

Technical and Bibliographic Notes / Notes techniques et bibliographiques

The Institute has attempted to obtain the best original copy available for scanning. Features of this copy which may be bibliographically unique, which may alter any of the images in the reproduction, or which may significantly change the usual method of scanning are checked below.

L'Institut a numérisé le meilleur exemplaire qu'il lui a été possible de se procurer. Les détails de cet exemplaire qui sont peut-être uniques du point de vue bibliographique, qui peuvent modifier une image reproduite, ou qui peuvent exiger une modification dans la méthode normale de numérisation sont indiqués ci-dessous.

- Coloured covers /
Couverture de couleur
- Covers damaged /
Couverture endommagée
- Covers restored and/or laminated /
Couverture restaurée et/ou pelliculée
- Cover title missing /
Le titre de couverture manque
- Coloured maps /
Cartes géographiques en couleur
- Coloured ink (i.e. other than blue or black) /
Encre de couleur (i.e. autre que bleue ou noire)
- Coloured plates and/or illustrations /
Planches et/ou illustrations en couleur
- Bound with other material /
Relié avec d'autres documents
- Only edition available /
Seule édition disponible
- Tight binding may cause shadows or distortion
along interior margin / La reliure serrée peut
causer de l'ombre ou de la distorsion le long de la
marge intérieure.
- Additional comments /
Commentaires supplémentaires:

Continuous pagination.

- Coloured pages / Pages de couleur
- Pages damaged / Pages endommagées
- Pages restored and/or laminated /
Pages restaurées et/ou pelliculées
- Pages discoloured, stained or foxed/
Pages décolorées, tachetées ou piquées
- Pages detached / Pages détachées
- Showthrough / Transparence
- Quality of print varies /
Qualité inégale de l'impression
- Includes supplementary materials /
Comprend du matériel supplémentaire
- Blank leaves added during restorations may
appear within the text. Whenever possible, these
have been omitted from scanning / Il se peut que
certaines pages blanches ajoutées lors d'une
restauration apparaissent dans le texte, mais,
lorsque cela était possible, ces pages n'ont pas
été numérisées.

THE
MONTREAL MEDICAL JOURNAL.

Vol. XXV.

JANUARY, 1897.

No. 7.

Original Communications.

THREE CASES OF PELVIC HÆMATOMA.

BY

WILLIAM GARDNER, M.D.,

Professor of Gynæcology in McGill University ; Gynæcologist to the Royal Victoria Hospital ; consulting Gynæcologist to the Montreal General Hospital.

THE PATHOLOGICAL REPORTS, BY C. F. MARTIN, M.D.,

Assistant Physician to the Royal Victoria Hospital ; Lecturer on Pathology in McGill University.

The association of pelvic hæmatocœle with cancer and tuberculosis of the genital organs of women must be exceedingly rare. In none of the recent works on gynæcology which I have examined is any mention made of it. This statement applies to the classical paper of Whitridge Williams on genital tuberculosis, the chapter on the same subject in the third edition of Pozzi's magnificent work on gynæcology just published (1897), and that of Sir William Priestley in Clifford Abbott and Playfair's system of gynæcology (1896). The same remark applies to cancer of the uterine appendages as treated in each of the works mentioned. This is certainly remarkable, especially as regards tuberculosis now known to be so frequent a disease of the tubes and ovaries, and to which so much attention has been devoted by many observers in recent years. That pelvic hæmatocœle may be associated with these diseases is proved beyond a doubt by the two cases I am about to describe. They are unique in my experience. Their exact relation as regards cause and effect is not so certain. The necessary nutritive and vascular changes may have preceded or co-existed with the cancer or tuberculosis, but may not have been the result of these marked processes. What we know of these diseases as they affect other organs or structures of the human body is surely a cause for wonder that effusion of blood is not frequently caused by the much more frequent tuberculosis of the ovaries, and especially the

Fallopian tubes. By most authors and operators pelvic hæmatocele is in the enormous majority of all cases held to be due to ruptured ectopic gestation. The evidence on which this opinion is based does not always bear close scrutiny. The necessary evidence of the presence of a foetus or chorionic villi or other decidual elements is not always to be had even when carefully sought for.

Extra-uterine Pregnancy.—Mrs. S., aged 35, was seen in consultation with her ordinary medical attendant, Dr. W. F. Hamilton. She has been married twelve years and is the mother of six children to full term. She had a miscarriage in January, 1896, for which an anæsthetic was given to remove some portion of the products of conception. In May she had regained her health and continued well till August. The last normal menstrual period occurred about the 5th of August, there was no return till the 10th of September. The discharge was then scanty and of short duration. From this time on till the time of operation on the 11th of November, there were discharges of blood at irregular short intervals, there were also paroxysms of pelvic pain, but no syncope or collapse. During the last two weeks previous to operation vomiting occurred several times, but at no time was there any elevation of temperature. When I first saw her about the middle of October, the uterus was somewhat enlarged and soft, and to its left and adherent to it there lay an elastic fixed mass; this rather rapidly increased in size during the three weeks I occasionally saw her before operation. At the time of operation there was a distinct abdominal tumour. The patient was admitted to my private hospital on the 11th of November.

Operation.—The uterus was dilated sufficiently to admit the finger to the fundus and the cavity found to be empty except for a general lining with decidual membrane; it measured five inches in depth.

Abdominal Section.—No free blood or fluid of any kind in the cavity; a livid tumour-like swelling adherent to the whole of the pelvic walls and floor, the adhesions not very dense. During the process of separation a large quantity of almost black fluid and clotted blood escaped. At the bottom of the pelvis lay the foetus and placenta, apparently detached, but lying in the sac described; part of the wall of the sac was formed by the posterior wall of the uterus. After the removal of the foetus and placenta the rest of the sac was easily separated and brought through the abdominal incision, when it could be as easily ligated as an ordinary empty ovarian cyst. No bleeding of any consequence followed the separation of the sac, so that the abdomen could be closed without drainage. Recovery has been absolutely uneventful.

The specimens presented, illustrate one of the most unusual varieties of ectopic gestation, and clearly show from a careful study of the relation of the parts how intimately associated may be the ovary and tube in ectopic gestation, the tube being the primary site of the event, while the ovary is to all intents and purposes purely passive.

The material was sent me by Prof. Wm. Gardner on November 11th, 1896, and on gross examination was seen to consist of four distinct portions:

1. A male fetus 12.2 cm. long with 3 cm. of cord attached.
2. A placenta 15 x 6 x 2 cm. in dimensions with a portion of cord 10 cm. long adherent to it.
3. A containing sac of about 12 cm. in greatest diameter. Its wall was of varying thickness, densest at its outer extremity (*i.e.*, the part furthest from the uterus) where there was seen a flattened out mass of tissue of 1½ cm. in thickness, and containing a few narrow, elongated spaces filled with clear, thin fluid (probably compressed ovarian cyst). This mass was intimately associated with the rest of the wall, gradually becoming thinner at its peripheral portions where it passed imperceptibly into the rest of the wall of the sac. Microscopic sections showed abundant evidence of its ovarian nature.

Elsewhere the sac was thinner; in some places quite translucent, in others moderately dense and thick. The Fallopian tube was seen coursing for several cm. along the superior portion of the sac, and terminating abruptly in the sac itself as a sudden dilatation, evidently the site of the ectopic gestation.

The inner lining of the sac was in some parts smooth and glistening, where presumably the amnion still remained, in other parts it was rough and ragged from the presence of placental remains and blood clots, all easily detached.

Round about the sac there was evidence of some adhesions with chronic inflammatory fibrosis and local thickenings of the peritoneum.

Microscopic Sections were made through eight different portions of the sac wall, and through two portions of the overlying Fallopian tube.

In the first place, specimens were examined from the outer thick mass of tissue suspected to be ovarian, and the condition revealed was as follows: An outer layer of peritoneum with unusual proliferation of the endothelium was seen to cover tissue, undoubtedly ovarian in nature inasmuch as a graafian follicle was found. The ovary itself was, to a large extent, markedly fibroid. Advancing further inwards, in the same specimens, towards the inner wall of the sac, one could distinctly see the mucosa of the Fallopian tube with great proliferation

of the epithelium and numerous fimbriæ projecting on all sides. Between the tube itself and the superimposed ovary no peritoneal coat could be found, the prolonged stretching, with its accompanying hyperplasia of connective tissue, evidently obliterating all such distinctions. The ovary then, as these sections clearly showed, was flattened out upon the sacculated tube, and helped to form a part of the wall of the sac, but its participation was obviously purely passive, and the condition cannot, by any means, be regarded as a true ovarian pregnancy.

Sections from the smoother, thinned-out portions of the sac showed no special features of interest. Those specimens, however, which included the placental remains showed the usual appearances of the villi, with the blood sinuses, decidual cells, hemorrhages and what has been regarded by Hubrecht, Webster and others, as remains of fetal epiblast. These cells or collections of cells are massed together, their nuclei staining deeply, as in the case of all embryonic tissue, and their protoplasm absorbing a diffuse eosine stain. They occupy what seem to be indifferent sites in various portions of the placental tissue.

The case then is of interest as showing how easily one may conclude the presence of an ovarian pregnancy, a condition which has been time and again denied, and certainly never been absolutely proven. While ectopic gestation is thought by many to occur primarily not only in the tubes and the ovary, but also on the abdominal peritoneum, the question seems recently to have been more fully studied by Webster, who bases his views on a variety of different methods of examination of a large quantity of material. By means of careful dissection, examination of gross frozen sections and microscopical specimens, he was enabled to show that many cases previously regarded as abdominal or ovarian were really after all but modifications of the tubal form; cases that might under ordinary conditions have been described as truly ovarian in origin were thus shown to be after all merely one or other form of tubal pregnancy, and he is led to consider that ovarian does not exist. Hence, he classifies all ectopic gestation cases under the three simple headings of ampullar, interstitial and infundibular, our own case being included in the last of these three varieties.

It has been granted by most authorities that the ordinary uterine and tubal mucosæ play, but a very minor rôle in the occurrence of pregnancy, and that the subepithelial connective tissue is that upon which the true fertilization occurs; it is for this reason that Orth and many other European authorities still believe in the possible occurrence of an abdominal pregnancy, arguing that the peritoneum itself contains tissue quite analogous to that beneath the uterine mucous membrane.

Were there nothing further required to induce this pregnancy there would be no reason for supposing it to occur almost anywhere in the peritoneal cavity, but Webster has shown that there is good reason for believing that some special cellular action must probably occur to induce the process of fecundation. He argues that wherever pregnancy occurs a genetic decidual membrane forms, associated probably in some way with nerve influence, and he further urges that this can take place only along the parts which take their origin from the Mullerian ducts. Hence ovarian and abdominal pregnancies would be impossible, and no one has yet proved a very early ovarian pregnancy to exist.

That some nervous influence is associated with the condition would seem to be true from the discovery made by him in a case of ectopic gestation where the nonparturient tube had likewise a definite decidua upon its inner surface.

Some months ago I had occasion to examine some specimens from a case operated on by Dr. Alloway, in which there had been a double tubal hemorrhage, arousing the suspicion of a bilateral ectopic gestation. In one of the tubes I readily found villi, though in the other there was no evidence of any chorionic tissue. The case, however, is suggestive as possibly being one similar in nature to that described by Dr. Webster.

In one of the recent numbers of the *British Medical Journal* there is a synopsis of an article from Chrobak's clinic in Vienna, referring to a case of ovarian pregnancy, which, however clear, seems to be none other than an ampullar tubal pregnancy if one regards the original site of the placenta. The ovary, as in our own case, forms a portion of the sac wall, and the ligament of the ovary enters directly into the sac, but nevertheless the placenta itself is described as being fixed to the uterus.

Pelvic Hæmatoma Complicating Malignant Disease.—Mrs. J. McC., aged 39 years, entered the Royal Victoria Hospital in July, 1896, complaining of pain in the right inguinal region radiating towards the umbilicus. This pain began in January, 1896, was of a dull aching character and remained constant for seven days, during which time the bowels were rather constipated. For the first three days there was constant vomiting, and the abdomen was somewhat distended; after the pain disappeared there was tenderness in the right inguinal region for a week. Since January, 1896, she has had intermittent attacks of pain in the same region, but no vomiting until June, when she had an attack similar to that in January, accompanied by vomiting and chilliness with constipation. Since then she has had

constant pain in the right inguinal region radiating towards the umbilicus with a sensation of dragging downwards of the navel. The patient has had three children and one miscarriage, the last child three years ago; the miscarriage seven years ago. Menstruation regular, at intervals of three to four weeks, duration three days, quantity moderate, no clots. On examination the abdominal wall was lax, with a tolerably thick layer of subcutaneous fat. Striæ fairly well marked, moderate tenderness in the umbilical region. No descent of either kidney. In the hypogastrium immediately above the brim and rising quite to the level of the upper surface of the pubes is a firm, rounded, smooth and sensitive tumour. Per vaginam; the cervix is cleft bilaterally, granular and everted, the os is patulous and admits the tip of the finger. The cervix is directed to the left side of the pelvis. To the right of the cervix is a moderately firm mass partially movable and continuous with the mass felt in the hypogastrium. The sound enters three inches and is directed to the right side. There is scarcely any mobility of the uterus independent of the mass.

OPERATION, July 31st, 1896.—*Abdominal Section.*—The omentum was adherent to a pelvic mass and to the brim of the pelvis. Several coils of intestine were also very firmly adherent to the mass. These were separated by the scalpel leaving portions of the sac wall attached to the gut. The sac lay in the vesico-uterine pouch adherent, but not very intimately. It was enucleated and tied off with cat-gut; the pedicle being composed of the right ovary and tube. The left tube and ovary were also removed. During enucleation the sac was partially ruptured and black fluid blood and portions of partly decolorised clot escaped, the oozing from the vesico-uterine pouch was controlled by pressure and the thermo-cautery. No drainage. Recovery speedy and uneventful. Discharged August 26th, 1896.

The specimen from this case was sent to the Laboratory on July 31st, 1896, and was found to consist of two distinct portions: (1) a large mass of tissue to which was attached the right ovary and tube, and (2) the left normal tube with a slightly cystic left ovary.

The large mass measured 14 cm. in greatest diameter, was moderately well encapsulated, and the tube which was of normal thickness could be seen stretched out upon the surface. On section the mass was seen to consist of shreddy friable material throughout, dark brown-red in colour, evidently containing much blood pigment. The whole friable mass appeared to be loosely held together by a moderate amount of fibrous framework. The central portions presented far greater disintegration than did the peripheral. The capsule itself varied in thickness, the average being 4-6 mm.

Microscopic sections were prepared from various portions of the mass. Those taken from the capsule and peripheral portions of the tumour, show a fairly dense fibrous tissue containing abundant blood pigment in crystals and amorphous granules, and a moderate degree of small round celled infiltration. The innermost portions showed a small number of epithelial cells arranged in an irregular manner amid the fibrous framework. Sections through the more friable portions of the growth revealed a tissue consisting almost entirely of epithelium and fibrous tissue. The epithelial cells were in parts arranged as glandular structures such as are seen in a multilocular ovarian cyst, but for the most part all trace of glandular arrangement was lost, and the irregular luxuriant growth of epithelial cells amid the stroma gave all the characteristic features of an adeno-carcinoma.

There was in addition abundant necrosis and a large amount of hæmatoidin. The tube was normal.

Pathological diagnosis. Adeno-carcinoma of the right ovary. Cystic left ovary.

Pelvic Hæmatoma Associated with Tuberculosis of the Fallopian Tube.—Mrs. L. J., age 34 years, came to the out-patient department of the Royal Victoria Hospital on August 14th, 1896, complaining of profuse discharges of blood per vaginam, pains in lower portion of abdomen and back, and tenderness in the hypogastric and right inguinal regions. Until the present illness patient has always enjoyed good health. The family history is phthisical. She has had eight children, but no miscarriage; labours all normal. Recoveries favourable. The last child April 11th, 1895. Menstruation was due on the 1st of July, but did not appear till the 4th, continuing till the 14th, when it ceased, and the patient began immediately to have hypogastric pain which continued till the next menstrual period. Since then she has had attacks of flooding with severe pain in the intervals. On July 30th she passed a large clot from the vagina.

Examination.—Abdominal wall tolerably fat, flabby and somewhat pendulous, striæ well marked, marked pigmentation from umbilicus to pubes. Tenderness in hypogastric, right inguinal and iliac regions. No descent of either kidney, no tumour or mass to be felt.

Per Vaginam.—Skene's glands inflamed, a purulent looking discharge can be squeezed from their orifices. Vaginal orifice torn and much relaxed, no evidence of disease of vulgo-vaginal glands. Descent of vaginal walls. Cervix bulky, thickened, firm and patulous, a bloody mucous discharge escaping. Uterus retroverted, its mobility diminished. To the right and behind the uterus an elastic, exceedingly

tender, pulsating mass. The patient was admitted to the gynæcological ward of the Royal Victoria Hospital.

OPERATION, August 19th, 1896.—*Dilatation and Curetting.*—Result moderate in quantity, endometrium roughish to the curette. Gauze packing.

Abdominal Section.—Intestines adherent to a mass in the true pelvis. After separation of some adhesions a cavity containing eight to ten ounces of black blood clot was opened and evacuated. In the floor of the pelvis lay the right ovary as large as a medium sized orange, adherent and containing a straw-coloured transparent liquid. The corresponding tube was dilated and contained a blood clot partly decolorised. Chain ligature of cat-gut and removal. The left ovary was also expanded into a cyst at least two inches in diameter. It was removed. The left tube was not removed, it was adherent but not enlarged to any extent. No drainage. Recovery speedy and satisfactory. Discharged September 8th, 1896, apparently in perfect health.

This specimen which was sent by Prof. Wm. Gardner on August 19th, 1896, consisted of a large hæmatoma—two ovaries and two tubes.

The one ovary (Rt.) was enlarged to more than twice its normal size, was mainly transformed into a bilocular cyst with generally thin walls and containing clear gelatinous fluid.

Attached to this ovary was an enormously distended and thickened tube evidently closed at both extremities. Its contents were hæmorrhagic in nature, its wall for the most part much thickened and distorted, the inner lining dotted over with fairly large tubercles and very few ragged portions of tissue. About midway, the wall was much thinned, shreddy, and showed a large irregular perforation evidently the original source of the hæmatoma of the broad ligament. The other ovary was enlarged to twice its normal size, firm, and with an apparently normal tube.

The existence of a hæmatoma associated with tuberculosis of the Fallopian tube seems to be an event of considerable infrequency inasmuch as the literature on the subject seems not to consider its occurrence at all, and yet in the very nature of tuberculous processes the occurrence of hæmorrhage is to be looked for rather than otherwise. Just as the exudates of tuberculous peritonis and pleurisy are for the most part hæmorrhagic, so, too, one might expect a similar occurrence in the chronic diffuse miliary tuberculosis of the Fallopian tubes.

ON RETROPERITONEAL AND PERIRENAL LIPOMATA.

BY

J. GEORGE ADAMI, M.A., M.D.

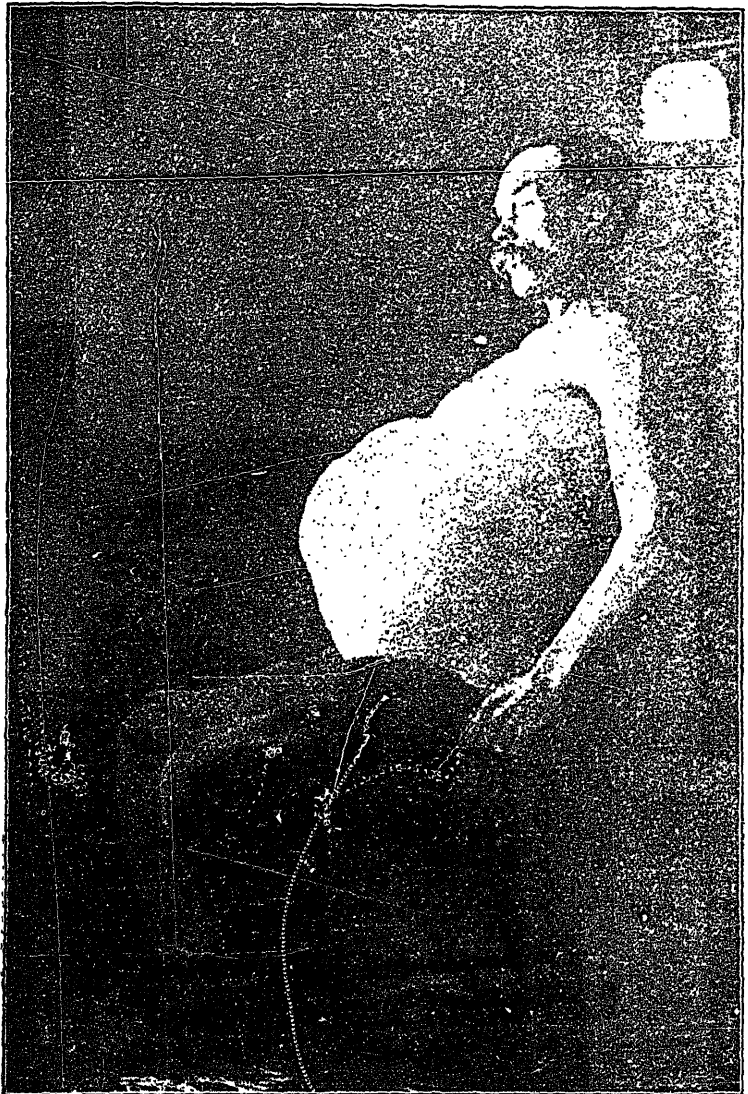
Professor of Pathology, McGill University. Montreal.

