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THE
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A. H. WRIGHT, B.A., M.D. Tor., M.R.C.S. England.

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PRELIMINARY SCIENTIFIC MEDICAL
EDUCATION IN SWITZERLAND.

BY PROF. R. RAMSAY WRIGHT.

During the summer I had my attention called to a paper by Prof. Herzen, the distinguished physiologist of Lausanne, on the above subject, which affords an excellent picture of the present regulations in Switzerland in regard thereto, and permits what must be always instructive for us—a comparison of these with our own.

Before 1886 the State examination in medicine was divided into a primary and final, very much after the fashion of the Council examinations here. The primary included physics, chemistry, botany, zoology (with comparative anatomy), anatomy (with histology), and physiology, together with practical examinations in chemistry, anatomy, and histology. No regulations existed as to the period of the students' course at which this examination should be passed; the student might present himself as soon as he had all the necessary tickets. Many, therefore, tried at the end of their third semester (*i.e.*, after two winter sessions and one summer session), but most did so at the end of the fourth semester (*i.e.*, after the second summer session). In both cases, however, there was the temptation to the raw student to plunge into the more advanced work of the primary at once, before he was ripe for it, because he had to present two winter

semester tickets in practical anatomy. These involved some twenty-four hours work per week during the winter, so that the student might be well prepared in that subject, but obviously had no time for anything else.

The neglect of the fundamental studies on which anatomy and physiology rest, had such a prejudicial effect on the education of the students that the various Swiss medical faculties were requested by the State to suggest a remedy. The remedy proposed was the subdivision of the primary into a physico-natural and an anatomico-physiological part, with the proviso that the first should be passed before the second.

This had the effect that the energies of the student, during the first two semesters, could be concentrated entirely upon physiology, chemistry, botany, zoology, and the associated practical courses which, in accordance with the spirit of the times, have to supplement the didactic teaching, while the next three semesters could be devoted entirely to anatomy, physiology, and histology. The temptation to plunge into practical anatomy in the first year was in this way removed, for the student who did so endangered his chance of passing the first division of the primary at the end of his second semester. Thus, in a medical course of five years (ten semesters), half of the time would be devoted to the primary, and half to the final, subjects (pathology and therapeutics, and the various professional branches).

This subdivision of the medical course met with various objections some who agreed that

it might be desirable to increase the term of study to ten semesters instead of eight, would nevertheless have preferred that the proportion allotted to the primary and final subjects should be four to six, or even three to seven, instead of five to five. Prof. Herzen, however, very properly points out that if any attempt is to be made to put the student *au courant* of the *present* position of these primary studies in relation to the science and art of medicine, and especially if they are to be employed for developing the scientific spirit and for training in scientific method, then, in view of the enormous progress of these sciences within the last twenty years, five semesters are certainly not too long to devote to them entirely.

Some other objectors desire to see the medical course unloaded of the elements of the physico-natural sciences—suggesting that only the applications of these to medical science should be treated of during the course. This obviously involves that the gymnasia (high schools and collegiate institutes) should be able to give sufficient instruction in them, and that the medical matriculation examination should cover these. At present the standing of *bachelier es lettres* from the gymnasia is all that is required for beginning the study of medicine, but already some institutions, such as we have at Neuchâtel, have begun to offer an additional year's course in science, which would be quite equivalent to the work covered in the first part of the primary.

Prof. Herzen thinks that an extension of such collegiate courses to other secondary schools, accepting of equivalents with any reduction of medical courses to four years, quite feasible.

An examination of the time-table proposed by Prof. Herzen is suggestive :

1st year, both semesters—
 Zoology and Compar. Anat. M. F. at 8
 Botany " " " 9
 Physics " " " 10
 Chemistry " " " 11
 Three afternoons a week for practical chemistry, one for physics throughout the year, and one for zoology in winter, and for botany in summer.

Three following semesters :
 Histology 3 times a week, at 9
 Anatomy 6 " " " " 10
 Physiology 6 " " " " 11
 Repetitions 3 " " " " 9

Winter afternoons to be devoted to practical anatomy, and those of the summer semester to histology, embryology, and physiology.

The following seem the most salient points in the above which invite a comparison with our arrangements :

1. Simplicity of time-table.
2. Deferring practical anatomy till second winter session.
3. Deferring materia-medica till after the primary.
4. The question of demanding more science in the matriculation examination.

SIMPLE OR PERFORATING ULCER OF THE DUODENUM.*

BY A. M'PHEDRAN, M.B.,

Lecturer on Clinical Medicine in the University of Toronto.

Comparatively little is said in most medical works on ulceration of the duodenum, many of them making no reference to it. This is doubtless due to the fact that the clinical phenomena so closely resemble those of gastric ulcer that many cases of duodenal ulcer are mistaken for the former disease. And then in autopsies, I fear, that only too frequently examination of the duodenum is neglected, so that doubtless not a few cases escape notice. According to the classical researches of Brunton, in about five per cent. of all autopsies, evidences of gastric ulceration are to be found; we are much less able to speak definitely on the frequency of duodenal ulceration, but many estimate its frequency at a ratio of about one to thirty of the stomach cases.

The first case of duodenal ulcer was recorded in 1828, by Robert of France, whose description of the symptoms is quite as clear as any that have been written in more modern times. Up to 1881, one hundred and twenty-three authors are given in the Index Catalogue of the Library of the Surgeon-General's Office of the United States. And since then, perhaps, half as many have been recorded. Some of these are doubtless not genuine, and many are cases of acute ulceration following burns, so that the undoubted cases on record do not, probably, much exceed one hundred. It is not to be forgotten in estimating the frequency of this affection, however, that many accurately observed cases have not been placed on record.

*Read before the Toronto Medical Society, Nov. 13th, 1890.

The relationship of age and sex is in curious contrast to that in the gastric affection; for while in the latter, young females are the chief sufferers, in duodenal ulceration, on the contrary, the majority of those affected are males, between thirty and forty. In Krauss' collection of sixty-four cases, only six were females. The disease has been met with in the new-born infant,* but it is rare in early life. As the ulcers in the two situations seem to be identical in pathology this difference is strange, and, at present, inexplicable.

Such constitutional conditions as erysipelas, septicæmia, albuminoid degeneration, diseases of heart and lungs, alcoholic excesses are given as associated with duodenal ulcer; they seem to have no influence in the causation of the same disease in the stomach.

A large proportion of the cases of duodenal ulcer reported have been in apparently exceptionally healthy men, living in healthy environments, and whose nourishment has been ample.

