part of the process. When the anæmia is slight, the first phase is very short or sometimes entirely wanting, the iron in this case causing an actual decrease in the number of red cells. Cl. Bernard considered that iron only stimulated the digestive organs and never entered the general circulation at all; but this has been disproved by Hayem, who administered in two cases for a period of two months the ferrocyanide of potassium with no effect in curing the anæmia, thus showing that an insoluble iron salt is of no use in increasing the value of the individual red cells. It is the quality of the red cells that is of so much importance. Prof. Donitz* of Japan speaks very highly of the albuminate of iron in the treatment of anæmia. He says that it can be tolerated when no other salt of iron can. It can be used hypodermically, and in this way it proved to be of great service in that disease called in India "beriberi." In this disease, hydræmia of a severe form is the most prominent pathological condition, especially in the early stages. Prof. Demarquay† of Paris has also found this salt of iron to act particularly well in cases where the other forms are not easily retained.

Next to iron, and in some forms of anæmia to be preferred to it, is *Arsenic*. It is the only drug that has been successful in the treatment of severe idiopathic anæmia. The following case recorded by Dr. Broadbent‡ is a good illustration of the value of arsenic in this disease: A woman, aged 42, who had been anæmic for four months, was admitted, and on examination she was found to have only 560,000 red cells per cubic millimètre, or 11.2 per cent. After taking 24 minims of arsenic daily for two months, the red cells had increased to 67 per cent. In the remarks appended to the report of the case, it is held "that there can be little doubt that it was a case of essential or pernicious anæmia; the patient had the appearance characteristic

* *Berl. Klin. Wochenschrift*, No. 35, 1879.

† *Medical Record*, Vol. XVI., p. 36.

‡ *Brit. Med. Jour.*, Sept. 25, 1880.

of this disease and the sub-febrile temperature, while the red corpuscles were not only reduced in number to an unusual degree, but deformed. Whether this diagnosis be accepted or not, the failure of iron to do good, and the rapid improvement during the administration of arsenic, are remarkable. In little more than two months the patient passed from extreme anæmia to apparently perfectly health, with wonderfully good colour of the cheeks and mucous membranes, and she continued well and strong for some months after leaving the hospital, up to the time when she ceased to present herself for examination."

Arsenic cured two cases of pernicious anæmia that were under the care of Dr. Finny* of Dublin. Whether arsenic acts in malignant lymphoma by virtue of its hæmatinic properties or not, it is a well established fact that it has proved curative in some of these cases. Several cures of this kind are reported by Billroth. Czerny has also cured cases with it. Israel† has reported the case of a woman, 65 years of age, who had a malignant lymphomatous formation infiltrating the glands of the neck, sufficient to cause difficulty in swallowing, completely cured by arsenic. The arsenic was used internally and also injected into the swelling.

Lugeois, in France, for ten years has held the opinion that mercury given in small continuous doses causes an increase in the body weight in healthy persons. Keyes‡ says "that mercury in small doses is a tonic to individuals in fair health, not syphilitic. In such individuals it increases the number of red blood corpuscles." Schlesinger§ has found that rabbits and dogs taking small continuous doses of corrosive sublimate for a year thrive better than animals placed on a similar diet, but not taking the sublimate. The red corpuscles of those taking the mercury are increased more than those not taking it. Their urine showed no change in spite of the increase of the body weight. Schlesinger concludes that mercury does not increase the amount of hæmoglobin or the number of corpuscles, but that

* *Brit. Med. Jour.*, Jan. 3 and 10, 1880.

† *Berl. Klin. Wochenschrift*, No. 52, 1880.

‡ *Amer. Jour. Med. Science*, January, 1876.

§ *Archiv. fur Exp. Path und Pharm.*, Band XIV.

it prevents the destruction of the latter. If it increased the hæmoglobin like iron, we should have an increase in the body temperature, in the pulse, and urine solids, but the latter is shown not to be the case.

FUCHSINE IN BRIGHT'S DISEASE.

Prof. de Renzi* of Genoa has used fuchsine in Bright's disease extensively. Almost after the first day there was noted a diminution in the amount of albumen in the urine and disappearance of the dropsy. The fuchsine was given in pill form 0.025 gramme twice daily. For some days the urine was coloured. In one case no result was obtained.

Dr. Brochut† of Paris has had ten cases of albuminuria cured by fuchsine. In every case the albumen rapidly decreased in quantity, and finally entirely disappeared after a longer or shorter period. The treatment generally lasted from one to six months, and the dose of the remedy varied from 10 to 20 centigrammes ($1\frac{1}{2}$ to $3\frac{3}{4}$ grs.) daily.

Dr. Jas. Sawyer‡ has used fuchsine in many cases of albuminuria—mostly in cases of contracted kidneys,—and says that no remedy has ever given him such good results. No untoward physiological effects have been observed from its use. The mucous membrane of the digestive organs becomes deeply coloured by its use, and also the plasma of the blood. Investigation shows this latter effect to be due not to any change in the hæmoglobin, but to the solution of fuchsine in the blood.

HOMATROPIN.

Bertheau§ has found that in frogs, in doses of 2 to 4 centigrammes, it causes motor paralysis, which affects all the muscles of the body, including the respiratory. Reflex action is first heightened and then decreased. Small doses have no effect on the pulse; large doses slow it, but do not cause any heart

* *Berl. Klin. Woch.*, Sept. 20, 1880.

† *Brit. Med. Jour.*, Oct. 11, 1879.

‡ *Practitioner*, January, 1881.

§ *Berl. Klin. Wochenschrift*, No. 41, 1880.

paralysis. In rabbits, small doses slow and large doses quicken the pulse. Electrical irritation of the vagus gives no constant result. This has also been observed by Rossbach. A few drops of a 1 per cent. solution causes a dilatation which lasts six hours. Dilatation of the pupils is produced by the internal administration of this drug, but it requires very large doses. It causes dryness of the mouth and throat. In man, doses of two centigrammes cause dilatation of the pupils. The pulse becomes slow; in no case was it observed to be quickened. This is quite contrary to what is seen in the experiments on animals, where we have first irritation and then paralysis of the vagus ends in the heart. Two centigrammes are not sufficient to paralyze the vagus ends in man, and large doses would be unsafe. Homatropin differs from atropine in requiring larger doses, and in its effects being much more transient. This last quality will make it valuable in many cases where temporary dilatation of the pupil is wanted.

JAMAICA DOGWOOD—(*Piscidia Erythrina*.)

This drug has recently been recommended as a substitute for opium. It is named the "fish-catching coral tree" by the natives of Jamaica. Dr. Isaac Ott* has investigated its physiological action very fully. He finds that it is narcotic, and without any action on the irritability of the motor nerves. Its action is on the sensory ganglia of the spinal cord, and not on the extremities of the sensory nerves. It reduces the frequency of the pulse, probably by an action on the muscular structure of the heart. The arterial tension is first increased, and then soon falls. It first contracts and then dilates the pupil. In its action on a man in health, it reduces the pulse, causes salivation and sweating, disturbance of vision, itching of the skin, sleep. It has been used in cases of neuralgia with considerable success.† I have found it to act well in the semi-delirium and sleeplessness of the very aged. It has caused in a few cases alarming symptoms.

* Brain, January, 1881, *Archives of Medicine*, February, 1881.

† See numerous cases reported in different numbers of the *Therapeutic Gazette*.

When better known it will no doubt prove to be a really useful addition to our lists of narcotics. For its introduction we are indebted to the ability and enterprise of Park, Davis & Co. of Detroit.

Dujardin-Beaumetz, in presenting his work, "Leçons de Clinique Thérapeutique sur le Traitement des Maladies du foie et des reins," to the Therapeutical Society of Paris, made reference* to the remarkable power the liver possesses in destroying some alkaloids, such as nicotine, hyoscyamine, and curarine. Under some circumstances this destruction is not complete, and we find that alkaloids that have been fixed for a variable time in the hepatic tissue are thrown out into the intestines along with the bile. This action of the liver is one of great importance, and through it we can explain the innocuousness of some substances administered by the mouth, and the more powerful effects we obtain by hypodermic injections. It also is likely the explanation of the cumulative action of some drugs. We know that some agents, when given for a time, do not produce their usual physiological action, but suddenly we find this exercised in the most pronounced manner, and for an explanation of this, the peculiar action of the liver, above referred to, seems a very likely cause.

QUARTERLY RETROSPECT OF SURGERY.

PREPARED BY FRANCIS J. SHEPHERD, M.D., C.M., M.R.C.S., ENG.

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[This quarterly retrospect I intend to devote almost entirely to a consideration of the proceedings of the Surgical Section at the late *International Medical Congress* held in London, Aug., 1881.]

SURGERY AT THE INTERNATIONAL CONGRESS.

Excision of the Kidney.—Several important papers were read on the above subject. Prof. Czerny of Heidelberg, in his paper, remarked that extirpation of the kidney is indicated in cases of

* *Bulletins et Memoires de la Société Thérapeutique Séance, du 23 février, 1881.*

wound of the kidney, floating kidney, pyonephrosis, calculous pyelitis, cysts of the kidney, and hydronephrosis, tumours, and fistulæ communicating with the ureter, as soon as the life of the individual is endangered and other methods of treatment prove ineffectual, provided that the other kidney is sound, when the kidney is fixed, or nearly so, he prefers operation by means of the lumbar incision; but for movable kidney he prefers abdominal section. He thinks, however, that the lumbar incision is the safer of the two plans, and, therefore, is worthy of further development. Prof. Czerny thinks it best to ligature the pedicle and cut it short, adopting antiseptic precautions. In cases of fixed hydronephrosis, empyema of the pelvis of the kidney, and echinococcus of the kidney, the best plan of treatment is, he considers, incision of the cyst and stitching its margin to the skin. He thinks the plan of catheterizing the ureters of women and constricting the ureters of men, in order to confirm the diagnosis of disease affecting one kidney only, has not been sufficiently practised.

Mr. W. Marrant Baker, of St. Bartholomew's Hospital, read a paper on "The Diseased conditions of the Kidney which admit of Surgical Treatment." This paper was illustrated by three cases. The first case was that of a girl 7 years old. She had pyelitis, which had followed an attack of hæmaturia. A fluctuating tumour was found in the region of the right kidney. This was incised and a drainage tube inserted, but little improvement followed, and the kidney was afterwards removed. Three months after the wound had nearly healed and the child's general health had greatly improved. The second case was that of a lad 16 years old, admitted into hospital on account of a large fluctuating tumour in the left renal region, recurrent attacks of pain and fever, followed by the appearance of large quantities of pus in the urine. Nephrotomy was performed through a lumbar incision and thirty ounces of pale, purulent urine were evacuated from an enormously dilated kidney. A drainage tube was inserted, and two months after the patient had gained flesh and strength and had suffered no pain. Drainage is still maintained. The third case was that of a feeble woman, aged 43. She had a

swelling in the right renal region, and a considerable amount of pus was always present in the urine. The swelling was punctured and 8 ounces of pus drawn off; three weeks after the tumour was explored through a lumbar incision, and was found to consist of a sacculated kidney containing a large branched calculus. The calculus was dislodged with considerable difficulty, and there was considerable hæmorrhage. The patient was much collapsed, never rallied, and died three days after the operation.