The fat which is normally present around the kidney is liable as is well known to great overgrowth when those organs are diseased, as, for instance, in cases of hydronephrosis, of renal calculus and in many forms of chronic renal disturbance; more especially when the organ has undergone atrophic change is this overgrowth apt to present itself and under these conditions it would seem to have originated as a compensatory development. To this form of hyperplasia Virchow has called special attention. There is however a condition of excessive hyperplasia leading to the development of enormous neoplasms concerning which, so far as I can find out, Virchow makes no mention in his great work on tumours; a form in which the kidneys primarily would seem to be unaffected and in which the development of new fatty tissue is so enormous that growths from 40 to 60 lbs. in weight develop in the course of a few months or, more frequently, of from one to three years.

That Virchow should make no mention of these or of retro-peritoneal lipomata in general is evidence of their rarity, indeed after a careful study of the literature of the subject I have been unable to collect descriptions either complete or partial of more than about twenty-four cases; nor again have I come across any general article on the subject in our language. Nevertheless where the condition is present the clinical histories and the appearances found at the autopsy present so uniform a character and one so clearly marked off in many respects from other abdominal overgrowths that it is well worth while to collate what has been written upon the subject and to indicate the special points which characterise this form of tumour. My attention has been more especially called to the subject from the fact that within a few weeks two very well marked cases of this condition came under my notice. For the history of one of these cases together with the tumour I am indebted to Dr. Hanna, of Perth, Ont.; for the history and notes in connection with the other I have to express my sincere gratitude to Dr. Billings, Dr. Lamb, and the authorities of the Army Medical Museum at Washington. This last case I am informed has never been fully recorded and is of especial interest to me in that in almost every point it is identical with the former.

It will be well before discussing the subject as a whole to give as briefly and as clearly as possible the facts in connection with these two cases.

Dr. Hanna's patient was John McK., aged 45 years at the time of death, by trade a harness maker. His mother had died of cancer at the age of 50. The father was still alive in 1893, aged 75, a brother and a sister were living and healthy. He had been strong and in excellent health until January, 1892, when he noticed that he was growing rather stout in the abdomen, while at the same time other parts of the body were becoming emaciated. There were no other symptoms: he ate well, slept well and felt well, and not until March of that year did he consider his condition sufficiently unsatisfactory to make it necessary for him to consult his local physician, who prescribed diuretics. The abdominal swelling continued to increase steadily and with it the emaciation, so that in April he came to Dr. Hanna who found the general condition of the patient good in every particular save for the presence of a large tense abdomen revealing fluctuation from side to side, more enlarged to the left; the girth at the level of the umbilicus was 37 inches. Aspiration yielded not a drop of fluid, hence a diagnosis of abdominal tumour was made and the patient was persuaded to enter the Montreal General Hospital. There Dr. Shepherd (to whom I am indebted for the accompanying illustration) made an exploratory incision on May 2nd, 1892, and found a solid uniform growth occupying the whole abdominal cavity. The relations of the tumour were found to be such that it was decided not to venture upon removal. The patient recovered well from the operation and in a fortnight returned home. From the date of his return until his death on February 9th, 1893, Dr. Hanna saw him at intervals of a fortnight. The course was one of continual growth of the tumour and steady emaciation of body, without throughout a single moment of pain or failure of appetite; the bowels and kidneys never failed to perform their functions. In October the measurement at the level of the umbilicus had increased to 47 inches, and in the middle of this month his physician noticed an apparent softening about the size of a saucer in the umbilical region, aspirated and drew off nine pints of sweet pus. From this date aspiration was practised every week or ten days, and in all close upon 60 pints were removed. Six weeks before death the patient presented slight signs of septicaemia and from this time onwards the pus aspirated was extremely offensive, while towards the end slight anasarca of the legs up to the knees manifested itself. The patient became weaker and weaker, respiration was impeded and he died on February 9th, 1893. To the



very end there was absence of pain and of any disturbance in the bowels or kidneys.

The necropsy on the following day revealed no disturbance of other regions, save great emaciation of face, extremities and chest and slight œdema of the lower lobes of the lungs. Upon opening the abdomen the bowels were found to be behind and to the right side of the tumour, with the exception of the descending colon which was stretched over the growth and which during life could be felt passing across towards the right side and the front of the tumour. This was covered by the expanded mesentery and peritoneum. There were a few slight attachments which were readily removed by the finger, and the tumour came away readily. With it came the left kidney and the spleen. The former was firmly adherent to and, in fact, imbedded in the growth, its lower extremity was atrophied by pressure and flattened, the ureter passed down along the back of the tumour to the bladder and was pervious; the spleen was partially imbedded in the tumour but not deeply, and it came away with comparative ease; the right kidney was healthy and unaffected: the liver had been pressed upwards and its measurement from above downwards was diminished. On section it presented the normal appearance. There was a loose adhesion of the pancreas to the growth.

The tumour when it reached me the next morning weighed 41 lbs., and that, after three pints or more of pus had been removed. Taking this into account together with the loss of fluid during transit, 44 or 45 lbs. would seem to have been the weight at the time of the necropsy. The kidney and a portion of the colon were still adherent, and the tumour presented a coarsely lobate appearance, the lobes being bound down and covered by several irregular and thin layers of fibrous tissue. Upon cutting into the tumour well-marked bands of connective tissue could be seen passing between the large lobes, which varied in size from that of a man's fist to that of a man's head; upon the upper and anterior surface were three or four lenticular lobes that appeared to be composed exclusively of fatty tissue and were completely cut off from the main mass by loose connective tissue; these in fact were capable of being moved to a slight extent over the surface of the rest of the growth. Within the lower and anterior portion of the tumour was a large cavity of which the front wall had fallen in. This still contained grayish-green pus and the tissue around was extensively broken down, of greenish colour, with here and there thrombosed vessels and patches of old hæmorrhage which had assumed a dark green tinge.

Sections from various regions showed that the tumour was in the

main composed of pure and typical fatty tissue. In many parts this was undergoing a mucoid change or degeneration; in some the fat had almost wholly disappeared or had more properly degenerated, the characteristic myxomatous cells being very well seen. On the surface where the growth appeared to be advancing, this appearance was wanting, hence I am inclined to regard the more mucoid regions as tending to be degenerated, and not, as one author to be presently cited would hold it to be, the primary condition. Well-marked connective tissue as a rule separated the fatty lobes, but in one region near the lower end of the tumour and not far removed from the abscess cavity an oat-shaped cell growth replaced well-formed connective tissue, so that sections from this area presented a markedly sarcomatous appearance. There was no cartilage or deposit of calcareous salts or osseous development present.

Here, then we are dealing with a huge retroperitoneal lipoma, which by some would, from its tendency to undergo mucoid degeneration be termed a lipoma myxomatodes, and which in parts would almost seem to have taken on more marked sarcomatous characteristics. I am inclined to consider, however, that the rapid cell growth referred to was largely due to the neighbouring inflammatory disturbance, although in some parts of the sections the sarcomatous appearance was so typical that the case may well be cited as one of chronic inflammation in a loose connective tissue resulting in overgrowth of embryonic tissue, that is to say leading to malignancy.

The Army Medical Museum at Washington received the material connected with the second case from Dr. W. W. Brown, of Brooklyn, who supplied the following details:

J. McN., aged 60, had been a temperate hard working man enjoying always good health. A tumour was first noticed in February, 1869, and then was about the size and shape of an ostrich egg, somewhat movable and painless. During the next two years it increased steadily in size, without, however, affecting the general health of the patient. Although latterly the liver became compressed upwards by the enormous size of the tumour, there was no dyspnoea. As an indication of his general condition it may be added that the patient was a regular attendant at church up to a fortnight before his death. Three weeks before death he walked a long distance to attend the funeral of a friend; the day was stormy and he caught a cold, which increasing in severity led to death from exhaustion in February, 1871.

The autopsy, performed by Dr. G. E. Smith, of Brooklyn, revealed

the following conditions: the anterior abdominal wall was infiltrated with and distended by serum, the muscles being atrophied. A tumour weighing 41.5 lbs., of irregular flattened shape was everywhere adherent to the wall. The liver and intestines were pushed well upwards diminishing the thoracic cavity. The stomach was compressed and adherent to the diaphragm by old adhesions, the right kidney contained one large and some smaller cysts, the left kidney was atrophied and flattened by the tumour to which it was adherent and in which it was partly imbedded. It contained a cyst the size of a walnut upon its convex border. These kidneys together with portions of the tumour and the plaster cast form specimens 8533 to 8536 in the Army Medical Museum. The casts shows above the descending colon passed over the growth.

Examined microscopically the tumour was found to consist "largely of adipose tissue in a voluminous stroma of embryonic connective tissue with abundant nuclei between the fat cells."

It is seen that both these cases present a similar history, of long duration and slow growth, accompanied by very little general disturbance. There is the same history of lack of pain and of disturbance of the general functions of the body till towards the last few days of life. Along with this lack of active disturbance of functions it is noticeable that both patients became extremely emaciated. In both the tumour consists of fatty tissue in which is imbedded a kidney showing little change beyond what would seem to be mainly the results of pressure of the tumour, both are retro-peritoneal and over both there passes a length of the large intestine.

(To be continued.)

WHEN SYMPTOMS ARE ABSENT.¹

BY

THOMAS JAMESON, M.D., Rochester, N. Y.

We cannot take up any medical journal, but we find papers by able writers, on almost every subject, connected, in even the remotest way, with medicine and surgery : but very often the essays, however ably written, do not affect the treatment we give in our cases, for often we have forgotten the subject matter of an essay, before a case, occurring in our own practice, brings the points forcibly to our minds ; for one case, under our own care, teaches us more than reading about 100 similar cases.

Therefore to-night I simply want to relate a few cases, that have come under my own observation, in which we shall see serious traumatic and pathological lesions have occurred, without the threatening symptoms which most text books lead us to think must occur, in order to have the lesions present. The reason for this is obvious ; there is a strong tendency for one writer to quote an older one as an authority, and often errors are in this way perpetuated in medicine, as they are in law, by looking for precedent.

We are accustomed to think that as soon as a perforation of the intestine occurs, in typhoid for instance, that immediately we have severe abdominal pain which develops in the right iliac fossa and rapidly spreads over the whole abdomen. Profound collapse ; the latter evidenced by feeble running pulse, cold sweat, and subnormal temperature, feeble respiration, great thirst, suppression of urine and frequent vomiting. Now these symptoms, as we know, do occur : that from autopsies I have seen I have reason to believe that they do not set in until from 6 to 12 hours after the rupture, and that the symptoms are then due, not primarily to the rupture, but to the resulting peritonitis. There is no symptom which is, of itself, evidence of a perforation of the intestines, either traumatic or pathological. Rupture of any of the internal viscera is not necessarily accompanied by severe symptoms immediately ; nor even in severe accidents do we at once get evidence of damage done. Hence, how often do we read in the daily papers, as the opinion of some doctor in an accident case, that a patient will recover, " unless he has been injured internally." Warren, in his text-book on "Surgical Pathology

¹ Read before the Rochester Pathological Society, December 17, 1896.

and Therapeutics," refers to this under the head of insidious shock, in which he says: "The person, though seriously injured, congratulates himself upon having made an excellent escape, and imagines that he is not only in no danger, but will soon be about again."

"The countenance, in this form of shock, has often a peculiarly melancholy expression, as if foreshadowing the fatal event; a sad smile plays upon the lips, and illumines the lower part of the face, while the upper part wears a gloomy aspect, in striking contrast to the other. It seems in such cases, that there had been an attempt at reaction, which had failed. The cheek may be flushed slightly, and the skin be dry and warm, but the pulse, although strong, is easily compressed, and it is evident to the careful observer that the patient's condition is most critical. He may greet you with a cheerful "Good morning, Doctor," and when asked how he feels, will respond, "fine," and yet the fatal end may come only a few hours later."

The following case will illustrate the point.

On October 27, 1894, I was hurriedly called to see a young man, aged 17, who had accidentally shot himself with a 22-calibre Flobert rifle. He was shooting rats in the rear of the house, and in some way discharged his rifle while it was pointing towards him. The gun was nothing more than a toy, being what boys commonly use, and his father, who came for me, thought that his son had only received a slight flesh wound. The patient, after his injury, walked from the yard up one flight of stairs to his bed, and when I saw him, I found the following condition. A ragged, bruised tear, extending longitudinally along the left side of the penis; a small oblique wound in the left groin, about half an inch above Poupart's ligament; one inch nearer to the symphysis pubis than to the anterior superior spine of ilium.

The patient was a muscular young man, and did not consider himself seriously hurt, his pulse was full, strong, and regular, and beat about 72 to the minute. He said he felt no pain whatever, his colour was good, nor was there any anxiety expressed on his countenance. There was no bleeding from the wound, and my impression at the time, judging from his condition, and the history of the case, was that we had probably a mere flesh wound, but, on running my probe into the bullet hole, I found that it entered the abdominal cavity. I advised immediate laparotomy and took the boy at once in a hack to the City Hospital. About an hour elapsed before everything was in readiness for an exploratory incision, and even when put upon the table, the patient was in good condition. I made an incision about 3 inches long, extending upward from the wound, and on opening the

peritoneal cavity, a sudden gush of bright red blood showed injury to a large vessel. After some delay, owing to the extent of the hæmorrhage, I succeeded in securing the artery, which was a branch of the inferior mesenteric. On carefully drawing out the intestines, I found eleven distinct holes, allowing fæcal contents to escape. These punctures bled profusely but were rapidly sewed up, with the assistance of some of the gentlemen present here this evening. One piece of ileum was so badly lacerated that I performed a resection, removing over three inches of the gut, and putting in a Murphy button. I now thought I had discovered all the injuries, but there being some evidence of further hæmorrhage, I enlarged the incision in an upward direction, and discovered a tear, about four inches long, which separated the descending colon from the meso-colon. This laceration being sewn up, and all apparent hæmorrhage stopped, the peritoneal cavity was very carefully cleansed and the wound closed. The patient never rallied, and died four hours after the operation, and about seven hours from the time of the accident. A partial autopsy being allowed, and feeling sure there was further hæmorrhage, I found, in addition to the injuries already described, that the bullet had buried itself in the spleen, from which there had been free bleeding, which burrowed down in the cellular tissue, toward the left kidney.

When we consider the extent of these injuries, it hardly seems possible that the patient had such slight symptoms, even an hour after his injuries.

A few weeks previous to the case just related, an Italian was shot in a saloon on West Avenue, the bullet entering the belly. He was removed to the City Hospital, but as he did not exhibit any signs of internal hæmorrhage, or of perforation, the attending surgeons thought it best to wait for symptoms calling for interference. About 36 hours after entering the hospital, he began to have symptoms of peritonitis. A laparotomy was then undertaken, and several punctures found, which were carefully sewn up, but the patient died of general peritonitis. Might he not possibly have been saved if an immediate operation had been done?

On the evening of May 9th, 1894, Dr. E. W. Mulligan sent me to make a call for him. I found a boy, aged 12 years, suffering with a bearing down pain over the bladder, and making ineffectual attempts to urinate. His parents said that he had complained of some pain for five or six days, but was not so bad as to interfere with his play, and they did not consider it necessary to send for a physician, but as he had not urinated all that day, they thought it time to have a

doctor "draw his water," as they expressed it. On examining the boy, I discovered an ovoid tumour, extending almost up to the umbilicus. On gentle percussion, it gave an absolutely flat sound. The belly was somewhat tender, but not markedly so. As I did not have a catheter with me, and the boy was very uneasy, I gave him a hypodermic injection of morphia, and went back to my office for a catheter. When I returned to the house, his mother told me that there was no need to pass a catheter as he had urinated some and felt all right; but on looking in the vessel I saw he had only passed a couple of drachms of urine. Feeling positive there was more urine than that in the bladder I examined the abdomen again, but was surprised to find that the tumour had entirely disappeared. I then passed a small soft rubber catheter, but succeeded in getting only a few drops of urine. The boy was very comfortable, did not complain of pain, but was tender all over the belly and had a temperature of 103° . Feeling sure the bladder had ruptured, I sent for Dr. Mulligan, and he saw the case about midnight. He urged immediate laparotomy, and took the child in his carriage to the City Hospital, made a median incision and found the abdomen full of fluid. The doctor discovered a small tear at the apex of the bladder which extended into the peritoneal cavity. He sewed the tear up and in washing out the peritoneal cavity found a gangrenous appendix, which he removed and the patient made a good recovery.

Here was a boy then with appendicitis, running around playing, suffering with a reflex retention of urine, subsequently having a spontaneous rupture of the bladder, with but little discomfort, and no symptoms of shock.

One Friday evening in January, 1895, a young man, a personal friend of mine, came into the office, complaining of pain in his right side. On examination I found there was slight tenderness over McBurney's point; no rise in temperature, nor in the rate of the pulse. As he was constipated, I ordered a purgative, told him to go home to bed and not to get up in the morning unless he felt better. On seeing him next morning, his bowels had not moved. He was uneasy but not suffering much pain; temperature and pulse normal. Ordering a large dose of castor oil and hot stupes, I left. When I saw him that afternoon, he was sitting up in bed reading the paper. His bowels had moved, and he felt quite comfortable, saying he was just waiting for my consent to get up and go skating; but I noticed his eyes were slightly jaundiced, and that his temperature had risen to 101° with a slightly more rapid pulse. The tenderness over McBurney's point was better, except on deep pressure and there was no rigidity of the

muscles of abdomen. I had difficulty in persuading him to allow me to have counsel, as he did not consider himself sick. Dr. Mulligan saw the case with me later in the afternoon and advised an operation, but as the family had always employed a homeopath, we called in their family physician, Dr. Adams. The doctor could not satisfy himself that the patient had appendicitis at all, but gave his consent to an exploratory incision. The patient was removed to the City Hospital that evening and I made an incision, and found a large tense appendix covered with inflammatory lymph, and apparently ready to rupture at the apex. I removed it, the patient making a rapid recovery, and is at present in the best of health.

Now here is a case that had progressed that far in twenty-four hours, with but little pain and no alarming symptoms.

A short time previous to this case, I was called one Monday night to see a young lawyer in the absence of his own physician. Before entering the room, the patient's wife met me, and said that her husband was very nervous, and often imagined he had appendicitis, whenever he had pain in the abdomen. I found the patient suffering apparently from colic. He had no tenderness; his abdominal muscles were lax; his temperature and pulse were normal, and most of his pain was in the region of the transverse colon. Taking the history of the case into consideration, I did not think he was sick, and told the family so, ordered a laxative, leaving an anodyne to relieve his pain, and advising them to call in their own physician if he was not better in the morning. On the following Thursday his own physician operated on him, and found purulent peritonitis, resulting from a ruptured appendix, from which the patient died.

These cases convey their own lessons. They teach that we may find serious conditions in the abdominal cavity, demanding immediate operative interference, if we would save life, without classical symptoms.

Dr. L. McLane Tiffany, in the *American Journal of the Medical Sciences*, reports four cases of wounds of the peritoneal cavity, and thinks the following propositions are justified:

“First.—A penetrating wound of the peritoneal cavity is not accompanied by symptoms commensurate with the extent of the injury.

Second.—Many fatal lesions may be present, and yet give rise to no marked symptoms.