These ulcers occur in the first portion of the duodenum; the other two parts are affected no oftener probably than any other part of the small intestine. Physiologically the portion of the duodenum above the orifice of the bile duct is a part of the ventricular cavity, as its contents are identical with those of the stomach, the acid chyme not being altered until it meets with the bile and pancreatic fluid. This fact, together with the similarity of simple ulcers in the stomach and duodenum, leaves little room for doubt that both owe their origin to a common cause. As to the pathogenesis of these simple ulcers little advance has been made on the views originally expressed by Virchow and others, viz., that there was first, arrest of blood-supply to a portion of mucous membrane; then, secondly, solution or digestion of this ischæmic membrane by the gastric juice, hence the designation "peptic ulcer." The arrest of blood-supply may be due to such causes as embolism, thrombosis, extravasation of blood from trauma, degeneration of arterial walls, etc. Some believe that abrasion of the mucous surface by a hard indigestible substance may originate an ulcer, and that such cause would be more likely to be effective in the duodenum on account of its narrow lumen and fixed position. If this be so, it offers some explanation possibly for the more frequent occur-

rence of duodenal ulcer in males, and at a more advanced age than obtains in the gastric affection.

I should state that I have not included ulcers occurring in cases of burns in this description. They are acute in formation and may cicatrize quite rapidly; cicatrization has been known to be complete in a month. It is uncertain how long it takes the simple peptic ulcer of the duodenum to cicatrize; the time probably varies, as it does in gastric cases, from a few months to several years. With cicatrization complete, the sufferer is not wholly free from danger, as such untoward results as stricture of the gut, obstruction of the hepatic or pancreatic ducts, the portal vein or hepatic artery, are possibilities to be borne in mind.

The clinical history varies greatly in different cases. Even in those with the most marked symptoms it is at least questionable if we can give more than a very probable diagnosis, as there will always be an element of doubt. The phenomena on which Bucquoy, Johnston, and others, have laid most emphasis are: 1. Sudden intestinal hemorrhage in an apparently healthy person, tending to recur. With or preceding this there may be hæmatemesis, if the bleeding has been sudden and free, so as to regurgitate into the stomach. 2. Pain in the right hypochondriac region, occurring late after meals—two to four hours. 3. Gastric crises of extreme violence and without reference to food. Hemorrhage is apt to occur at the time of these crises.

Of these symptoms the intestinal hemorrhage is considered the most important. Occurring in the absence of such common lesions as hæmorrhoids, dysentery, malignant and tubercular disease, and the hemorrhagic diathesis, duodenal ulceration, it is said, may be recognized by this one symptom alone. Yet fatal intestinal hemorrhage has occurred without any of these causes, and no ulcer been found in the stomach or duodenum.

The occurrence of pain after meals is not present in nearly all the cases; not probably in more than half of them, if in so many even. Its cause is usually referred to the passage of the chyme through the duodenum, in which case the pain should begin within half-an-hour after the meal, *i. e.*, as soon as the chyme begins to pass, unless it be due, as some believe, to the greater acidity of the latter part of the chyme.

**American Journal of Medical Science*, Vol. ii., 1888.

Several cases are reported during the last few years in which there were no symptoms present until perforation occurred, with peritonitis, followed by death in a few hours. This specimen, presented by Dr. Wilberforce Aikins, is one of this kind. It is from a man apparently in good health, who was seized during the night with sudden extreme pain in the abdomen, diffused all over it. He died next day. At the autopsy this large oval ulcer was found in the anterior wall of the pyloric orifice. Such cases are probably not rarely mistaken for strangulation of the bowel, but the rapidity with which collapse sets in should nearly always serve to distinguish them from strangulation, in which collapse develops more gradually. In perforation of the duodenum the opening is nearly always found in the anterior or upper walls; when the ulcer is in the lower wall, adhesion to the pancreas usually prevents perforation into the peritoneal cavity.

In like manner many cases of gastric ulcer are met with, in which there are no symptoms until perforation occurs. This appears to be especially true of ulcers situated in the lesser curvature, where they seem to be removed, to a certain extent, from irritation by the chyme.

It should not be forgotten that in some cases of duodenal as well as of gastric ulcer, so much thickening takes place about the base of the ulcer as to give rise to evidences of tumor, thus strongly simulating malignant disease.

The following are cited as probable cases of duodenal ulcer. They serve to illustrate the uncertainty that must surround their diagnosis, and the difficulty of distinguishing them from the gastric affection:

Case 1. Mr. W., æt. 25, a teacher from the western part of the Province, had suffered more or less from dyspepsia for several years, with so-called bilious attacks at times. He consulted me in March, 1889, for pain and discomfort in the right epigastric region, coming on from half to an hour after meals. His digestion was poor and he was in miserable health. During February and March he had, on two occasions passed a moderate amount of blood by the bowel. There was no evidence of rectal disease to account for it. There had been no vomiting. There was nothing more than general discomfort to pressure in the epigastric

region; no localized tenderness or induration. I heard from him a month later that there had been no return of hemorrhage but that he was not improving. I have not heard of him since. In this case the symptoms are chiefly referable to the stomach, whose functions, in any case, were very imperfectly performed. The pain may have been either stomachic or duodenal, or both; the hemorrhage was most probably from the duodenum; but there is room for reasonable doubt even on this point.

Case 2. Mr. X., æt. 30, a book-keeper; had lived rather a fast life. Had been healthy till the autumn of 1889, when he began to suffer from pain and distress beginning about fifteen to thirty minutes after meals and lasting an hour or two. At times the pain would be extreme; it was referred to the region of, and above, the umbilicus. His appetite and digestion continued fairly good. On Dec. 12th, 1889, while walking along the street he suddenly became faint, fell down, and vomited some dark brownish fluid, which some one, who extended to him a friendly hand, said looked like catsup. He was taken home and two hours later had a free liquid motion which he did not see. He had another motion at once on returning to his room—this time he used the chamber vessel and saw that the stool was dark liquid blood and very copious. Smaller motions continued to pass for the next three days. He was unconscious for nearly a week. He was taken to the General Hospital where he remained till February, by which time he was able to walk about, though still weak and very pale. His stomach gave him no trouble and he had considerable appetite.

April 14th, 1890. He consulted me for a return of pain in epigastric and umbilical regions; it began about half an hour after meals and lasted a variable time; he had no vomit nor melæna; the tongue was clean; bowels tended to be constipated; the pallor was very marked; he was given bismuth, codeine, and hydrocyanic acid, to soothe the stomach and relieve pain; diet, liquid in small quantities at short intervals. He improved satisfactorily though it was difficult to induce him to persevere long enough to ensure cicatrization of any ulceration that might exist. He is now quite well.

The occurrence of pain so soon after food points strongly to gastric ulcer while its seat, the umbilical region, indicates no special seat of lesion. The hemorrhage, from the sudden profuseness of the intestinal part of it, while little was vomited, indicates the duodenum as its probable, if not its only possible, source. Had it escaped from a gastric ulcer, the stomach would have been distended with blood and more would have been vomited, while its evacuation from the bowel would not have taken place so quickly or in such profusion. Of course it is quite possible that ulceration may have occurred in both stomach and duodenum; in that case the pain was due to the lesion in the former, and the bleeding arose from the erosion of some blood vessel in the latter.

