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Original Communications.

HYSTERECTOMY FOR LARGE FIBRO-CYSTIC TUMOR.

BY A. B. ATHERTON, M.D., HARVARD, L.R.C.P. AND L.R.C.S. EDIN.

Lecturer on Surgery Woman's Medical College, Toronto.

Read before the Ontario Medical Association.

Mrs. M., widow. Youngest child 11 years old. Consulted me for the first time on August 27th, 1886. She was 49 years of age, and had usually enjoyed good health till the beginning of the present trouble three years ago. Menstruation had always been free, and since the appearance of the tumor has been much more copious, with the exception of the last two periods, when it was scanty. During the first year, after it was noticed, the tumor grew very rapidly, and at the end of that time had attained nearly its present size. During the last two years she had been much troubled with swelling of the legs, with which she was at one time confined to bed for several weeks.

Present condition: Marked emaciation; pulse 90; feeble; a large, softish, solid tumor fills the abdominal cavity, most prominent above the umbilicus and thrusting outwards the thoracic walls; dull on percussion all over front and right side; no distinct sense of fluctuation anywhere; superficial veins somewhat enlarged, and some œdema in hypogastric region; circumference of abdomen, 45 inches. *Per vaginam*: Vaginal walls somewhat œdematous; cervix in normal position, widens out above into the tumor; sound passes five inches, somewhat backwards and to the right.

Treatment: Advised to try ergotine for the present, and wait for menopause.

Nov. 23. Menstruation continues regular. Measurement around abdomen, 40 inches; treatment continued as before.

May 20, 1887. No menstrual flow from November to April; then reappeared.

August, 1888. Has not varied much in size during the last fifteen months; menses irregular both in time and quantity.

August 10, 1889. Has been increasing in measurement again since last year; only one slight flow of blood during last six months; now girts from 46 to 48 inches; some œdema of genitals of late; also œdema of lower abdominal wall is greater than formerly, and there is distinct superficial fluctuation in flanks and epigastric region; sound enters 4¾ inches, somewhat to right side.

Patient is becoming more emaciated; pulse 92; feeble; complains of being unable to take much food because of a feeling of fulness; is troubled much with flatulence; during the last day or two she has suffered a good deal from pain about right ilium and groin, for which I was called to see her.

Operation advised and agreed to.

August 21. After careful preparation of the room and patient, the following operation was done, assistance being rendered by Drs. Burns,

Carson, and Dobie:—Incision from ensiform cartilage to the pubes; about two quarts of ascetic fluid escaped; tumor found free on anterior surface; a cyst at its upper part tapped, and about ten ounces of thin serous fluid drawn off. In right iliac region, at site of pain, which was felt ten or twelve days ago, the tumor was glued to parietes by soft adhesions, which easily broke down. Posteriorly the small intestine was closely and firmly united to growth at one point, requiring to be dissected carefully away with knife. Several catgut ligatures used to control bleeding from raw surface of wound. On left side the tumor was also closely connected with sigmoid flexure of colon.

After freeing the tumor, a wooden skewer about eleven inches long was thrust through its anterior surface and a thick piece of twine looped over its ends, thus affording a means of holding and steadying tumor while lifting it out of the abdominal cavity. Tumor found to grow from lower side of left body of uterus and from upper part of left cervix, the fundus being thereby pushed over to right side. As a better pedicle could be got by removing fundus and body of uterus along with tumor, it was determined to do this. The broad ligament vessels were ligatured in two places on either side, and an incision made between them so as to loosen up the parts, then a rubber tube was wound three times about neck of mass and tied; the tumor with uterus was now cut away, a knitting needle being thereafter thrust through stump to prevent any possibility of the tube slipping off.

The right tube and ovary were removed with the tumor; left not seen. A large number of silk ligatures were used to control bleeding from left side of stump, which extended two or three inches in this direction; main portion of stump was fashioned so as to come together in two flaps, one on either side of median line; then a continuous buried catgut suture was put in so as to bring the deep parts of flaps tightly together, and a half dozen or more silk sutures were applied along the peritoneal edge of the flaps, their ends being left long. By occasionally loosening rubber ligatures, other bleeding points were recognized and secured by ligatures. Finally, when no further hemorrhage of consequence occurred, the rubber tube was removed, and the stump stitched with catgut all around to edge of wound in peritoneum. The ends of the silk sutures which had been left long were now tied over a broad abdominal director placed transversely across lower end of abdominal wound, a glass drainage-tube introduced an inch or so above stump, and the abdomen closed by sutures; iodoform powdered over stump, and salicylated cotton applied to this part; a carbolized sponge was placed over the end of the drainage-tube in the usual way; and the upper wound dressed with bichloride gauze. A large amount of cotton wool was required to fill up the concavity in the epigastric region, lying between the expanded thoracic walls, which stood out on either side like a pair of wings.