Third.—Fatal lesions may exist, and yet shock be wanting.

Fourth.—The wound of entrance should be enlarged, and if the missile has entered the abdomen, a section is called for.

Fifth.—Operation is proper soon after the injury, before the peritoneum has become infected, or much blood lost.”

In suspected peritoneal sepsis from any cause, the presence of a slight degree of jaundice is often a valuable danger signal, not to be ignored, but we must avoid placing too much reliance on the presence or absence of any symptom, but try to take a mental picture of each case on its own merits, supplementing symptoms with a careful physical examination.

Before closing, I wish briefly to call attention to another form of abdominal disease, from which its insidiousness, is, I am sure, often overlooked. I refer to tubercular peritonitis, which, one writer has said, can simulate anything from an ovarian tumour to pregnancy.

The following two cases occurring in my own practice will illustrate what I mean :

Last May, I was called to see a girl in a neighbouring village, who had been suffering for the past year from a slowly progressing enlargement of the abdomen. She had not menstruated for three months ; had no nausea or vomiting ; no pain ; appetite fair ; bowels regular ; temperature and pulse normal. After a careful physical examination of the abdomen, I diagnosed the case as one of ovarian tumour, and advised laparotomy. She came to the City Hospital and was apparently in very good condition, but on examining the lungs, I detected a small amount of fluid in the left pleural cavity, which I aspirated. This led me to change my diagnosis from ovarian tumour to that of probable tubercular peritonitis. Opening the abdomen a day or two later, I found the cavity full of serum, and the whole peritoneum studded with tubercles. The Fallopian tubes were very much thickened, and the ovaries somewhat disorganized. Nothing was removed. A glass drain was put in for twenty-four hours. The patient made a good recovery, and has apparently been greatly benefitted by the section. She has gained in weight and in strength, and her menstrual functions have returned.

The second case is of a similar nature.

A young girl, aged 22, came into my office complaining of a feeling of weight in the pit of the stomach after eating, and of indefinite pains in her side. She had consulted a physician in Pennsylvania, who told her she had gastric catarrh, and that her slight cough came from her stomach. The patient gave a history of slight loss of weight, and of general weakness. Having the previous case in my mind, I examined her very carefully, and found a small amount of fluid in the right pleural cavity, but could find no further evidence of lung trouble. On palpating the abdomen, I thought I detected fluid and

advised exploratory incision, asking her to see Dr. W. B. Jones to get his opinion. Dr. Jones agreed with me, so I operated a few days later, and found a condition as bad, if not worse, than the previous case. Mere drainage was followed by the same happy results, the patient apparently fully regaining her health.

If such results can be obtained in even these late cases, if it were possible to diagnose these cases earlier, might we not expect even a better and perhaps more permanent recovery?





MALFORMATION OF THE HANDS AND FEET.

BY

A. E. GARROW, M.D.,

Assistant Demonstrator of Surgery and Clinical Surgery, McGill University ; Assistant Surgeon Royal Victoria Hospital.

E. P., male, aged 7, applied at the Out-door Department of the Royal Victoria Hospital, complaining of severe pain in both big toes when wearing boots.

With the exception of his hands and feet, he is a well developed boy for his age.

The accompanying skiagraphs kindly taken by Professor Callandar show the deformity beautifully.

The deformity of the hands is symmetrical, they are spatula shaped, the thumbs being replaced by fingers, having three phalanges, and articulating with a long metacarpal bone.

The interphalangeal joints of the first two digits, on the radial side, show marked limitation of movement on closing the fist, the first finger passing beneath the second to a slight extent.

In picking up small objects he employs the first and third fingers, ignoring the second altogether, but on using a spoon he puts the first two fingers on the upper part of the handle, the others beneath.

The feet are also symmetrically deformed, showing the condition of polydactylism and syndactylism, the big toes are permanently adducted, and in wearing boots gives him considerable pain.

The skiagraph, shows that the first metatarsal bone articulates with two distinct phalanges, and each of the latter with two distinct terminal phalanges, the latter in the left foot evidently being developed from a single epiphysis.

Clinically these two are inseparably united, a plantar and a dorsal groove indicating the line of attachment, there being only, one broad, slightly furrowed nail.

The child's suffering was relieved by amputating the terminal phalanges of both big toes.

PRESENCE OF TUBERCLE BACILLI IN FÆCES FROM A NON-TUBERCULOUS INTESTINE.¹

(From the Medical Clinic of the Royal Victoria Hospital.)

BY

R. B. SHAW, M.D.,

Resident Physician, Royal Victoria Hospital.

The subjoined report is made in view of the following interesting conditions:

1. The presence of tubercle bacilli in the fæcal matter of a non-tuberculous intestine.
2. A pernicious type of anæmia incident to senile tuberculosis.
3. The association of meningeal hæmorrhage and grave secondary anæmia.
4. The existence without symptoms of a psammoma.
5. The presence of an auricular endocarditis.

The patient was a man æt. 54, a mechanic by trade who entered the medical wards of the Royal Victoria Hospital on June 8th, 1896, *complaining* of persistent diarrhœa and general weakness.

He was born in Scotland and came to Canada when 20 years of age. Of his *past history* he was unable to give a very satisfactory account and apart from some indefinite statements about his having had "fever and ague" while in Cuba some four or five years ago, there was nothing of importance. He had been of moderate habits and gave no history of venereal disease.

The *family history* was negative.

Present illness. Late in the fall of 1894, the patient had a severe chill lasting about five minutes and he subsequently suffered so much from general weakness that he was obliged to give up work. Diarrhœa supervened and a week later he entered the Montreal General Hospital where he remained about one month and was then discharged feeling restored. Within a very short time afterwards the diarrhœa returned and has persisted ever since. He had suffered too for the last year or more from general weakness, and entered the Moore Convalescent Home in April 1896, walking about daily until the diarrhœa and weakness became so severe as to necessitate recumbency. So far as he knew no blood had ever been passed in the stools, which had been more or less liquid for the past six months. His appetite had been steadily failing but there was no vomiting. He had observed for the past six months that he was rapidly losing

¹ Read before the Montreal Medico-Chirurgical Society, Nov. 20, 1896.

flesh but had never suffered from cough though from time to time slight expectoration was present.

Present condition. The patient is a much emaciated and markedly anæmic-looking man of good intelligence. His skin has a somewhat subicteroid hue but the sclerotics are of a bluish tinge. He sleeps well and has no pain but his appetite is very poor and he is so weak that he is able to sit up in bed only a few minutes at a time. He has no cough, though from time to time he expectorates a small amount of greenish muco-purulent sputum. Temperature $97\frac{2}{3}^{\circ}$: Pulse 88. Respirations 20.

Lymphatic glands. The glands of the groin are somewhat enlarged and indurated but the other superficial lymphatic glands are normal.

Blood. Red blood corpuscles, 670,000; leucocytes, 6,000; hæmoglobin, 11%.

Locomotor system. The muscles are wasted. The bones and joints are in good condition. There is a ganglion about the size of a large bean in connection with the tendon of the left extensor longus pollicis and another more than twice as large with that of the right flexor carpi radialis.

Nervous system. Mental state is good as a rule but at times the patient is somewhat delirious. His memory is distinctly impaired.

The *motor and sensory functions* and the *reflexes*, superficial, deep and organic, are all normal.

Special senses. The fundus of the left eye, as examined by Dr. Martin showed recent retinal hæmorrhages. Otherwise the special senses show nothing abnormal.

Respiratory system. Respirations 20. There is no dyspnoea and though there is practically no cough the small amount of greenish muco-purulent sputum which is expectorated from time to time is found to contain large numbers of tubercle bacilli but no elastic tissue.

The *chest* is fairly well arched, but the intercostal spaces are much retracted and there is some flattening in the right infra-clavicular region and some retraction below the cardiac area. The apices expand poorly especially on the left side. *Vocal fremitus* is increased on both sides of the chest.

Percussion. The right supra-clavicular region gives slight dulness and there is also slight dulness over the first rib 5 c.m. from the sternum. The right axilla is hyperresonant. The left lung in front and in the axilla is hyperresonant everywhere.

On *auscultation* in front fine sibilant râles are heard at the right apex, and below the first rib the breath sounds are diminished but expiration is not prolonged. Over the left lung the breath sounds

are feeble from the clavicle to the second rib, close to the sternum. Percussion and auscultation behind give dulness on right side from apex down to almost the angle of the scapula, while over this area a few moist and sibilant râles are heard. The bases of both lungs are hyperresonant with somewhat weakened respiratory sounds.

Circulatory system. The pulse is small and weak but is regular in volume and rhythm. The radials are somewhat thickened. *Heart.* The apical impulse is extremely weak and can just be seen and felt in 5th interspace in the nipple line. The cardiac dulness is entirely masked by hyperresonant lung. All the sounds of the heart are much weakened but there are no murmurs present nor is there any accentuation of the pulmonary second sound.

Digestive system. The tongue is very pale and flabby with a greyish coating. The upper teeth are absent and the lower are much decayed. The breath has a cadaverous odour. Attacks of diarrhœa are frequent, the motions being small, fluid and dark green in colour containing small green and greyish flaky particles. On microscopical examination of the flaky material *tubercle bacilli* were found in moderate numbers.

The abdomen is much sunken and yields slight tenderness on pressure in the left iliac fossa and in the hypogastrium. The spleen is not palpable nor is there any splenic dulness. The liver does not extend beyond the costal margin in the nipple line.

Genito-urinary system. The testes are normal. The urine is clear, straw-coloured, acid in reaction with a specific gravity of 1012, and on standing gives a moderate yellowish deposit of amorphous material, principally urates. It contains a trace of albumin and numerous hyaline, granular and waxy casts.

The subsequent course was progressively downward. The diarrhœa continued, the temperature remained constantly subnormal, the delirium gave place to semi-coma deepening into coma and finally death on June 16th, eight days after admission. Cultures taken from the blood on June 10th gave negative results. Examination of the blood on June 11th showed 670,000 red corpuscles and 8% hæmoglobin, but few white corpuscles could be seen, and again on June 15th, 400,000 red corpuscles and 8% hæmoglobin. There was marked poikilocytosis, with great variation in the size of the red cells, likewise several nucleated red corpuscles of various sizes.

AUTOPSY BY DR. MARTIN.

The body is that of a much emaciated old man with the usual signs of death. The pupils are equal and not dilated. The upper teeth are absent and the lower are decayed. There is a small ulcer on upper gum opposite the right canine tooth. There is a small ganglion over the left extensor longus pollicis and another over the right flexor carpi radialis. The abdomen is very shrunken.

The *Abdominal Cavity*—The panniculus is greatly atrophied and the fat is bright yellow. The muscles are thin and gelatinous looking. The abdominal cavity is dry. The intestines are collapsed, their serosa pale, smooth and glistening. The small intestines have here and there blue-black patches of discolouration opposite the mesentery. No tubercles are seen. The omentum is pale, broad, thin, non-adherent and irregularly disposed throughout. The liver descends to the costal margin. The diaphragm is at the 4th interspace at the right side and at 5th rib on the left.

The *Spleen*—Is small soft and red, measuring $8\frac{1}{2} \times 6\frac{1}{2} \times 2$ cm., and weighing 60 grms. There is a recent perisplenitis and one small older local thickening. On section the organ is red—atrophic, and the malpighian bodies rather distinct. There is no tubercle, nor is there any evidence of amyloid disease. The pelvis and ureters are normal.

The *Left Kidney* weighs 110 grms. It is small. The capsule is somewhat adherent, leaving a finely granular pale surface with numerous small cysts. Throughout the surface are a number of minute dark brown clots, chiefly within cysts. These on microscopic examination show blood pigment. The organ is firm. The cortex is pale, smaller than normal and is quite irregular. There are no tubercles. The pelvis and ureters are normal.

The *Left Suprarenal* has a central cavity. It presents no change.

The *Right Kidney* measures $10 \times 4\frac{1}{2} \times 3$ cm, and weighs 110 grms. It is like the left with a more granular and redder surface, but with fewer cysts.

The *Right Adrenal* is like the left.

The *Bladder* is distended with slightly turbid urine. Its mucosa is very pale. There are no hæmorrhages.

The *Prostate* is normal. The seminal vesicles have a moderate amount of fluid.

The *Testes* appear normal.

The *Stomach* is normal. It contains semi-fluid curds. There are no hæmorrhages.

The *Duodenum* shows acute catarrhal inflammation.

The *Jejunum* and *Ileum* present a number of *dark grayish headed ulcers* situate mostly in the ileum and occupying a longitudinal direction opposite the mesenteric attachment. These are all cicatrized and have irregular and somewhat cœleomatous edges, while the floors show fibrous strands and in some places puckering of the cicatrix. In all these there is much blackish pigment. There are no tubercles.

The cæcum and appendix are normal.

The *Large Intestines* have a much thickened mucosa—much firmer than normal; is pale, and here and there shows *patches of pseudo-membrane*. There is no tuberculous anywhere.

The *Rectum* is somewhat congested and the mucosa is thickened, though less so than in the colon.

The *Liver* is small, weighing 1250 grms., and measuring $24 \times 18 \times 9$ cm. The surface is smooth. The organ is fairly firm, and the cut surface has a pale brown colour. There is no evidence of deposited hæmoglobin. The lobules are distinct. The gall-bladder has dark green, thick, viscid bile. There are no gall-stones. The common duct is pervious, though the orifice is somewhat obstructed. The glands are normal.

Pancreas is pale and firm. There is no fat necrosis.

The mesenteric glands are normal.

The *Thorax*—The costal cartilages are in part ossified. On removing the sternum, which appears normal, both lungs retract. The right is gathered up at the vertebral column in its upper half, where it is adherent behind and at the apex. There it is puckered very much. Both pleural cavities are dry.

The *Left Lung* weighs 325 grms. There are slight apical adhesions and much anthracosis. The lung is fairly crepitant in general, with a few nodules of consolidation here and there, and on the surface there are some pseudo tubercles. The apex is puckered with a thickened pleura, and there is a small caseous and fibroid mass.

Centrally in the upper lobe are isolated tubercles, broncho-pneumonic areas, with

purulent bronchitis, all well localized. There is slight marginal emphysema. The lower lobe is anæmic and dry, but otherwise normal.

The bronchi contain slight mucopus. The vessels are free. The peribronchial glands are pigmented and calcified.

The *Right Lung* is much contracted and puckered at the apex, where it is alternately solid and emphysematous. The upper lobe on section has slight cavitation, with smooth walls and a few caseous flocculi. Around this are areas of tuberculous pneumonia with isolated tubercles and pus cavities. In the upper half of the lower lobe there is a small area of simple pneumonia, and near it a patch of tubercular pneumonia as well, each of the size of a filbert. At the lowest part is also another patch of simple pneumonia. The bronchi are filled with thick mucopus. The vessels are free. The peribronchial glands are pigmented, but not tuberculous.

The *Heart*—The pericardial cavity is normal. The visceral layer shows extensive thick anterior and less extensive posterior milk spots. There is much pericardial fat anteriorly, which is yellow in colour.

The heart weighs 135 grammes. The right side is flaccid, the left in systole. Section for large vessels liberates a very small amount of pale fluid blood. The tricuspid orifice admits four fingers easily and the mitral one finger. The tricuspid orifice is 10 cm. in circumference, the pulmonary 6 cm. The tricuspid valves are somewhat thickened. The mitral valves present an *acute verrucose inflammation* and a similar process on the *aortic* above the valves. There is no continuity between the valvular and auricular lesions. The muscle wall is of normal thickness. The right chamber is dilated. The aortic valves are thickened, calcenatous and fenestrated but there are no vegetations. There is slight fusion of the valves. The cardiac muscle is pale brown in colour, not very friable. There are abundant patches of myomatia, especially in the papillary muscles and columnæ carneæ. The coronaries are dilated. The aorta shows early fatty plaques.

Neck Organs—There is early fibrinous tuberculosis of the epiglottis with subjacent hemorrhage. The laryngeal box is ossified. All else is normal.

The *Brain* weighs 1350 grammes. The dura mater externally is normal, but rather opaque. On its inner surface is a *fine fibrino-hæmorrhagic film* on both sides. The pia is normal. The convolutions are of normal size. There is much cerebro-spinal fluid. The ventricles and substances of the brain and cerebellum are normal.

Superiorly in front of the vermis cerebelli, and apparently attached to the pia, is a *small bean-sized oval tumour*, brownish-gray in colour, and varying in firmness—in some parts being fairly soft, in others calcified.

The *Retina* of the right eye presents *several recent hæmorrhages*.

The *Bone Marrow* of the femur is very red, looking like red jelly. There is very little evidence of fat.

Cultures taken from the heart blood and pericardial fluid gave growths of the diplococcus hæmocolatus; from the liver and left lung, staphylococcus pyogenes aureus and diplococcus hæmocolatus.

The spleen pulp remained sterile.

Remarks.—As will be seen from the above case report, the patient was suffering from advanced senile tuberculosis, and yet the subjective symptoms were comparatively slight—a condition which indeed seems to be by no means uncommon in the tubercular processes of the aged. In the present instance, persistent diarrhœa and the grave anæmia had rendered the physical condition so weak as to give the pulmonary symptoms far less prominence than might be expected under other conditions and in a younger subject.

The presence of a blood condition, which is indistinguishable from that of pernicious anæmia, is one which has long been recognized

as a possible occurrence, though the association with retinal and meningeal hæmorrhages is of more than usual interest. Hæmorrhages into the meninges, so far as the literature indicates, seem to be particularly rare under such conditions.

It may, perhaps, be argued by some that the relative proportions of hæmoglobin and corpuscles is not such as to warrant the application of the term *pernicious* to the type of the anæmia, and yet Eichholt distinctly refuses to acknowledge that in pernicious anæmia there is necessarily a relative increase in the amount of hæmoglobin. The most interesting feature perhaps, however, in the present case is the occurrence of tubercle bacilli in the fæces, when no anatomical lesion in the intestines, suggestive of tuberculosis, could be found. The explanation is, however, of course obvious—the patient having swallowed the sputum which was maintained in such a condition as to render examination for tubercle bacilli a comparatively easy matter. The lesions found in the intestines presented absolutely no evidence of tuberculosis, the pigmented scars being in all probability merely healed typhoidal ulcers. (It is to be regretted that the Widal-Johnston method of serum diagnosis had not yet been added to the hospital service at the time, June, 1896, as it might have aided in clearing up definitely the nature of these cicatrices.) The persistent diarrhœa was obviously associated with the chronic colitis.

The cerebral tumour present, while close to important structures, had evidently not attained sufficient size to present characteristic symptoms, and it is interesting to note that this is the second tumour attached to the vermis cerebelli which we have noted within the past twelve months, where no symptoms were present to arouse the suspicion of an intracranial growth.

THREE CASES ILLUSTRATING THE VALUE OF THE BACTERIOLOGICAL DIAGNOSIS OF LEPROSY FOR PUBLIC HEALTH PURPOSES.¹

BY

WYATT JOHNSTON, M.D.,

Lecturer on Bacteriology and Medico-Legal Pathology, McGill University ;
Pathologist to the Montreal General Hospital.

AND

W. H. JAMIESON, M.D.,

Demonstrator in Pathology, McGill University ; Assistant Pathologist to the Montreal General Hospital.

(From the Laboratories of the Board of Health of the Province of Quebec and the Montreal General Hospital.)

The case which we wish to bring before the Society to-night is that of a Chinaman, aged 27, who was brought to the Montreal General Hospital in a dying condition, and died a few hours after admission. The man had been a little over a year in the country and was not known to be suffering from any serious illness.

As some suspicions of violent death arose, a coroner's autopsy was performed.

External examination of the body showed a gangrenous, ulcerated area, 2 inches in diameter, involving the skin over the right elbow, surrounding which the tissues were thickened, firm and nodular. Numerous firm nodules were seen on the skin over the face, extremities, back and genitals ; over the surface of the glans these were especially well marked.

The nodules on excision showed no signs of necrosis or suppuration and appeared to be chronic. The cellular tissue of the right upper arm was cedematous, with ecchymosis in the course of the lymphatics, and during the autopsy numerous ecchymosed areas, varying from 2 to 6 inches in extent, were found in regions which excluded the idea of their being the result of contusions. The most marked ecchymosis was beneath the right iliac and psoas muscles.

Bacterial examination of these ecchymoses showed a few short, thick bacilli (*Proteus*) staining by Gram's method ; no micrococci.