Mr. Arthur E. Barker read a paper "On some points connected with Operations on the Kidney." He only treated of questions in connection with operations on the kidney for calculous disease. He divides cases into two groups: (a) Early calculous disease, with little or no disorganization of the kidney; (b) Stone, with extensive damage to renal tissue and more or less implication of perinephritic structures. He then points out that stone may be, and has been diagnosed in the kidney very early; also, that it can be safely removed at this time by simple nephrotomy or by nephrectomy, with excellent results, compared with operations undertaken at a later stage. [The difficulty of early diagnosis is very great, and Mr. John Duncan, surgeon to the Edinburgh Infirmary, in the *Edinburgh Medical Journal* for July, has pointed out that the needle exploration is not always infallible, as in a case of his, a necrosed transverse process exactly simulated the feel of a calculus in the kidney. Mr. Barker claims to have been the first who successfully sounded for stone in the kidney by passing a needle through the loin to the kidney. It is about a year since Mr. Henry Morris read his paper on Nephro-lithotomy before the Medical Society of London. He was the first who successfully extracted a stone from a kidney by means of incision where there was no previous suppuration or sinus to guide the operator. Peters, a German surgeon, had previously, in a case of renal calculus, passed a trocar and canula into the kidney, striking the stone. Being unwilling to undertake the risk of incising the kidney, he left the canula *in situ*, dilated the wound afterwards with tents, passed in a lithotrite, and crushed the stone before removing it. Mr. Barker had previously also operated in a case of renal calculus, but the

stone being branched, and difficult of removal, the patient died. He, previous to operating, sounded the stone through the loin by means of a needle, and so settled the diagnosis, which rested between renal calculus and tubercular disease. Marchetti, in the 17th century, successfully removed a renal calculus from the English Consul, Hobson, but the operation never found favour with the profession, and Charles Bernard, in 1696, says writers "ought not to have so magisterially exploded the operation." The kidney has been frequently exposed for suspected stone, and nearly every time without fatal result. The operation was generally undertaken to relieve severe neuralgia, supposed to be caused by stone. The neuralgia in every case was relieved, and in some permanently. One boy in Guy's Hospital was not only cut for stone in the kidney, but for stone in the bladder also, no stone being found in either situation. He recovered, and the neuralgic pains were temporarily relieved.]

At the Congress, Messrs. Barwell and Clement Lucas each reported a successful case of nephrectomy. In Mr. Barwell's case, the kidney was removed for nephrolithiasis, the stone having been previously detected through a sinus, and he had failed to remove it by simple incision. In Mr. Clement Lucas' case, the kidney was excised for pyelitis, in a man aged 36. The lumbar incision was used. The man is now in good health, free from pain, has gained two stone, and is able to work.

In the discussion which followed the reading of the papers, Dr. Martin stated that he had seven times removed a painful floating kidney, and once a malignant tumour of the kidney, with five recoveries in all. Three methods of removal were described: The lumbar, intra-peritoneal, and the abdominal extra-peritoneal. Dr. Martin stated that in the removal of the kidney from the front of the belly, the peritoneum falls together so completely that it does not require stitching. The precise diagnosis of the conditions of the kidney which justifies removal is a point on which more light is required.

Causes of Failure in obtaining Primary Union in Operation-Wounds, and on the methods of treatment best calculated to secure it.—This was perhaps the most interesting and important

subject which engaged the attention of the Surgical section of the International Medical Congress. Mr. Sampson Gamgee of Birmingham, in his paper, said that operation-wounds heal, as a rule, directly and without complications when their surfaces and margins are placed and maintained in apposition accurately and without tension, and when effusion, air, and accumulation of liquid within and near the wound is prevented. These ends, Mr. Gamgee holds, are promoted by light manipulation, drainage, dry and infrequent dressings, pressure, and absolute rest. His views on the treatment of wounds are, from his numerous contributions on the subject, well known.

Prof. Humphry of Cambridge also read a paper. He attributes the causes of failure to (1) the delicacy and sensitiveness of the tissues in infantile and early life, which renders them liable to inflammation and ulceration upon slight irritation; (2) the deficiency of the nutritive energy requisite for the healing processes in the atonic and the aged, evinced most especially in the lower limbs, when there is disease of the arteries; (3) the presence of foreign substances in the wound, especially blood or bloody fluid, which separates the surfaces and has, further, a tendency to decomposition. The methods best calculated to secure primary union, Prof. Humphry says, are therefore those which maintain the apposition of the cut surfaces most effectually and with least irritation, and which provide against the presence of blood and bloody fluid in the wound—sutures of such material and applied in such a manner as is least likely to cause irritation, quietude of the part, gentle, uniform pressure, and fixing on a splint where that can be done. The effusion of blood into the wound after it is stitched up is best prevented by carefully securing the vessels by ligature or by torsion; the actual cautery may be freely used as an adjunct; the use of ligatures and stitches made of material which undergoes absorption; the insertion of a drainage tube and the expression of blood from the wound through it as long as it continues to flow. Prof. Humphry holds that antiseptics are an additional precaution, preventing the decomposition of any bloody-fluid which, in spite of the above-mentioned precautions, may be effused into the wound. They are especially

valuable when cavities are opened. He thinks that Esmarch's bandage promotes bleeding from cut surfaces soon after its removal, but rather lessens the risk of subsequent effusion.

In M. Verneuil's paper on "Primary Union," he says, in conclusion, that the attempt to obtain primary union is sometimes essential and necessary, sometimes only a supplement to the operation, and altogether optional. Before aiming at primary union, in which it is only optional, not essential, the surgeon should satisfy himself that the patient is not the subject of some morbid state which would make it more advisable to give up or postpone the attempt. The surgeon should avoid the risk of failure, which is more or less associated with danger, and seek some of the dressings which, while offering a more rapid cure, secures greater safety to the patient.

Mr. Savory, in the discussion which followed, pointed out that primary union was most likely to occur when the fresh surfaces are brought together in their natural state and maintained so without disturbance. The chief cause of failure he believed to be "meddlesome surgery," and essential principles were rest, cleanliness, and asepsis, which admit of almost endless variation in detail. He asserted that his Cork statistics had not been surpassed, though equally good results were obtained by many different plans of treatment. Prof. Esmarch's statistics of his own practice were very remarkable. In 398 great operations (six deaths), 85 per cent of the cases cured healed by first intention with *one* dressing; in 15 per cent the dressing was renewed; and this ratio had improved of late. There were 146 excisions of large tumours, 40 excisions of mammæ and axillary glands, 14 castrations, with one death from pericarditis and old syphilis, one from apoplexy, and one from fatty heart. Of 51 major amputations (thigh, 18; leg, 27; arm, 5; forearm, 1), one died from shock and hemorrhage, and one from *delirium tremens*. There were 61 resections; 11 exarticulations; 26 necrotomies; 13 nerve-stretchings, one for tetanus, which was fatal; 8 hernias: 21 large cold abscesses; 12 large wounds; 49 compound fractures. The cases were all dressed with pads soaked in iodoform and absolute alcohol (10 per cent), fastened

on by an iodoform bandage, over that a large pillow of jute and gauze, a moist bandage, and over all an elastic bandage. (Report in *London Lancet*, Aug. 13, 1881.) These statistics are certainly wonderful, and go far to confirm the confidence of surgeons in rest, support, and infrequent dressings. In fact, much evidence was offered and many opinions given which only corroborated the above, and all tending to support the views which Mr. Gamgee has so ably advocated, viz., the success of dry dressing, with support and compression, combined with antiseptics, in the treatment of wounds. A few days before, in the discussion on the recent advances in the surgical treatment of intra-peritoneal tumours, Dr. Keith had startled the section by stating that after having had a succession of eighty successful cases with Listerism, he had five deaths in the next twenty-five—two from carbolic acid poisoning, one from septicæmia, and two from acute nephritis. On account of this mortality, and of the very frequent high temperature the evening after the operation, he had *abandoned the spray* in all operations, and had had one death in twenty-seven ovariectomies without antiseptic treatment. Prof. Lister, in closing the discussion on the causes of failure of primary union in operation wounds, in reference to Dr. Keith's experience, stated that he had dissuaded him from using antiseptics in the first instance, as carbolic acid, in wounds of the peritoneum, increased the effusion and lessened absorption. He said that recent experiments showed that both blood serum and blood clot were not favourable to the development of organisms. He expressed his belief that it is "solid bits of dirt" that are the deleterious agents, and that too much attention has been paid to finest particles floating in the air. He admitted that he himself might at some future time be able to say "fort mit dem spray" (away with the spray), but that at present he could not accept irrigation as a substitute for the spray. (*Lancet* Report.) From this discussion, I should predict that the spray, and, perhaps, also the mysterious germ, are doomed, at no very distant period, to follow into oblivion many other "fads" and rituals which have before held the surgical world in bondage. The value of antiseptics is recognized by all, but many other simpler methods than Listerism are now

showing as good results. We must all admit, however, that we owe much to Prof. Lister, and his name will be always remembered as one who revolutionized the surgical treatment of wounds by directing the attention of surgeons to the importance, not only of antisepticism, but of rest and support, and the possibility of preventing suppuration and the septic conditions it leads to. I have always attributed the great success of Listerism, not principally to the use of antiseptics, which answers only one of the requirements of wound treatment, but to the accurate adaptation of the wounded surfaces, the thorough drainage, the masses of stiff gauze used in dressings (make gauze a beautiful splint by its elasticity and adaptability to surfaces and parts it is applied to), also to the careful bandaging over this gauze splint and the uniform and safe compression thus obtained. The spray, &c., may be looked upon as merely ornamental adjuncts which, if somewhat troublesome, are imposing.

Recent advances in the Methods of Extracting Stone from the Bladder.—Every one must admit that Dr. Bigelow of Boston, by the introduction of his operation, has not only made one of the most distinct advances in the treatment of stone in the bladder which has taken place in the last decade, but that his operation may be considered to be one of the most important improvements in modern surgery. At the late International Congress, all were agreed as to the great value of lithotripsy at one sitting, and gave Prof. Bigelow full credit for its introduction, and also for his axiom that the bladder was more tolerant of instruments than sharp fragments of stones, and that their immediate removal was the best mode of practice.

Sir Henry Thompson, in his paper, stated that he had performed the operation of "lithotripsy at one sitting" 91 times, with 88 recoveries. He, however, contended that the size of the instruments should be proportionate to the size and hardness of the stone, and never larger than necessary, that risk to the patient was greatly augmented by the employment of instruments which distended the urethra beyond its natural calibre. Here his views are at direct variance with Prof. Bigelow, who believes no harm results from distending the urethra. Sir Henry advises occasion-

ally the combination of a urethral opening in the perineum with a crushing operation in the bladder as an available means of evacuating both *débris* and urine.

In the discussion which followed, Mr. Coulson spoke of having removed 4 ounces of *débris* at one sitting. Mr. Teevan said there was complete absence of cystitis after "Bigelow's operation." Mr. Th. Anger of Paris advocated the performance of supra-pubic lithotomy by means of the thermo-cautery, when there was an enlarged prostate which was firmly wedged into the true pelvis; in other cases, the perineal incision should be preferred. In using the cautery, the operation is rendered easy, methodical and bloodless, the wound made is dry, and renders the patient less liable to urinary infiltration. Mr. Spence of Edinburgh said his experience was chiefly limited to lithotomy. In children the results of lithotomy were so successful that he would never think of performing lithotrity in them. In lateral lithotomy he used Dr. Buchanan's rectangular staff, except in the case of old men with enlarged prostates, then he preferred Lister's curved staff. In cases of enlarged prostate, where the gland is much condensed, dilatation with the finger made no progress, and it was necessary to use the knife to get room for the forceps, and in withdrawing the stone the dense prostate was forcibly wedged against the ramus of the pubis; such cases frequently died some weeks after the operation, and although the wound was not directly affected and the patient's death was spoken of as due to some intercurrent disease, they died as truly from the operation as if they had died on the operating table. Such cases, if they could be diagnosed, would no doubt best be dealt with by the supra-pubic operation. He could not, however, see the advantage of the thermo-cautery which M. Anger had so strongly recommended, as he had not been favourably impressed by the condition of the wound in cases of tracheotomy in which he had used it. Mr. Teale of Leeds said that the fatality after lithotomy had been lessened of late years by two factors—firstly, the improved sanitary condition of hospitals, and, recently, by the more gradual extraction of the stone, the surgeon taking pride, not in the rapidity, but in the carefulness of his manipulations.