Altogether the operation and dressing lasted about four hours, an hour being consumed in securing bleeding points after stump had been sutured. When put to bed, the patient's condition was good, pulse being only 84.

On examination the tumor was found to be smooth and round at its upper three-fourths. At the base, however, there were a number of out-growths from its surface, varying from the size of a walnut to that of the fist. Some of them were pedunculated. They consisted in large part of cysts, containing a slightly opalescent thin fluid. The weight of tumor was a little more than forty pounds.

Aug. 22, 9 A.M. Rested fairly well; has had two ½ gr. morphia suppositories since operation; pulse 88; temperature in axilla normal; some tympanites, and considerable raising of wind, but not much vomiting; ℥ij. of sulph. magnesia and ℥ss. ol. terebinthinæ administered as an enema in a cup of warm milk and water.

11 P.M. Bowels have moved freely, and tympanites is less; pulse 96; temperature 100°.

During the first week following the operation the temperature never rose above 100° in the evening, and it was but little above normal in the morning. Drainage-tube removed on the seventh day. All the sutures removed on the ninth day. On the evening of the ninth day the temperature suddenly rose to 101.2°, and on the following morning there was a slight discharge of pus from about stump, after which the temperature soon became normal.

Two weeks after the operation the silk ligatures (or sutures) which were fastened to the abdominal director were removed.

During the third week patient was moved to a couch; at the beginning of the fourth week sat up in a chair for half an hour; weighed 96 lbs. at end of 5th week; and went out of doors at end of 6th.

April, 1890. For some months after last report, patient was troubled off and on with soreness and some pain and induration about the sinus leading to stump, these attacks being generally followed by the discharge of one or more silk ligatures. There is a sinus still existing, leading down 2½ inches, but for three or four months it has given little or no annoyance. There is only a very slight discharge. She goes about everywhere when the weather is favorable, and weighs about fifty pounds more than she did five weeks after the operation.

Remarks: In the above report there are several points which seem to me worthy of remark. In the first place, the large size of the tumor makes it deserving of record, as there are comparatively few cases of recovery after removal of tumors of this character, weighing as much as forty pounds. Again, the fact that this fibroid tumor, after having diminished perceptibly in size, grew larger again after the apparent menopause, proves that the climacteric does not necessarily lead to the cessation of growth or disappearance of these neoplasms. I have met with another very large fibro-cystic tumor which brought about a fatal issue after fifty years of age. As a rule, however, there can be no doubt that the cessation of menstruation does favorably affect such growths. It seems probable from the cystic degeneration that was manifest in several portions of the tumor, that this is what led to its increased size during the year preceding removal.

I would call attention to the use of the wooden skewer to take the place of the broad cork-screw which Mr. Tait recommends to be used for the purpose of lifting out more readily and safely myomata of the uterus. It seemed to answer the purpose as well as, or even better than, any single cork-screw could have done in handling so large a tumor. Besides, it has the merit of costing nothing, which, in these days of many surgical inventions, is not unimportant.

As to the persistence of a sinus in the abdominal wall, I suppose there are still one or more silk ligatures inside. The sinus might be forcibly dilated and the ligatures thus got at and removed, but as it is giving the patient so little trouble I prefer to wait a little longer. If there should arise any considerable disturbance in the part, however, I would make an effort to find and remove the cause.

Finally, a few observations on the treatment of the pedicle (that much vexed question) may not be amiss. As you are aware, up to a very recent date, the methods employed have been two, viz., first, the use of a clamp or rubber ligature with fixation of the stump in the lower angle of the wound, termed the extra-peritoneal; and secondly, ligature of the stump by silk, followed by its being dropped back into the peritoneal cavity, as in the case of ovarian tumors, this being the usual intra-peritoneal method. Both have, in some hands, given good results. In Great Britain, most of the leading abdominal surgeons have preferred the former, while on the continent of Europe many have followed the latter plan. There are, however, objections to both. In the extra-peritoneal treatment by clamp or rubber ligature, although protection against hemorrhage is assured, yet there exists the danger which arises from the presence of a sloughing mass above the constricted portion of the pedicle. Again, when the stump is ligatured with silk and dropped back into the abdomen, we encounter, first, the risk of secondary hemorrhage from the shrinking of the muscular tissue included in the ligature, and furthermore, the danger of infection of the peritoneal cavity through the cervical canal. Sloughing of the pedicle seldom, if ever, occurs, and may be practically left out of consideration. In order to overcome these various difficulties, several modifications have been suggested and tried at different times. In the case above reported, I followed very nearly the plan pursued by Dr. Howard Kelley, as described in the April number of the *American Journal of Obstetrics* of last year. The chief point in which I deviated from his method was in the way of securing the ends of the silk sutures attached to the stump. Instead of tying the ends of the sutures over a director placed transversely, as I did, he seizes them in the bite of a forceps, and lays the latter back over the abdominal wound above.