Case 3. Miss Y., æt. 30. Had always been healthy with good appetite and digestion. Her mother and one sister died of phthisis; another sister has had two extremely severe attacks of gastric ulcer. The past summer was spent on the Island where bathing was freely indulged in, but never long enough to cause depression. She was well till about the middle of August, when, in common with others in the household, she had considerable diarrhœa; not certain of the character of the stools, but they were probably dark. It was noticed that she looked more pale and unwell than the diarrhœa would account for; still her appetite was fair, but there was some flatulence. On Sept. 2nd she vomited some dark grumous material. Thought the motions were dark. Sept. 3rd, a similar vomit, and passed a copious motion of blackish fluid; she felt very faint and was extremely pale; not feeling any discomfort from food, she ate heartily of ordinary diet; after dinner she vomited about a pint of dark fluid, mostly blood. For some days the motions contained much blood. The loss had been so great that she was not able to raise her head from the pillow. Never having been ill she was reluctant to have advice, but submitted when she felt herself become so weak. She had no pain or tenderness: the hemorrhage was the only phenomenon. She was kept quietly in bed, given sedatives for the stomach, and given liquid diet; her improvement has been uninterrupted and she seems now as well as ever.

From the increasing pallor and almost certain

dark character of the stools, it is very probable that she was passing blood daily during the diarrhœa she had before her condition became alarming. This with the later very free evacuation of blood by the bowel would indicate the duodenum as the seat of lesion. In that case the hæmatemesis occurred only when the bleeding became so free that the blood regurgitated into the stomach.

Case 4. The following case which I had the privilege of seeing with Drs. Wm. Woodruff and H. A. Macallum, of London, in December, 1889, finds appropriate reference here though it was not one of simple ulcer.

Mr. Z., æt. 40, an architect, had always enjoyed good health until 1887, after which he began to complain of indifferent ailments. In Sept., 1888, he began to pass large dark stools every few weeks and his strength failed somewhat. In February, 1889, he passed a very copious black stool followed by extreme faintness. Dr. Woodruff saw him and attributed his condition to the loss of blood. The stools were black for several days. He improved and returned to his professional work in a few days. Continuing to pass dark stools at varying intervals, in May he consulted my colleague, Dr. J. E. Graham, who attributed the symptoms to ulceration of the duodenum, possibly malignant in nature. Shortly afterwards he saw two of the most eminent physicians of New York, who diagnosed gall stones, and advised rest at the seaside. This advice he followed, and he returned home after a few weeks greatly improved. But the black stools recurred again; still he was able to persevere with his work till the end of November, three weeks before I saw him. By that time he had several dark stools daily, and often vomited grumous blood also. Dr. A. B. Macallum, of the University of Toronto, had found glandular crypts from the pyloric end of the stomach in the evacuations, leaving no room for doubt as to a destructive lesion. He was very prostrate, pallid, with a lemon tint. Dr. H. A. Macallum found the blood to present the changes indicative of pernicious anæmia. There was tenderness, with well-defined thickening, in the region of the first portion of the duodenum. Percussion note was dull. Food, especially solid, caused pain and uneasiness. Pulse, 140; temperature, 100°. Death occurred a few days

after : no autopsy. Though the condition here was doubtless malignant disease of the duodenum and stomach there is little doubt but that the disease began in the former with ulceration of its mucous surface ; the hemorrhage from the bowel left little room for doubt as to there being such ulceration.

Few will be inclined to dispute Wilson Fox's opinion that the symptoms of duodenal ulcer differ but little from those which are met with, when the disease occurs in the stomach. (*Kejnolds' Sys. of Med.*)

Pain is much oftener absent in the duodenal disease, owing, some believe, to this part of the canal being more fixed, and subject, therefore, to less movement than the stomach. When present, as already remarked, it is often extremely severe, making the patient writhe while it lasts ; it may occur at irregular intervals without reference to food, as *e.g.*, at night ; or, if due to food, it is said to begin from two to four hours after the meal, but may, doubtless, occur as early as half an hour. The occurrence of such pain in the right hypochondrium, in absence of other symptoms, is considered sufficient by some to establish a diagnosis of duodenal ulcer.

As to the significance of hemorrhage in the absence of causes in the lower bowel, sudden profuse discharge indicates strongly the duodenum as the seat of bleeding, as do also repeated small bleedings ; in the latter case the blood is all tarry. In gastric hemorrhage, if small, the blood passed by the bowel will probably be found more altered by the action of the gastric fluid, and if large the vomiting will be more prominent than the alvine evacuations ; while the converse probably holds true when the bleeding is duodenal.

SANITATION IN ST. JOHN'S, NEW-FOUNDLAND.

BY ALAN MACDOUGALL,

Member Canadian Society Civil Engineers.

Built on a steep hillside on an almost solid rock foundation, which fortunately prevented the construction of privy pits, the sanitary question in the City of St. John's, N.F., presents a problem not met with in Canada. The city was devastated by fire in 1846, the population, fisher folk, too poor to put up expensive build-

ings, and without building material of a solid nature, had to use wood. The population has grown gradually till it is now estimated at thirty thousand. The town site, or more properly hillside, is intersected by a number of water courses, twelve or fourteen in all, which have gradually become sewers emptying into the harbor, after the manner of the Toronto sewers. No system of sewerage was considered till last year, when a thorough plan was elaborated, submitted to, and endorsed, by Mr. Rudolf Hering, of New York.

The Government of the colony has from time to time constructed a number of sewers, more as storm water drains than as sewers. It also controlled the city government until two years ago, when a municipal council was elected, who have considerable powers, but not such as city councils in Canada enjoy. During its control, it had to look after the cleaning and sanitation of the city ; need it be said that so long as it was a "government" institution it could not be effectively performed ; and when it was contracted for, the latter condition was worse.

The city has an abundant supply of beautiful pure lake water supplied by gravitation, which is furnished to the poorer parts of the city through public fountains. These houses cannot afford to have water put into them, even if they had sewerage in the streets. The water supply is assured, and the system of going to the public fountains has worked, and continues to work, well. The night soil and garbage has to be collected. It is a very fortunate circumstance they have never had privy pits, or the condition of the town would be something terrible. It is admitted by everybody that before the existence of the municipal council, the streets were very badly kept, and were often shockingly dirty.

The cross streets, and those on which the poorer classes dwell, are very steep ; it is almost impossible for a horse to draw half a ton up some of them ; narrow lanes, and crooked paths through which a cart can hardly pass, makes scavenging very difficult. A contractor would naturally take the wide and easy streets.

Under the municipal council the system is different, and to the writer's mind is the most perfect he has experienced. The whole outfit belongs to the Council. There are fourteen

tightly closed night soil carts, and fourteen open garbage carts, which are worked by fourteen horses. The carts start out at midnight to collect night soil, which is left on the street in iron pails an hour or so before, they complete the collection in about three hours and a half; the horses are fed and go out about five o'clock to collect garbage, finishing about eight o'clock; after another rest they go out to collect the street sweepings, and get back to stables about mid-day. The force is worked to its full power all the time, and horses and plant have no rest. The writer testified with the greatest pleasure to the extraordinary cleanliness of these lanes and by-ways, and of the city generally. No refuse lies about; the empty tin, the ragged coat, old bed sacks, and other abominations of civilized life, are not found; and above all things, the smell of the privy pit is absent.