The nerves showed no changes and in particular no nodules in the nerve sheaths. The lungs were deeply congested, no consolidation, no tubercles, or other nodular deposits. In the left epididymis there were several firm, whitish nodules the size of peas. Cut surface firm and

¹ Read before the Montreal Medico-Chirurgical Society, Nov. 9, 1896.

smooth. The other organs showed nothing of special note. Nutrition was good. The gangrene of the skin over the elbow and the evident condition of septicæmia present appeared to explain death.

The general nodular skin eruption did not correspond with either syphilis, lupus, glanders, variola, nor with any of the forms of skin diseases ordinarily met with. It was only towards the close of the autopsy that the idea of the eruption being due to leprosy occurred to us. A cover slip was then prepared by smearing it with a drop of the juice obtained by scraping one of the nodules. On staining this with carbol fuchsin and decolorizing with sulphuric acid and methylene blue (Gibbett's fluid), innumerable, slender, red rods were seen, many of them arranged in the peculiar clumps designated as lepra cells.

Examination of the nodules in the testicle showed also the presence of numerous lepra bacilla, and sections of the skin showed large numbers in the deeper layers. Cultures from the smaller nodules of the skin on Loeffler's serum and glycerine remained sterile. Inoculation of a small nodule into the anterior chamber of a rabbit's eye, shows at the end of three months a nodular exudate over the anterior surface of the iris. No signs of tuberculosis appeared in the animal, the general condition being good and its weight not diminished.

The examination of cover slips thus established the nature of this case with certainty in a few minutes, whereas without this neither the post-mortem nor the clinical examination by the house physician or the physician in attendance had led to the discovery of its real nature.

The bacteriological method appears to be thus eminently adapted for the examination of any doubtful case of skin disease which may be leprosy, as the bacilli are certain to be found in large numbers in cover slips prepared from the material obtained on scraping the nodules of the skin.

The microscopic resemblance between the leprosy and tubercle bacilli should not form a serious source of error, as in tuberculous lesions of the skin the bacilli are always very scanty, and usually only a few are found in the entire cover slip, while in lepra each microscopic field shows enormous numbers of them.

The lepra bacilli also readily stain by the simple aniline dyes, while tubercle bacilli do not.

The ease and certainty by which the diagnosis of leprosy can be made was also shown in a case which one of us (Johnston) examined for Dr. Shepherd six years ago. This patient, a West Indian mulatto, had a good position as waiter in a Montreal hotel, and to avoid losing

his position, allowed himself to be treated for three years for syphilis without any improvement resulting. He then visited Dr. Shepherd's skin clinic, where a diagnosis was made at once from the appearance of the skin eruption and the presence of anesthetic areas, this diagnosis being confirmed by the microscopic examination.

Recently a case has come under our notice where a Chinese laundryman in Three Rivers, supposed to be a leper, was kept under observation and isolated while a scraping from one of the skin lesions was forwarded for bacteriological examination to the Laboratory of the Board of Health of the Province of Quebec.

No leprosy bacilli were found. Subsequently our personal examination of the case showed it to be one of psoriasis, and a repetition of the bacterial tests again gave negative results.

While authorities differ as to whether leprosy under certain conditions is actually contagious, there can be no doubt as to the advantages of the bacteriological method of diagnosis for public health purposes, since by this means an obscure case can be made out in the course of a few minutes, and if the suspected person is situated at a distance from any laboratory, the samples scraped from a nodule of the skin may be sent by mail enclosed in an envelope addressed to the bacteriologist. In choosing a nodule from which to take the specimen, it is perhaps better to select one in an early stage, before much scarring has taken place, by pricking or scraping off the top of a nodule, and collecting the fluid which exudes on pressure. When dried on an ivory vaccine point or a glass slide samples may be more readily sent by post.

Manson has recommended rendering the nodule anemic by clamping the base with forceps before taking the sample, but in our experience this is not necessary, as the blood does not interfere with the examination.

We have reported these cases because in spite of the dread with which leprosy is regarded by the public, this simple means of diagnosis does not seem to have been as frequently made use of as it should be by the sanitary authorities.

AMBULATORY LOBAR PNEUMONIA.

BY

G. GORDON CAMPBELL, B.Sc., M.D.

Demonstrator of Medicine, McGill University, Assistant Physician, Montreal General Hospital.

This case is of interest mainly from its rarity, the disease itself presenting no unusual features. In hospital practice, where the great bulk of patients comes from the poorer classes, it is not unusual to meet with acute pleurisy with effusion in the out-patient department. Several times I have been consulted for "shortness of breath and slight cough" of a few days duration and found one pleural cavity almost completely filled with fluid. Pneumonia, or at least that form which sets in abruptly with a severe chill, met with during adult life is extremely rarely encountered in an out-patient hospital practice. The following are briefly the particulars of the case.

N. M., aged 49, born in Ireland, a wood carver by trade, came to the Out-patient Department of the Montreal General Hospital on Oct. 23rd, 1896, complaining of cough with slight expectoration and general malaise. Inquiry into the history of the disease revealed the fact that it had been induced by a severe wetting which he got on Oct. 18th. On the morning of the 19th he rose as usual at 4 a.m., but shortly after had a severe chill lasting one hour and followed by pain in the side. During the day he took to bed and at night cough and expectoration set in. During the following day, Oct. 20th, he remained in bed, but on the 21st got up and sat about the house "not feeling" as he expressed it "quite able to go to work." On the 23rd feeling that he was not improving he came to the hospital, a distance of over a mile from his home and walked a part of the way.

The personal and family history contained nothing of interest. He had been a hard drinker in his early manhood but had been temperate for a number of years.

On examination the temperature was found to be 101.5° , the pulse 120. The right lung showed dullness from the spine of the scapula down, and at the side and front, corresponding very closely with the lower lobe. Over the dull area there was intense dry blowing-breathing and bronchophony. The vocal fremitus was slightly if any increased. A diagnosis of acute lobar pneumonia was made and the patient advised to remain in the hospital. To this however he

¹ Read before the Montreal Medico-Chirurgical Society, Nov. 20, 1896.

demurred not feeling as he said that he was "ill enough for it." After the grave nature of the disease was explained to him, he consented to be admitted but insisted on going home first, which he did. The same afternoon, Oct. 23rd, he was admitted to the wards under Dr. Molson and to his resident physician Dr. Mitchell. I am indebted for the further history of the case. The temperature shortly after admission, rose to 103° and remained between that and 101° until death occurred on Oct. 28th, the tenth day of the disease. The expectoration was rusty, viscid and contained pneumococci. The urine contained no albumin. On the 26th, two days before death, an area of consolidation was detected in the base of the left lung.

The autopsy, made by Dr. Wyatt Johnston, revealed: Acute lobar pneumonia, total grey hepatization of the right lung with commencing red hepatization of the left lung. Acute bronchitis; chronic right and acute plastic left pleuritis; old apical tuberculosis; spleen large and firm; hogsback kidneys with mixed nephritis and some fatty degeneration; slight cirrhosis of the liver; very marked dilatation and hypertrophy of the heart; polypoid white thrombus of the right ventricle; and slight pulmonary embolism.

Clinical Lecture.

RENAL CALCULUS.

CLINICAL LECTURE DELIVERED IN THE MONTREAL GENERAL
HOSPITAL ON THE 5TH JANUARY, 1897.

BY

GEORGE E. ARMSTRONG, M.D.,

Associate Professor of Clinical Surgery in McGill University.

GENTLEMEN,

The first case that I will bring before you to-day is one of suspected stone in the kidney. Although it has been known for many generations that stone sometimes formed in the kidney, yet the diagnosis during life and the surgical treatment of this condition is a matter of recent years. When certain substances, which are normally in solution in the urine, are present in excess they crystalize out, and the passing of these crystals in the urine constitutes what is called gravel, the gravel being generally composed of crystals of uric acid or oxalate of lime. But if a few of these crystals become cemented together by mucus or blood clot, and increase in size by fresh deposits from the urine, a calculus is formed. Although the majority of renal calculi have a uric acid or an oxalate of lime nucleus, other substances, such as carbonate of lime, phosphate of lime, a mixture of phosphate and the ammonio-magnesian phosphate (that is, the fusible calculus), cystine, xanthine, and finally urate of ammonia, or the mixed urates, or a blood clot are found occasionally, though rarely, either as the nucleus or chief constituent of renal stones.

It would seem that age and diet have a determining influence on the character of the stone. Thus, while it is true that renal calculi may form at all periods of life from the latter weeks of intra-uterine life up to old age, yet the nature of the nucleus differs with the age and diet of the patient.

Mr. Thomas Taylor, who made the analyses of the calculi in the Hunterian museum, found in the calculi occurring in children the nucleus was generally composed of urate of ammonia, in middle life of uric acid, and in patients over forty years of age of oxalate of lime. He proposed to call the stones having a urate of ammonia nucleus, the infantile calculus.

Renal calculi in children are generally found among the poor who are often fed on food too coarse for their feeble powers of digestion to properly assimilate, while among the children of the well-to-do

renal calculi are rare. Mr. Cadge thinks that the frequency of renal calculi among the children of the poor is due to the absence from their diet of a sufficient quantity of milk.

On the other hand renal calculi in adult life generally occur among the rich, who live well and take insufficient out of door exercise.

You will notice also that although the stone forms in the kidney, that the kidney is not the organ at fault. The kidneys are probably doing all of their share of the work, and it is the digestive organs that are functionally unequal to the task imposed upon them. The stomach, liver, pancreas and small intestine are the overworked or functionally inadequate organs, and it is to these that we must direct our attention in attempting to prevent the formation of renal calculi.

When a calculus has originated in a uriniferous tube or in one of the calyces of the kidney it may remain there and continue to grow by accretion, or it may pass down the ureter into the bladder. It may then pass out along the urethra during micturition or remain in the bladder and there form the nucleus of a vesical calculus. Its passage along the ureter is generally accompanied by very severe pain. It is forced along by a sort of peristalsis of the muscular walls of the ureter and by the pressure of urine behind it.

The pain caused by a stone passing along the ureter is called renal colic. As a rule the pain is intense, starts down along the course of the ureter towards the bladder, and is felt in the testicle, the penis and the inner side of the thighs. The patient leans towards the affected side and the leg of that side is drawn up. It is relieved by hot fomentations, or a hot bath and by opium. A hypodermic of morphia relieves the pain and also favours the passage of the stone by relaxing the muscular contraction of the ureteral wall. After the passage, or suspected passage of a kidney stone into the bladder you should direct the patient to carefully observe if a stone is passed during micturition, and if so to preserve the stone for analysis and to confirm the diagnosis.

Recurring attacks of colic arise from fresh formation of renal calculus. I pass around these small stones which have been passed through the urethra. They serve to show you the size of stone that can pass along the ureter, and one of them especially is rough and angular and caused great pain during its passage.

Unfortunately kidney stones do not always pass, but sometimes remain in the kidney increasing in size and extending into the calyces and pelvis of the kidney. Both kidneys may be affected simultaneously or one subsequently to the other.

A stone lodged in the kidney acts as an irritant. It excites inflammation of the mucous membrane lining the pelvis and calyces, a cal-

culous pyelitis. It may excite suppurative nephritis, or fatty degeneration of the kidney, or drop over the mouth of the ureter and by obstructing the outflow of urine, cause a hydronephrosis and later on, the urine becomes decomposed and a pyonephrosis results or a perinephritic abscess, renal fistula or renal abscess. The kidney may be converted into a large abscess cavity, may burst externally or into the peritoneum, stomach, intestine, lung or pleura. The patient may be worn out after months or years by continuous suppuration and die of hectic or exhaustion.

I removed this large stone which I pass around from a large kidney abscess which pointed externally. The peri-renal tissues were absorbed, and the skin thinned to such an extent that a slight superficial incision made without an anæsthetic enabled me to remove it.

The symptoms of stone in the kidney are both subjective and objective, and sometimes there are no symptoms at all. A stone of considerable size may exist for years without causing the patient sufficient annoyance to lead him to consult a physician. Such stones are occasionally found after death.

One subjective symptom is pain in the region of the kidney. The pain may be severe or hardly more than a feeling of distress or discomfort. It is generally increased by exercise, or riding over a rough road. It is not the severe pain that occurs in renal colic, when the stone is passing along the ureter. The pain of renal colic is transmitted along the genito-crural and spermatic nerves to the genitalia and thigh. The nausea and vomiting of renal colic are explained by the connection between the renal plexus and the pneumogastric. The pain caused by a stone remaining in the kidney is rarely as severe or as widely diffused as the pain of renal colic. It is more of an ache. The patient sometimes complains of tenderness over the kidney. In one instance it is reported that the patient could by manipulating the side cause the stones to grate one upon another, so that the gratings could be felt and heard. The appetite is sometimes affected and a degree of lassitude is complained of. An examination of the urine often gives valuable evidence of the presence of a stone. You expect to find in such urine blood, pus and crystals of uric acid and oxalate of lime.

The blood is generally small in quantity and can often only be found by the use of the microscope. You should never feel satisfied that blood is absent from the urine until you have examined carefully with the microscope several samples, passed before and after active exercise. The same applies to pus. It is often small in quantity, and its presence should be sought for with the microscope. Pus in acid

urine is significant. Crystals of oxalate of lime are nearly always present in the urine from a kidney containing a stone. Tenderness on deep pressure over the kidney is a valuable sign. Sometimes violent shaking of the patient as in succussion will cause pain in the region of the kidney. It is thought that the varying pressure of the abdominal viscera, the passage of feces along the colon and the variations of intra-renal pressure, are all capable of exciting pain by making the renal tissue press against the surface of the stone.

The diagnosis of stone in the kidney is very difficult. Ransohoff has collected forty cases, in all of which the symptoms of renal calculus existed, and in which exploration of the kidney failed to find a stone. In fact I think that there are but few surgeons who have explored any considerable number of kidneys for stone who have not occasionally failed to find one. In many of these cases, however, the symptoms have been relieved. The simple opening of the kidney capsule sometimes is followed by relief of symptoms. In some cases a small abscess has been found and emptied. Mr. Reginald Harrison has recently reported a series of cases, where incision of the kidney capsule and exploration of the pelvis has relieved a long persistent backache with pyuria. We need further light on the diagnosis of stone in the kidney. I believe it to be important to recognize the difference in symptoms between stone remaining in the kidney and recurring attacks of renal colic, due to the repeated formation of small stones which pass down into the bladder. The symptoms of the latter condition are more severe and characteristic than are those of the former.

The presence of blood and pus in the urine only after active or violent exercise or in notably increased quantities after such exercise points strongly to the presence of stone in the kidney. This was the case with the patient from whom I removed this large stone which I have here. This stone weighs about six hundred grains. It was removed from the right kidney. In the same kidney were these small faceted stones, twelve in number. The left kidney also contained five large stones and a quantity of gravel, yet the urine seldom contained pus and blood except after exercise in a gymnasium. To show you how free from pain such a patient may be, I may tell you that the patient from whom I removed this stone bicycled through England last summer for two months without suffering any inconvenience or pain, and only consulted his family physician because he noticed that his urine was always bloody after he had exercised in a gymnasium. He gave a history of having had renal colic sixteen years ago and again fourteen and twelve years ago. At the time of operation the only guide as to

which kidney I should explore was a vague feeling of discomfort on the right side, which was present the greater part of the time. He had felt some distress occasionally on the left side, but much less than on the right.

In women it is easy by means of this ureteral catheter to catheterise the ureters and thus obtain a specimen of urine from either kidney. In man up to the present we are not able to do this with any degree of facility.

A condition which closely simulates stone in the kidney is tubercular pyelitis. In the early stage either condition may cause frequency of micturition and purulent urine and hæmaturia. These symptoms occurring in a thin emaciated patient would suggest tubercular disease, occurring in an otherwise robust and healthy patient would suggest stone. Later on tubercle bacilli might be found in the urine. In cases of doubt bacilli should be carefully looked for.

Treatment.—Bearing in mind that the kidney although the sufferer is not the offender and that the digestive organs are the ones at fault, to the latter we direct our attention. The diet should be such as is easily assimilated. Sugars, fats, and alcohol should be excluded. Spirits and water are less harmful than wines and beer.

Nitrogenous food should be used in moderation. Do not exclude animal food altogether, with the idea that by so doing you prevent the formation of renal calculi. The frequent occurrence of renal calculi among the poor who seldom taste meat is sufficient evidence that an exclusively vegetable diet is not a preventive. The diet should be mixed, varied and such as to promote good health and good digestion.

Sir Henry Thompson advises the use of salines, especially as found in the natural mineral waters. He prescribes the Friedrichshall and Hunyadi Janos waters, given in the morning, hot, and in sufficient quantity to be gently laxative. Citrate of potash and carbonate of lithia may prove useful, as alkalies, neutralizing the excessive acidity. Hot fomentations and anodynes may be required to allay pain.

If the stone remains and grows and is injuring to the kidney, resort must be had to surgical measures. Nephro-lithotomy, nephrotomy or nephrectomy are the operations generally performed.

Nephro-lithotomy was first performed by Mr. Henry Morris, of the Middlesex Hospital, London. Its aim is to open the kidney, remove the stone and to leave a healthy kidney afterwards. It is an operation devoid of much danger and, as a rule, satisfactory in its results. An incision is made about four inches long, three-quarters of an inch below and parallel with the last rib. It begins just external to the erector-spinae muscle and is carried rapidly down through the muscular

layers until the peri-renal fat is arrived at. The outer edge of the quadratus lumborum may be incised if found necessary. The fat around the kidney may be divided by tearing with two pairs of forceps, or by a pair of forceps and the finger. When the kidney is reached it should be carefully explored. First pass the finger over the posterior surface of the kidney and its pelvis. If no irregularity or hardness is felt, pass the finger along the anterior surface. Should no indication of the situation of the stone be detected by this plan, the kidney may be explored by a needle. A long hair-lip needle answers very well. With this, several punctures may be made in the kidney with safety. In doing so, however, have a method. Begin at one end of the kidney and introduce the needle at intervals along the convex border until the other extremity is reached. You may safely make eight or ten punctures in this manner, and probably one of them will strike the stone. Failing to find a stone by puncturing with a needle, do not conclude that there is no stone. Ask your assistant to make firm pressure upon the abdominal wall, pushing the kidney up towards the wound. Then with a scalpel incise the capsule and slowly with a gentle boring motion insert your forefinger through the capsule and kidney tissue into the pelvis. Do not give up your search until you have thoroughly explored the pelvis and calyces of the kidney with your finger.

It is sometimes extremely difficult to find a small stone deeply embedded in a kidney. In one instance, Mr. Henry Morris failed to find a stone after carefully exploring the kidney. The symptoms, however, continued and Mr. Morris removed the kidney. It was laid on a table and even then no stone could be detected. One was present, however, and was discovered when the kidney was laid open.

Some operators prefer to open the pelvis of the kidney instead of the convex border. I have always opened the convex border myself. It is more accessible, the hæmorrhage is not troublesome, and there is less danger of a urinary fistula remaining.

When a stone is found it is seized with a pair of calculus forceps and removed, or sometimes it is more easily slipped out in advance of the finger. If the stone is a large one it may be broken and removed in segments, thus doing less damage to the kidney substance.

After removal, a rubber drainage tube may be inserted through the opening in the kidney into the pelvis for drainage. It should be allowed to remain forty-eight or seventy-two hours.

Iodoform gauze may be lightly packed around the kidney and the wound partially closed.

The dressings should be antiseptic and frequently changed. I like

to give these patients boracic acid or salol for two or three days before operation with a view to preventing urinary fever which may occur after this operation, as well as after an operation upon the urethra or bladder.

Nephrotomy is the term employed to indicate incision into the kidney for purposes of exploration or treatment.

The term nephrectomy means the removal of the kidney and nephrorraphy means exposure of a movable kidney through the lumbar incision and its attachment to the edges of the incision.

Nephro-lithotomy is the ideal operation for renal calculus. It aims at removing the stone and leaving a useful kidney afterwards.

RETROSPECT

OF

CURRENT LITERATURE.

Obstetrics and Diseases of Infants.

The Effects of Endometritis on Pregnancy and Labour.