It seems to me that Kelley's plan of treating

the pedicle is the best extra-peritoneal one yet devised. While it guards against hemorrhage by traction on the stump, and by having most, if not all, of the cut surface outside of the peritoneal cavity and therefore within constant observation, it minimizes or entirely avoids the slough which is produced by the constriction of the stump in a clamp or ligature. On the other hand, a longer time is consumed in securing the parts in this way than in the use of the clamp. This is not of so much importance where the patient's condition is good. A goodly number of surgeons are, however, still seeking after some more perfect intra-peritoneal method of dealing with the pedicle.

At a meeting of German gynæcologists last September, Martin reported two successful cases of hysterectomy for myomata, in which he enucleated the whole cervical stump. He claims that the unfavorable results obtained when the latter is dropped back into the abdomen, are chiefly due to infection from the cervical canal, and proposes to remedy this by its entire removal. Whether this opinion will be confirmed by future experience remains to be seen. Dr. Stimson, and some other American surgeons, have tried and speak well of the method.

Still another course of procedure has lately been recommended by Drs. Dudley and Goffe of New York, each of them having had four successful cases of hysterectomy. After the tumor and uterus have been cut away, and before the rubber ligature is removed from the stump, the peritoneum is dissected off from the latter and its muscular portion inside of the peritoneum, transfixed and firmly tied with a double silk ligature. Then the peritoneum is united over both muscular tissues and ligature by means of a continuous suture of catgut, thus placing them outside the peritoneal cavity. At the end of the fourth or fifth day, when suppuration has been established, as indicated by a rise of temperature to 101° or thereabouts, the cervical canal is dilated by means of steel sounds or a steel dilator, and the imprisoned pus and debris of sloughing tissue above the ligature allowed to escape. A metal drainage tube is then introduced, and antiseptic fluids are injected from time to time to cleanse the pus cavity. After from ten to seventeen days the silk ligature comes away, and the parts are soon healed. The chief objection to this method of treatment seems to me to be the disturbance of the patient at such a critical period after the operation. But its advocates state that the cervix at this date is soft and easily dilatable, and the dilatation produces so little pain that the administration of an anæsthetic is not required for the purpose.

PERI-TYPHLITIC ABSCESS.

BY A. GROVES, FERGUS.

Read before the Ontario Medical Association.

Peri-typhlitic inflammation, although comparatively rare, is still of sufficient frequency to render its considerations a matter worthy the attention of every member of the profession. It is only in recent years that the nature of the disease, its importance, and its appropriate treatment, have become thoroughly understood. My limited experience, I am quite aware, gives me no right in any way to speak with the voice of authority, seeing I have had only seventeen cases of peri-typhlitic inflammation, of which thirteen went on to the formation of abscess and were operated on, the remaining cases having terminated in resolution. My experience, however, may be of some slight value to the profession, for I have had the good fortune never to have lost a case either as a result of operation, or for the want of an operation.

It is commonly supposed that inflammation in the cæcal region results from foreign bodies having become impacted in the vermiform appendix, but although this is probably a common cause, it is by no means certain that it is the sole or possibly even the most frequent cause. This form of inflammation may arise from impacted masses in the appendix, or in the cæcum, or as a result of typhoid ulceration, and perhaps as a result of external injury.

The diagnosis is not usually difficult, for the increase of temperature, pain, and localized swelling are usually sufficient to indicate the nature of the disease. Tenderness is not, as a rule, very marked, although always present. The general abdominal tenderness of peritonitis is wanting. In a case of this kind the appropriate treatment is perfect rest, and thorough emptying of the bowels, if there seems to be

impaction in the cæcum, opiates to relieve pain and locally warm applications, if they are grateful to the patient. Bleeding, blistering, the inunction of mercurial ointment, and such like measures, are positively injurious, and can fill no useful indication.

Should resolution not take place speedily, or should the symptoms point to the probable formation of pus, an operation should be at once undertaken, for delay is, in such a case, particularly dangerous. It must be admitted that no positive rule can be laid down as to the proper moment for operating, that being a matter altogether for the judgment of the operator, but there can be no question that an early operation is, in every way, best. In my opinion the point at which the opening should be made is of the utmost importance, in order to avoid opening into the abdominal cavity. I am aware many surgeons speak lightly of opening the peritoneum, and too often have the courage of their opinions; but, although I have no morbid dread of intra-peritoneal surgery, nevertheless I retain a lingering respect for peritoneal integrity, and am old-fashioned enough to think that, other things being equal, it is better to keep outside the peritoneum. The rule I follow is to make an incision about two inches long, and not more than one inch to the inner side of the anterior superior spinous process of the ilium, dissecting down, using the surface of the bone as a guide until the abscess cavity is reached. I have found no advantage from using a drainage-tube, nor does there seem to be anything gained by elaborate antiseptic precautions; at the same time, if an iodoform odor tends to reassure the surgeon, it will be quite harmless. I have never had the misfortune of opening the peritoneal cavity in these cases, possibly because I have been especially careful to avoid doing so, nor have I ever had to perform a laparotomy for the purpose of washing the pus of a ruptured abscess out of the cavity, but if the abscess has already burst into the peritoneum an immediate laparotomy is imperatively demanded, for on this depends the sole hope of saving the patient. In my cases there were but four where there was actual communication between the bowel and the abscess at the time of operating, and in one of these about four square inches of gangrenous intestinal wall came away, rectal injections flowed freely from the wound and fæces were discharged, yet in a few weeks the parts were entirely healed, and the patient now enjoys perfect health.