Collection and cartage of night soil and garbage at night is the desideratum of civil organization; it is exceedingly offensive to everybody's feelings to pass carts of garbage, and worse still, night soil, during the day. The city of St. John's, in a quiet unobtrusive way, has now for two years carried on this work, creating a perfect transformation where formerly the sights on the streets were very offensive, and more than the sense of sight offended. The work of collection is by no means easy; the grades on the cross streets are very great, the majority of them rise from 1 foot in 8 to 1 foot in 4; the streets are not laid out as in Canadian towns in nice square blocks, they run at all angles and end in *culs de sacs*. The carts have to travel over the same ground more often, and make detours to get at points which would be readily reached on a Canadian street.

The refuse matter is carted into the country by three different roads, the city being divided into divisions to suit, and dumped on the land. The night soil is first put out, on it a few hours later the garbage is thrown, and later still all street sweepings. This covers the night soil fairly well, the farmers frequently add peat bog to it, thus forming a valuable compost; they are glad to have this refuse put on their lands for the sake of the rich manure, which costs them nothing: for stable manure they pay fifty cents per load.

The work has been satisfactorily carried on so

far, no complaints have been received from any of the neighbors, nor has the public health been endangered. During the hot season the refuse is dumped on lands at a distance from the public roads and houses.

The manure is found to be very valuable, and is sought after by farmers and market gardeners in the neighborhood of the city; it forms a good manure for cabbages, large quantities of which are grown round the city.

The department costs about \$17,000 per annum; and it is cheap when its efficiency and the health of the community are considered.

The Board of Health is a Government body, possessing the powers of our Provincial Board; the chairman of the municipal council has a seat upon it; its powers extend over the island. It has been in existence for some years, but it was only in July of last year (1889), that special duties were laid upon it with reference to the city of St. John's. A serious outbreak of diphtheria occurred which had to be checked by a strong hand; the arrangements in existence were inadequate, proper disinfection and quarantine could not be effected. On the top of a high hill, at the entrance to the harbor, stand the old barracks and hospitals of the Imperial Government, disused for the past twenty years and going to decay. They have been used at various periods for hospital and quarantine when the city was visited by cases of smallpox; these were put into good order, and constitute the present quarantine station. The hospital is by itself, on a lower level, about 300 feet above the sea, and a quarter of a mile from the other buildings, which stand on the top of the hill, about 250 feet higher. Here in the old barracks, there is a Lazaretto, or convalescent house, and the home where the other members of an infected family are kept during the period of probation—if no disease appears they are sent home. These houses are enclosed in separate yards, preventing any contact or communication between the inmates.

There is a good supply of excellent water from wells sunk deep into the rock. The two houses are washed down with disinfectant and lime wash every fortnight; clothes are steeped in a bichloride of mercury solution of 1 in 2000 for three hours, and then washed in a 1 in 3000 solution.

Fumigation of clothing has hitherto been done by sulphur. A steam fumigator made in Nottingham, Eng., is being erected.

At the hospital, the wards are large, high, well lighted, and admirably adapted for the purpose.

Fumigation of houses and disinfection of clothing, etc., where cases occur is done by the Board, sulphur process being used; steam will be used when the fumigator is erected. It is intended to send all articles requiring fumigation to the hospital where the steam fumigating chamber is being erected. Houses are placarded and watched by a special constable.

CASES OF OVARIOTOMY.

BY KENNETH N. FENWICK, A.M., M.D.

Prof. Obstetrics and Gynecology, Royal College, and Woman's Medical College, Kingston.

Since my last published case of this operation I have had a number of others which may present some points of interest to the profession. Ovariectomy is an operation where dexterity is only gained by experience; where so many complications may arise that the patience, presence of mind, and courage of the operator, are put to the test, and justice demands that only those should attempt it who have facilities and experience, and not merely from the desire to gratify personal ambition.

In all the cases ether was used as the anæsthetic, except in No. 10, where chloroform was preferred.

Antisepsis was carried out very carefully in all, and in every case of recovery, union of the abdominal wound took place by first intention without a drop of pus, except in No. 7 and No. 2, and in both of these the cause was traced to carelessness in the preparation of the antiseptic solution of bichloride. In every case the abdominal wound was closed by the continuous catgut ligature, beginning at the peritoneum, then sheath of rectus, and finally skin; a method which I am satisfied is infinitely better than the interrupted suture, and which I first saw done by Dr. Thomas, of New York. In all the cases the pedicle was tied with silk, which was cut short and dropped. A drainage tube was not employed in any of the successful cases, although I am inclined to use in suitable cases

simply a strip of antiseptic gauze, as I saw a year ago used by Dr. Hame, of Berlin, and in Albert's clinic, at Vienna.

Case 1. Mrs. J. S., æt. 44. Has had one child. For over a year noticed a tumor beginning on left side. At time of operating the tumor was the size of a seventh month pregnancy. Having been properly prepared, the usual incision was made three inches long, the cyst tapped with an ordinary trocar, and the clear fluid removed. The cyst was found to be multilocular, so after removing sufficient fluid to draw the sac out through incision, and being free from adhesions, the pedicle was tied and dropped; the abdominal wound closed by continuous suture, and moist bichloride gauze, absorbent cotton, and bandage. Her recovery was rapid, no elevation of temperature, and she left for home in two weeks.

Case 2. Miss Sarah N., æt. 27. A little over a year ago she had cystitis and a great deal of pain in right iliac region. On examining her I found the right ovary enlarged and cystic, about the size of fist, and as the symptoms were all evidently due to this, advised its removal.

On opening the abdomen the left ovary was found also to be cystic, and it first came in sight at the wound. In trying to remove it the cyst burst, so its pedicle was tied and the tumor removed. The right ovarian cyst, which was tougher, was removed entire, the pedicle tied and dropped, and the peritoneal cavity thoroughly sponged out. She made a rapid recovery with no elevation of temperature, but considerable pain, which I thought was largely due to her nervous temperament. The abdominal wound took three weeks to heal, owing to some defect in the preparation of the bichloride solution. The pain and cystitis have quite subsided since.

Case 3. Miss M. J. W., æt. 30. About three years before the operation she took a severe pain in her right side after a long walk, and a few months after this she noticed some abdominal enlargement, but could not remember exactly when it began. Some months after this she was tapped and eighteen pints of fluid removed. She was subsequently, at intervals of six months, twice tapped again, the fluid being highly albuminous and containing chole-

terine. A few months after this she returned, and I determined to try and remove it.

On opening the abdomen the cyst appeared to be divided into two parts by a fibrous partition running obliquely across it, but as it was so firmly adherent to the anterior and lateral wall of the abdomen, I decided not to risk completing the operation, so I closed the wound, and in two weeks she was up and around again. The cyst was afterwards tapped in two places, above and below the site of the partitions, when a large quantity of thick oily amber-colored liquid was got from one cyst, and three quarts of thin greenish fluid from the other.