Treatment of Aneurism by Esmarch's Elastic Bandage.—A number of papers were read on the above subject. Dr. Walter Reid, R.N., related the history of the original case in which this treatment was employed, and explained the principles on which it was conducted. Mr. Bellamy, of the Charing-Cross Hospital, said in his paper that he had tried the bandage in four cases; in three the treatment utterly failed. He considers the bandage quite useless in the treatment of cases in which the aneurism is of rapid development and the sac is highly compressible, and where there are heart complications. Mr. A. Pearce Gold, of Westminster Hospital, also read a paper in which he pointed out that while other methods of treatment lessen or entirely stop the flow of blood through part or parts of the main blood channel, they do not interfere with the blood current in the secondary vessels, or control the anastomotic circulation. Esmarch's Elastic Bandage, on the other hand, when firmly applied, stops the circulation in *all* the vessels of the part, and thus does not cause a deposit of fibrin, but may cause a coagulation of the blood *en masse*. Thus this mode of treatment was not applicable to all kinds of aneurisms. He insisted on the value of preparatory treatment.

From the whole discussion, it appears that the bandage is not likely to supersede the older methods of treatment, but that in certain cases, where consolidation has already commenced, it is likely to hasten the cure, and may be occasionally resorted to with success.

Excision of Joints.—M. Ollier, in his paper on the "*Comparative value of Early and Late Excisions in different forms of Articular Disease,*" said that the results of resections of joints depended on the following conditions: 1. On the method of operating; 2. On the amount of existing disease. Any method may prove useless if the joint be too much disorganized. As a general rule, the earlier the excision is performed the better the result which will be obtained. Age has a great influence on the results. Antiseptic treatment makes early excision more advisable than formerly. The author then enquired into the different resections of the larger articulations, and gave an analysis of

one hundred resections of the elbow performed by him. After giving some rules applicable to resection for injury, he said primary resections were apt to be followed by a too extensive deposit of new bone. He demonstrated the advantages of secondary excisions and the disadvantages of postponing the operation too long.

Prof. Kocher of Berne read a paper on the "*Results of the Treatment in Chronic Disease of the Knee Joint, including an account of fifty resections of the joint.*" The following is a summary of the paper: 1. Amputation of the thigh is indicated in cases where white swelling occurs in patients suffering from tuberculosis of the internal organs, or those whom the disease has rendered very anæmic, or who present a constant high temperature, or are reduced by prolonged suppuration. 2. In all other cases, resection is the best treatment, if contraction of the joint or considerable functional disturbance have occurred. 3. Under these circumstances, resection in every way gives better results than are obtained by conservative treatment. 4. Resection should only be resorted to in exceptional cases in childhood or advanced age. The results are as good, or better, as regards union of the ends of the bones, in adult life than in childhood. 5. Since the author has commenced the practice of resection, the mortality has only been 12 per cent, and now—thanks to recent improvements and the introduction of antiseptics—the operation has become free from danger. 6. The author's present endeavour is so to improve the method, that movable and, at the same time, firm joints may be secured.

In the discussion which followed the reading of these papers, Mr. Teale advocated subcutaneous incision of the capsule for the arrest of incipient joint disease. He considered rest of the first importance, but subcutaneous drainage of serous fluid and external drainage of pus, or trephining of diseased bony structures, necessary adjuncts. Mr. C. Heath protested against early excision when general and local treatment were available, but regarded excision as required in incurable cases; he also declared that excision in private practice was almost unknown, and not required on account of the good hygienic surroundings of the

patients. Mr. MacNamara thought the majority of cases of joint disease might be cured in their early stages, and thought it wise to relieve tension of the joint where it contained much watery fluid, and after evacuating the fluid, he advised encasing the joint with cotton wool and an elastic bandage. He also mentioned that he had had recently under his care two cases which showed that acute inflammation of the epiphysis of a long bone is apt to involve not only the periosteum, but also to cause osteomyelitis. In both these cases he had removed the whole shaft of the tibia, leaving only the epiphysis and the periosteum. In the one case the bone had been reproduced and the patient had a useful leg; in the other (referred to in last Quarterly Retrospect), after six months no such reproduction occurred, so he had transplanted some perfectly fresh and very small pieces of bone and periosteum (from the foot of an amputated limb) into a groove made in this patient's leg, in the situation of the tibia. At the present time (six weeks after the transplantation) a narrow ridge of bone could be felt in the desired situation.

Mr. Croft remarked that many patients suffering from acute articular disease did not get well without operation, but added that recent statistics showed that excision of the hip-joint diminished the average duration of the disease by one year; further, seven out of thirty-three cases of morbus coxæ, cured without excision, presented $3\frac{1}{4}$ inches shortening, which was as much as ordinarily occurred after excision. Mr. Howard Marsh pointed out that to perform early excision was to renounce the attempt to cure incipient disease and to resort to the easy method of cutting out the affected part. If this was right for joints, was it not also for the testis, which, like them, might be a source of systemic infection. He also said that in private practice joint affections were curable and excision almost unknown. Sir William Ferguson introduced excision as a substitute for amputation. This was truly conservative. He aimed at saving the limb by removing the joint. But to remove so important an organ as the knee joint for incipient disease was, surely, to turn the dial of progress many degrees backwards. Excision, like amputation, must always rank as a mutilation, and as such, he main-

tained, it should, if possible, be avoided. Real progress lay in the direction of insisting on the importance of early treatment by complete rest.

In the section of *Diseases of Children* there was also a discussion on the *Treatment of Chronic Diseases of Joints*. Prof. Hueter, of Griefswald, read a paper on the *Scrofulous Inflammation of Joints*. After describing what constituted a scrofulous inflammation of the joint and the results of such an inflammation, he affirmed that the early stage of scrofulous inflammation might be successfully treated by the injection of a 3 to 5 per cent. solution of carbolic acid into the joint, and that antiphlogistic treatment (fixation, massage, compression, extension, blood letting, blistering), was of little or no value. Incisions, drainage, scraping away granulations, &c., were to be discarded, and that carbolic acid injections having failed, excision is the best treatment, especially after suppuration has set in. Excision should be total, and when practised early the results are more satisfactory.

M. Ollier, in his paper on the *Excision of Joints in Children*, said every excision of a joint during childhood interferes with the subsequent growth of the limb and that the subperiosteal method interferes less with the growth. Inequality in length becomes visible only after a time, and varies with the extremity. This arrest of growth, which is quite inevitable, should induce the use of antiseptics and the "abrasion articulaire." Where ankylosis is desired as little should be removed as possible (knee), but where mobility is essential, efforts should be made to secure a new joint (elbow.)

Prof. Sayre, of New York, believed that if these joint affections could be diagnosed early enough, resection would never be necessary. He advocated the application of an apparatus to the limb which took off all pressure from the joint and allowed the patient to get about. If the case went on to suppuration, then excision was the best operation, and often attended with wonderful success. M. Fochier advised fixation of the joint in the early stage. Mr. Benton thought with Prof. Hueter, that fixation and extension were of little use in chronic disease of the

knee joint. He advocated movement of the knee; the pain, he thought, was due to adhesion, and the true way was to break down these adhesions with a sudden jerk, which snapped them in the middle; the child should then at once be made to walk about. Mr. Timothy Holmes did not understand how a disease which depends, as Prof. Hueter says, on auto-infection, can be cured by so simple a means as mere rest; yet, that it was so cured, is a very well known fact. He thought it rather too absolute a method to say inject with carbolic acid, and if that fail excise the joint. He did not feel inclined to accept this advice as final, though he had a great respect for the opinion of Prof. Hueter. He thought it necessary to give the joint rest; that it was important to achieve this end, more important even than to obtain fresh air, as was evidenced by the experience even of London hospitals. He thought the injection of joints and other violent methods unnecessary. Prof. Hueter, in reply, said he fancied scrofulous cases were more grave in Germany than in England. He did not deny that a joint might be cured without injections, &c., but he believed that it was cured by time and not by rest. (Report in *Brit. Med. Jour.*, Oct. 1, 1881.)

From the discussions in both sections it was clear that English surgeons only resort to excision in extreme cases, and all thought rest the most rational and conservative treatment in the early stages of joint disease, and deprecated the early excision of joints as a cutting of the Gordian knot. No doubt the anti-septic system is responsible to some extent for this reckless cutting out of joints; but the principal reason is that hospitals have not the space nor means to keep cases of joint disease month after month in their wards undergoing the treatment of rest, and that until more space is given by hospitals for the special treatment of joints by rest, the temptation will be to excise and so save time. John Hunter has said "to perform an operation is to mutilate a patient whom we are unable to cure; it should therefore be considered as an acknowledgment of the imperfection of our art."

Treatment of Spinal Curvature by Sayre's Method.—Papers were read on the above subject, in the section of Diseases of

Children, by Dr. Bellem, of Lisbon; Mr. Golding Bird, Mr. Henry F. Baker, Mr. Walter Pye and Mr. Arthur Barker, all of London. Dr. Bellem accepted almost to the full Sayre's views, but did not approve of the "jury-mast." Mr. Golding Bird said that in early cases of general curvature cure might be confidently expected with Sayre's jacket, but that in advanced cases little benefit could be derived from it. In spinal caries the plaster jacket gave the required "physiological rest" to the inflamed spine, and might be applied during either vertical or horizontal extension. He considered it the best form of spinal apparatus yet devised. Mr. Baker said that in angular curvature the use of the plaster jacket did not give the required rest to the spine, that it was liable to constrict injuriously the chests of growing children, and that a state of recumbency was absolutely necessary to prevent the deformity increasing in the first stage of the disease. In a very limited number of cases where the disease had been arrested and other forms of support could not be obtained, it was undoubtedly of use. In general curvature the suspension as recommended by Sayre was a useful addition to other methods of treatment, but the plaster jackets were inferior to those made of steel, which could be adjusted at any time by the surgeon. Mr. Walter Pye thought that in many cases the jacket was hastily and needlessly applied, and that its employment was often actively harmful; that it was of no use in rickety spines or simple lateral curvature. In certain cases of true spinal caries in infants in the early stages the older plan of rest in the horizontal position succeeded better, and was free from risk, but in older children the jacket might be used from the first. It might also be used from the first in cases in which the heart and lungs are affected in addition to the spinal affection, and cases in which carious spine is associated with any high degree of paralysis, incontinence of urine, &c. Many jackets he considered were too thick and strong, also badly shaped and badly fitted. He strongly disapproved of the use of the swing, and advocated, when applying the jacket, holding the child by the arms, with the feet resting on the floor. He also advocated the use of the inclined plane. Mr. Arthur Barker

believed Sayre's method for the treatment of spinal caries to be the best yet devised, and that failure was due to want of care in carrying out the directions of the designer.

A very spirited discussion followed the reading of these papers, in which Dr. Sayre took part. Mr. Timothy Holmes summed up as follows:—1. Nobody seriously contested the priority of Dr. Sayre as the introducer of the method. 2. The discussion had dealt almost exclusively with angular curvature, to which it would perhaps have been wiser to have altogether limited it. 3. More speakers who recommended the jacket treatment seemed to be agreed that the earlier it was employed the better, but we were unable still to say whether and how far symptoms of decided spinal irritation or inflammation should be taken as contra-indicating it. 4. Only a small minority of the speakers rejected the method; the majority agreed that at any rate in a large majority of cases the method offered very great advantages. 5. No form of extension (by suspension or otherwise) was a necessary part of the treatment; the jacket could be applied when the patient was suspended, or erect, or horizontal. 6. There appeared to be no evidence that any actual straightening of the spine had ever been produced. 7. Though Dr. Sayre and most other speakers appeared to prefer the plaster, there seemed no valid reason why other plastic material might not do as well. The possibility of changing the inside shirt without removing the jacket was an important practical point brought out in the discussion. [This referred to a suggestion made by Mr. Oxley, of Liverpool, viz., that patients might be kept clean by changing the undershirt. This might be done by putting on two undershirts when the jacket was first applied. When the shirt was to be changed a clean singlet was tied on to the lower edge of the singlet next the skin, and by drawing the soiled shirt off the clean one was drawn on.] 9. That there were many drawbacks in the shape of ulcers, abscesses, &c., seemed not only possible but inevitable. The extent and nature of these drawbacks should be stated, but they formed no radical objection to the treatment. 10. It seemed probable that the average length of time required for cure would be found much less than the

treatment by rest in bed. 11. Finally the general opinion seemed to be that this was a real and great advance in practical surgery.—*Brit. Med. Jour.*, Sept. 24, 1881.