In no case have I seen any after ill effects of the disease, nor have I known any case in which a second abscess developed.

ALCOHOLIC PERIPHERAL NEURITIS.

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

In connection with the case of this somewhat rare affection, reported in THE PRACTITIONER of August 1st, by my clinical clerk, Mr. W. A. Barnhart, the following will prove interesting:

M. J. O'C., æt. 45, an hotel-keeper; a robust, well-built man; has taken strong liquors to excess for years, indulging even more freely than usual lately. When first seen in July, he was on the verge of an attack of *delirium tremens*. Alcohol was wholly forbidden; milk and ærated water given as freely as possible, and some sedative medicine, to quiet his excitement. To induce sleep at night, sulphonal, grs. 35, was given at six o'clock, after some milk. He progressed favorably, the sulphonal giving him very good sleep, but his mental condition continued greatly "muddled"; it was with difficulty he could comprehend or follow any conversation. In a day or two he began to complain of his legs and feet feeling numb and painful; he said he had rheumatism in them. They were tender to pressure; no knee-jerk, but plantar reflex was present; he walked awkwardly. In a few days the hands became numb and painful also, but retained fair strength. The walking by this time became quite ataxic, and standing quite uncertain. The legs grew so weak that he could scarcely go down stairs. He could not be induced to walk out to a carriage. He continued much the same for about three weeks, when he gradually improved. The walking became steadier, and the legs stronger; the pains and numbness grew less, but still continued to trouble him considerably; still no knee-jerk, and standing is somewhat uncertain; the muscles of the legs are very soft and flabby. It was not convenient to test the electrical reaction. About the middle of August he walked about two hundred yards to the boat, to go across the

lake. It was with the utmost difficulty that he managed this walk, and reached the boat quite exhausted.

With excess in drinking alcoholic liquors so common, it is rather surprising that multiple neuritis is so infrequent, especially in the male. It is probable that many of the rheumatic cases among the intemperate are really mild attacks of neuritis. The disease was not understood generally until five or six years ago. It is said to be more frequent among the higher classes, whose nervous system is more highly developed.* The spirituous liquors, as brandy and whiskey, are most apt to produce the disease, and their long continued use rather than their excessive use for a short time. In arsenical neuritis, on the contrary, it is the acute poisoning, and not the prolonged use of arsenic, that usually gives rise to neuritis. This is well illustrated by the case published in THE PRACTITIONER of January 1st, 1890.

The result of the distinctive symptoms is usually sudden, being preceded, however, by the usual signs of excessive drinking, as gastritis, insomnia, etc. The symptoms consist in various disturbances of sensation, motion, and nutrition, in the parts supplied by the affected nerves; and while the feet and legs, especially in their extensor muscles, are usually the earliest and most frequently involved, yet the disease may affect any nerve or group of nerves. Paralysis of one arm, of the respiratory muscles, of the muscles of deglutition, and, in one instance, of the external recti of the eye-balls,† has been met with.

The disease is not only erratic as to the part that it may attack, but is so especially in the manner in which it affects any particular nerve, for, in even a small nerve, fibres in a very advanced stage of neuritis, and perfectly healthy ones, may be seen in microscopic sections side by side.‡ This explains the absence of the deep and superficial reflexes, the latter not being lost, however, in some cases. It also explains the frequent persistence of Faradic irritability, although requiring a stronger current to induce response at the same time that the galvanic current shows commencing degeneration. The diagnosis is usually not difficult, if the association of symptoms, the causation and progress, are taken into account. The liability is, of course, to ascribe the phenomena to some lesion of the spinal cord. The ataxia, loss of knee-jerk, pains, inability to stand with the eyes closed, optic neuritis, etc., may occur in multiple neuritis as well as in tabes dorsalis. In the former, however, the symptoms develop much more rapidly; there is numbness and anæsthesia; sensation of part being "asleep"; weakness and tenderness of the muscles, with some degree of atrophy; and tenderness along the nerves—these will be sufficient to distinguish it. Very severe cases of neuritis, with complete paralysis and rapid wasting, may easily be mistaken for anterior poliomyelitis; but the onset is slower, with numbness and pain, tenderness along the course of the nerves and in the muscles, and the gradual invasion of fresh groups of muscles, instead of widespread sudden paralysis, followed by early improvement in all except those that undergo atrophy.