Case 4. Mrs. E. O., æt. 46. Three years ago first noticed a tumor in right iliac region. On examination I felt a hard tumor about the size of a child's head, with some fluctuation. It had every appearance of being fibro-cystic, especially as the cavity of uterus was abnormally deep, and menorrhagia was marked. Dr. McLean, of Michigan, who examined it with me at this time, also agreed with its being fibro-cystic, and advised letting it alone; the subsequent history only shows how impossible it is to be quite sure of the nature until the abdomen is opened. Some months after this, the tumor becoming very large and troublesome and fluctuation everywhere present, I decided to operate. Some slight adhesions to the omentum were found, and after evacuating the cyst the tumor was found to be a fibro-cystic of ovary with large hydrosalpinx. The tying of the pedicle was, therefore, a matter of difficulty. She did fairly well until the third day after operation, when, the pulse beginning to fail, she sank and died. On *post mortem* examination found the ligature had slipped and allowed some oozing, which, although very little blood was found, no doubt this, added to the shock of the operation, caused the fatal result.

Case 5. Mrs. C., æt. 55; never had any children. Two years before the operation noticed abdominal enlargement. On examination I diagnosed an ovarian cyst, and on using a fine aspirator found it to contain colloid matter. She had had an attack of peritonitis a few weeks before, but as she had so much discomfort she urgently desired some relief, and preferred to run the risks, which she was told were greatly against success. On coming down to

the cyst found recent adhesions in every direction, which broke down easily, and firm adhesions which had to be tied and cut. When the pedicle had been tied and cut, and the cyst removed, having previously emptied out enough colloid matter to remove it, the bowels were glued together so as to remain above and leave the cavity occupied before by the cyst. The wound was then closed, but she only survived the shock about an hour.

Case 6. Mrs. J. C., æt. 32; has had no children. About two years ago noticed abdominal enlargement. The operation was very simple: the fluid was clear and watery; no adhesions; the pedicle, which was small, was tied and dropped; the entire operation being completed in twenty-five minutes. Recovery was rapid and complete.

Case 7. Mrs. N., æt. 35; has had several children. Suffered for years from ovarian dysmenorrhœa, and as every remedy failed I advised removal of ovaries. On opening the abdomen found uterus and ovaries firmly bound down by fibrous bands of adhesions, and so matted that it was impossible to bring up the ovaries, so, for fear of serious consequences, abandoned their removal and closed the wound. She recovered in ten days without any trouble except some pus in the abdominal wound, which took three weeks to completely heal.

Case 8. Mrs. J. D., æt. 34. Never had any children. Three or four years ago she noticed abdominal enlargement, and on admission to the hospital she was prepared for operation. As soon as abdomen was opened the cyst wall was noticed to be unusually vascular. A large amount of a greenish fluid was removed by trocar, and on draining out the cyst, which was free from any adhesions, it was found to be a fibro-cystic attached to fundus of uterus; so in order to remove it, either the uterus and ovaries had to come away and the pedicle treated by extra-peritoneal method, or the sac could have been stitched to abdominal wound and drained. The latter is the way it ought to have been done, but instead I stitched up the opening in cyst with catgut and dropped it, and closed the abdominal wound. She recovered quickly without any bad symptoms, but I have had to tap her since through abdominal wall.

Case 9. Ann B., æt. 32, a prostitute and

masturbator, who has suffered for years from abdominal pains. I advised removal of tubes and ovaries, which was done in usual way. Recovery rapid and complete.

Case 10. Mrs. F., æt. 35. Never had any children. Has had an abdominal tumor for thirteen years. On opening the abdomen and inserting a trocar into cyst a thin sebaceous matter came away with difficulty. A dermoid cyst was at once diagnosed, and the opening was enlarged with a knife until the hand could be inserted, when the contents, which consisted of sebaceous matter, hair, and bones, were scooped out. The cyst was multilocular, and after breaking through partition the other cysts were emptied in the same way. Several adhesions between cyst and abdominal wall were broken down with the hand, while two firmer bands were tied and cut. The abdominal wound had to be enlarged to fully six inches to remove the remainder of cyst. The pedicle, which was broad, was tied in sections and dropped. The abdomen was washed out with hot weak bichloride solution, thoroughly sponged out and the abdominal wound closed. There was hardly any shock, and recovery was rapid and complete. The operation just lasted sixty-five minutes, and the tumor must have weighed altogether about 35 lbs.

Selections.

CASE OF EXTENSIVE INJURY OF THE LEFT FRONTAL LOBE FROM A WOUND.

BY THOMAS LEISHMAN, M.B. AND C.M., BRECHIN.

W. C., 20 years of age, farm servant, was on Wednesday, 12th May, 1887, engaged scaring crows by firing at them with an old gun. During his dinner-hour he went out to have a shot behind the house. His mother heard the report of the gun, and as he did not return as expected to his dinner, she went out to look for him. She found him lying insensible on his back in a pool of blood, about one hundred yards distant. He had evidently discharged his gun while resting it on the top of the wall, with the result that it had burst, the breech being blown out. The fragment had been hurled upwards and backwards, and had struck the lad on his left temple, knocking him over. His friends at once con-

veyed him to the house and sent for me. When I arrived, about an hour after the accident, I found him lying in bed in a semi-conscious state, breathing stertorously, and incapable of speech. The pulse was very weak and irregular, and he was in a very collapsed condition, partly due to shock, partly to hemorrhage, which had been very considerable. His face was much engrained with powder, principally on the left side. The pupil of the right eye responded to light. The left eyeball was completely destroyed, having evidently been struck by part of the breech. In the middle of the margin of the upper left eyelid a small piece of tissue was punched out, about the size of a millet seed. Slight hemorrhage from the left nostril and mouth was observable. The principal wound was a cavity in the frontal bone, extending upwards from the middle of the left supra-orbital ridge for a distance of two inches, transversely at the upper margin one and a half inches, at the lower margin nearly one inch. The superficial wound appeared to be smaller than that in the frontal bone, the tissues being very much torn and lacerated. The fracture in its outline was very irregular. No fragments of bone could be detected until the finger was inserted into the wound, when a small piece about the size of a shilling was felt embedded in the brain substance. This was found to be slightly adherent to the dura mater, and had to be twisted off with dressing-forceps. It proved on examination to be concave and smooth on its inner surface, and was evidently a portion of the inner table of the frontal bone. Several other small spiculæ were also found and removed without any difficulty. On inserting the finger deeply into the wound, while searching for bone fragments, violent vomiting was set up, which resulted in the ejection from the stomach of a large quantity of greenish offensive fluid, preceded by a little blood. The brain substance was much injured.