Few besides Dr. Sayre advocated the use of the jacket in lateral curvature of the spine, and the majority also condemned his method of extension. On the whole, however, Dr. Sayre could not but feel flattered at the almost universal acceptance of this jacket as a means of treatment for spinal curvature. After Mr. Holmes' masterly summary of the results of discussion nothing more need be said with regard to it.

Partial Excision of the Bladder.—Dr. Adolf Fischer, of Buda-Pesth, in his paper mentioned that ancient surgeons believed a surgical wound of the bladder would terminate fatally, but that in more recent times, however, comparatively large portions of the bladder have been removed on account of prolapsus without fatal result. He has made a number of successful experiments in dogs, and comes to the conclusion that in dogs at least, wounds of the bladder which are afterwards carefully united by sutures are not particularly dangerous, and that good results depend principally on the accuracy of the suture. Dr. Fischer says that the indications for partial excision of the human bladder may be brought at present under the following heads:—

1. Traumatic injuries of the bladder with contused edges.
2. Diverticula of the bladder, containing encysted calculi.
3. General dilatation of the bladder, when the cause of the disease has been removed or is removable.
4. Benign and malignant tumours involving the wall of the bladder.
5. Vesico-abdominal, vesico-vaginal and recto-vesical fistulæ.
6. Destructive ulcerations threatening rupture and withstanding other modes of treatment.

I fancy that this operation is not very likely to come into fashion, especially for the diseases mentioned in the list. The diagnosis of several is by no means certain, and with regard to the others the remedy might be almost considered worse than the disease.

On the Permanent Retention of the Œsophageal Bougie.—Dr. Krishater stated in his paper (1) that the Œsophagus tolerates the presence of a bougie for an indefinite length of time, (2) that

the bougie should be introduced through one of the nostrils, and (3) that the presence of a bougie leads to dilatation of stricture of the œsophagus and renders the introduction of larger bougies possible, as in the urethra. He also stated that a security against starvation is ensured and the danger of false passage avoided. It is of great use in the performance of operations about the mouth, nose, &c.

The different opinions on the variety of Chancre, by C. R. Drysdale, M.D., London.—The author said a wide difference of opinion existed on the question of primary lesions of syphilis. In France, and on the Continent, the dualistic theory was maintained, viz., that the chancre of syphilis was quite distinct from the soft sore. The former was always, the latter never, followed by the secondary symptoms of syphilis, unless the two sores co-existed on the same patient. Having shortly described the distinctive features of the two sores, both as to appearance and course, the author said he was wholly convinced of the truth of the dualistic view. But there was in England a strong school which did not hold this view, and its leader, Mr. Hutchinson, had said some years ago that “dualism was dead.” Statistics collected at the Hôpital du Midi in Paris were opposed to Mr. Hutchinson’s position, which was this, that soft sore was due to an inoculation with pus modified by the presence of syphilis in the person from whom it was derived. But the speaker believed that the soft chancre was a distinct disease, that it bore the same relation to syphilis as measles did to scarlet fever.

Mr. Jonathan Hutchinson said that everybody believed in the clinical difference between the hard and the soft sore, and could, as a rule, make a prognosis from the aspect of the sore, but he doubted whether it was always possible to recognize with certainty the soft sore from the hard sore, though with characteristic sores there was no difficulty. He believed that the soft sore was a sort of appendage to syphilis—an epiphenomenon. The soft sore was due to the inoculation of inflammatory secretions only, but modified, in some way which he could not explain, by the coincident presence of syphilis in the individual who yielded the pus. It was a sort of abortive inoculation. Soft chancre bore the same

relation to syphilis that imperfect vaccination, which often caused much irritation and even ulceration, bore to perfect vaccination. But he agreed that the soft sore was only a transitory affection, while the hard infected the system: so that the difference between him and Dr. Drysdale was, so far as practice went, not great.

Dr. Louis Julien (Paris), in a paper on *Excision of Chancre*, believed that excision under certain circumstances suppresses all subsequent manifestations, and where it failed to do this, the subsequent disease was milder and more slowly developed.—*Brit. Med. Journal Report*, Sept. 17, 1881.

Reviews and Notices of Books.

Cyclopedia of the Practice of Medicine. Edited by Dr. H. VON ZIEMSEN, Professor of Clinical Medicine in Munich, Bavaria. Vol. XX. General Index. New York: Wm. Wood & Co.

This is the concluding volume of this exhaustive work. The index consists of 50 pages, and seems to have been constructed with great care, so that any subject in the whole of the immense field covered by the nineteen volumes can be at once turned up. The arrangements of type, &c., to separate the various words and divisions are specially good. It is a model index, and worthily brings to a close a *Cyclopedia* which will long rank as one of the most valuable works of reference in the English language.

General Medical Chemistry for the use of Practitioners of Medicine. By R. A. WITHAUS, A.M., M.D., Professor of Chemistry and Toxicology in the Medical Department of the University of Vermont, Professor of Physiological Chemistry in the Medical Department of the University of the City of New York. New York: Wm. Wood & Co. Montreal: J. M. O'Loughlin.

The above belongs to the series of "Wood's Library." It embraces both organic and inorganic chemistry, but it differs considerably in its arrangement and method of treating the

subject from most similar text-books. The author keeps always in view the fact that it is *medical* chemistry he is teaching, and thus special stress and most space is given to the bearings of chemistry upon physiology, hygiene, therapeutics and toxicology. It is not illustrated, as it was thought that the limited room for such an extensive subject could best be occupied by letter-press, and indeed, except with reference to technical manipulations, &c., such aids are hardly required. It is a well composed text-book, and can be recommended as a trustworthy exponent of the medical chemistry of the present day.

Clinical Lectures on the Diseases of Old Age. By J. M. CHARCOT, M.D., Professor in the Faculty of Medicine of Paris, Physician to the Salpêtrière, Member of the Academy of Medicine, &c., &c. Translated by LEIGH H. HUNT, B. Sc., Laboratory Instructor in Pathology in the Medical Department of the University of the City of New York. With additional lectures by ALFRED L. LOOMIS, M.D., Professor of Pathology and Practical Medicine in the Medical Department of the University of New York, &c., &c. New York: Wm. Wood & Co. Montreal: J. M. O'Loughlin.

The fact that many diseased processes are much modified by age in their course, duration and severity, renders it extremely important that we should be familiar with such modifications both with reference to the young and also the aged. The study of the pathology of the diseases met with in persons of advanced years is instructive as showing that the changes resulting from a given morbid state vary in accordance with the condition found in the structures it affects. These lectures of Prof. Charcot illustrate all these points, and will repay perusal. The first two lectures are extremely interesting, even to the general medical reader. They are upon "General Characteristics of Senile Pathology" and "The Febrile State in the Aged." The remainder treat principally of the rheumatic and gouty affections of old people as well as several other forms of articular affection to which they are peculiarly liable. The three concluding

addresses are devoted to the subject of the thermometry of senile disorders. Under this head most valuable information is to be obtained, and the author clearly shows and lays much stress upon the great clinical importance of frequent and accurate thermometrical observations by those who have sick persons who are aged under their care. Dr. Loomis adds in an appendix a number of lectures upon senile affections. These are of an eminently practical character, and are composed in the happy style of this well-known writer. They include senile pneumonia, chronic bronchial catarrh, asthma, fatty heart, apoplexy, softening, chronic gastric catarrh, constipation, and hypertrophy of the prostate gland. This volume belongs to "Wood's Library," and well deserves a place in that excellent collection.

A Treatise on Diseases of the Joints. By RICHARD BARWELL, F.R.C.S., Senior Surgeon and Lecturer on Surgery, Charing Cross Hospital. Illustrated by numerous engravings on wood. Second edition, revised and much enlarged. New York: Wm. Wood & Co. Montreal: Dawson Bros.

Although this appears as the second edition of Mr. Barwell's well-known treatise on the joints, yet it will be found on examination that the additions and alterations are so numerous and extensive as to cause it to be in fact a new and modern work upon this important subject. The name of the author has long been identified with the study of this special branch of surgery, and he is well known as having introduced many novel views into the pathology of joint disease, and also many valuable improvements in the mechanical treatment of these serious disorders. The present work, besides treating very fully of all the various forms of disease to which the joints of the body are liable, is specially valuable from containing an unusually large number of illustrative cases fully detailed and with a great many wood cuts. It is thus made extensively clinical in its features, and therefore, of course, by so much the more of a practical character. As a work of reference, it will be found very serviceable for the same reasons. This addition to the library of standard authors has been a most judicious one, and will no

doubt be welcomed by the subscribers and the profession generally.

Landmarks, Medical and Surgical. By LUTHER HOLDEN, Consulting Surgeon to St. Bartholomew's and the Foundling Hospitals. Assisted by JAMES SHUTER, M.A., Camb., F.R.C.S., Assistant Surgeon to the Royal Free Hospital. From the third English edition, with additions by WM. W. KEEN, M.D., Professor of Artistic Anatomy in the Pennsylvania Academy of the Fine Arts. Philadelphia: Henry C. Lea's Son & Co. Montreal: J. M. O'Loughlin.

This admirable little book of Mr. Holden's comes to us in a new form from the American publishers. The American editor has also introduced a few practical additions, which add to its value. The study of these landmarks by both physicians and surgeons is much to be encouraged. It inevitably leads to a progressive education of both the eye and the touch, by which the recognition of disease or the localization of injuries is vastly assisted. One thoroughly familiar with the facts here taught is capable of a degree of accuracy and a confidence of certainty which is otherwise unattainable. We cordially recommend the Landmarks to the attention of every physician who has not yet provided himself with a copy of this useful practical guide to the correct placing of all the anatomical parts and organs.

The Mother's Guide in the Management and Feeding of Infants.

By JOHN M. KEATING, M.D., Lecturer on the Diseases of Children at the University of Pennsylvania, Visiting Obstetrician to the Philadelphia Hospital, &c. Philadelphia: Henry C. Lea's Son & Co. Montreal: Dawson Bros.

This little volume of Dr. Keating has been prepared expressly for the purpose of being put into the hands of young mothers for their guidance; and from a short perusal of it, we are satisfied that physicians in charge of families cannot do better than recommend a frequent reference to this work in order that infants in their care may be intelligently watched and judiciously man-

aged. To a doctor caring for a sick child, it is of the utmost importance that the mother or attendant should have a reasonable knowledge of the conditions natural to early life, and should be able to recognize, and inform him of, deviations therefrom. The actual safety or the material comfort of an infant may thus come to depend upon the intelligence of those who have the immediate care of him: and the only means possible for mothers without experience to acquire such knowledge is the careful study of some book specially intended to meet their case, such as the above. It is written in plain, untechnical language; and all the directions and explanations are simple and easily understood.

We hope that Dr. Keating's manual may be widely introduced, for the inculcation of its many sound sayings and wise counsels will prove of great service amongst our infantile population.

The Physician's Hand-book for 1882.—By WM. ELMER, M.D., and ALBERT D. ELMER, M.D. New York: W. A. Townsend.

In this hand-book the compiler has endeavoured to bring together, condensed into as small a space as possible, a large amount of general information and useful facts which may be called for at any moment. It is a combination of a visiting list, abbreviated ledger, and practitioner's *vade mecum*, all in one, and yet the size does not exceed that of an ordinary pocket-book. It has been in use for a number of years, and is extensively used by physicians in the United States and in this country.