The prognosis, if the cause be removed, is good, unless the health be undermined by excesses. For treatment, in ordinary cases, little requires to be done except good general care. The salicylates have been recommended in the early stage; given freely, as in acute articular rheumatism, they are said to be of marked benefit. Exalgine, in doses of one or two grains, given as needed to relieve pain, will be found useful. For the same purpose, antipyrin and phenacetine have been used. The former may produce dangerous depression. The diet should be carefully regulated; at first, milk will be sufficient, and to render it more easily digested, it should be diluted with seltzer, vichy, or soda water. This furnishes the fluid for free diuresis, by which the excess of excreta in the blood is eliminated. Alcohol should be promptly stopped. If a stimulant is needed, some other, as digitalis and spiritus æther. comp., should be given. The utmost vigilance will be needed to prevent secret drinking; if satisfactory recovery is not being made, this will usually be found to be the cause. If pain is severe, gentle rubbing and hot fomentations are of use in soothing the parts. Warm baths aid not only as local sedatives, but also in quieting the patient and inducing sleep.

*M. Allen Starr, *Medical Record*, 1887.
†Buzzard, in *British Medical Journal*, Vol. I., 1890, p. 1420.
‡Hale-White, Trans. Lond. Path. Soc., 1887.

After the acute stage is passed, the object of treatment is to promote repair in the diseased nerves, and to prevent muscular waste. Both of these objects are best attained by warm baths, massage, and electricity. These measures stimulate the circulation, and thus maintain nutrition and promote the reparative processes. The administration of arsenic and strychnine, in small doses, will also prove useful.

Selections.

REMARKS UPON A CASE OF EMPYEMA, COMPLICATED WITH PLUMONARY ŒDEMA.

BY FRANCIS HUBER, M.D.

Read at Section of Pediatrics (Academy of Medicine), New York.

Though the subject of empyema has but recently been discussed before this section, I have taken the liberty to present the following case, in order to direct attention to a not infrequent complication, and to lay stress upon a practical point in the management of cases complicated with œdema of the other lung.

The little patient, Jesse W., aged twenty months, was referred to me, through the courtesy of Dr. D. Cook, December 5, 1889. Unfortunately, I was not able to see the child until midnight, though notified earlier in the evening that effusion was present with œdema of the other lung. I found the patient, who had been ill sixteen days, in a very precarious condition, extremely restless, tossing about wildly and crying incessantly. Marked orthopnœa present during a number of hours. Face and extremities cyanosed; pulse feeble; limbs cold; eyes sunken and heavy. Several drachms of brandy were given, and the child, seated in its mother's lap, was aspirated, and about six ounces of purulent fluid drawn off, very slowly, through a small needle. Though the breathing became easier, the general condition was bad. The child was at once placed in bed with the head low, hot bottles being applied to the extremities, and warm applications over the præcordial region. Very soon the little one rallied and grew quiet, a little later fell asleep, and passed a fairly comfortable night. The next day, as the child had gained ground and looked considerably better, it was determined to operate, the œdema of the other side having subsided. Accordingly, assisted by Dr. Cook, the child was placed upon the healthy side, and without an anæsthetic, the chest was incised posteriorly below the angle of the scapula, and a drainage-tube inserted. The cavity was now irrigated with hot water and an antiseptic dressing applied. Irrigation was subsequently employed once or twice to wash out some lymph masses. A sheet of rubber, several inches square, was placed over the drainage-tube to act as a valve. This innovation, however, did not impress Dr Cook or myself very favorably, and was dispensed with after a few days. The subsequent course was favorable, and in less than four weeks not only had the lung expanded fully, but even the integumental wound had healed.

Hyperæmia or congestion of the lungs is a very grave complication, which may result in œdema and even cause free albuminoid and frothy expectoration, often terminating in asphyxia and death by suffocation, œdema pneumonia serosa of Traube—acute albuminoid expectoration of the French authors.

When pulmonary œdema occurs as a complication of purulent pleurisy, it adds to the gravity of the case, and may be the immediate cause of a fatal termination. The treatment should be prompt and bold. Stimulants of various kinds must be administered and the chest aspirated without delay. The quantity to be drawn off must necessarily vary with the circumstances of the individual case. Even in simple cases of effusion there is ordinarily greater or less danger of producing fresh congestion and hyperæmia of the lungs in removing large quantities of the effusion. It must not be lost sight of, that our purpose is to relieve the intrathoracic pressure, to free the overburdened heart, and to remove the symptoms of oppression. As has been well said, "slowness in the withdrawal of the fluid, as well as the small quantity drawn, lessens the probability of any unpleasant effect." Bowditch says, "I always draw with great deliberation. I pull so lightly upon the handle of the piston that it seems as if the fluid itself were pressing out from the chest and pushed the piston upwards, my hand simply following the impulse."