The wound was thoroughly washed out with a weak solution of carbolic acid, and dressed with pads of boracic lint, lightly secured with a bandage. Cold water cloths, to be frequently renewed, were ordered to be applied to the head. Perfect quiet was ordered, and a little fluid nourishment to be given at intervals. Towards evening he rallied a little and passed a fairly quiet night. Next morning, when visited, his

pulse was found better than on the previous day, being stronger and more regular. The dressings had become adherent to the wound from oozing of blood, and were removed with some difficulty. The wound was washed out antiseptically, and carbolic oil on lint was used for the next dressing. The brain substance was now seen protruding through the broken table of the skull and pulsating strongly.

For the first week the patient remained in much the same condition, the wound suppurating and discharging freely. Though he uttered words he could not speak intelligibly. He seemed to feel little or no pain, except when the wound was dressed. Generally he lay in a drowsy state, from which at times it was difficult to rouse him. His bowels were obstinately confined, and castor oil had to be given to obtain relief. During this period the rise in temperature and pulse was slight. He was fed on milk food and beef tea.

About the beginning of the second week the stupor became deeper. The temperature and pulse gradually rose. Towards the middle of the week there was difficulty in swallowing, and involuntary passage of urine and feces. He seemed at the same time to be in a most uneasy condition, groaning and rolling his head about. At other times he seemed to obtain temporary relief from lying on his face with his head pressed down into the pillow. On being asked a question, he would mutter some words, but no information could be derived from what he said.

The discharge from the wound now became very offensive, and the protruding mass of brain substance began to change color, becoming first brown, gradually shading into black. Charcoal poultices were applied, when a slough began to separate from the brain substance, and was then easily removed in pieces. The largest piece was about the size of a shilling, and about an eighth of an inch at its thickest part, thin at the edges. As the surface of the wound became clean and healthy, the urgent symptoms gradually passed off, leaving the patient at the end of May in a very weak and exhausted condition. The carbolic dressings were again used, the wound showing signs of cicatrization from its edges. The injured eye had entirely disappeared, and the resulting cavity had much the appearance seen after enucleation of the eyeball.

About this time he would use profane language whenever the wounds were touched, or when he was annoyed in any way. In contrast to this, when he improved and was able to be out of bed, he spent much time in reading the Bible. His memory began to return, and he commenced to speak intelligibly, although it was difficult for him to concentrate his thoughts on any subject for even a few minutes. His recollection of events up to the time of the accident was perfect, but everything after that for a period of about three weeks was a complete blank. He continued gradually to improve, and gained strength both mentally and physically till the end of June, when he was able to be out of bed. Red lotion was applied to the wound, as the process of healing was slow, and about the beginning of August the wound had closed. During July he suffered much from toothache on the left side, but would not permit the decayed tooth to be extracted. The sight of the right eye was much impaired for near objects, though distant ones were fairly well seen. He was so nervous that he would not suffer an examination to be made through the ophthalmoscope. Iodide of potassium was given in small doses, under which his sight seemed to improve, but his obstinate dislike to taking medicines was such that the remedy was not persevered with.

From this time till the end of the year, on three different occasions, pieces of dead bone worked their way out at the cicatrix, varying from less than half to an inch in length, of a white ivory-like appearance. On all of these occasions there was much pain and discharge, which continued for some days after their removal, accompanied with febrile disturbance. The wound always closed up shortly afterwards. The glands of the neck were enlarged and painful. The appearance of the cicatrix in the spring of 1888 was that of a marked depression over the cavity in the frontal bone, covered in with a thin, whitish, semi-transparent membrane, which moved with the pulsations of the brain.

For the last eighteen months the patient has been working off and on in the fields at light employment. He takes his food fairly well, but is very thin. His intelligence, as far as can be ascertained, was never very highly developed before the accident, and has certainly not been improved thereby. He is very irritable, and the

least annoyance brings on a fit of violent passion, which leaves him weak and nervous. His memory is very defective. Severe headaches trouble him periodically—so much so that he has to remain in bed for a day or two at a time. He is afraid of going out at night in the dark alone; and unless someone is with him to guide him, is in danger of falling. At times he is very secretive and will hardly speak. Lately he has complained of pain and slight loss of power in his right hand. His sight is steadily becoming worse. When he reads, his face is almost touching the book. Owing to his having removed with his parents from the immediate neighborhood, he has not been seen by me for some time; but his latest symptoms were described to me by his mother, whom I chanced to meet some weeks ago. The continuance and increase of symptoms up to the present time seem to indicate that some retrogressive lesion is extending into the brain substance.—*Edinburgh Medical Journal*.

UNIVERSITY OF PENNSYLVANIA HOSPITAL.

[Service of Dr. J. WILLIAM WHITE.]

I. EMPYEMA OF THE ANTRUM SIMULATING SOLID GROWTH.

Mrs. P., æt. 59, white, was sent to the hospital by her physician for the purpose of having her left superior maxillary bone removed for a tumor of that structure. The patient gave the following history: About a year previous to admission she received a blow upon her left cheek. She had a tooth extracted about this time, a portion of the root of which remained. Three months subsequently she noticed that her left cheek was swollen, and an acrid, offensive secretion appeared in the mouth. The enlargement increased, and the discharge into the mouth continued. She suffered very little pain.

On examination, the left cheek was seen to be very prominent, and the hard palate depressed. The skin was not involved. The appearance was that of a non-malignant solid growth, *e. g.*, osteoma or chondroma. Although the enlargement closely simulated tumor, it is a matter of experience that a collection of pus in the antrum may give rise to this condition. Dr. White, therefore, decided to make an exploratory puncture

before taking any steps toward the removal of the superior maxilla. A trocar was accordingly forced through the anterior wall of the antrum, and its withdrawal was followed by the discharge of a considerable collection of pus. The opening was enlarged with bone forceps, and the cavity washed with a saturated solution of boric acid. It is very fortunate for the patient that excision of the upper jaw was not needed, as she has mitral and aortic heart disease, and contracted kidneys, so that it is improbable that so grave an operation could have been performed without serious consequences resulting.

Abscess of the antrum may result from a carious tooth, traumatism, caries of its walls, and a catarrhal inflammation of the lining membrane, becoming purulent after obstruction of the orifice, etc. Sometimes the diagnosis can be made by the discharge of pus through the nostril of the affected side. Often, however, the use of an exploratory trocar, as in this case, is necessary.

The after-treatment consisted of the free use of the boric acid lotion several times daily. The patient left the hospital in a week, the discharge having entirely ceased, and the prominence in the cheek rapidly subsiding.

II. HYPOSPADIAS.

Arthur J., æt. 7, a victim of this malformation, was brought to the hospital for operation. The hypospadias was of the peno-scrotal variety, and the penis was united to the scrotum throughout its entire length. Duplay's method was employed, and the first operation consisted in freeing the penis from its attachment to the scrotum, and the free transverse division of the band which united the glans to the hypospadiac orifice. This allowed the complete straightening of the penis, and it was then bandaged against the pubis to maintain this position. In a few days the patient was allowed to go home, as it is inadvisable to perform the next step in the operation until a satisfactory result of the first has been assured.