The Medical Record Visiting List for 1882 (Wm. Wood & Co., New York), is again to hand, and fully equals its predecessors from this well-known publishing house. Two varieties are printed this year for 30 or 60 patients, the volumes being handsomely and at the same time strongly bound (a great desideratum for a physician's diary) in red leather. We have much pleasure in recommending this book to our *confrères*, and feel assured if they once begin its use, they will not care to make any change.

The New England Medical Monthly.—We have received the first number of a new journal bearing this title, and published at Newtown, Conn. It is a handsome, 50-page, double column sheet, and contains some very good original articles from known

writers, along with editorial and other matter of interest. It will, no doubt, find a field for usefulness, and, as its editor says, "it has come to stay," we hope to find it a regular visitor, and wish it cordially a successful career.

Books and Pamphlets Received.

ESSENTIALS OF THE PRINCIPLES AND PRACTICE OF MEDICINE: A HANDBOOK FOR STUDENTS AND PRACTITIONERS.—By Henry Hartshorne, A.M., M.D. Fifth edition, revised; with 144 illustrations. Philadelphia: Henry C. Lea's Son & Co.

PHOTOGRAPHIC ILLUSTRATIONS OF CUTANECUS SYPHILIS.—By George Henry Fox, M.D. Nos. X, XI and XII. New York: E. B. Treat.

THE DIAGNOSIS AND TREATMENT OF THE DISEASES OF THE EYE.—By Henry W. Williams, A.M., M.D. Boston: Houghton, Mifflin & Co.

A TREATISE ON THE DISEASES OF CHILDREN.—By J. L. Smith, M.D. Fifth edition, revised; with illustrations. Philadelphia: H. C. Lea's Son & Co.

THE PHYSICIAN'S CLINICAL RECORD FOR HOSPITAL OR PRIVATE PRACTICE. With Memoranda for examining patients, Temperature Charts, &c. Philadelphia: D. G. Brinton.

ECZEMA AND ITS MANAGEMENT.—By L. Duncan Bulkley, A.M., M.D. New York: G. P. Putnam's Sons.

A MANUAL OF OPHTHALMIC PRACTICE.—By Henry S. Schell, M.D. With fifty-three illustrations. Philadelphia: D. G. Brinton.

A TEXT-BOOK OF PHYSIOLOGY.—By M. Foster, M.A., M.D., F.R.S. Second American from the third revised English edition. With extensive notes and additions by Edward T. Reichert, M.D. Philadelphia: Henry C. Lea's Son & Co.

A SYSTEM OF SURGERY, THEORETICAL AND PRACTICAL, IN TREATISES BY VARIOUS AUTHORS.—Edited by T. Holmes, M.A., Cantab. First American from second English edition. Thoroughly revised and much enlarged by John H. Packard, A.M., M.D., assisted by a large corps of the most eminent American surgeons. Vol. II. Philadelphia: Henry C. Lea's Son & Co.

Society Proceedings.

MEDICO-CHIRURGICAL SOCIETY OF MONTREAL.

This Society held its regular meeting on October 28th, 1881. the President, Dr. Geo. Ross, presiding, who delivered the following address:—

Gentlemen,—Before introducing the regular business of the meeting, will you allow me to say a few words upon our beginning a new year. In the first place, I have to thank you very sincerely for my election as your President for the year. I can assure you that I deem it no small honour to occupy the first position in the Medical Society of our metropolitan city, and I shall endeavour to perform the duties of that office with such efficiency as I can, trusting always to the kind consideration

which your Chairman has invariably met with at your hands. The fact confronts me at once that I am succeeding in this chair a series of men, the acknowledged leaders of the profession in this city for many years past—men whom age, experience and prolonged opportunities for observation, have rendered ripe for evolving wisdom and counsel for their juniors. I cannot fail to see the disadvantage under which I thus labour; but I hope that an earnest desire and attempt to serve faithfully the interests of the Society may to some extent remove these deficiencies on my part.

With your permission, I will make a few remarks upon the work already accomplished and still to be done by this Society. At our last meeting the retiring President gave us an account of the work done by this Society during his term of office; and when we consider the number of our members and our comparatively limited opportunities, I think that we have reason to congratulate ourselves upon the result. The aim of this association is chiefly to promote by mutual intercourse and by friendly criticism the mental furnishings of every individual member. This object has been constantly kept before us, and the interest taken by the members has been shown by the large number of original papers read and discussed—by the fact that nearly at every meeting men have brought forward facts of general interest coming under their own observation, or points in actual cases either difficult of explanation or presenting some anomaly important to be made known, or some peculiarity which rendered them worthy of note. These short communications are, to my mind, a valuable feature of our gatherings, and one which we should in every way encourage, especially because it is a part of the proceedings in which even the youngest member can take an active part. He is just as likely as any of his seniors to meet with cases of the greatest medical interest, and with more time at his disposal is able to observe all the more carefully the peculiarities of a case. Already several of our most recently acquired members have thus added their quota to the general stock. Cases, apparently affording little prospect of instructive debate, have sometimes proved most useful as bringing out the ideas,

experiences, failures and successes of many who have thus been led to participate in the discussion following. I would therefore ask the members in their daily practice to think often of the Society and not to wait for a case of great rarity or unusual interest, but to bring to us the thoughts on even very common cases which have occurred to themselves, because these often make a text from the working out of which great profit may ensue.

Another function of this Society, and one which it has on several occasions made worthy efforts to perform, is that of taking cognizance of prevailing or epidemic diseases, and offering such expressions thereon to the local authorities as may be of service to them in promoting the health of the city and of the public generally. I might mention the action taken by the Society with reference to the scourge of small-pox, which so long made our city a by-word and a reproach. That action went a long way to assist in forwarding the plans of the sanitary authorities for the general enforcement of vaccination. Our discussions here may also be said to have been influential in securing the adoption of animal vaccine in place of the old, deficient, humanized virus or imperfectly preserved crusts. A member of this Society has also recently still further advanced the cause of vaccination by showing that children with eczema, and probably many other kinds of skin disease, may not only be vaccinated with impunity, but that, in many such cases, the performance of the operation has a curative effect upon the cutaneous complaint. By such means it is to be hoped that we have done our share towards promoting correct views upon these important matters.

Here also was first pointed out, with tolerable certainty, the fact that the milk supply in this city, as elsewhere, is sometimes to be taxed with being the vehicle for the conveyance of typhoid fever; and the facts laid before us led to important recommendations to the Sanitary Board concerning inspection of milk and dairies. This disease is again very rife amongst us, and it is to be hoped that some one may investigate and report to us the probable causes of its undue prevalence this year.

There is also, at the present time, a scheme in the hands of

the Municipal Health Officer looking towards the extension and improvement of the sanitary by-law for the city of Montreal. Many clauses of this by-law affect the medical profession very closely, and it behoves their representatives here to see that the views of the profession are properly represented to the framers of the bill. This scheme contemplates also the possible inauguration of a general Act for similar purposes to govern the entire Province of Quebec. In this connection it is to be noted that the profession in Nova Scotia have this year moved in the same direction, so as to secure sanitary legislation for that Province. The ultimate aim of this should undoubtedly be the establishment of a permanent Health Department for the Dominion at Ottawa, which would govern and unify the results and actions of the combined Provincial Boards. This Society, as you are aware, named a committee, which has been in conference with the Medical Health Officer and Aldermen on the subject. Affairs of this kind move but slowly, and the committee have not yet reported any definite action, but no doubt before long their united efforts will have produced some good results.

The Council of the Society, by consent of the members, has committed to its care the examination into all ethical disputes which may chance to arise between members—an important office, and one which it has always hitherto fulfilled in a fair, judicial spirit, and in a manner which, by giving satisfaction, has been the means of averting strife, promoting harmony and preventing the continuance of heart-burning. I think those who best know the condition of the profession in Montreal, as compared with that in other Canadian cities, will agree with me in saying that in no other is there so little of professional jealousy, so little tendency to underrate the abilities of a rival, to grudge the good fortune or envy the success of a *confrère* as there is here; and it is but right to recognize the undoubted fact that one reason for this satisfactory state of things is the existence of this Society, where all are equal—where a professional injustice or breach of ethics is met by a suitable rebuke, and where nothing so tends to give a man the respect of his fellows as the knowledge that all his actions are fair, above-board, and invariably

governed by a gentlemanly instinct. It is to the credit of the profession that the work of the Council in this respect during the past year has been almost *nil*. Let us hope that they may continue in the future to enjoy prolonged immunity from such tasks.

The exhibition of morbid specimens is, without doubt, one of the most important parts of our proceedings, and we are extremely fortunate in having such a large and varied assortment of pathological illustrations and curiosities presented to us annually; and we fully recognize the debt we owe our Pathologist for his labours in this direction. There is just one suggestion which I would make. It has appeared to me that if the member who reports a case with fatal termination and autopsy were himself to describe in a general way the morbid appearances whilst presenting the specimen for the inspection of the Society, it would be more advantageous than our present method, whereby the descriptions are all given by the gentleman who performs the examination. I think this would lead to a more careful and thorough personal study of the parts dissected, and further familiarize some with the technical anatomical delineation of diseased viscera and structures. At the same time also the connection between what is observed in the organs and what was noticed during life could be simultaneously pointed out for our instruction. Nor would this at all interfere with our having the benefit of Dr. Osler's views upon the pathology of the case, for I think in nearly every instance he would be expected to add further observations of his own to what the reporter may have previously brought forward. It appears to me that some arrangement of this kind would tend to increase the interest taken by our members in the work of the Society.

I might enumerate a number of matters of general professional interest which have been discussed by us, and some of which will no doubt come up again,—such as the general tariff of fees, insurance fees, registration of births and deaths, coroner's inquests, and many others which will occur to every one. The views expressed here on these important subjects always carry weight, because the general consensus of opinion is pretty sure to be a reflexion of the ideas of the profession at large.

It is to be remembered also that the usefulness of the communications and discussions in this room does not cease with ourselves. They are published in the local journals, and are read by great numbers of our fellow-practitioners throughout the country: and I have reason to know that a very widespread interest is attached to these published proceedings. The transactions of the Toronto and other local Medical Societies are likewise published in the journals of that city, and it should be matter of pride to every member here to add his share to the interest of the meetings in order to show that this Association is fully able to hold its own, at the very least, with any other in the value of the papers placed before it, and in the keenness of criticism and debate.

Quite enough, gentlemen, has been said to show that there is plenty of work to be done by this Society. It has been steadily growing in favour, influence and numbers. It has done very good service for several years past, and I sincerely trust that each year will see it becoming more important, more active, and more respected.

Dr. Osler then exhibited a specimen of extreme dilatation of the bile ducts without suppuration. The patient, a woman, aged about 40, was admitted to Hospital in September, 1880, with symptoms of jaundice, believed to be catarrhal, but the jaundice deepened and the liver rapidly enlarged. She remained in Hospital several months, and the enlargement of the organ, the continuance of the jaundice, and the loss of flesh, suggested the probability of cancer. She was admitted again in the spring of this year under Dr. Osler, with symptoms materially unchanged—intense jaundice, enlarged liver, smooth, no nodules, no fever, no sweats, moderate emaciation. She lingered until June. At the inspection, which was made in the dissecting-room, great narrowing of the lower two inches of the common duct was found, and dilatation of the main branches in the liver, which formed large sacculi filled with a clear fluid. There was no inflammation of the wall. The gall-bladder was very much distended and contained several small calculi; walls roughened; orifice of the cystic duct closed. Dr. Osler remarked that the narrowing might have been due to

inflammation caused by the passage of a gall-stone. Dr. Ross thought it more probably succeeded catarrhal inflammation, as the woman had never had any symptoms of gall-stone.