If this be true of an uncomplicated case, the lesson applies with far greater force to a case in

which the danger to be avoided already exists and presents itself to us face to face. Some years ago, after reading of a number of cases of empyema cured by aspiration, I was in the habit of withdrawing large quantities, and did not meet with any bad effects in ordinary cases of purulent effusion. In several instances in which œdema was present upon the other side, though the aspiration was slowly conducted and the patients stimulated, the œdema progressed, and the cases resulted fatally within thirty-six hours. It is true, the cases were unfavorable, œdema of the lung being well marked, but, in the light of subsequent experience, I am forced to concede that had the quantity drawn off been less, the circulatory change would not have been so extreme within a comparatively short time, and the failing heart might have regained its tone, and the termination perhaps been made favorable. Since then three other cases of empyema with pulmonary œdema have come under my observation. From four to six ounces of pus only were drawn off, the patient stimulated, and the heart allowed to regain its force; the pulmonary œdema gradually subsided within six hours, and, as in the case reported above, subsequent incision with drainage was practised, followed by recovery. The complication in my experience occurs rather in the acute suppurative pleurisies, in which class, as a rule, the constitutional symptoms are severe, the effusion of liquid rapid, and the heart's action greatly enfeebled. It occurs rather early, too, in the history of the case; sometimes within one or two weeks. I have not observed it in the subacute or chronic variety, where the heart has an opportunity to accustom itself gradually to the extra work demanded.

Its mode of onset, too, may be rather sudden. A child three years old was left fairly comfortable on the morning of the seventh day; unforeseen circumstances prevented the evening visit. During the night I was called out, and found the patient suffering from orthopnœa, cyanosed, with the usual symptoms of extreme "air hunger," due to marked œdema of the other lung. I was compelled to aspirate at 3 a.m. and drew off about four ounces, sufficient to relieve the urgent symptoms. The same afternoon, when Professor Jacobi saw the case in consultation, the danger was over. A few days later the child was operated on and recovered perfectly.—*Archives of Pediatrics.*

A CASE OF GUNSHOT INJURY, IN WHICH A PIECE OF LEAD REMAINED EMBEDDED IN THE SKULL FOR THIRTY-ONE YEARS

By DAVID M. GREGG, M.B., F.R.C.S. Ed., Dundee.

The following case is, I think, worthy of being recorded, on account of the length of time the piece of lead remained in the bones of the skull, the few symptoms to which it gave rise, and the difficulty which was evidently experienced in attempting its removal.

Sergeant D. C., formerly of the 2nd Bengal European Fusiliers, formed one of a storming party at the siege of Delhi, on 14th September, 1857. He was running towards the walls with his head bent down in the act of loading his musket, when he was struck on the head by a leaden bullet. He was rendered unconscious for a minute or two, but soon recovered consciousness, and while a comrade was bandaging the wound, he received a wound from a musket shot in the left forearm. He was taken to the field hospital, where a round musket bullet was extracted from his left forearm, and where the surgeon "found the skull fractured and raised up, and he replaced it." No further attention seems to have been paid to the head injury, and after a stay of three months in hospital, he returned to duty, the wound in his head not having healed. Soon after this a native barber, while shaving the scalp round the wound to facilitate dressing, discovered a piece of lead sticking firmly in the wound. The patient then returned to hospital, where two unsuccessful attempts were made to remove the foreign body. On account of this injury he was discharged from the army in 1859, and soon afterwards came to Dundee, where he obtained work in a calender. This work, however, he was soon obliged to abandon, as any attempt to lift heavy weights made the wound bleed rather freely. From then till his death he was employed as a gatekeeper. The wound never entirely healed.

He first came under my notice in 1880, and at that time he had an open wound about the size of a shilling on the vertex in the line of the

saggital suture, just behind its junction with the coronal suture. The wound was surrounded by cicatricial tissue, and presented a few weak granulations. In the floor of the wound, firmly embedded in the skull, was a piece of lead about a quarter of an inch in diameter. This could be scratched with a knife, and gave the characteristic mark to Nelaton's probe. There was a slight purulent discharge from the wound, but otherwise he suffered no inconvenience from it. Venous oozing accompanied by giddiness and faintness occurred on the patient making any extraordinary effort, especially if made in the stooping posture. As any pressure on the lead caused considerable oozing, and as the patient was averse to any operation, no further attempts at removal were made. From this time till his death, which occurred in 1888 from an abdominal complaint, there was little change in the above condition, except that the cicatrix became slightly more depressed from absorption of the surrounding bone. Evidently the bullet had struck the right parietal bone obliquely, about three-quarters of an inch from the coronal and half an inch from the sagittal suture. It had passed backwards and to the left, grooving the bone until it reached the saggital suture, where it had produced a depressed fracture, the portion displaced being about the size of a shilling. In the posterior and deepest part of the depression, firmly embedded in the bone, and exactly above the superior longitudinal sinus, was a piece of lead four-tenths of an inch long, and one-tenth broad. Close to the piece of lead was a small foramen, which allowed the passage of a small vein to the longitudinal sinus. Probably after producing the fracture the bullet had split, and the smaller portion had remained embedded in the bone. Originally the piece of lead must have been considerably larger, as on many occasions small pieces had been removed by scraping with a knife. The sagittal suture in the neighborhood of the fracture had been considerably obliterated.