In a few months he presented himself again, and as the organ had remained perfectly straight, the second part of the operation, that of forming an urethra, was done. This is effected by tunneling through the glans with a trochar in the proper position; a flexible catheter is then passed through this opening, and along the under sur-

face of the penis in the normal position of the urethra. An incision through the skin is now made a few millimetres on either side of the catheter, and flaps raised in both directions. Those next the catheter need be but small, so as to partially encircle the latter, the outer flaps being more freely dissected to enable them to meet over the catheter. These flaps, thus made, were brought together and retained by modified button sutures. Union was obtained for one-half the length of the penis, and a third operation, similar to the last, resulted in establishing a perfect urethra. It then remained to close the hypospadiac orifice, and to render the urethra continuous from bladder to meatus. This is the third step in the method. It is done by carefully freshening the edges; a catheter is then introduced into the bladder, and flaps raised, as in the second proceeding. In this case the catheter was allowed to remain three days. The result was excellent, and the patient left the hospital with a patulous urethra extending from the glans penis backward.—A. C. WOOD, M.D.
—*University Medical Magazine.*

HANDS OFF.—Dr. Geikie and his colleagues in Trinity Medical School, and their sympathizers in the sectarian universities of this province are quite sore over the fact that the Provincial University has re-established her medical faculty and is engaged in the work of medical education. The worthy Dean of Trinity pretends that he and his sympathizers are instigated to this opposition out of regard for the public good. The real reason is that they fear opposition, and that they dread a more scientific system of teaching the healing art, and that a lot of them are consumed with sectarian prejudice. To all these gentlemen connected with rival or sectarian institutions we say Hands Off the University of the people of Ontario. When the people of this province as a people object to their university extending its usefulness and widening the service it renders to the public it will be time for the legislature to curb the spirit of progress lately shown in the Queen's Park; until then the rivals and the sectarians had better speak for themselves as rivals and sectarians, and not for the people. There is one thing the people of Ontario ought to remember: that the legislature

of this province is supreme in educational affairs, and that it is the fountain of university powers. Yet these sectarian universities have the ungracious trick of obtaining powers and favors from the Provincial Legislature, and then turning about and combining against the Provincial University and crying down the public system of education. Some of them even deny the power of the Province to amend their "royal charters." Queen's goes to Ottawa for an amendment of her powers, and Trinity bases her pretensions to open a degree-conferring establishment in Great Britain on a royal charter issued by the home authorities. But when it comes to attacking the Provincial University they work in the Legislature, and if they seek to get a hand in the control of public education they work on the Minister of Education, who is a politician first and therefore they think open to sectarian pressure. All these sectarian establishments would like to secure provincial aid; they would, if they could, close up the people's university and apportion it out amongst themselves. But they take good care, as Mr. Blake said, to keep out of the provincial audit. They would like to cripple the Provincial University, to interfere with public education so as to benefit themselves, to obtain, if possible, a provincial grant, but they on their part object very strongly to the province having a word to say in their management or their policy, or to inspect their accounts. The Provincial University, on the contrary, has never interfered with them or their rights; she has chosen to go on in her own way and to endeavor to serve the people of Ontario, and to advance our noble system of state education. Let Dr. Geikie and his colleagues go on in their work, improve their school and their methods, and let them leave to the people of the province, who have faith in the provincial educational institutions, the business of their management. By their conduct in the establishment of schools of their own they have declared a want of confidence in the state institutions; it is not for them, prejudiced as they admit themselves to be, to advise what is in the best interest of our great system of public education, completed as it is by a great and expanding public university. They ought to have all they can do in running their own establishments.—*The Toronto World.*

THE
Canadian Practitioner

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

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

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TORONTO, DECEMBER 16, 1890.

FORCIBLE DILATATION OF THE CER-
VIX UTERI.

Many are the minor surgical operations produced by modern gynæcology. Not the least important among them is that which is known as "forcible dilatation of the cervix." We have always looked upon it as one of the most barbarous procedures known to surgery, and were much pleased to notice in the November number of *Buffalo Medical and Surgical Journal* some remarks on the subject by Dr. Joseph Price, of Philadelphia.

Dr. Price read a paper before the Philadelphia County Medical Society on the subject of "Certain Causes of Major Pelvic Troubles Traceable to Minor Gynæcology," in which he made comments on Emmet's cervical operation, forcible dilatation, inconsiderate use of the uterine sound, and intra-uterine applications. He admits that a certain measure of success may follow a forcible dilatation of the cervix in some cases of dysmenorrhœa due to stenosis of the cervical canal, but he considers that the procedure involves very great dangers. He says: "Rapid dilatation of the cervix is a distinct traumatism, and along with it run all the dangers incident to septic absorption that attend any other violent procedure, and where traumatism, incident to natural causes, is confessed to be the cause of so much subsequent mischief, it ought not to be expected that operative injury can be harmless. This conclusion, reached inferentially, has been abundantly confirmed on the operating table by much of my later pelvic work. In a number of cases with a history of preceding dilatation, the after-operation has exhibited an inflammatory condition of affairs as complicated as any other in

my experience. Some of the dilatations were done with pre-existing disease, which was made worse by this interference, whilst others were done simply to relieve the dysmenorrhœa, and resulted in the establishment of a complicated surgical disease in which operation was necessary purely to save life. All in all, I believe that, judged simply by its remote effects, the operation of rapid dilatation is a dangerous one, and results oftener in subsequent harm than in lasting good."

The dangers connected with the operation are thus described by Dr. Price in a very concise and rather graphic manner. The words of warning from such a prodigious worker, such a careful worker, and so brilliant a gynæcologist, are worthy of careful consideration; and we feel that we are justified in giving them considerable prominence, together with our hearty endorsement.

APOLLINARIS WATER.

Apollinaris water is a pure mineral water, its chief virtue consisting in the fact that it contains a very large proportion of carbonic acid gas. The spring from which it is obtained is situated on the bank of the river Ahr, near the village of Nuanahr, in Germany. It was discovered accidentally in the year 1851, from the fact that vines would not flourish on a particular spot because carbonic acid gas issued from the ground. On the advice of Professor Bischof, of Rome, who was consulted, a well was sunk, and at a depth of forty feet a spring was reached, which rose to the surface with tremendous force. The volume of carbonic acid gas expelled with the water is so great that it is dangerous to approach the spring on a windless day. In 1873 an English company purchased the property, and have since that time distributed this celebrated water to all parts of the world. A correspondent of *The London Times* gives some interesting statistics which show that the supply is abundant, and the methods of bottling and distributing are complete. Last year about sixteen millions of bottles were exported. About seven hundred tons of straw, for packing, and fifty-seven tons of corks were used in the same year. They fill the bottles at the rate of ninety thousand a day, and four hundred and fifty persons are engaged in the works. Careful tests show that the pre-

sent well can supply sufficient water to fill forty million quart bottles yearly. When the demand grows beyond these limits the company may have to sink a second well.

NOTES.