M. V. BUE. "Des Endométrites Gravidiques."—*Archiv. de Gyn. et de Tocologie*, Juin, 1896, p. 147.

The history of endometritis in its relations to gestation and labour is a question of comparatively recent date. Acute and chronic endometritis are commonly found apart from pregnancy and their etiology is well established. The uterine mucous membrane is affected, sometimes in the cervix only, sometimes in the body, but generally in both. Is pregnancy possible when the mucous membrane is thus affected? Undoubtedly yes, but fecundity is much diminished. It is difficult for an ovule to attach itself to an inflamed uterine mucous membrane and dislodgement is easy. In cases where the cervix is much involved, pregnancy is generally prevented, the plug of mucous mechanically preventing the upward progress of the spermatozoa. Whether an endometritis preceded gestation or has developed during its course, the symptoms are the same. Either the decidua lining the uterine cavity or that enveloping the ovum may be more or less affected, hence the endometritis of pregnancy has been divided into the *decidual* and *placental* varieties, to which should be added the *cervical*.

From the point of view of pathological anatomy, endometritis has been described as *diffuse hyperplastic*, *polypous* and *cystic*; but pure types are rarely found, a mixed type being most common. From the point of view of symptomatology, three varieties have been described, the *catarrhal* or *mucous*, the *haemorrhagic* and the *purulent*, the last being very rare. The etiology of this disease is interesting and worthy of study. The causes may be local or general. Its commonest local cause is blenorrhagia; the gonococcus of Neisser finds an excellent culture medium in the uterine mucous membrane. It often causes cervical endometritis, more rarely the purulent variety. Blenorrhagic endometritis may precede conception and is then usually

aggravated by it, or it may occur during the course of gestation. Old puerperal metritis is another local cause; traces of a localised infection may persist for a long time after an abortion or a confinement in the form of metritis. Sterility often results, or if pregnancy does occur subsequently, the hæmorrhagic tendency which remains promotes abortion. Primitive uterine tuberculosis, cancer of the cervix and fibrous nodules in the cervix, are other local causes of endometritis. Among the general causes are syphilis, tuberculosis, lead-poisoning and acute infectious diseases such as measles, scarlatina, typhoid fever, cholera and influenza. When abortion occurs the cause may be hyperpyrexia, direct poisoning of the foetus by the infective agent or its products, or it may be a primitive inflammation of the uterine mucous membrane. It is not right therefore to ascribe all abortions occurring during the course of the infectious fevers to endometritis; but if the foetus is expelled alive with abundant uterine hæmorrhage and there is retention of the decidua, endometritis is most probably the case.

Pregnancy complicated with endometritis may run a normal course; everything depends upon the intensity of the uterine affection. The symptoms most frequently observed in cases of pregnancy with endometritis are important. Vomiting is apt to be more frequent and is often uncontrollable; leucorrhœa is almost constant, yellowish white and slightly viscous when it comes from the corpus, gelatinous and sometimes yellowish-green and staining the linen when it comes from the cervix. Watery discharges may occur either in the earlier or later months, described by some observers as *decidual hydrorrhœa*. Hæmorrhages may occur in the first six months or in the last three months. In the latter case they are due either to a premature separation of a normally situated placenta or to a vicious insertion of the placenta, both conditions being consequent upon endometritis. Some authors have noticed expulsion of fragments of decidua; others have ascribed great uterine tenderness (*rhumatisme utérin*) to inflammation of the endometrium. It is evident therefore that endometritis leads frequently to the interruption of gestation before term, but the contrary is sometimes found. Gestation may be prolonged on account of the slow detachment of the membranes from the lower uterine segment to which they have become unusually adherent. On examining a case of cervical endometritis one may find erosions, ulcerations, fungosities, mucous polypi, or an accumulation of thick fluid which may obliterate the cervix or may even cause agglutination of the lips of the external os. The cervix itself is large, congested and painful. The course of labour may be affected by endometritis. Abnormal

adherence of the membranes may delay labour by rendering the pains weak, infrequent, irregular and inefficient. Inflammation of the neighbouring nerve endings may cause hyperexcitability and lead to tetanus uteri. The dilatation of the cervix is apt to be slow and painful and the membranes which are friable are apt to rupture prematurely. Hæmorrhages during the course of labour, and partial or total adherence of the membranes after expulsion of the placenta, are frequent and troublesome complications. When portions of the membranes or placenta have been retained, hæmorrhage or sepsis may occur. Among the later complications are deciduomata, benign or malignant. In the benign, the placental villousities remain almost normal in structure but proliferate actively; in the malignant the stroma of the villosity is transformed into embryonic sarcomatous tissue (sarcoma chorio-cellulaire). These deciduomata provoke repeated hæmorrhages which soon induce grave anæmia; the malignant variety is subject to metastasis and is liable to return after removal.

The diagnosis of endometritis requires a local as well as a general examination, and no single symptom is decisive or pathognomonic. The prognosis is grave for the fœtus and may be grave also for the mother, depending upon her previous general health as well as the intensity and causation of the disease. The treatment is important. Prophylaxis is the ideal treatment when the patient is seen early enough. The endometritis should be treated first locally (cauterisation, curettage) and then if it depends upon an intoxication or a general infection, the specific cause should be attacked. If pregnancy has begun, one must prepare for accidents. In cases of hydrorrhœa or hæmorrhage rest in bed should be ordered. Warm injections, copious and with but little force, are helpful in some cases. If there are labour pains and abortion is threatened, opiates are indicated; when it is unavoidable, the uterine cavity should be completely cleaned out. During labour, it may be necessary to treat hæmorrhage, rupture the too resistant membranes, or even dilate the os artificially. During the third stage of labour, special pains should be taken to secure the complete expulsion of placenta and membranes and guard against the dangers of retention. Subsequent hæmorrhage or sepsis may require curetting, douching and packing the uterine cavity with iodoform gauze.

Polyneuritis Complicating Pregnancy and Labour.

CH. VINAY. "Polynévrite consécutive à la grossesse et à l'accouchement. Paralytic des quatres membres. Guérison."—*Archives de Gyn. et de Tocol*, Juin, 1896, p. 432.

Polyneuritis occurs sometimes during the course of gestation, some-

times during the puerperal state. The former variety is rare, the latter more common. The assertion of Möbius that puerperal neuritis is confined to the cubital and median nerves is incorrect, cases having been reported of general motor and sensory troubles in all four extremities. The only characteristic feature of this form of neuritis seems to be its septic origin, the nerve extremities being affected by the septic poison in a manner similar to that observed in other infective diseases such as diphtheria, pneumonia, typhoid fever, la grippe, &c. Polyneuritis in pregnant women is much rarer, only four authentic cases having been recorded. The type was more severe in these cases, and uncontrollable vomiting seems to have been the pathogenic condition in all. In the present case which is reported at length, the paralytic symptoms began only at the end of gestation, were preceded by uterine hæmorrhage and accompanied by abundant vomiting, but complete paralysis did not occur till the fourth day after labour. The patient, at 38, had borne 6 children and had 2 abortions; there was no neurotic history. During the last three or four months of pregnancy, there were frequent hæmorrhages, the blood coming away sometimes liquid and red, but more frequently in dark clots. These hæmorrhages were painless but caused great exhaustion. During the last two months she had attacks of vomiting and complained of pains in the calves of the legs with tingling in the feet and hands. She could walk easily but became tired very soon. Labour was normal, the child was small, and the delivery of the placenta was followed by considerable loss of blood. On the third day she complained of general malaise and headache, but had neither chills, diarrhœa nor abdominal pain; there was elevation of temperature for 48 hours. On the fourth day she tried to get up, but found that she could not stand, and to her astonishment she fell to the floor. The arms were equally powerless; she could not hold her child, put her hands behind her head, carry food to her mouth, sew, or open the blade of a knife. In a state of repose she felt lancinating tingling sensations in the arms and legs. She nursed her child for a month and was then, admitted to hospital. Her general condition and appetite were good there was slight constipation and the lochia had ceased. The temperature was normal, heart and lungs sound, no albumin in the urine, no trouble in defecation or micturition. The muscles of respiration, of the tongue, face and eyes were unaffected, the patellar reflexes were abolished; there were no trophic troubles except wasting of the muscles in both arms and legs; the organs of sense were unaffected, the intelligence was normal and there was no objective troubles of sensibility. Electric sensibility was intact.

The treatment prescribed was a hypodermic injection of Ergotine (1 gram.) every other day, and on the alternate days a half-hour electric bath for the legs. Under this treatment the symptoms gradually improved; at the end of three months the arms had regained their natural movements and the legs were strong enough to allow her to stand and to walk slowly with a little hesitation. A couple of weeks later she was able to resume her ordinary household duties. The diagnosis was easy, poliomyelitis being the only disease to exclude. The pathogeny is obscure; probably a general dyscrasia resulting from repeated hemorrhages and severe vomitings during pregnancy, a considerable hemorrhage at the conclusion of labour and a slightly febrile puerperium acted as marasmus, chlorosis and diabetes sometimes do, and caused a polyneuritis. Neuritis occurring during pregnancy is more serious than that of the puerperal period. It was found necessary to induce abortion in the case reported by Desnos and the patient took two years to regain health and strength. Soloviev's case died. In paralysis from neuritis as in paralysis from traumatism, the examination of the general sensibility as well as of the electric sensibility gives valuable information respecting the probable course of the disease.

Air Embolism in Placenta Prævia.

LESSLE. "Ein weiterer Fall von Luftembolie bei Placenta prævia."—*Zeitschrift für Geburtshülfe und Gynäkologie*.—Band xxxv, 2 Heft.

Placenta prævia occurs frequently in Berlin. In August, 1894, Heuck¹ reported a fatal case of air embolism while version was being performed for Placenta prævia in the Berlin Clinic. Previously two similar cases had been reported by Kramer² and Krukenberg.³ On 8th April, 1896, a IV-para with a marginal placenta prævia was admitted. Her first labour ended spontaneously, her second was terminated with forceps and her third with version. She was strong, well-nourished, somewhat anæmic, with a pulse of 80, regular and strong, and was in the 9th month of pregnancy. She had a sharp hemorrhage on the 4th April and again in the afternoon and evening of the 7th. As her general condition was good, the pains weak and the bleeding slight, a tampon was applied. After several hours the os was sufficiently dilated to allow two fingers to be passed, and it was decided to perform version. A few drops of chloroform were given.

¹ *Zeitschr. f. Geb. & Gyn.* 1894, S. 140.

² *Zeitschr. f. Geb. & Gyn.* Bd. xiv, Heft 2.

³ *Centralt. f. Gyn.* 1892, S. 109.

the membranes were ruptured, two fingers were passed into the uterus and the left foot was seized and brought down through the os uteri without any difficulty. During the manipulation, a moderate quantity of liquor amnii flowed away and both pulse and respiration were regular and quiet throughout. Suddenly the breathing stopped for a moment, then began again but remained superficial and gasping. The lips were cyanotic, the countenance livid, consciousness gone, the pupils reacting. The hips were raised, hypodermics of ether were administered together with saline injections, followed by artificial respiration and heart massage. The pulse was imperceptible, but by auscultation the heart beat was found to be 30 to 40 per minute. The bleeding had now entirely ceased. The condition of the patient changed from time to time and she was kept alive for five hours by the continuous use of artificial respiration. At the post-mortem, a quantity of large and small air bubbles escaped when the right heart was opened under water; it contained much liquid blood. The left heart was empty and contracted, the heart muscle and valves normal. Both lungs contained air and on section a quantity of bloody froth exuded. There was some air in the smaller branches of the pulmonary artery, but none in the larger branches.

The cause of death was undoubtedly air embolism.

The important question in this case is "How did the air get into the circulation, and how did she live for five hours afterward?"

In Heuck's and Kramer's cases, strong pains set in immediately after rupture of the membranes, before version was performed. Heuck's opinion was that the air which was between the uterine wall and the separated portion of the placenta was forced by these pains into the veins, whence it was aspirated into the spermatic vein and so into the vena cava and right heart by the sudden lowering of abdominal pressure and the cessation of uterine contractions. Kramer thinks it more probable that after the cessation of the pains a deep inspiration made the blood pressure in the abdominal veins negative and rendered the entrance of air easier. A mechanical pressing inwards of the air by the operator's arm which tamponed the vaginal outlet, and the sudden outflow of liquor amnii may have been subsidiary causes. Freudenberg considers the sudden discharge of liquor amnii under high pressure to have been the principal cause, but in Lessé's case there was only a moderate quantity of liquor amnii flowing away with little force. Lessé's explanation is that air was carried up by the hand during the operation of version and was mechanically forced into the open lumina of the veins. That the patient lived for five hours he thinks explainable by the continued use of artificial

respiration and the slow accumulation of air in the right heart. These cases prove that version in placenta previa is attended by danger, quite independent of ammonia from hemorrhage. When performing version in such cases, the danger of air embolism should be borne in mind and the manipulation should be as gentle as possible.

Is Uterine Tympanitis an Indication for Cesarean Section?

AMFIELD. "Gibt Tympania uteri eine Indication zur Entfernung des uterus in partu?"—*Zeitschrift für Geburtshilfe und Gynäkologie*. Band, xxxv. 2. Heft.

The Porro operation of Ludwig in Sept., 1895,¹ and the Singer operation of Esser² in Jan., 1896, for the termination of labor complicated with *Tympania Uteri* have been variously criticised by German obstetricians, and a warm discussion has ensued respecting the circumstances which warrant the extirpation of the uterus during or after labour. Esser did a conservative C. Section after he had failed to deliver with forceps an immature fetus with enormously distended abdomen. He might have perforated the abdomen and delivered without much difficulty, but fearing to expose the mother to the risks of sepsis from the possibly decomposed or purulent fetal tissues he preferred to do a Singer operation. Fritsch, Chrobak, Dohrn and Ahlfeld criticised his treatment, declaring that C. Section was not indicated under the circumstances. In Ludwig's case, the patient was in her 14th pregnancy and the child was unusually large. The physician in attendance extracted the head with forceps and brought down one arm but could not deliver the rest of the body. A second physician having also failed, the patient was finally transferred to Chrobak's Clinic. On admission the temp. was normal, pulse 120, uterus tympanitic, and an intolerable stench proceeded from the passages. On account of the softness and friability of the fetal tissues, it was found impossible to use force enough to extract the child's body. Podalic version was then attempted, and one foot was brought down, a quantity of gas escaping during the manipulation; but the leg tore away at the knee and delivery could not be effected on account of the size of the child and the softness of its tissues. A Porro operation was then performed and a child weighing upwards of 7,700 grammes was extracted. The Porro operation was selected because it was thought that delivery by embryotomy would have taken a long time and would have exposed the mother to serious risks. Ludwig gave it as his opinion that in a roomy pelvis, unusual size of

¹ *Centralblatt f. gyn.* 1896. No. 8.

² *Centralblatt f. gyn.* 1896. No. 12.

the fetus together with softness and friability of its tissues would make delivery so difficult that C. Section should be preferred to embryotomy in the mother's interests. On the other hand, Ahlfeld criticises Ludwig's views and practice, holding that delivery could have been accomplished better otherwise, and that C. Section was unnecessary. Chrobak supports Ludwig's contention on the ground that the radical removal of the uterus was indicated on account of the sepsis which existed, especially as the loss of the uterus would no longer be of so much importance to the patient on account of her age and the size of her family (14th pregnancy, 13 living children).

In discussing these cases, Ahlfeld proposes the following questions:

(1) Is *tympania uteri* during labour an indication for C. Section (Porro)?

(2) Has the obstetrician the right to remove the uterus for the purpose of sterilising the patient?

While considering the first question it must be remembered that a large number of women who have developed *tympania uteri* during labour have recovered without operation, and have even had a normal puerperium. In cases of uterine tympanitis, the obstetrician is seldom in the position to give a prognosis *quoad vitam* with any degree of certainty. In the present state of our knowledge, we can not predict in any individual case that without operation the patient will die nor that the removal of the uterus will save her life. On the contrary, delivery by embryotomy with subsequent cleansing and disinfection of the uterine cavity will be more likely to yield favourable results. Moreover if blood-poisoning is so far advanced that an unfavourable prognosis is warranted, the removal of the uterus will no longer help matters, according to Ahlfeld. In his own practice, in cases of fever during labour and septic endometritis, he has obtained excellent results by washing out the uterus with alcohol immediately after delivery. He uses several litres of a 50 per cent. alcohol. The treatment is not painful and no ill effects have been noticed, the puerperium being in many cases normal or complicated with only a slight rise of temperature.

It is more difficult to answer the second question, whether an obstetrician is warranted in removing the uterus for the purpose of sterilising the patient. There can be no question of the advisability of such a course when pregnancy is complicated with such pathological conditions as carcinoma or fibroma uteri or osteosarcoma; but it is an entirely different matter when it comes to the removal of the uterus from a previously healthy woman for some impediment to delivery.

The wishes of the patient, her family and friends must be taken into account in such a case. The endeavour of every obstetrician should be to bring the mother safely through labour without damaging her genital organs or interfering with their subsequent ability to function. Ahlfeld concludes that the removal of the uterus is indicated during or after labour, only in those cases where life is to be directly saved by the operation (as in uncontrollable hemorrhage or septic endometritis (?)), or where there is some complication independent of delivery itself (as fibroma, carcinoma or osteomalacia.)

The Use of Steam in Puerperal Endometritis.

EMANUEL KAHN. "Die therapeutische Anwendung des Dampfes gegen Endometritis puerperalis." *Centralblatt f. gyn.*, 5th Dec. 1896.

After eight or nine years experience of steam in uterine surgery, Prof. Snegirjow in 1895, recommended its use as a cauterant and hæmostatic, claiming that it checks hæmorrhage, destroys odour, lessens the sensibility of the internal uterine wall, and possesses valuable antiseptic properties. It has since been used with success in cases of inoperable cancer of the corpus uteri, in hyperplastic endometritis, in putrid abortion and recently in puerperal endometritis. The apparatus consists of a metal reservoir mounted on a stand, heated by a large spirit lamp or gas flame. From the top projects a thermometer registering up to 200° C. The steam is conveyed from the dome of the reservoir by means of elastic tubes to which may be attached nozzles of various shapes and sizes. A stop-cock is provided to regulate the passage of the steam. The nozzle is passed cold into the uterine cavity through a speculum; the steam is turned on and made to play upon the affected part in a single jet or in several small jets according to the requirements of the case. The temperature of the steam is kept at 100° C. for two minutes and is then raised to 115° for a quarter of a minute to a minute. The steam fills the uterine cavity stretching its walls and exciting powerful contraction. The patient feels no discomfort except the slight pain caused by the strong uterine contraction. No subsequent ill effects have been noticed even in cases where the infective process had already spread into the tissues around the uterus. The powerful uterine action excited by the steam is found to continue and involution is more rapid. In regulating the temperature of the steam and the time of its application, the consistence of the uterine wall must be taken into account. The thinner and softer it is, the lower should be the temperature of the steam; the thicker it is, the higher may be the temperature used, and the stronger will be its action. If there is

inflammation without as yet pus formation, the results will be good; but steam should not be used if there are collections of pus in the tubes. If there are blood-clots in the uterus or portions of placenta or membranes, they must be first removed by means of the finger or curette, as steam hastens decomposition in such materials. When steam is brought directly in contact with the internal uterine surface, the scalded endometrium forms a protective covering preventing fresh infection. The subsequent treatment consists of an intra-uterine douche on the second or third day of hot sterilised water or an ordinary saline solution or a one per cent. lysol solution. Nine case-reports are given with temperature charts, and the author concludes that steam applied thus to the uterine cavity

- (1) is without injurious results and but slightly painful;
- (2) removes or diminishes uterine tenderness;
- (3) arouses powerful uterine contraction;
- (4) removes odour;
- (5) destroys bacteria directly;
- (6) through the closure of the blood and lymph vessels by the coagulation of albumen, forms a protective covering beneath which fresh granulations form.

J. C. Cameron.

Pediatrics.

Treatment of Scarlet Fever.

CAILLÉ. "Scarlet fever, prevention and disinfection."

ACKER. "The hygienic management and general treatment of scarlet fever."

JACKSON. "The treatment of the throat, nose and ear in scarlet fever."

NORTHUP. "The treatment of scarlet fever in the Willard Parker Hospital."—*Archives of Pediatrics*, November, 1896.

In these four papers we have the treatment at present employed in scarlet fever by some of the most eminent of American writers on diseases of children.

With regard to the question of prevention, the character of the germ, its condition of life, and the method of its transmission from one individual to another, naturally arise; and, although the microbe itself has not yet been isolated, all agree that it is a specific poison, capable of reproducing itself and transmitted mainly by personal intercourse. The presumption is also in favour of its entering the system by the naso-pharynx and respiratory tract, hence Caillé advises washing out with salt water several times a day the nostrils of children exposed to the disease, in order to remove as far as possible any decomposing secretions present there. He considers the view that domestic animals can themselves suffer from the disease and convey it to man as not proven, the milk and drinking water epidemics, reported from time to time, being necessarily lacking in bacteriological proof.