The inner surface of the skull presented a prominent irregularity, corresponding to the depression seen on the external surface.—*Edin. Med. Jour.*

EXCESSIVE VOMITING DURING PREGNANCY.—B. C. McDougall, M.D., in *Mass. Medical Journal.*—I was requested to see Mrs. P., who was in the sixth month of pregnancy and could not retain anything on her stomach—no food and no drink. She had consulted two medical gentlemen, one of whom had advised purgation, which was tried, as were also the various remedies recommended in such cases, but all had been of no avail. The other physician, who was subsequently called in, concurred in the opinion that she was in great danger; advised a certain course, but would not consent to the procuring of abortion, as the fœtus was not viable, and he was a zealous adherent of the Roman Catholic church.

I prepared to do whatever was necessary to save the mother, or both fœtus and mother, if it could be done. I found the pulse 96; incessant nausea; vomiting whenever anything was taken into the stomach; sleepless at night and also during the day; no delirium, no tinnitus aurium; no dimness of vision. I claimed a delay of twenty-four hours to try two remedies. One was the hypodermic injection of morphia over the region of the stomach, and the other was the injection of beef essence and brandy into the rectum. On the next day I found that the remedies had done no good. She vomited, as ever, the little ice-water she took, and the injections could not be retained at all.

My mind was now made up as to the course to be pursued, and I examined the neck of the womb with my finger. I could readily introduce the index finger into the os tincæ and carry it up to the internal os, and the examination convinced me there was granular erosion of the cervix. Nothing effective could now be done, short of abortion; the method of procedure was the only question. To dilatation by means of tents, there were these objections: it is slow in its operation; and in this particular case, the pathological condition would lead to a metro-peritonitis, or to a pelvic cellulitis. I have seen these arise after dilatation, even when there was no granular erosion of the cervix, nor any other lesion of that part of the womb, and when dilatation was practised for other objects. The detachment of the membranes according to the method of Kiwisch is also objectionable on account of its slowness and uncertainty.

I determined to puncture the membranes, and for the following reasons: the child was not viable and could not be saved. I have

known cases, when the child was viable, as in the eight or ninth month of pregnancy, and when I brought on premature labor to allay excessive and uncontrollable vomiting, that the vomiting did cease, almost immediately after the rupture of the membranes and before emptying of the uterus. With a small sized uterine sound, I punctured the membranes. In an hour after the operation, she took, with decided appetite, some beefsteak and retained it; at night she did the same, and when I saw her in the morning, she and her mother informed me that she had slept well, and that she had a good appetite, having eaten various things for breakfast. About forty-eight hours after the operation, fœtus and secundines came away, and she made a rapid r covery.

I am aware that there is high authority against the emptying of the uterus in cases of excessive vomiting during pregnancy. I am aware, too, of the sudden and favorable changes which sometimes take place in such cases. The experienced physician can often foresee that such will be the result, and he will persevere with his remedies. I will admit that it does happen, even when he despairs. But it also happens, that although our patient occasionally gets well when we expect them to die, on the other hand they sometimes die when we expect them to g t well. We must reason from a general rule and not from an exception.

The only authority I will quote is that of Tyler Smith: "When all other means fail, and when the exhaustion of the patient cannot be arrested, the remedy is the emptying of the uterus, and this should never be delayed so long as to put the patient in a state of imminent peril. Nature herself often terminates the distress by spontaneous abortion. It has happened to me to have been twice consulted, within a recent period, in cases in which the induction of premature labor artificially was so long delayed that the patient had died before abortion could be induced. Paul Dubois has stated that he met with twenty fatal cases in thirteen years. It is a reproach to our art that such cases should occur."—*Archives of Gynæcology and Obstetrics.*

THE USE OF SPIRITS AND MALTED DRINKS IN NURSING WOMEN.—Dr. Jacobi opened a discussion on this subject at the recent meeting of the New York Academy of Medicine (Section of Pædiatrics.) He thought the question intimately connected with that of diet generally, as to whether it was possible for foreign substances in the blood to get in to the secretions of the mammæ, and from there into the digestive organs of the baby. The speaker then dealt at length with the whole subject of the chemical and physiological experiments on milk secretion. He pointed out that the character and quality of the breast secretions of the mother were subject by many causes to continual variation. As long as the milk was a real secretion there was little danger that any deleterious matter which might be floating in the blood would get admixed with the mammary secretion; but as soon as the woman became anæmic or got below par the secretion would no longer be simply milk, but part of it would be serum and other material foreign to its normal composition. Whatever floated in the serum would find its way into the mammæ and into the baby. This could be seen when we compared colostrum with milk. Conditions of the mother's milk, which in the later months of the child's nursing life would be absolutely devoid of danger, might, immediately after birth, and while the milk still contained colostrum, produce much mischief.