Dr. Ross showed a case of Ulcerative Endocarditis. He said the patient was sent to Montreal General Hospital in September, supposed to have typhoid fever. Suspicions were first aroused by the marked remissions of temperature—in the evening, 104° , and morning normal, which continued with occasional chills. General condition was typhoid, the patient being weak, heavy, and listless. Previous to admission, had severe pains in joints. On examination, found a mitral murmur; spleen enlarged; entire absence of abdominal symptoms of typhoid fever. It was at first doubtful whether the case was not one of pyæmia from deep-seated suppuration, but observation for a short time resulted in a positive diagnosis of ulcerative endocarditis. There was a large fungoid growth both on the mitral and aortic valves; no disease in the lungs.

Dr. Hingston exhibited a patient, a young man, on whom he had operated for a firm, broad-based, fibrous, naso-pharyngeal polypus, at the Hotel-Dieu Hospital, a fortnight before. He had followed the method advised by Professor Bruns of Tabingen, consisting of a temporary resection of the bony skeleton of the external nose, and turning aside the bony and cartilaginous portions in connection with soft parts. He made an incision below the edge of the left alæ nasi, carried it to the right across the upper lip without wounding the mucous membrane of the mouth; a second incision over the root of the nose at the naso-frontal suture, and a third joining these two on the left side. With saw and bone forceps the hard parts were then divided. The vertical section of the septum was cut through from above and below, and with Langenbeck's osteotomes, the nose was thrown over till its tip touched the right cheek. Room obtained in this way was found to be insufficient, and the periosteum, for some distance on the left superior maxilla, was raised and the subjacent bone removed. A piece of cord was then passed through the back part of the tumour, above the soft palate, passed out at the mouth, and entrusted to an assistant. The tumour was detached with

periosteum. The hæmorrhage was alarming, and at one moment threatened suffocation and fatal syncope. The operation was concluded with patient's head and shoulders hanging down. The nose was then placed *in situ*, and has united without any displacement or deformity. Dr. Hingston thinks this method preferable to that recommended by Mr. Syme (excision of superior maxilla), or that through the antrum, as, although it is more difficult, from having less room to work in, the results are better, in an entire absence of deformity, without a scar across the cheek, and with no interference with the lachrymal passage, and therefore without epiphora.

The meeting then adjourned.

Extracts from British and Foreign Journals.

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

Antiseptic Inhalation in Pulmonary Affections.—J. G. Sinclair Coghill, M.D., F.R.C.P. Ed., in *British Medical Journal*: The objects of treatment are: 1. To lessen secretion; 2. To promote evacuation of what secretion is formed; 3. To disinfect the air which may pass into surrounding or deeper healthy portions of the lungs. Again he says, "Besides acting as disinfectants, antiseptic inhalations promote expectoration by increased energy of expiratory acts." Dr. Burney Yeo also recommends antiseptic inhalations, "if they have only the effect of temporarily cleansing, as it were, the pulmonary surface. It is a process analogous to that of washing away the decomposing discharges of a foul superficial ulcer." Dr. Clifford Albutt has broadly stated, and as truthfully, that "most phthisical patients die of septicæmia; and the arrest of this daily repointing is a primary object of treatment." Antiseptic inhalations again assume a still more important position, if the latest pathological theory of the contagiousness of phthisis through the respired air be well founded. . . The apparatus is extremely simple. It consists of a space for a pledget of tow or cotton wool, inclosed between the perforated surface of the respirator and an inner perforated plate, which

can be raised so as to permit the tow to be saturated with the antiseptic solution. Elastic loops are attached to pass over the ears and retain it in position. The inhaler may be procured either plain or of a slightly smaller size, and covered with black cloth for wearing out of doors. The pledget of tow, which may be changed once a week or so, sprinkled with from ten to twenty drops of the antiseptic solution, from a drop-stoppered vial, twice a day at least, according to the extent to which the inhaling may be carried on. Of this the patient is the best judge, and the length of time and quantity of solution should be regulated by tolerance and effect. The most important times for inhaling are for an hour or so before going to sleep at night, and after the morning expectoration, which leaves the suppurating surface or cavity dry to be acted upon—disinfected, so to speak—by the antiseptic vapor. A great many of my patients have of their own accord come to use the respirator almost continuously day and night from their experience of its good effects. I attach the utmost importance to the mode in which the respiration is conducted while inhaling. The patient should be carefully instructed to respire through the mouth alone, and expire through the nose. In this way the breath is drawn through the saturated tow in the perforated chamber of the inhaler, and passes directly into the lungs laden with the antiseptic materials. Expiring through the nose only, necessarily involves a complete circulation of the medicated air. The breathing should be short at the beginning of the inhalation, but gradually deepened, so as to displace and effect the residual air in the more distant portions of the lungs. This form of respiration itself is not only of great use in favoring the circulation of the blood in the lungs, and thus aiding local and general nutrition through that fluid, but it helps very much the expulsion of the sputa by means of the increased energy and thoroughness of the expiratory acts.

After many trials of the now formidable list of antiseptics, I find that carbolic acid, creasote, and iodine, in combination with sulphuric ether and rectified spirits of wine, are the most efficacious and satisfactory. The want of volatility in boracic, salicylic, and benzoic acids, and their salts, proves a bar to their employ-

ment by this method. Dr. Horace Dobell, who has had a very favorable experience of this treatment, writes to me that he has found thymol, in the form of Shirley's thymoline, very grateful and efficient in many cases where the smell of carbolic acid and creasote was intolerable either to patients or to their friends. Of the three antiseptic agents I chiefly use, I find iodine most useful in the second stage of phthisis, when the expectoration is passing from the glairy into purulent character. I use the tincture for inhaling purposes made with sulphuric ether instead of spirits of wine, and this ethereal solution has a singularly soothing effect on the cough and pulmonary irritation. In combination also with carbolic acid as carbolized iodine, or iodide phenol, it is extremely useful in the purulent expectoration accompanying the resolution of pneumonia, both catarrhal and croupous. In the stage of excavation, whether tubercular or pneumonic, the combination of iodine with carbolic acid and creasote is most potent. The acid seems to have the greater influence in checking the amount and purulent nature of the sputa; while creasote acts merely as a sedative in the cough, apparently by reducing the irritability of the pulmonary tissues. The addition also of varying proportions of sulphuric ether and chloroform greatly assists in soothing and allaying irritation. These combinations also act frequently like a charm in the profuse expectoration of purulent bronchitis, as also in bronchial asthma.

The Diagnostic Importance of Odors.—

In a recent lecture Dr. Julius Althaus, of London, says—: I must say a few words on the diagnostic importance of certain smells in the sick room, which was formerly much insisted upon; indeed, whole treatises have been written on the recognition of disease by sniffing. Dr. Heim, who was the popular physician of the day at Berlin some fifty years ago, recognized measles, scarlet fever, small-pox by their peculiar smell on first entering a house, and before having seen the patient. Mr. Bernard, of Upton Park, has recently recorded in the *Lancet* two cases of small-pox in which the patients themselves perceived a dreadful smell, apparently just at the moment of being exposed to contagion; and one of them, when suffering from the eruption, said

that his perspiration had the same smell as that which made him sick before. When attending Skoda's clinique in Vienna, twenty-five years ago, I noticed that this celebrated teacher was in the habit of sniffing when approaching the bedside of patients from the last stages of pneumonia, phthisis, typhoid fever, etc., and he would give a bad prognosis when he perceived what he called the "cadaverous smell." Mr. Crompton, of Birmingham, has noticed a peculiar earthy smell from the body, a week or a fortnight before death, which, he says, has never deceived him; an appropriate illustration of the saying. "Earth to earth." Dr. Begbie distinguished typhus and typhoid fevers by the sanguineous (others call it "mousy") smell of the former. Prof. Parkes has noticed a peculiar order in the skin of cholera patients. A pungent smell in the chamber of a lying-in woman shows that lacteal secretion is well established, while an ammoniacal smell has been said to indicate the approach of puerperal fever. Many women emit a particular odor while menstruating, which resembles a mixture of blood and chloroform, and that is believed to arise, not so much from the discharge, as from the more pungent character of the sweat secreted in the axilla. Persons of costive habits have a fecal smell; and this is also often noticed in hypochondriacs and lunatics. In uræmia, whether owing to kidney disease or to severe retention of the urine, a urinous odor is emitted by the body, and the presence of pus in some part of the body has been recognized by a peculiar warm, milky smell of the patient.

Apart from the odor of the sick room and the body generally, the smell of the sputa, urine, fæces, sweat, ulcers, etc., was carefully noted by the older practitioners and utilized for prognosis and treatment. Unquestionably there was much that was fanciful in such ideas; but occupied as we are at present with the study of more precise and definite symptoms, we have perhaps gone to the other extreme in neglecting such signs altogether. Everybody has his own special odor, and this varies according to the circumstances of life, the food taken, and the state of health in which he happens to be. That it should be altered in disease, and that special diseases should have special odors, is only what

one would expect; yet the increase of cleanliness and ventilation has no doubt done away with a large variety of smells which formerly used to assail the nostrils of the physician.—*Mich. Med. News.*

New Treatment of Abscesses.—Dr. Steven Smith, of Chicago, has inaugurated a new treatment of abscesses, which he affirms to be very successful. It is thus described in the *Chicago Medical Review*: —“When the abscess points it is opened and the contents evacuated. The cavity is then injected with carbolised water, and over-distended for two or three minutes. The water is then pressed out, and over the whole area undermined by the cavity, small, dry, compressed sponges are laid and bound down with a bandage. Carbolised water is then applied to the bandage and injected between its layers until the sponges are thoroughly wet, after which a dry bandage is applied over all. The sponges by their expansion make firm and even compression upon the walls of the abscess, and hold them in perfect apposition, thus favouring a union. The dressing is left on for five or six days, unless there is a constitutional disturbance, or pain in the seat of the former abscess. It is found, in most cases, when the bandage is removed, that the abscess has completely closed by an approximation of its walls, and the external wound heals readily under a simple dressing of carbolised oil. A case was recently seen where this admirable result was secured in a child, although the abscess was a large one, originating in caries of the head of the femur, and opening on the outside of the thigh. No constitutional disturbance, no discharge, no reaccumulation, and no pain followed its use. Mammary and submammary abscesses have been treated by this method with excellent results.”

Precautions in Thoracentesis.—M. Raynaud (*Journal de Médecine*) insists on a certain number of precautions which he considers it important to observe in thoracentesis. To avoid severe attacks of coughs, which often occur in the course of the operation, and are extremely painful and inconvenient, he recommends the subcutaneous injection of a full dose of

morphine before performing puncture. In this way, the cough is almost always prevented, or, at least, very considerably diminished; rigorous cleansing of instruments, and especially the trocar, with antiseptic solutions, he considers a matter of the utmost importance, and recommends the most minute precautions with the view of avoiding subsequent suppuration. The simplest method is to pass the instruments to be employed through the flame of a spirit-lamp, and subsequently to plunge them in carbolic acid solution. When the operation is for empyema and modified injections are employed, in lieu of leaving the patient seated, as is often done, it is preferable to lay him on the opposite side to that on which the operation has been performed; in this manner all the diseased parts are reached by the fluid, while, if the patient remains seated, the lower parts only are reached. Further, it must not be forgotten that the greatest care is necessary in performing these injections; for, in certain cases, rare it is true, but still far too frequent, epileptiform convulsions have followed, ending in rapid death. The washing-out should, as far as possible, be performed by means of a syphon; or, if any other injecting apparatus is used, great care should be taken to prevent the jet produced from attaining too great a force and directly striking the lung.—*Brit. Med. Journal.*

Hemorrhage into the Ventricles of the Brain.—The symptomatology of primary, intermediate, or direct hemorrhage into the cerebral ventricles has been carefully investigated by Dr. Edward Sanders of New York, from an analysis of the clinical histories of 94 cases which he has diligently collated. The results of the study form an important contribution to the literature of this little-known subject, and are published in the October (1881) issue of the *American Journal of the Medical Sciences*. The premonitory symptoms, as indeed those of onset, do not differ materially, where the effusion takes place primarily into the ventricles, from those of ordinary cerebral hemorrhage. Cephalalgia is the most common and constant of the premonitory symptoms, and may have existed for a long time; dizziness is less frequently observed. The attack may be

immediately fatal, or it may be ushered in by convulsions, by paralysis without loss of consciousness, by paralysis with partial or complete loss of consciousness, or by partial or complete loss of consciousness without paralysis: the latter being the most frequent mode of onset met with in primary intraventricular hemorrhage, at least in this particular series of cases. The symptoms are elaborately considered. As regards the leading phenomena and their significance, it is stated that coma, whether light or profound, is to be considered "as a constant symptom of primary intraventricular hemorrhage." As regards motor disturbances, no direct relation can be traced between the seat, amount, and extent of the ventricular extravasation and the presence or absence of muscular contractures, and the greatest variation is noticed in different cases in the amount, persistence, permanence, or tetanic characters of the spasm. Sanders says in regard to general clonic convulsions, that he believes them to be "one of the most important and frequent symptoms of immediate ventricular extravasation." This may be attributable to direct injury from the effusion, or to its pressure upon adjacent motor centres. A careful comparison of simple and complicated cases, however, shows "that the variety or extent of the complication has no essential bearing in the occurrence of convulsions, the ventricular extravasation itself being undoubtedly the inducing cause." The *tâche cérébrale* also may be present. Where apparent improvement takes place, it is generally soon followed by symptoms of the most aggravated kind, terminating in death, no second remission having been observed in a single case.