On the point of incubation and duration of infection one gets no information. A limit of three weeks must elapse after exposure before freedom from attack is secured, and an isolation of at least six weeks is demanded (Caillé).

Preventive measures are to be carried on in three ways: 1. Isolation of the patient and avoidance of the sick room; 2. Disinfection (personal and of rooms); 3. Ventilation to prevent concentration of poisonous matter. To the usual directions contained in all text-books are added a few practical points, such as, not allowing the nurse to take food in the patient's room, but requiring her before going to meals to disinfect hands and arms with green soap and 1-2000

bichloride, and to put on a long loose gown which hangs outside of the sick-room. Again, of using the same disinfectant, 1-2000, for her hair as for her body at the termination of the case. In all cases the removal of the patient to an isolating hospital, if possible, is to be insisted upon as the best means of preventing the spread of the disease. In schools, attention is drawn to the excellent breeding ground for germs which is provided by a small, hot room, densely packed with damp overcoats and wraps. Caillé also refers to a point made by him on several occasions, that scarlet fever is more prone to attack children with carious teeth, large tonsils, and adenoid growths; and finally he considers sulphur fumigation as absolutely valueless, and advises a trial of chlorine as a substitute.

For the fever no treatment is required in the mild cases, which constitute nearly ninety per cent. of the whole. They, however, must be put to bed and given fluid diet for the first two weeks, soft food for the third week, and solids only after they are allowed up. Acker would make the dieting even more rigid, keeping entirely to milk until desquamation is well advanced.

High temperature demands the use of antipyretics, and in hospital practice at least, all others have been abandoned for cold water, either in the form of sponging, baths, or wet packs. Acker advises beginning with the milder tepid sponging and going on to baths if necessary. Northrup alludes to the inherited fear of treating exanthemata by cold water on account of the danger of the eruption "striking in," and insists most strongly on the paramount importance of reducing the temperature by this, the only means at our command. In mild cases he modifies the wet pack by keeping warm blankets applied to the extremities, while the face and trunk are being freely sponged. The grave cases of hyperpyrexia are put at once into tub baths and treated vigorously until the cerebral symptoms and quality and rapidity of the pulse beats show that the temperature is being reduced. "This struggle with excessive temperatures early in the eruptive stage of scarlet fever is as imperative as that of sunstroke, and more prolonged. . . . At the Willard Parker Hospital it is considered a duty very becoming to the most experienced man on the staff to personally superintend the early bathings."

The eruption, which from its itching and burning, is a constant source of irritation in many cases, Acker treats by oiling the entire surface with some bland oil or bacon rind. He mentions a number of substances lately in favour for this purpose, among others carbolic acid, eucalyptus oil, and ichthyol.

Irrigation of the throat by very hot saline or boric acid solutions

seems to meet with general favour. For the nose, however, Jackson considers that irrigation increases the danger of otitis media through inflammation of the Eustachian tubes. Spraying, provided the child does not snuff up the solution, and wiping out the anterior nares with pledgets of cotton soaked in boric acid solution are recommended.

Nephritis, the most serious of complications, it is impossible in many cases, even with the greatest care, to prevent. Where the onset is acute with headache, vomiting, stupor, convulsions and suppression of urine, diaphoresis is to be induced as rapidly as possible. Northrup gives a hot-tub bath followed by a wet pack with hot drinks and Dover's Powder. Copious draughts of water are given while the patient is in the pack. Nitroglycerine in doses of $\frac{1}{500}$ — $\frac{1}{200}$ of a grain every two hours, he has also found highly efficacious.

Among other complications one notes true diphtheria as distinguished from the usual membranous sore throat by the presence of the Klebs Loeffler bacillus, and Jackson points out how rarely the pseudo-membrane, spreads to the larynx, and how prone it is to invade the nostrils and be the direct cause, perhaps, of a fatal septicæmia. Affections of the joints, Acker looks upon as a form of rheumatism, and treats them as such with the administration of salicin or salicylate of sodium. Northrup, on the other hand, looks upon them as somewhat resembling gonococcal arthritis clinically, except that there is great local heat and redness. The only treatment used is cold locally followed by pressure and passive movements later on. In most of the cases recovery is complete.

G. Gordon Campbell.

Pathology.

"La Doctrine des Cirrhoses du Foie."

(Continued.)

The scheme of origins of connective tissue overgrowth in the liver given by me in the last number of the *JOURNAL* is not in any respect visionary. We obtain clear evidence that fibrosis may show itself, especially in one or other of the six regions mentioned. But it is equally true that when the different parts are so intimately connected, a fibrosis originating in one region must almost inevitably affect very seriously other regions and thus, save in the earliest stages of the disease, it is practically impossible to meet with uncomplicated cases of one or other form. Every cirrhosis recognized clinically is truly mixed. If, for example, obstructive disease of the large bile ducts leads to fibrous overgrowth around the interlobular bile ducts that overgrowth tends to affect the whole portal sheath, and the interlobular portal veins and the branches of the hepatic artery became sooner or later involved in the new growth; so also the disturbance does not only affect the bile ducts, but tells upon the bile capillaries of the lobules, and the apparent invasion of the periphery of the lobule characteristic of biliary cirrhosis would seem to be largely of the nature of a replacement fibrosis, the peripheral cells becoming atrophied. Thus too a portal cirrhosis does not merely affect the branches of the portal vein, but sooner or later implicates the other structures in the portal sheaths; and not only is this the case, but as Senator points out, the presence of one form of cirrhosis may render the conditions favourable for the subsequent development of another form.

Nevertheless I am strongly of the opinion that any classification of cirrhosis to be satisfactory must be based upon the primary anatomical lesion, for such classification alone can indicate or elucidate the causation and the clinical course of the disease.

It must be freely acknowledged that there is yet very much to be accomplished. Our knowledge of cirrhosis as of fibrosis in general is, as I have pointed out elsewhere, very imperfect and insecure. Still the many observations of the last five years, more especially of French workers, all, I think, support a classification such as that here suggested, and I cannot do better than pass in view the separate forms

pointing out how the anatomical classification is at the same time aetiological.

I. *Portal cirrhosis.* This, it does not need to be said, is already well recognized by all writers on the subject. There is a general consensus of opinion, on the part of recent workers, that it is of toxic origin, namely, that matters passing from the stomach and intestines into the portal blood set up irritation along the medium-sized branches of the portal vein and so predispose to the development of new connective tissue around them. Early stages of this condition show that there is a definite small cell infiltration in the portal sheaths. We have clear evidence of inflammatory disturbance.

By the contraction of and compression exerted by the bands of fibrous tissue is produced the typical hob-nailed or gin-drinker's liver. All recent writers point out that this last name is in many cases libellous. The condition is not confined to alcoholics. Drs. R. P. Howard, Rolleston and others have found the hobnailed liver in children who have never tasted alcohol in any form, while contrariwise the evidence of the post-mortem room is that the confirmed toper only exceptionally presents the small contracted liver. It is only true that in most cases of hobnailed liver there is a history of indulgence in alcohol. Krawkow¹ suggests that alcohol acts by inducing a gastro-intestinal catarrh which permits the absorption of poisonous substances from the intestines and these in their turn lead to the cirrhosis around the portal vessels. I would refer those interested in the relation between alcohol and cirrhosis to a very full abstract of the thesis by W. J. Kerr, in the *Manchester Medical Chronicle* of last year,² in which the matter is carefully studied, and in which it is shown that the typical alcoholic liver is enlarged and fatty. On the other hand several observers, mostly French, have shown that feeding animals with cultures of certain microbes, and the introduction into the circulation of filtered culture fluids in which bacteria have been grown, may equally lead to cirrhosis, and so the theory that atrophic or portal cirrhosis is due to toxic absorption is becoming very generally accepted.

II. *Biliary cirrhosis.* Biliary cirrhosis proper, like the main cause of biliary obstruction (gall stones) occurs most frequently in women, and, with Senator, I would distinguish this from the "hypertrophic cirrhosis" with jaundice. Rolleston has published a very instructive case of congenital obstruction (cystic liver) in which the growth of connective tissue around the bile ducts was admirably defined. At a later stage, as already indicated, the fibroid change spreads and im-

¹ Krawkow, Arch. de Med. Exp. et d'Anat. Path., No. 2, 1896.

² *Manchester Medical Chronicle*, New Series, IV., 1895-96, pp. 225 and 310.

plicates surrounding tissues, but into these subsequent effects of biliary obstruction I will enter when discussing pericellular cirrhosis.

III. *Arterial cirrhosis.* It is generally held that fibroid overgrowth around the branches of the hepatic artery is a rare condition, and that in general arterio-sclerosis, the liver shows no such arterial changes as are recognizable in the kidneys, spleen and other organs. It is true that in the liver the arteries do not stand out so prominently as they do in sections of the organs above mentioned. But it must be remembered that relatively to the size of the organ the hepatic arteries are in the healthy condition singularly small, and even when their walls are considerably thickened and present fairly extensive peri-arterial change, they may escape notice. Examining sections of livers from about one hundred consecutive necropsies I have been surprised to find that hepatic arterio-sclerosis is far from uncommon. At the same time I have encountered no extreme case of this condition. It may be very well marked in ordinary portal cirrhosis. Here the conditions leading to the periportal change lead also to general arterio-sclerosis, and it is difficult to say whether the "peri-arteritis" is of independent origin, or is an extension of the fibrosis affecting the portal sheaths in general.

From the fact that the bacterial products introduced into the general circulation may induce cirrhosis, Rolleston is inclined to urge that the cirrhosis in such cases originates through (? or around) the hepatic artery, and is consequently of arterial origin. This may be so, but it does not strictly follow: that is to say, the poison in such cases circulates through all the system and reaches the liver by the larger portal as well as by the smaller arterial circulation. We require further details as to the character and distribution of the fibroid change in these experiments.

On the whole therefore it must be admitted that primary arterial cirrhosis, in the sense employed by me, leads to relatively slight hepatic disturbance. Clinically this form does not seem to be capable of recognition.

IV. *Secondary.* This form also is clinically unimportant. From a pathological standpoint it is important inasmuch as it calls attention to the fact too often neglected that in the production of fibrosis the lymph channels of an organ play a very prominent part. In portal cirrhosis for example it is not the toxic agents circulating in the portal veins that directly set up the fibroid change, but rather it is these same diffusible toxic agents transuding through the vessel walls into the surrounding lymph spaces and channels which there set up irritation and fibroid overgrowth. It is around the branches of the portal

vein that we see the small cell infiltration which we are accustomed to recognize as the earliest stage of portal cirrhosis.

In the extension of fibrous strands inwards from the thickened and chronically inflamed capsule of the liver, just as in the development of interstitial pneumonia secondary to chronic productive pleurisy, we can only explain the connective tissue overgrowth by assuming that toxic substances are conveyed from the surface into the organ along the lymphatics, and that in their course they set up that irritation which leads to connective tissue overgrowth.

V. *Centrilobular*. This form apparently only develops as a consequence of chronic heart or lung disease associated with passive congestion of the liver and the condition of nutmeg liver. Passive congestion in general may lead to fibroid overgrowth originating around the veins, and it is around the central intralobular branches of the hepatic vein that such fibroid overgrowth may at times be recognized. While sundry French observers would ascribe one form of hypertrophic cirrhosis to this central development of fibrous tissue, it is difficult to agree with them. The liver of passive congestion may be larger than normal but congestion is not hypertrophy, and associated with any degree of centrilobular cirrhosis there is marked atrophy of the liver cells, while the amount of connective tissue laid down is relatively slight as compared with what may be developed in perilobular cirrhosis. It is unfortunate that this term, hypertrophy has been introduced at all in connection with cirrhosis. This form also is incapable of being recognized clinically; it may be suspected in long continued obstructive disease. It is in every respect one of the minor forms.

VI. *Pericellular or Replacement Cirrhosis*. While I am inclined to think that in portal cirrhosis there is primarily an overgrowth of connective tissue around the medium sized branches of the portal veins and recognise a similar deposit occurring around the bile ducts, arteries and branches of the hepatic veins, there is another highly important deposition or development of new connective tissue in the liver which yet remains to be discussed, one which has up to the present received too little attention, although from time to time high authorities such as Kelsch and Wannebrouck, Hamilton, Beale, and Grandmaison have more or less directly called attention to it. This is the replacement fibrosis to which I referred at some little length in a recent communication.¹

Where isolated cells of a tissue or collections of cells atrophy and die there is in general an attempt to replace them, if not by cells of a similar nature, then by connective tissue, or, failing this, by fluid (as

¹ Middleton Goldsmith Lectures. N. Y. Medical Record, March, 1896.

in some cyst formations.) A replacement fibrosis of this nature may be localised, as after scattered necroses through the liver substance. Such fibrosis very possibly explains in part the cirrhosis occurring in malaria, and in those infectious and septic diseases in which sporadic necroses of the liver are becoming more frequently recognized.

Or on the other hand it may be more generalised, affecting the periphery of the lobule or in some cases the whole lobule. In the Pictou cattle disease this could be seen in its various stages. Pictou cattle disease is a chronic, infectious disease of cattle in Nova Scotia characterised especially by extensive cirrhosis of the liver. In early cases, as first pointed out by Dr. Wyatt Johnston, the liver cells show various evidences of degeneration, and this stage is followed by atrophy so extensive that in advanced cases all the cells of some lobules may become unrecognisable, their place being taken by a delicate connective tissue. In other regions, short columns of the atrophied cells may be isolated and surrounded by similar connective tissue, while, as in biliary cirrhosis, there may be very numerous imperfectly formed bile canals, examples of what I have termed "reversionary" degeneration of the liver cells. Along with this there is in general singularly little small-celled infiltration. The process is essentially one of atrophy of the liver cells by toxic agency followed by replacement fibrosis.

In congenital syphilis the process appears to be of a like nature and, in acquired syphilis, accompanied by multiple gummata in the liver I have seen a very similar condition for a considerable distance around some of the more recent formation infiltrations.

In syphilis, however, the process is frequently complicated by not a little small-cell infiltration and the presence of cellular gummata.

In Hanot's hypertrophic cirrhosis, and in the cirrhosis following biliary obstruction the periphery of the lobules presents the same process, complicated in the latter case by changes of another nature.

It is interesting to note that in all cases where this pericellular cirrhosis is well marked the liver tends to be enlarged—hypertrophic—or if not enlarged is not found hobnailed. There appears to be a difference in the way in which the new connective tissue is laid down. Whereas in ordinary portal cirrhosis there is a frankly inflammatory infiltration of small round cells, followed by connective tissue growth, the new tissue is typically cicatricial, *i. e.*, with full development it contracts very markedly, and so produces the hobnailed condition. In such cases the atrophy of the liver cells is secondary and is in the main due to the presence of the fibrous bands. In the cases of extensive replacement cirrhosis above referred to, there is curiously little

small-celled infiltration ; a loose transparent connective tissue develops which evidently is not nearly so prone to contract.

Degeneration and atrophy of the liver cells may be brought about in four ways :

1. By pressure.
2. By toxic substances reaching the cells by the circulation.
3. By toxic substances reaching them along the bile capillaries.
4. By arrest of function resulting from obstruction of the bile ducts.

To the first of these I have already referred : the contraction causing the atrophy does away with the opportunity for a replacement fibrosis. About the third possible way we know little. It is unlikely that toxins should diffuse up the bile canals in a direction contrary to the flow of bile. With regard to bacteria penetrating the liver along the bile ducts and producing toxins we are in doubt. We know from the researches of Welch, Flexner and others that pathogenic microbes are not infrequent in the gall bladder, and in the last two cases of hobnailed liver coming to the postmortem room of the Royal Victoria Hospital I was not a little surprised to gain cultures of the *B. coli communis* (the most common form to be found in the gall bladder) from the liver juice when other glandular organs did not show this form. But on the whole it is for the present to be regarded as unlikely that degeneration of the liver cells and cirrhosis are induced to any considerable extent by toxic agencies passing up the bile ducts and capillaries. It would seem more probable that obstructed and perverted action of the liver cells by closure of the bile ducts, leads to their degeneration.

The other two are, it would seem, the main causes, arrest of functions by obstruction and intoxication from the blood.

It may well be that as Senator suggests Hanot's hypertrophic cirrhosis differs from the biliary cirrhosis of obstruction.

The ecchymoses which are one symptom of the former disease are suggestive of an infectious agency, as again is the accompanying leucocytes. As Hanot and Meunier have shown¹ the number of white corpuscles in the blood of five cases was increased to 13,000 or 20,000 per cb. mm. No such leucocytosis is observable in ordinary atrophic or hypertrophic cirrhosis. It may well be that the cirrhosis of Hanot's disease like that Pictou cattle disease and congenital syphilis is of bacterial origin and hæmatogenous (if the expression be permissible) and that herein lies the distinction between it and the cirrhosis following biliary obstruction.

Briefly to sum up the conclusion to be arrived at from the analysis

¹ Soc. de Biol. Jan. 25, 1895.

of the forms of fibroid change which may manifest themselves in the liver, it would appear that some—the arterial and centrilobular—are clinically unrecognisable; one (that secondary to perihepatitis) may lead to a contracted condition and uneven surface of the organ resembling portal cirrhosis; another, portal cirrhosis, is clinically and histologically the most sharply defined form; biliary cirrhosis proper would seem to present a combination of replacement and irritative fibroid changes, and according to the relative extent of one or the other do we obtain either enlargement or contraction of the organ. While where the liver cells undergo primary degeneration and atrophy we obtain characteristically replacement fibrosis with little tendency to contraction but on the contrary with some enlargement of the organ.¹ This replacement fibrosis following upon degeneration of the cells appears to account for a large number of the anomalous and debatable forms of enlarged cirrhotic liver.

J. G. Adami.

¹ This enlargement would seem to be due not so much to an excessive development of connective tissue as in part to active proliferation of the liver cells, replacing those that have atrophied, in part to an infiltrated, almost oedematous condition of the new connective tissue. Jaundice may or may not accompany this form. Where it is present it is due, not to obstruction of the larger ducts, but probably as Hunter has suggested in another connection to a catarrhal condition of the bile capillaries and a modification of the excreted bile.

Canadian Medical Literature.

[The editors will be glad to receive any reprints, monographs, etc., by Canadian writers, on medical or allied subjects (including Canadian work published in other countries) for notice in this department of the JOURNAL. Such reprints should preferably be addressed to Dr. Kenneth Cameron 903 Dorchester street, Montreal.]

PERIODICALS.

OCTOBER, 1896.

THE CANADIAN PRACTITIONER.

Some recent developments in Medical Science—Geo. A. Peters, Toronto, p. 700.

The operative treatment of mammary carcinoma—W. Burt, Paris, Ont., p. 722.

THE CANADA LANCET.

Operation for volvulus of the vermiform appendix—F. L. Vaux, New York, p. 59.

Symphysiotomy—Alex. Forin, Duluth, Minn., p. 61.

CANADA MEDICAL RECORD.

Notes of a trip to Jamaica—W. H. Drummond, Montreal, p. 1.

Montreal General Hospital notes—F. W. Campbell, Montreal, p. 4.

THE CANADIAN MEDICAL REVIEW.

Inaugural Address—Toronto Clinical Society—By the President, Dr. Allan Baines, Toronto, p. 43.

The theory of eliminative and antiseptic treatment of typhoid fever—W. B. Thistle, Toronto, p. 97.

Clergyman's sore throat—Price-Brown, Toronto, p. 100.

THE DOMINION MEDICAL MONTHLY AND ONTARIO MEDICAL JOURNAL.

Proceedings at the meeting of the Medical Council of Ontario (continued) p. 369.

THE MARITIME MEDICAL NEWS.

Address in Surgery, at the meeting of Canadian Medical Association, Montreal, Aug. 27th, 1896—John Stewart, Halifax.

L'UNION MÉDICALE DU CANADA.

Le Goitre, son traitement médical et chirurgical—D. Marsil, St. Eustache Que., p. 577.

Traitement de l'éclampsie puerpérale—E. A. René de Cotret, Montreal, (suite et fin), p. 584.

Traitement des affections syphilitiques du globe oculaire par les injections intra-veineuses de cyanure d'hydrargyre—Jehin Prume, Montreal (suite et fin), p. 589.

LA CLINIQUE.

De l'épithélioma de la face, et de son traitement (suite)—Jehin Prume, Montreal, p. 86.