A HOSPITAL CENSURED BY A CORONER'S JURY.—A patient, with alcoholic delirium, committed suicide, last month, in the Long Island College Hospital of Brooklyn. She was confined in a private room, with hands and feet manacled, and was tied to the bed. She managed to get rid of her fastenings, and jumped out of a window, which was not latched. The verdict of the coroner's jury contained the statement that "the authorities of the hospital are responsible, for being negligent in not providing the proper care to prevent the said patient from taking her own life." The profession and the public will probably agree with the verdict. It is very difficult, and often impossible, to treat such patients outside; but when they are taken into a hospital, they should not be allowed to throw themselves out of windows.

Pathology.

BACILLI OF ENTERIC FEVER IN URINE.—Recently Karlinski, (*Prag. Med. Wochenschr.*), undertook a research with regard to the occurrence of the specific germ of enteric fever in the urine of patients suffering from that disease. His observations were made upon the urine of thirty-eight living patients, and microscopic examination was had also of the kidneys of six patients who had succumbed to the fever. In twenty-one out of the forty-four cases the result of the search for bacilli was positive, and in these twenty-one albumen was present in the urine. When albuminuria was transient, bacilli were, as a rule, absent. Sometimes the bacilli show themselves much earlier in the urine than in the fæces—on the third day in the urine, but never before the ninth in the fæces. On these grounds K. thinks the examination of the urine of value as a means of diagnosis. The process of urine examination also is much simpler than in the case of fæces. Some experiments of the observer showed that the increase of the typhoid bacilli in albuminous

urine is irregular, certainly, but always occurs, and more freely at 39° C. than 32° C. In two enteric typhoid cases the bacilli died in the urine, which was albuminous, in five days at 36° C.—J.C.

PUS FORMATION.—Kapper (*Wien. Medicale Presse*) has recently reported a case of abscess formation, in which micrococcus tetragonus was the only microbe to be found in the pus. Accordingly he considers it as the cause. Whilst this form has long been known, and particularly as an inhabitant of lung cavities, it has been treated as an accidental occurrence in these cases. It will apparently have to be added to the list of pyogenic microbes.—J.C.

Book Reviews.

A Dictionary of Practical Medicine. By various writers. Edited by James Kingston Fowler, M.A., M.D., F.R.C.P., Senior Assistant Physician to the Middlesex Hospital, etc. Philadelphia: P. Blackiston, Son & Co.

This work gives an account of important subjects comprised under the head of practical medicine, including also the diseases peculiar to women. The editor and contributors in their description of the various diseases, and treatment of the same, have aimed at practical utility rather than completeness of detail. Surgical subjects, as a rule, have been excluded, but in some of the articles dealing with the diseases of women certain details of surgical procedures have been given. The work resembles Quain's Dictionary of Medicine, which is very well known in this country. As Dr. Fowler's dictionary is fully up to the mark in every respect, and quite abreast of the times, we believe it will be found an exceedingly valuable and interesting book for the general practitioner.

Cyclopedia of the Diseases of Children, Medical and Surgical. The articles written especially for the work by American, British, and Canadian authors. Edited by John M. Keating, M.D., Vol. IV. Philadelphia: J. B. Lippincott Company.

The contents of the volume include one chapter on Diseases of the Ear, three chapters on Diseases of the Eye, seven chapters on Hygiene, and twenty-eight chapters on Diseases

of the Nervous System. Some of the monographs on subjects connected with hygiene are especially interesting. Among these are one on physical development, by John M. Keating; one on School-Hygiene, by Dr. D. F. Lincoln; one on Juvenile Crime and Public Methods of Prevention and Reclamation, by Dr. J. Percy Keating; and one on Medico-Legal Testimony by Dr. Jerome Walker. The chapters on Diseases of the Nervous System occupy the greater portion of the volume, and are all that could be desired in that important subject. Among the authors are the following: Dr. Allen McLane Hamilton, Langdon Carter Gray, A. Jacobi, Abner Post, J. J. Putnam, Mary Putnam Jacobi, Charles L. Dana, P. S. Conner, Charles B. Nancredi, James Stewart, E. C. Seguin, etc. This volume is fully equal to the admirable ones that have before appeared.

Personal.

DR. J. H. RICHARDSON, of Toronto, presented some specimens of the beautiful rifle bird to the Biological Museum of the University of Toronto.

DR. C. MCLELLAN, of Trenton, also presented some admirably mounted specimens of the Canada goose and pin-tailed duck.

DR. P. H. BRUCE, of the Provincial Board of Health, delivered a lecture on "Underground Waters as a Source of Public Supplies," before the Engineering Society of the School of Practical Science, December 2nd.

DURING Professor Ramsay Wright's absence in Germany his classes in the University of Toronto will be conducted by Dr. A. B. Macallum, Mr. E. C. Jeffrey, B.A., and Mr. J. J. McKenzie. Dr. Macallum will, however, do the lion's share of the extra work.

DR. W. H. ELLIS delivered an address on "The Chemistry of Photography," before the University Natural Science Association, Dec. 2nd.

DR. J. W. MCLAUGHLIN, ex-M.P.P., Bowmanville, was married December 3rd, to Miss Wilkenson, of Rosedale, Toronto.

Births, Marriages, and Deaths.

MARRIAGES.

ACHESON-PHYMISTER.—On December 3rd, George Acheson, M.A., M.B., of Toronto, to Louie, second daughter of Mr. James Phymister, Montreal.

DEATHS.

SUTHERLAND.—At his late residence, Oakville, on Sunday, 30th November, Thomas J. Sutherland, M.D., in his 53rd year.

WATSON.—On Sunday, Nov. 23rd, at Euclid ave., Frederic Sidney, youngest son of Dr. A. D. Watson, aged 1 year and 5 months.

Miscellaneous.

A SIMPLE METHOD OF REMOVING A NEEDLE.—I think it may be of service to record a simple means by which I obtained the removal of a broken needle from the heel of a young girl, aged 12, whom I saw lately walking about on her toes to avoid her right heel, into which a needle had been broken, touching the ground. The buried end could be felt, but any pressure led to its further entry. I directed her to wear a large thick corn-plaster around the spot, with a little wet cotton-wool in the centre, and to tread freely on the heel. Within a week afterwards she showed me the needle, which had protruded, and she had easily withdrawn it. Thus no wound was made, and no scar left to be a tender spot on the plantar surface—CHAS. STEELE, M.D., F.R.C.S., in *Brit. Med. Jour.*

Dr. Bergmann, of Berlin, in a recent clinic, stated that the Koch method, apart from its curative virtues, would be an important aid in diagnosis. In illustration he reported a case of tumor of the larynx, where it was doubtful whether the affection was tubercular or cancerous. As the treatment produced no constitutional reaction, Professor Bergmann concluded that the tumor was cancerous.

FANCY DISEASES.—"Diseases is very varius," says Mrs. Parington. "Now old Mrs. Hayze has got two buckles on her lungs, and Mary Simmes is dying of hermitage of the lungs. One person has tonsors of the throat and another finds himself in a jocular vein. New names and new nostrils everywhere!"

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