Opening and Drainage of Cavities in the Lungs.—

It is only a little more than a decade since Prof. Mosler of Greifswald, in Germany, conceived the brilliant idea of combating cavities in the interior of the lungs by surgical means. Although experience has since demonstrated that this procedure is of no avail in consumptive cavities for which it was first employed, yet the operation did this much good, that it called the attention of the profession to the surgical treatment of cavities in the lungs, and indirectly established the fact that such cavities might be opened and drained with comparative impunity.

Drs. Fenger and Hollister of Chicago, in a paper on this subject in the October number of the *American Journal of the Medical Sciences*, state that thus far only six cases of this form of interference with cavities have been reported, and only one, their own case, was successful, in so far that it terminated in complete recovery. The clinical histories of these several cases are communicated in this paper, the original case being one of suppuration around a large echinococcus cyst in the lung of 12 years' standing. An incision was made in the third intercostal space anteriorly, through which the large cyst was subsequently removed. A counter opening being made between the fifth and sixth ribs, a drainage tube was introduced, and daily injections of carbolic acid practised. The authors conclude that "the operation is justifiable in any case where the presence of a gangrenous or ichorous cavity having been ascertained, it is found that, notwithstanding an outlet through the bronchi for a portion of the contents of the cavity, it steadily fills up again, the partial evacuation does not relieve the patient, who gradually loses strength and progresses towards a condition of collapse, a steady or intermittent rise in temperature continues; the infection of the healthy portions of the lung from the decomposed contents of the cavity has commenced, or is evidently about to take place; the breath and expectoration continue fetid; absence of appetite; increasing weakness, with or even without fever, etc. These indications will enable any medical man of some clinical experience to determine, in the majority of such cases, when the disease has reached a point from which spontaneous recovery is impossible." At the same time it is observed that any cavity covered by the scapula, or situated within the supra-clavicular and infra-clavicular regions may at present be regarded as inaccessible. The immediate indications and details of the operation are fully discussed in this paper, as well as the methods of after-management of an interesting class of cases otherwise not amenable to treatment.

Treatment of Typhoid Fever by Salicylate of Soda.—M. Caussidou made a communication to the French Association for the Advancement of Science at

the Congress of Algiers, which was based on thirty-two cases of typhoid fever treated by salicylate of soda, and in which the rise of the temperature and the influence of this drug on the febrile process had been registered with the greatest care, as attested by numerous tracings shown by the writer. M. Caussidou arrived at the conclusion, in opposition to the facts observed in several wards of the Paris hospitals, that salicylated medication gives larger, more certain, and more permanent effects than refrigeration. M. Caussidou has even been in doubt if, by administering salicylate of soda from the outset of typhoid fever, it would not be possible to limit the duration of the disease to the first week (?), and if, at least, it would not be possible to obtain a number of cases belonging to the abortive form. Nevertheless, M. Caussidou does not conceal the dangers of salicylate medication. Like other observers, he has noted dyspnoea, precordial trouble, and exhaustion in patients where the salicylate of soda brought on a too sudden apyrexia. To avoid these objectionable results, he proposes to administer salicylate of soda in fractional doses of one gramme given every two hours, and to stop as soon as the temperature falls below 38° Cent. (100.4° Fahr.) In a complicated case of erysipelas, the salicylic medication was powerless to produce a febrile recrudescence brought on by this complication. M. Hérard declared that he had nothing but commendation for the use of antiseptics, such as carbolic and salicylic acids, in the treatment of febrile diseases.—*London Medical Record*, July 15, 1881.

Viburnum Prunifolium.—The black haw bush, or small tree, everybody knows; but medicinally, very few know that the profession have in it a real remedy in threatened abortion, or flooding after it. I was called to a lady in her seventh month of pregnancy, with violent pains coming on every five minutes, and which had been increasing for several hours. I gave her at once one drachm of the fluid extract, with thirty grains of hydrate of chloral. In an hour the pains moderated somewhat, and I repeated the viburnum, with twenty grains of chloral. Two hours after, I gave the same and the pains subsided.

The patient slept several hours. In six or seven hours the pains returned again, and I again gave one drachm of viburnum and twenty grains of chloral ; I gave three doses, subduing the pains. Being called away to a labour case, I was absent twelve hours, and being sent for hurriedly, I found my patient, as before, with more violent pains, and the os uteri opened three-fourths of an inch. I repeated the same doses four times, and the pains subsided. This condition continued about eight days, but required less chloral each day. Every three or four hours I gave milk freely, keeping the bowels open by enemata. The patient bore the medicine well, and made a good recovery ; and two months afterwards went through her labour satisfactorily.

I had often tried hydrate of chloral and other medicines vainly to check abortion or miscarriage after the womb commenced opening.

Two months afterwards I was called to a similar case in threatened abortion, with flooding. I gave the viburnum alone, as I desired the patient to be awake in order to report hæmorrhage. In two hours the pains and hæmorrhage both ceased, with good recovery.

I was called last year to another patient, flooding dreadfully, and the contents of the womb were partially removed. I gave viburnum and ergot, and used hot-water injections with the bag syringe (otherwise called fountain syringe), a great improvement on the rubber bulb. The flooding was violent, and required continuous use of the syringe and medicine for two days before the hæmorrhage ceased. The abortion was complete.

A short time since I was called again to the same lady, in her seventh month of pregnancy, with violent pains every seven minutes, but no flooding. I gave viburnum and chloral, as before ; but the stomach rejected three doses in succession. I then gave four drachms of viburnum and eighty grains of chloral by enema. In one hour the pains moderated somewhat. I gave half the quantity for the second dose, and the pains gradually stopped without further trouble. I used the fluid extract prepared by Parke, Davis & Co., Detroit. If this preparation is not accessible, I would use the decoction of the fresh bark.

The profession can rely on this remedy, and doubtless many lives will be saved by its prompt use.—*Dr. Cullen in American Medical Bi-Weekly.*

Accidental Ante-partum Hemorrhage.

—Dr. E. L. Partridge of New York contributes an article in which, after briefly reviewing the current doctrines concerning so-called accidental hemorrhage preceding the birth of the child, he boldly challenges the expediency of the practice of rupturing the membranes. He believes that rupture of the membranes does not meet the indications—*i.e.*, it does not in itself or in its results offer any reasonable probability of checking the hemorrhage—and that the method is highly dangerous from the increase of facilities for loss of blood, and because it adds to the difficulty and danger of proper subsequent steps in treatment. As to whether it really does check hemorrhage, it cannot do so unless a decided decrease in uterine bulk can be secured and maintained thereby. There must, therefore, be a considerable number of cases in which, a small amount of liquor amnii being present and the reduction in size being very slight after its escape, no benefit can accrue. In cases which present an average amount of amniotic fluid, after its evacuation the uterus is decidedly, though not greatly diminished in size. What is to show, however, that this decrease is sufficient to close the mouths of bleeding vessels? There is no practitioner who cannot affirm that alarming hemorrhage does often threaten after the birth of the child, and before or after the complete separation of the placenta, when the uterus is *greatly contracted*. Even this degree in the reduction of bulk fails to close the uterine sinues in the intervals of contraction. All those writers who advise rupture of the membranes couple with this advice the information that there is danger of continued hemorrhage. One says, “Of course there is risk,” while all suggest methods by which they think a loss and a large accumulation of blood can be prevented after the escape of the amniotic fluid—these suggestions looking toward the maintenance of contraction. Accidental hemorrhage usually takes place prior to or during the occurrence of infrequent and slight early uterine contractions, when the os is slightly dilated or not at all. Superadded is the

condition of collapse. If the liquor amnii is now permitted to escape, can any candid, practical obstetrician admit, the author asks, that there is any known way by which a momentary reduction of uterine bulk can be maintained for a period which will check an alarming hemorrhage? The uncertainties and tediousness of efforts at excitation of the uterus in cases of induction of labour afford a good illustration of the difficulties which would be encountered. Ergot is uncertain and almost valueless, for the stomach will either reject or fail to absorb it; or, if absorption does take place, or if the drug is given by the hypodermic method, its action is imperfect when there has been a great drain upon the vital powers. The abdominal binder cannot be applied in a way to crowd the resilient uterine tissue into contraction. Manual efforts cannot be kept up with any precision or efficacy during a period necessary to check the hemorrhage and keep it in control. Good uterine action cannot be excited when the uterus is surprised into labour. Good labour pains will not occur when the patient is exsanguinated. The suggestion of Leishman, to the effect that the placenta will be compressed between the uterus and the child after the escape of the liquor amnii, and hemorrhage thus be checked, is, Dr. Partridge thinks, fanciful; for no sufficient uterine action will take place to effect this. There are a great many chances also that the part of the child nearest the placenta would not be one which could make an even, perfect compression, if suitable uterine action did take place. Far from meeting the emergency, the method greatly increases the dangers. If the uterus does not contract promptly and permanently after the escape of the liquor amnii, an ample space is afforded for a further extravasation of blood. A very limited space will afford room for a dangerous extravasation. Another danger is from a more extensive detachment of the placenta when the uterus is even temporarily contracted. Another objection to the early removal of the liquor amnii in accidental hemorrhage is, that an obstacle is created to the use of the most efficient method for securing dilatation of the os—*i.e.*, by the dilators. Their use would be improper, lest, acting also as a tampon, they should prevent egress of diffused blood, and add to the accumulation.