KINGSTON MEDICAL QUARTERLY.—Vol. 1, No. 1.

Some diseases of bone—D. E. Mundell, p. 5.

Foreign body in right bronchus—W. G. Anglin, p. 10.

Obstetrical and gynecological notes—R. W. Garrett, p. 13.

Puerperal eclampsia—E. Ryan, p. 17.

Food for infants—L. Wood, p. 21.

Two cases of intraocular hemorrhage—J. C. Connell, p. 25.

"True" or grave diabetes—pancreatic treatment—D. E. Mundell, p. 28.

Antitoxic treatment of diphtheria—W. T. Connell, p. 29.

MEDICAL NEWS, (OCT. 31ST).

Peripheral Neuritis—Alexander McPhedran, Toronto, p. 185.

NEW YORK MEDICAL JOURNAL, (OCT. 17TH.)

The functional value of cortical cerebral motor centres in different animals—
Wesley Mills, Montreal.

(OCT. 31ST.)

On the application of the serum diagnosis of typhoid fever—Wyatt Johnston,
Montreal.

NOVEMBER, 1896.

THE CANADIAN PRACTITIONER.

Skin, hair, and nail lesions, produced by the action of "X" rays—E. F.
King, Toronto, p. 780.

A report of forty cases of diphtheria treated with antitoxine—A. B. Eadie
and T. F. McMahon, Toronto, p. 791.

A note on amputation at the hip-joint in advanced tuberculous disease—A.
Primrose, Toronto, p. 799.

THE CANADA LANCET.

A case of septicaemia with endocarditis, complicating gonorrhoea, recovery—
H. B. Anderson, Toronto, p. 113.

An appendix abscess perforating the diaphragm, and discharging through a
bronchus, also perforating an intercostal space—A. McPhedran, Toronto,
p. 115.

CANADA MEDICAL RECORD.

Thrombosis of the petrosal, cavernous and circular sinuses occurring in scarlet
fever, and due to acute suppurative otitis media, J. W. Stirling, Mont-
real, p. 49.

Clinical lecture delivered at the Western Hospital (Department for diseases
of the Throat and Nose), G. T. Ross, Montreal, p. 51.

THE CANADIAN MEDICAL REVIEW.

Typhoid fever—W. J. Wilson, Toronto, p. 127.

THE DOMINION MEDICAL MONTHLY AND ONTARIO MEDICAL JOURNAL.

One hundred cases of retroversion of the uterus treated by ventrofixation
and Alexander's operation, with subsequent results, A. Laphorn Smith,
Montreal, p. 481.

Appendicitis—Dr. Schooley, Welland, Ont., p. 488.

The differential diagnosis of "Neurasthenia" and its treatment—Elmore
S. Pettyjohn, Alma, Mich.

Evisceration of eyeball, with sclero-optic neurectomy—Ernest Hall,
Victoria, B.C., p. 495.

A case of fracture of the skull—Hamilton Merritt, St. Catharines, Ont., p.
497.

Prolapse of uterus—Dr. Armour, St. Catherines, Ont.

THE MARITIME MEDICAL NEWS.

Chronic seminal vesiculitis—Foster MacFarlane, St. John, N.B., p. 341.

Puerperal Eclampsia—F. F. Kelly, Charlottetown, P.E.I., p. 352.

L'UNION MÉDICALE DU CANADA.

Le goître, son traitement médical et chirurgical—D. Marsil, St. Eustache,
p. 641.

- La médecine moderne—E. P. Benoit, Montreal, p. 650.
 De l'emploi du séro-diagnostic de Widal, dans la fièvre typhoïde et de sa mise en pratique dans les laboratoires d'hygiène—Wyatt Johnston, Montreal, p. 661.
 Les écoles vétérinaires en Canada—M. F. T. Daubigny, M.V., Montreal, p. 666.

LA CLINIQUE.

- De l'épithélioma de la face et de son traitement (suite)—Jéhin Prume, Montreal, p. 125.

DECEMBER, 1896.

THE CANADIAN PRACTITIONER.

- The serum diagnosis of typhoid—J. J. Mackenzie, Toronto, p. 869.
 The better operation for hæmorrhoids—F. L. Vaux, New York, p. 872.
 Chairman's address at the tenth annual banquet of the Medical Faculty of the University of Toronto—A. T. McNamara, p. 876.
 A report of three cases of post-typhoid neuritis—Geo. J. Preston, Baltimore, p. 882.

THE CANADA LANCET.

- A case of cerebellar ataxia—Campbell Meyers, Toronto, p. 167.
 A critical view of the modern methods of operating for the cure of inguinal hernia—J. Coplin Stinson, San Francisco, Cal., p. 169.

CANADA MEDICAL RECORD.

- Neuralgia of the peripheral nerves, with special reference to that dependent on trauma or degenerative changes—Thomas H. Manley, New York, p. 115.
 Faith cures and auto-hypnotism—R. J. Midgley, Montreal, p. 128.

THE CANADIAN MEDICAL REVIEW.

- Syphilis and its treatment—A. R. Robinson, New York, p. 159.

THE DOMINION MEDICAL MONTHLY AND ONTARIO MEDICAL JOURNAL.

- Tapeworm—A. Bethune, Seaforth, Ont., p. 593.
 Report on contagious diseases for the quarter—C. H. J. Chipman, Ottawa p. 600.
 The surgical treatment of retro-deviations of the uterus—Augustin H. Goelet, New York, p. 601.

L'UNION MÉDICALE DU CANADA.

- La bactériologie, l'hygiène et la médecine—E. P. Lachapelle, Montreal, p. 705.
 Contrôle des hémorragies des voies respiratoires supérieures—H. M. Duhamel, Montreal, p. 712.
 Des principales cause d'insuccès dans l'opération qui a pour but la suture du col utérin—A. L. Smith, Montreal, p. 715.

LA CLINIQUE.

- Les bains électriques et la dyspepsie—Adelstan de Martigny, Montreal, p. 174.
 La syphilis cause d'avortement—J. A. Ouimet, Valleyfield, Q., p. 182.

THE BRITISH MEDICAL JOURNAL (DEC. 5TH.)

- Clinical lecture on operative interference in typhoidal perforation—G. E. Armstrong, Montreal, p. 1621.
 Observations on the serum reaction in typhoid fever and experimental cholera by the dried blood method—Wyatt Johnston and D. D. McTaggart, Montreal, p. 1629.
 Observations upon the relation between leukæmia and pseudo-leukæmia—C. F. Martin and G. H. Mathewson, Montreal, p. 1634.
 Editorial on the sixty-fifth annual meeting of the British Medical Association to be held in Montreal, 1897, (with illustrations), p. 1647.

(DEC. 12.)

Notes on the composition of the blood serum in pernicious anæmia—R. F. Ruttan and J. G. Adami, Montreal, p. 1700.

(DEC. 19.)

The artificial feeding of children—Andrew Macphail, Montreal, p. 1706.

ARCHIVES OF PEDIATRICS.

Notes on a case of insolation in an infant thirteen months old—Henri A. Lafleur, Montreal, p. 908.

Lesions produced by the action of "X" Rays—E. E. King.

An interesting case is reported of a man who, while giving public exhibitions of the "X" rays, was exposed for from two to six and eight hours daily for about eight months. About the middle of the third month the right hand, which had been towards the coil and tube, began to swell, and large blisters accompanied by great pain appeared on the dorsal surface. Treatment by picric acid rendered the hand less susceptible and he continued to use the apparatus. Later on the cheek became swollen and tender on the exposed surface but was not blistered. There was œdema of the eyelids, and conjunctivitis. A metal shield was used without affording any protection and he had to give up the work. In about three weeks the injuries had healed, there being only an amount of tenderness remaining. When seen some time later, the hands were examined and the skin was noticed to be infiltrated, unusually smooth, congested, and on the left almost entirely free from hair. All the nails were exfoliating, there being two ridges which clearly showed two distinct injuries. The left side of the face showed an entire absence of hair in the region of the temple and for some distance behind the ear; the eyebrows, except a small portion remaining near the nose, the moustache, the whiskers of the cheek, chin and neck, on the left side were almost all gone. That side of the face was nearly smooth and of a very different feeling from the other. There was a subacute conjunctivitis, and he thought that the sight was somewhat impaired.

A Case of Cerebellar Ataxia—Campbell Meyers.

This case, which was exhibited before the members of the Canadian Medical Association at the recent meeting in Montreal, first came under the writer's notice on December 24th, 1895. He was seventeen years old and an only child, and had been attending school regularly. His paternal grandfather died at 75 of diabetes mellitus, his maternal grandmother of consumption, and his maternal grandfather of locomotor ataxia. His mother was of a nervous disposition but otherwise healthy. His father was healthy without any suspicion of specific disease. No trace of a like condition could be found among his relatives.

He was born by the aid of forceps but the labour was not prolonged nor attended by any serious difficulties. He began to walk early, and no defect in his development or health was noticed until he was three years of age, when he began to suffer from diabetes insipidus and which has continued. Five years ago sugar appeared in the urine, in considerable quantity, but disappeared after treatment. Three years ago it was first noticed that his gait was affected and had become steadily worse. His speech, at times, was peculiar. His general health was good. Thirst had always been extreme. Condition on examination showed the patient to be a well developed boy without any noticeable deformity about the head or body. The knee jerks were decidedly increased and there was moderate ankle clonus on both sides, the wrist, elbow and superficial reflexes were very active. Jaw jerk absent. There was no disturbance of sensibility. The gait was uncertain and staggering, the feet being placed widely apart. He could not start to do anything quickly. When attempting to walk he hesitated for a moment, started, walked with uncertainty and turned round with difficulty. His speech was slow and scanning, the separate syllables being all pronounced. Movements of the muscles of the face were slow. Innervation seemed equal on both sides, the muscles did not remain unduly contracted nor were there contractions of any of the skeletal muscles. His movements were awkward and often it was with difficulty he could prevent himself from falling backwards. He had a certain amount of difficulty in bringing his finger tips together when the eyes were closed. He could not stand steadily when his feet were together, nor could he maintain his balance when one foot was placed immediately before the other even with the eyes open, but he at once fell sideways if the eyes were closed. There were no defects in smell, hearing or taste; urine sp. gr. 1008, pale and clear, no sugar or albumin present; discs were normal. A chart of the field of vision showed a bilateral contraction in the outer part for white, a more marked concentric contraction for red and decidedly contracted field for green. Central colour sense was good. There was no irregular contraction of the pupils; no appreciable heterophoria with the phorometer, though the right eye appeared to roll upwards. Slight nystagmus if the eyes were fixed in an upward position.

Reviews and Notices of Books.

A Practical Treatise on Medical Diagnosis. By J. H. MUSSEY.
M.D. Lea Brothers & Co., Philadelphia. 1896.

The number of books on medical diagnosis is legion, but among them all it has been hard to find one which can satisfactorily fulfil the requirements of the student and busy practitioner. In one, we find elaborate treatises on the physical laws governing auscultation and percussion, instead of practical diagnostic points alone; in another rather than the essential chemical tests for clinical examinations, the author obliges the reader to cull out of many pages the best and simplest means of chemical diagnosis—while in a third we find the volume so uneven in its quality as to render many chapters practically of no value.

It may truly be said, however, that Dr. Mussey's work has overcome all these failings, and that the medical student will find a clear, concise and well arranged text-book, giving all the essential features of medical diagnosis in an admirable style.

The illustrations and charts are excellent, the various chapters admirably subdivided for mental classification, and the tests as given include all that is necessary without burdening one's memory or occupying too much of the reader's time.

The chapter on the bacteriological diagnosis, in which the author has evidently drawn largely upon Abbott, is short and comprehensive. There is perhaps scarcely enough said of the clinical aspects of the typhoid bacillus, and hardly enough insistence on the absolute necessity of a bacteriological examination of cases of tonsillitis as differentiated from those of diphtheria.

The malarial parasite of the tertian variety sporulates within 48 hours, not 4, as stated.

We have looked in vain for numerous names in the index, the insertion of which would give added facility to the reader, though in other respects the whole arrangement is beyond criticism.

The chapter on diagnosis by electrical reaction could not be more clear, though in the synopsis of the various nervous diseases some important symptoms are omitted, while in other places the symptoms are given rather too dogmatically, for example, in the remarks on hereditary ataxia no mention is made of the foot deformities, while it is further said that reflexes are lost, though we do not think this by any means always the case absolutely. More information regarding the stigmata of hysteria with reference to abnormalities would have been acceptable.

All in all, however, the work is the best of its kind yet published, a great improvement on the previous edition and an invaluable aid to the medical student, the general practitioner and the teacher.

C. F. M.

Literary Notes.

Mr. W. B. Saunders announces, for early publication, a new book entitled "Anomalies and Curiosities of Medicine." It is the result of several years of work by the editors, Geo. M. Gould and Walter L. Pyle, and is to be a complete encyclopedia and book of reference on the subject. This will make it especially useful to all who are interested in sociological and scientific topics, as cases have been collected from all sources, both ancient and modern. The whole has been carefully indexed so that reference is easy, and foot notes, showing whence the information has been derived, are added.

It promises to be a most complete work, of use to both the physician and surgeon, as well as the specialist, and will merit a careful inspection.

Mr. E. B. Treat announces that the 1897 volume of "The International Medical Annual" will soon be issued. It is a condensation of the principal work done in the medical world during the past year and comprises a review of therapeutics with articles on new remedies and their uses, a dictionary of new treatment giving the latest methods of treatment of various diseases, both medical and surgical, the whole being well illustrated. New instruments and appliances are also figured. The work is so well-known that it has merely to be mentioned to be recommended.

Society Proceedings.

MONTREAL MEDICO-CHIRURGICAL SOCIETY.

Stated Meeting, November 9th, 1896.

GEORGE WILKINS, M.D., PRESIDENT, IN THE CHAIR.

Hypoplasia of One Kidney.

Dr. J. G. ADAMI read a paper on this subject, illustrating his remarks by two specimens. Will appear later.

Dr. WYATT JOHNSTON referred to five cases in his experience where there was absence or hypoplasia of one kidney. In one of these the death was due to a rupture of the remaining kidney, and in another the removal of the functionally active kidney was followed by anuria and death.

Serum Diagnosis in Typhoid Fever.

Drs. WYATT JOHNSTON and MACTAGGART communicated the result of three hundred and ninety observations on the serum reaction of typhoid. These were made, partly in hospital cases, and partly in cases when samples were received at the laboratory of the Board of Health of the Province of Quebec. The results obtained were shown in the following table:

Total cases of genuine or suspected typhoid.....	143
<i>Positive Results.</i> —Decision on first examination. (Of these complete reaction in 112; partial reaction, 6. Three of these before the third day)....	118
Doubtful on first examination; decisive on second examination. (Of these 4 were first examined before sixth day).....	5
Total positive results.....	123
<i>Negative Results.</i> —(Decisive cases proved by subsequent history to be something other than typhoid, viz.: meningitis, malaria, pneumonia, constipation, etc. 14	
<i>Negative results remaining in doubt.</i> —Mild cases of typhoid first examined during convalescence.....	3
Primary examination negative, clinical history typhoid, no re-examination..	2
Severe fever of typhoid type, negative results both by Widal and the dry method (examined three times).....	1
Total negative results in cases of possible typhoid.....	6

They considered that about 90 % of successful results could be obtained by the method in public health laboratory work, although typical hospital cases gave a much higher percentage. They had never met with a typical reaction apart from typhoid fever.

Dr. ADAMI congratulated Dr. Johnston on having worked out this simple method of diagnosis in typhoid fever. Although the author of

the paper had endeavoured to show that Dunham had been the originator of the serum reaction for typhoid, and that Widal had first popularised it, Dr. Adami thought that Dr. Johnston deserved still greater credit for having devised this simple test which was so generally applicable. It was evident that Widal was wrong in contending that the dried blood was not so good for examination as fluid blood. Without doubt this method would come into general employment in the health offices of cities throughout America and eventually in Europe.

Dr. H. A. LAFLEUR draw the attention of the Society to the great value of the test in differentiating the various febrile conditions grouped under the name of febricula. This term was mainly a cloak for our ignorance, and included among other things a certain number of cases of mild or abortive typhoid. If in any given case of so-called febricula the typhoid reaction of Widal was present, one should be on the watch for a possible relapse and should exercise caution in feeding

Dr. J. B. McCONNELL thought this an important method of detecting typhoid fever, not only in the earliest stages but in masked forms. Typhoid fever had so many anomalous forms, epidemics varied so much in their character, and difficulties in diagnosis were so frequent, that it certainly was to be regarded as a very great advance. In a few cases which he had sent to Dr. Johnston the diagnosis had been made at once. He had had a case recently in which he found it especially useful, it was a case of supposed malarial fever, but the symptoms also resembled those of typhoid. The patient had been in one of the city hospitals and had been discharged as being better, but he still felt ill and went around until at the end of three weeks he came to the Western Hospital. He had frequent chills and perfect intermissions of fever, some enlargement of the spleen with great depression, but no characteristic spots. An examination of the blood for plasmodia was negative except one slide which gave some evidence of the parasite, and this added to the difficulty of coming to a conclusion. The diazo reaction was present. A positive diagnosis was made by submitting a sample of the blood to Dr. Johnston. The man died, as most cases of ambulatory typhoid do, and the post mortem examination fully confirmed the serum diagnosis of typhoid fever.

Dr. F. G. FINLEY, speaking of the value of this method in cases of so-called febricula, cited a case which was brought into the hospital a few days previously with all the symptoms of typhoid, although they were not pronounced enough to enable him to come to a decision. He submitted a sample of the blood to Dr. Johnston who reported that it gave the reaction.

THE PRESIDENT thought that probably the first case on which Dr. Johnston had tried this reaction had been a patient of his who came to the hospital some time in September, presenting symptoms of typhoid. He had shortly before read an account in the *Progrès Médical* of Dieulafoy's attempt to make a diagnosis by this method.

Dr. JOHNSTON, in reply, said that in his first case the examination had been made at the request of Dr. Wilkins. In mild cases, clinically doubtful and when the reaction was ill marked the corroborative evidence obtained by bacteriological examination of the stools should be very valuable. The dry blood method had appeared to offer certain advantages for public health laboratory work, but was not necessary for hospital work. Dieulafoy had brought Widal's work before the Académie de Médecine, but had not himself modified the technique.

Bacteriological Method of Diagnosis in Leprosy.

Drs. WYATT JOHNSTON and W. H. JAMIESON read a communication on this subject, and exhibited slides illustrating this method. (See page 548.)

Stated Meeting, November 20th, 1896.

J. G. ADAMI, M.D., FIRST VICE-PRESIDENT, IN THE CHAIR.

The Presence of Tubercle Bacilli in Fæces from a Non-Tuberculous Intestine.

Dr. C. F. MARTIN read for Dr. R. B. SHAW and himself a report of this case. (See page 542.)

Dr. GORDON CAMPBELL thought this was an extremely interesting case. When one considered the difficulty often experienced in detecting tubercle bacilli in the stools in cases of tuberculous disease of the intestine, the fact that they had here passed through in sufficient numbers to lead to the diagnosis of that disease seemed remarkable. He asked for more particulars regarding the number found.

Dr. R. B. SHAW, in reply, stated that the bacilli were sufficiently numerous for three to be within the field of the microscope at one time.

Dr. J. G. ADAMI alluded to the fact that mucus was a very insoluble substance and was acted on but slightly by the intestinal juices. This, and the small quantity of fæces passed, were two considerations which favoured the finding of the bacilli in the present case.

Congenital Dilatation of the Colon.

Dr. C. F. MARTIN exhibited specimens from this case and read the report. Will appear later.

Dr. WESLEY MILLS drew attention to the dilatation of the colon sometimes occurring in the insane which he attributed to their inattention and want of regularity in their habits, together with the dulness of their senses. He referred to one case reported by him in a paper on hibernation where the dilatation was evidently produced by accumulation of fæcal matter.

Ambulatory Lobar Pneumonia.

Dr. G. G. CAMPBELL reported this case. (See page 551).

Stated Meeting, December 4th, 1896.

GEORGE WILKINS, M.D., PRESIDENT IN THE CHAIR.

Impetigo Contagiosa.

Dr. G. E. ARMSTRONG reported this case as follows:

This young man was admitted to the Montreal General Hospital on the 12th November, 1896. He is nineteen years of age and single.

This rash is now, as the result of treatment, much less distinct than on admission. It appeared first about six weeks before he was admitted to the hospital. It was first noticed on the lower part of the abdomen, then on the buttocks, afterwards extending to the over extremities. A little later it appeared on the arms and in the axilla. The back, chest and face have almost entirely escaped. In its geographical distribution then, it does not follow any special order, except that it is most abundant on those parts of the body, most likely to be infected by the patient himself in scratching. It has from the first been intensely itchy. No parasites were found on his body or clothing. He has lived in a rather crowded boarding house, but no other inmates of the house have suffered from any skin disease so far as he knows.

He is a leather cutter by trade, and has generally been in fairly good health. Uses alcohol and tobacco. Has had three attacks of gonorrhœa within the last twelve months, the last attack appearing fifteen days ago. There is no rheumatic or tubercular history.

The rash appears at first as slightly elevated papules which are very itchy, and after the irritation of scratching develop into pustules, and these rupture and form these thick crusts which you see. Several of them may be seen running together. The flexor and extensor surfaces seem to be about equally affected. The glands in the groin and the epitrochlear glands are enlarged. When admitted to the hospital the lower abdomen, buttocks and thighs were one mass of scabs. There was also a scab about the middle of the dorsum of the penis.

This case has had added interest in the hospital, from the fact that different views as to its nature have been held by different members of the hospital staff.

On the one hand it is contended that the rash is a syphilide, and the sore on the penis, the primary lesion. Against this theory is the patient's positive and persistent statement that the sore on the penis only appeared two weeks after the rash on the abdomen. Also it may be urged that there is no sore throat or falling of hair.

I have regarded the case as an impetigo, but just what was the source of infection I have not been able to determine with any degree of certainty. It has, to me, the appearance, of a case of neglected scabies, but no furrows or parasite have been discovered. He is rapidly improving, however, under the daily inunction of sulphur ointment and hot baths. The sites of the crust you notice are red, but hardly can be called copper coloured. I think the case of considerable clinical interest, and shall be glad to bear an expression of opinion from the members as to its nature.

A Series of Cases of Pelvic Hæmatomata.

DRS. WM. GARDNER and C. F. MARTIN read a paper on this subject (See page 521.)

Some Points in the Treatment of Potts Disease.

Dr. C. W. WILSON read a paper on this subject. To appear later.

Dr. T. G. RODDICK thought Dr. Wilson had covered the ground very thoroughly and agreed with almost everything he had said in regard to treatment. Mr. Howard Marsh's plan of keeping these cases in a recumbent position, a treatment which had stood the test of seventeen years, Dr. Roddick thought was the most satisfactory of any. With regard to Sayre's jacket he had given it a thorough trial. Having been present in Manchester when Dr. Sayre first demonstrated its use he became very enthusiastic about it and provided himself with this means of treating cases. He now felt that the fixation secured by it was not sufficient to give quite satisfactory results, and he had abandoned it for a modification of Taylor's spring jacket, the great difficulty of which was in getting it made properly.

For the abscesses he felt that aspiration should be practiced once or twice before they were opened, and that injections of iodoform as mentioned by Dr. Wilson were beneficial. For the paralysis which so often occurred he first tried the recumbent treatment and cited a case as evidence of its value.

Dr. G. E. ARMSTRONG, referring to the apparatus shown by Dr. Wilson, thought it a very satisfactory one. He had found it no easy

matter to keep children quiet in bed. The length of time the apparatus should be worn was an important point. He felt that the children should be kept in bed until the disease had ceased to be progressive, and the process of repair had begun. He had yet to be convinced that the head or shoulders could be adequately supported by any apparatus up to the present devised. A jury mast controlled the movements of the head and neck, but did not support the former. No apparatus that would altogether lift the head and take its weight from diseased cervical vertebræ could be borne for any length of time. The same was pretty much the case with apparatus to support the shoulders in mid-dorsal disease. It controlled movement, but did not carry the shoulders and head.

Bursitis of the Knee.

Dr. E. C. KIRKPATRICK exhibited two enormously hypertrophied bursæ which he had removed from the knees of an elderly woman. They had been present for a number of years, but had grown more rapidly of late.

Montreal Medical Journal.

A Monthly Record of the Progress of Medical and Surgical Sciences.

VOL. XXV.

JANUARY, 1897.

No. 7.

BRITISH MEDICAL ASSOCIATION.

Owing to the fact that the meeting of the General Council of the Association has been delayed until January 20th, we are still ignorant of the names of those selected to give the general addresses, and to be office holders in the various sections in the forthcoming meeting. It is quite possible that many of the well-known leaders of our profession in the old country may be unable to visit us, but on the other hand we hear of many prominent members of the profession who have signified their intention of coming, and we trust that the list of office bearers will be such as in point of distinction will compare most favourably with those of previous meetings.

Dr. Roddick, President-Elect, left Montreal on the 1st inst., for England, where he will devote some weeks to the business of the Association. His visit seems to us very well timed; not only will he be able to post the officials of the Association with all necessary information concerning what has been done in Canada, but he will, we trust, be able by personal interviews to secure the attendance and active co-operation of many who are first and foremost in the profession.

As an indication of the hearty co-operation of all parts of the Dominion, we may point out that the following leaders of the profession have accepted positions upon the Executive Committee and have offered their co-operation.

Dr. W. Tobin, President, Halifax Branch British Medical Association.

Dr. G. L. Milne, " British Columbia " " " "

Dr. C. R. Church, " Ottawa Branch " " " "

Dr. A. Catellier, " Quebec " " " "

Dr. L. J. A. Simard, (Quebec), President College of Physicians and Surgeons, of Quebec.

Dr. A. F. Rogers, (Ottawa), President College of Physicians and Surgeons, Ottawa, Ont.

Dr. J. A. Duncan, President, British Columbia Medical Council.

Dr. J. McLeod, (Charlottetown), President, P. E. I. Medical Board.

The Presidents of the following Medical Associations have joined the Executive:

Dr. V. H. Moore, (Brockville), President, Canadian Medical Association.

Dr. J. W. Daniel, (St. John), President, Maritime Medical Association.

Dr. Coventry, (Windsor.) President, Ontario Medical Association.

Dr. H. H. Chown, (Winnipeg), President, Manitoba Medical Association.

Dr. J. P. McDonald, (Hopewell, N.S.), President, Nova Scotia Medical Society.

D. A. J. McCully, (Moncton, N.S.) President, New Brunswick Medical Society.

Dr. Page, President of the Provincial Medical Board, Nova Scotia, writes that he will be unable to attend, but that the Board will send a delegate.

There are yet more names to be added to the Executive. In the absence of any official year-book of our profession, the Secretaries have found some difficulty in determining the present holders of official posts in connection with the leading medical bodies of the Dominion, and as a consequence the invitations to join the Executive have been delayed.

With regard to excursions, the G. T. R. and C. P. R. Companies offer to the Association and its guests, journeys at half rates over the whole of their systems as far as Sarnia on the one and Port Arthur on the other, and in addition the C. P. R. will give the same rates to those wishing to cross the continent as for the local excursions, that is, return tickets to Winnipeg or Vancouver for one single fare. This privilege will be extended to Canadian members and American guests.

THE FIRST MEDICAL PEERAGE.

It is with profound satisfaction that all members of our profession must have received the announcement that, among the New Year's Honours, a Peerage has been offered to Sir Joseph Lister. Until now the profession in Great and Greater Britain has always felt that it has not received adequate recognition from the great ones of the earth who have been abundantly ready to testify their appreciation of those dealing death to the enemies of the country, and have been as abundantly chary of honouring those preserving the lives of good Britons.

No one in the Empire has done greater service to humanity than Sir Joseph Lister, and it is most fitting that he should be chosen to be first and foremost to receive this token of honour and appreciation. We are rejoiced that it has come to him, and are only sorry that it did not come long ago, and that it is unaccompanied by a spontaneous offering from the Government and the nation. Surely no one thus honoured has deserved it more.

MEDICAL WRITERS AND PUBLISHERS.

We have received the following letter from Dr. G. M. Gould and, appreciating the valuable work that he has achieved for our profession on this continent, we publish it very willingly, even though while sympathizing with his views, we cannot perhaps entirely accept his argument.

TO THE MEMBERS OF THE MEDICAL PROFESSION.

I would be pleased to have an expression from you, either personally or through some medical journal, as to the relations of the lay publishing firms of medical journals and the profession. The request is suggested by the fact that Messrs. Wm. Wood & Co., of New York, refuse to permit the editors of *The American Year-Book of Medicine and Surgery*, to use in our abstracts of Medical Progress articles and illustrations first printed in the *Medical Record* and the *American Journal of Obstetrics*.

This decision seems to me to be wrong for the following reasons:

1. IT PREVENTS THE DISSEMINATION OF MEDICAL KNOWLEDGE.—*The Year-Book* condenses, systematises, and criticises the year's medical work in a shorter space and more permanent manner than the journals, and has thousands of readers no single journal can claim, or hope to reach. Every physician writes and publishes articles in order that every member of the profession may, if possible, learn of his work, and that science and progress may thus be furthered and humanity benefited. To interfere with such dissemination of our literature in reputable publications is, I think, discourteous and unjust to the profession and an injury to Medical Science.

2. This injustice and injury to Medicine become all the more striking when physicians do not receive a cent of pay for contributions, from the publication of which the lay-publisher is supposed to make considerable financial profit.

3. No other publisher in the world, not even those who pay authors for their contributions, have in the least objected to our reproduction of quotations, abstracts, and illustrations from their journals.

Do you wish to limit the dissemination of your contributions to medical science by such an exclusion of them on the part of publishers from reputable publications? Is this literature the property of yourself and of the profession or not? Does your gift of it to a journal make it the private property of the publishers of that journal? Is it not rather a loan for temporary use only?

Will you not hereafter demand that there be printed with your article a statement that the right of abstracting the text or reproducing illustrations is guaranteed?

Sincerely yours,

GEO. M. GOULD.

119 S. 17th Street, Philadelphia, Pa., Dec. 1896.

As we have already said we cannot but sympathize with Dr. Gould. Undoubtedly, every one of us who writes for the medical press, does desire that what he writes shall obtain the greatest possible publicity,

and speaking on behalf of this JOURNAL, we of the Editorial Staff, who are at the same time proprietors of the JOURNAL, may state that so long as the JOURNAL has priority of publication, we are rejoiced when any article appearing in this JOURNAL is published elsewhere, whether in abstract or in its entirety. Being human we would make the proviso, that the fact be always noted that the abstract of the article has already appeared in our pages. We note with pleasure for example, within the last few weeks, that one of the leading Indian Medical Journals published conscientiously every word of one of our retrospects, reproducing even sundry unfortunate typographical errors.

But while thus we are willing to have our articles reproduced with due acknowledgment, we cannot but appreciate as publishers the other side of the question. It is quite true that every physician writes and publishes articles that every member of the profession may if possible learn of his work, but at the same time every author in all subjects writes and publishes with a like end in view, and if we mistake not, the number of authors or writers who obtain adequate remuneration is peculiarly small. In our experience men write to or for the leading and most flourishing journals, medical or otherwise, because by so doing they are likely to reach the greatest number of readers, and thus the publishers of the leading journals who through their business capacity work those journals up to their present high standard have more "say in the matter" than Dr. Gould would seem to admit. Let us suppose for example, that there exists a leading journal in medicine or any other subject, and that another periodical appears upon the market, the object of which is to publish fully the best articles appearing in that and other high class journals, we can well understand that the proprietors of the former should object when they see the possibility of the latter periodical being so well conducted that the reading public may prefer to procure it in place of their own organ and may prefer to have by them a careful selection of all that is best rather than to wade through a collection of what is good, bad and indifferent at more frequent intervals.

While it is true that medical writers work in general for no pay, we cannot, after careful thinking over the matter, see that medical literature is widely separated from other literature. Just as we feel that journals, like the *Review of Reviews*, which subsist by extracting at length all that is best in general literature, are harmful and ought to be suppressed, so do we feel that there should be a limit to the extent of the extracts made by year-books in medicine. Year-books ought not to take the place of journals, they ought merely to publish extracts sufficiently full and sufficiently suggestive to lead those who

read them to consult the original articles. There is in this country altogether too great a tendency to subsist upon second-hand matter, and an unwillingness to consult original authorities. The good of the year-book or retrospect is to draw attention to the subject matter of articles, that those articles may be consulted in the original.

If the *American Year-Book of Medicine and Surgery* desires to publish merely careful abstracts of papers, then we cannot sufficiently censure the conduct of Messrs. William Wood & Co. If on the other hand the editors wish to publish verbatim, large portions of important articles, neglecting to print those portions which to them seem unimportant, or again if they want to publish articles *in extenso* without permission of the publishers and without payment to the authors, then in either case we cannot but think that Messrs. William Wood & Co have right on their side. All must depend upon the spirit in which the Editors of the Year-Book conduct their enterprise.

AN INTERNATIONAL CATALOGUE.

While upon this subject of publication of abstracts of medical work we may here call attention to a very important work first introduced to the public, we believe, by Professor Michael Foster, in his address before the International Medical Congress, at Rome, two years ago, and notably furthered by a conference which met in London last July under the auspices of the Royal Society.

All investigators in medical and other branches in science, know how difficult it is to obtain anything like a complete bibliography of the subject or subjects engaging their attention. In Medicine we are perhaps better provided for than in most other subjects, for the *Index Medicus* is singularly complete so far as regards the titles of papers, notwithstanding, those who have occasion to employ the *Index* frequently, know that it is far from satisfactory. What is wanted is not merely an index of titles, but an index of contents of papers, and at last it seems as if these may be obtained in some branches at least of Medicine. The conference held in London was attended by delegates from all the leading countries of the world (the Hon. Sir Donald A. Smith, representing Canada).

The following are some of the more important resolutions agreed to:

That it is desirable to compile and publish by means of some international organism, a complete Catalogue of Scientific Literature, arranged according both to subject matter and to authors' names.

That in preparing such a Catalogue regard shall, in the first instance,

be had to the requirements of scientific investigators, to the end that these may, by means of the catalogue, find out most easily what has been published concerning any particular subject of enquiry.

That the final edition and the publication of the Catalogue be entrusted to an organism, hereinafter called the Central International Bureau, under the direction of the International Council.

That any country which shall declare its willingness to undertake the task shall be entrusted with the duty of collecting, provisionally classifying, and transmitting to the Central Bureau, in accordance with rules laid down by the International Council, all the entries belonging to the scientific literature of that country.

That in indexing according to subject-matter regard shall be had, not only to the title (of a paper or book), but also to the nature of the contents.

That the Catalogue shall comprise all published original contributions to the branches of science hereinafter mentioned, whether appearing in periodicals or in the publications of societies, or as independent pamphlets, memoirs or books.

That in judging whether a publication is to be considered as a contribution to science suitable for entry in the Catalogue, regard shall be had to its contents, irrespective of the channel through which it is published.

That the Central Bureau shall issue the Catalogue in the form of "slips" or "cards," the details of the cards to be hereinafter determined, and the issue to take place as promptly as possible. Cards corresponding to any one or more branches of science, or to sections of such sciences, shall be supplied separately at the discretion and under the direction of the Central Bureau.

That the Central Bureau shall also issue the Catalogue in book form from time to time, the entries being classified according to the rules to be hereinafter determined.

That the issue in the book form shall be in parts corresponding to the several branches of science, the several parts being supplied separately, at the discretion and under the direction of the Central Bureau.

That a contribution to science for the purposes of the Catalogue be considered to mean a contribution to the mathematical, physical or natural sciences, such as, for example, mathematics, astronomy, physics, chemistry, mineralogy, geology, botany, mathematical and physical geography, zoology, *anatomy, physiology, general and experimental pathology, experimental psychology and anthropology*, to the exclusion of what are sometimes called the applied sciences—the limits of the several sciences to be determined hereafter.

That English be the language of the two Catalogues, authors, names and titles being given only in the original languages except when these belong to a category to be determined by the International Council.

That it is desirable that the Royal Society should be informed at a date not later than January 1st, 1898, what steps (if any) are to be taken, or are likely to be taken, in the countries whose governments are represented at the Conference, towards establishing organisations for the purpose of securing the end had in view in Resolution 16.

That January 1st, 1900, be fixed as the date of the beginning of the Catalogue.

MCGILL MEDICAL SOCIETY OF UNDERGRADUATES.

The society meets every alternate Friday during the session. To show the work that the students are doing we publish the programme for the winter term :

FRIDAY, January 8.—1. Paper, "Functional Disorders of the Stomach," A. C. Jost, B.A. ; 2. Paper, "Albinism," W. H. Dalpe, B.A.

FRIDAY, January 22.—DEBATE, Resolved, "That Douching is always contra. indicated in Normal Labour," For the affirmative, F. W. F. Wilson, W. T. Pallister ; for the negative, J. Barclay, J. J. Roy.

FRIDAY, February 5.—1. Paper, "On Evolution," Martin Powers, B.A. ; 2. Paper, "Intestinal Digestion," A. H. Gordon ; 3. Paper, "Milk Analysis," W. O. Rose ; 4. Exhibition of Pathological Specimens."

FRIDAY, February 19.—1. Paper, "Vascular Compensation," A. Smith, B.A. ; 2. Paper, "General Paralysis," F. T. Tooke, B.A. ; 3. Paper, "Monstrosities," A. A. Loeb ; 4. Reporter's Statement.

FRIDAY, March 5.—1. Paper, "Our Native Poisonous Plants," H. B. Cushing, B.A. ; 2. Paper, "Function of the Thyroid," F. N. McNaughton, B. A. ; 3. Paper, "Emesis," H. M. Standfield, B.A.

FRIDAY, March 26.—Closing Address, Dr. Blackader.

It reflects the utmost credit on the programme committee, which is composed of the president, Mr. R. J. Midgley '97, the secretary, Mr. W. L. Barlow '98 and Mr. R. Law '99. The society has been in existence for many years but latterly the scope and interest has been much extended. The students themselves supply the various items of the programme and only occasionally is one of the professors brought in to give an address on some special subject.

With the object of stimulating its members to conduct original and research work, the society offers in competition annually a senior and junior prize, each of the value of forty dollars, for the best paper on any subject pertaining to the final and primary branches of the medical curriculum respectively, authors of papers to have full freedom in their choice of subjects. Through the kindness of the Faculty of the College, a committee of Professors will constitute the Examining Board and the prizes will be awarded at the Annual Convocation of the College.

The Western Ophthalmological, Otological, Laryngological and Rhinological Association meets in St. Louis, Mo., the second Thursday and Friday of April, 1897. Physicians desiring to read papers are invited to send Subjects to the Secretary at once. The railroads will give one and one-third fare on the certificate plan. Programmes will be mailed Feb. 1, 1897. The profession are cordially invited to attend. Hal Foster, Secretary, Kansas City, Mo.

The *Journal of Nervous and Mental Disease* announces the following arrangement of the staff for 1897: Editors, Drs. Charles L. Dana, F. X. Dercum, Philip Coombs Knapp, Charles K. Mills, James J. Putnam, W. Allen Starr; Associate Editors, Drs. Philip Merowitz, Wm. G. Spiller; Managing Editor, Dr. Charles Henry Brown, 25 West 45th Street, New York, to whom address all editorial and business communications.

The Chairman of the Committee of Arrangements, Dr. H. A. Hare, for the Semi-Centennial meeting of the American Medical Association to be held in Philadelphia June 1st, 2nd, 3rd and 4th, 1897, acting under the instructions of the General Committee of Arrangements, desires to extend a cordial invitation to such members of the Canadian Medical Association as may be in attendance upon the meeting in Canada to attend and take part in this meeting of the American Medical Association.

The following has been sent to us from New York showing the deadly perils which beset life across the border:

SELF-PROTECTION IN BOSTON.—A man of genteel breeding and intellectual force told us the other day that he wears sewed to his undershirt a card with this inscription "My appendix has been cut out." And he gave this reason for his action: "You see, these are the palmy knifing days of the surgeon. If a man falls in a fit or faints, or is disguised mentally by a drug, and is carried consequently to a hospital, the surgeon operates on him for appendicitis without delay."—*From the Boston Journal.*

NEW BOOKS, ETC., RECEIVED AND NOTED.

Ophthalmic Operations as Practiced on Animals Eyes. By Clarence A. Veasey, A.M., M.D., Philadelphia: The Edwards & Docker Co.

The Practice of Medicine. By James Tyson, M.D., Philadelphia: P. Blakiston, Son & Co.

A Plea for Conservative Oral Surgery, with Practical Illustrations. By G. Lenox Curtis, M.D. Reprint from the N. Y. Medical Journal.