A fourth danger will be from the increased difficulty encountered in the performance of version if the child is not surrounded by liquor amnii. This operation is often imperatively demanded in the treatment of accidental hemorrhage, under circumstances, too, when its ease of performance is of great importance. There is one class of cases of accidental hemorrhage in which the amount of blood lost does not fully explain the degree of shock. In these the factors in the production of collapse are the over-distension of the uterus and consequent irritation of the peripheral nerves of that organ, as well as the abstraction of blood from the circulation. Here, then, we might believe, was found sufficient ground for the treatment by early rupture of the membranes, relieving thereby uterine distension and the resulting irritation to the nervous system. Upon consideration, however, we find, first, that it is impossible to prejudge in these cases. It is only *after* delivery, when the amount of effused blood can be estimated, that we discover that the shock was proportionately greater than the hemorrhage. Again, collapse brought about in this way does not obstinately refuse to yield to treatment, but will be remedied usually by the customary measures, such as stimulants, the application of external heat, etc., without the need of any decided local interference. Finally, this variety of the accident is not very common, as indicated by clinical records, the possibility of its occurrence being so lightly regarded as hardly to be mentioned by writers. What, then, should be the treatment looking toward the safety of mother and child when immediate delivery cannot be resorted to, owing to incomplete dilatation of the os? By all means *preserve the membranes intact*, and thus tampon the uterine cavity with liquor amnii. Then, in the great majority of cases, employ Barnes's dilators until the desired result is obtained. Of course, this or any similar treatment must be employed at a suitable time. It must not supersede efforts for the relief of collapse, and it may be necessary to defer all operative measures until the patient can be rallied from the alarming constitutional symptoms. The os being sufficiently dilated to enable delivery to take place, rupture of the membranes is proper, and should be followed by manual efforts to compel the uterus to

descend upon the child, whose expulsion should be immediate. Version fulfils the indications better than the forceps, as by the former operation there is less danger from delay during delivery, and because it can be successfully resorted to at an earlier period in the dilatation of the os than the forceps can. Bimanual version should not be considered for a moment, as in cases apparently most favourable it cannot always be accomplished, while in this accident the irregularity of the internal uterine surface caused by the collection of blood would certainly interfere with the change of position of the child. During the entire time stimulants must be freely used and warmth to the surface, and in exceptionable cases, when the hemorrhage does not appear to be continuing, it is proper to wait for returning vitality before operative measures are undertaken, lest the condition of collapse be aggravated. The danger is not necessarily over after delivery, for it is often difficult to bring about reaction from the dangerous condition, and convalescence will often be slow.—*N. Y. Medical Journal and Obstetrical Review.*

For Night-Sweats in Phthisis.—Köhnborn recommends the dusting of the body every evening with the powder used in the Russian army for sweating feet (*Medical Bulletin*):

Acid. salicylic,	- - - - -	3 parts.
Amylum, :	- - - - -	10 “
Powdered talcum,	- - - - -	87 “

If the skin be very dry, it may be rubbed with bacon, alcohol, or tannin, which will cause the powder to adhere to the body. The patient should hold a cloth to the mouth and nose during the dusting, that bronchial irritation from the salicylic acid may be prevented. Success has attended this method of treatment after quinine, atropia, digitalis, boletus laricis, cold sage tea, and frictions with alcohol, tannin, and bacon had failed. Waldenburg holds that the action of salicylic acid, when given internally in night-sweats, is similar to atropia, but far more effectual.

CANADA

Medical and Surgical Journal.

MONTREAL, DECEMBER, 1881.

MONTREAL VETERINARY COLLEGE.

The fifteenth session of this institution was opened on Tuesday, 4th Oct., at eight o'clock in the evening. The opening lecture was delivered by Principal McEachran, and a large number of citizens and students listened to his most interesting address.

We learn that this institution is still making progress. The number of students is larger this session than ever before, and from the fact that a matriculation is now required, the standard of education has advanced. The number of students attending the classes this session is about forty. The following students passed successfully in the matriculation examination held by Mr. A. Shewan, M.A., viz. : Messrs. H. C. Kingman, Middlebro', Mass. ; Geo. Rennicks, Huntingdon, P. Q. ; J. E. Gardner, Springfield, Mass. ; T. A. Bishop, Montreal, P. Q. ; E. P. Balls, Stanstead, P. Q. ; W. P. Robins, Montreal, P. Q. ; Villade Seguin, Rigaud, P. Q. ; Joseph A. Levis, St. André, P. Q. ; A. P. Belair, St. Rose, P. Q.

The following extracts are taken from the Principal's address :
The importance of veterinary science and the necessity for both governments and individuals according to this profession the aid and influence necessary to enable us to prosecute those researches which are now found to have so much influence on the prosperity of a country, is becoming more and more felt ; never was this more felt than at the present moment. European countries were slow to see the importance of encouraging the educational development of this profession, but the destruction

of their herds, the injury to their agriculturists by contagious diseases, led them at the close of the last century to expend large sums of money on their veterinary colleges, to organize regular systems of veterinary sanitary science, and police controlled by the Government, and in this way gave the profession a social status which slow England has not yet awakened to the necessity for. What is the consequence? When contagious diseases of cattle were imported from the Continent, where they had worked havoc among their herds for generations, few among the members of this neglected profession, which had been left by their Government to drag along uncared for and unencouraged, without means to pay competent teachers (most indeed of the pupils requiring to work for their existence while they struggled at their studies), recognized the enormity of the danger, and while they discussed the question of the contagiousness of the disease, and the Government turned a deaf ear to their warning voice, pleuro-pneumonia and foot and mouth disease rapidly spread, and soon gained a permanent foothold in the country. Again, when from neglect of quarantine regulations, the dread rinderpest reached the shores of England, the same blundering took place, and the profession, with a few exceptions, notably Prof. John Gamgee, proved themselves incapable, from the same cause, of dealing with the question, and the Government maintained the same masterly inactivity. The disease meanwhile spread from end to end of the land, decimating the herds and completely paralyzing the agricultural community, producing death and starvation among the labouring classes, and causing the destruction of over a quarter of a million head of cattle. Who will hold a Government blameless which would trifle with such a weighty matter? Who will deny that the persistent neglect of veterinary science by the British Government has a very direct and important influence on the condition of her agriculturists to-day? Their means destroyed by cattle disease, which ruined many and seriously crippled the majority, could they be prepared to stand a few bad years of indifferent crops and low prices from American competition? Who will deny that the neglect of veterinary science in Britain will

indirectly lead to the emigration of large numbers of her best farmers to make homes in Canada? Does it not astonish the world that a country like the United States, foremost in the invention and adoption of everything for the benefit of the farmer, celebrated for intelligence and all that tends to progress, with all the above facts before them, has followed the unfortunate example of the mother country, has turned a deaf ear to the pitiful wailings of thousands of ruined farmers in England, and failed to see the black spots on their sanitary maps which mark their Atlantic states as infected places and hells of cattle disease? It seems inexplicable that men of intelligence can shut their eyes to the fact that they are in the most imminent danger of having the most destructive of all scourges, pleuro-pneumonia, introduced among the countless herds in the vast cattle regions of the West.

Those who slight our profession do so in ignorance; there is none more important, none more honourable, none more independent. Whether you will succeed in occupying influential social or professional positions, will depend on yourselves. If you are proficient in your profession attend to your business, conduct yourselves like honourable men and gentlemen; your profession holds out high and honourable positions for you. It is not a profession that makes a man respectable or respected, but the man the profession.

At the outset, therefore, I beg of you to aim high, have high aspirations, feeling proud to belong to what, to my mind, is the most noble of all professions, whose object is the relief of suffering and curing of disease in those poor dumb companions of our earthly pilgrimage. You should cultivate a love for animals, their care and comfort should be your constant thought, you should never inflict unnecessary pain yourselves, and you should under all circumstances discountenance it in others.

I am happy to be able to inform you that since we last met, important changes have taken place, all tending towards the advancement of the profession. Valuable scientific discoveries have been made, notably the artificial propagation of bacteria: and the value of inoculation by ameliorated virus as a protec-

tion of the system against the otherwise fatal influence of the unmodified virus, which has been demonstrated by M. Pasteur, may prove of incalculable value to medical science generally, as has already been demonstrated by him, in preventing the dread malady, anthrax.

During the past summer, following the example of the medical profession, the veterinary held a congress in London, at which this College was ably represented by Dr. Osler, where subjects of great importance to the profession were discussed, and from which great good will no doubt result. On the American continent, in which we are after all most interested, we find that important strides have been made. A regular Veterinary Department has been created at Washington, with Mr. C. Lyman at its head, in connection with the Department of Agriculture, by whom investigations have been conducted and reports published on all reported outbreaks of disease. Besides this, the Treasury Department have appointed a separate commission, consisting of Prof. Law, Mr. Shayer and Mr. Saunders, to enquire specially into pleuro-pneumonia and other contagious diseases. Veterinary surgeons are now appointed to the United States army, port inspectors are about to be appointed, and this year will see that the profession is at last receiving that recognition which is its just due, and which it ought to have received long ago.

It is gratifying too to know that the service of the profession in Canada continues to be appreciated, and has a just claim to the credit of being of some value to the country. It is gratifying also to see that each year a number of our young men graduate in both professions, and, thus acquiring a knowledge of both sciences, place themselves on the same professional and social footing as medical practitioners. The introduction too of practical work in comparative pathology and comparative anatomy into medical courses tends greatly to elevate veterinary medicine, for the comparative pathologist is essentially a student of veterinary science.

I have mentioned that at the beginning of the present century dates the establishment of a few veterinary colleges in Europe

and Britain, and I may add that these few existed under great disadvantages, especially in the quality of students who were found to enter the profession. Now all that is changed. Veterinary colleges now form important institutions in almost every state in the civilized world, and most of them have adopted a moderately high standard of education; the courses delivered at most of them are equal in all respects to those of medical colleges.

OUR REPORTS.—We devote a considerable amount of our space this month to reports upon Surgery and upon the progress of Pharmacy. The former gives a condensed account of all the most noticeable features of the discussions in the Surgical section of the great International Congress of last summer. The latter is the completion of a very able report presented by Dr. Stewart to the Canada Medical Association last August at Halifax. Although the space thus occupied precludes us from presenting the usual number of pages of selected matter, still we have every reason to believe that the substitution therefor to some extent of periodical reports, is appreciated by the readers of the JOURNAL. We have communications from numbers of our friends in various parts of the country stating the value which they attach to the Gynecological reports we have been publishing, and we have no doubt the same feeling is entertained towards these others. The system has the advantage of presenting at stated times a *resumé* of all important work done in that department, and if these be preserved, they form at the end of the year a compilation extremely useful for future reference.

Medical Items.

PERSONAL.—James Ross, M.D., and James L. Foley, M.D., were admitted L.R.C.P., London, on 27th October. William Cormack, M.D., has obtained the double qualification of L.R.C.P. and L.R.C.S. We have learnt that on this occasion 60 per cent. of the candidates were rejected.

—Erasmus Wilson has been knighted on account of his munificent gifts for the support of hospitals and the encouragement of medical study.

—L. D. Mignault, M.D. (McGill), has been appointed as Lecturer on Anatomy in Victoria Medical College, in this city, *vice* Dr. Bibaud, deceased.

—Lawson Tait speaks of Listerism as “one of the largest, best-blown and most attractive bubbles ever displayed to a surgical audience.”

—In Maine they have a law that no medical student shall be allowed to graduate and practice medicine who has not had regular practice in the dissecting-room. Then they passed a law that no bodies, save only the bodies of executed criminals, should be cut up in dissecting-rooms. Then, as a climax to all this, they abolished capital punishment.—*St. Louis Globe-Democrat*.

ANOTHER MRS. PARTINGTON.—“How flagrant it is!” said Mrs. Mixer, as she sniffed the odor of a bottle of Jamaica ginger. “It is as pleasant to the oil factories as it is warming to the diagram, and so accelerating to the cistern that it makes one forget all pain, like the ox-hide gas that people take for the tooth-ache. It should have a place in every home where people are subject to bucolics and such like melodies; besides, a spoonful is so salubrious that when run down like a boot at the heel in walking, one feels like a new creature.”—*The Druggist*.

THE FUTURE OF INNOCULATION.—*Customer*—“My nephew is just starting for Sierra Leone, and I thought I could not make him a more useful present than a dose of your best yellow fever. Would you tell me the price, please?” *Chemist*—“Well, ma’am, the germs are so difficult to cultivate in Europe that I would advise your waiting for the next West India mail, when I am expecting a nice, fresh consignment from St. Thomas. Meanwhile we would recommend our half-guinea travellers’ assortment of the six commonest zymotics, and could add most of the tropical diseases from stock at five shillings each. We have some nice Asiatic cholera just ripe, but they are more expensive.”—*Punch*.