Discussing then the subject of alcohol, the speaker said that the difficulty at once presented itself as to the woman's exact condition. Some women could take a certain quantity of spirits, while a feeble person taking the same quantity might produce results deleterious to the baby. It had been stated that the nursing woman must not have spirits, but that she must have beer. Most of those who insisted on this point were the nurses themselves. Blood saturated with alcohol could not be good nutriment for the fœtus, and the same was true of the baby; and supposing the milk secreted to be, from any disturbance in the health of the mother, partly serum, then alcohol taken by her would certainly be found in the mother's milk. It might be true that this could only be urged in the case of those who were habitual drunkards, but he saw in the best families wet-nurses who would get drunk, and who would in that way be certainly likely to injure the baby. It has been stated, among other things, that alcohol

increased the quantity of milk secreted. This has been also denied. There was only one remedy which, in the speaker's knowledge, would influence the secretion of milk and cause its increase, and that was salicylate of sodium. Alcohol, when taken, acted as the carbohydrates generally did. It had a certain amount of nutritive action, but when given in larger quantities it was not utilized in the milk production. This disposed, in the speaker's mind, of any idea of the necessity of giving malt liquors or spirits. There might, however, exist a necessity for its use on general medical principles. When stimulation was required, wine or beer might be indicated. The most that could be urged in favor of its general use was that a small quantity, if regularly given, would not be harmful. If it was expected that the hops in beer would act as a stomachic, it might be given with two or three of the meals. Whatever the carbo-hydrates in alcoholic drinks could do might be done equally well by carbo-hydrates administered in some other form. Whatever beer could do might be done just as well by milk and farinaceous foods, both supplying the large amount of albumin necessary. A woman who was not nursing required ninety grammes of albumin daily, and one who nursed one hundred and sixty grammes. A greater amount of milk and farinaceous food in the woman's diet would supply this extra seventy or eighty grammes. He should prefer those foods which contained a large amount of albuminoids, such as oatmeal and barley.—*N. Y. Medical Journal.*

PRINCE BISMARCK AS A PATIENT.—Prince Bismarck used to have the reputation of thinking anything but nobly of the medical profession, and his differences of opinion with the late Professor Frerichs as to the pathology and therapeutics of that important political organ, the liver, were expressed in language more familiar perhaps to scientific controversialists than to diplomatists. It is probable that the great statesman was a refractory patient, but bitter experience seems to have taught him that throwing physic to the dogs is not the most satisfactory treatment for the growing infirmities of age. He is now, according to a statement which he recently made to a representative of the *Daily Telegraph*, a model patient, paying the most exemplary obedience to the counsels of his medical adviser, Professor Schweninger. The Prince some years ago was in some danger of becoming the largest, as well as the greatest, man in Germany, but Dr. Schweninger relieved him of the growing load of "too, too solid flesh," by the judicious application of Oertel's method, which has been made known to English readers by Dr. Mitchell Bruce and others. The details of the Prince's present dietetic regimen may be interesting to those interested in the treatment of obesity. He says:—"I am only allowed to drink thrice a day—a quarter of an hour after each meal, and each time not more than half a bottle of red sparkling Moselle, of a very light and dry character. Burgundy and beer, both of which I am extremely fond of, are strictly forbidden to me; so are all the strong Rhenish and Spanish wines, and even claret. For some years past I have been a total abstainer from all these generous liquors, much to the advantage of my health and my 'condition,' in the sporting sense of the word. Formerly I used to weigh over seventeen stone. By observing this regimen I brought myself down to under fourteen, and without any loss of strength—indeed, with gain. My normal weight now is 185 lbs. I am weighed once a day, by my doctor's orders, and any excess of that figure I at once set to work to get rid of, by exercise and special regimen. I ride a good deal, as well as walk. Cigar smoking I have given up altogether; it is debilitating and bad for the nerves. I am restricted to a long pipe, happily with a deep bowl, one after each meal, and I smoke nothing in it but Dutch Knaster tobacco, which is light, mild, and soothing. Water makes me fat, so I must not drink it. However, the present arrangements suit me very well." Had Prince Bismarck shown himself as amenable to medical control in his robust prime as he finds himself compelled to be now, he would not perhaps have to submit to so strict a rule of life in his declining years.—*Brit. Med. Jour.*

COLLAPSE FOLLOWING THE INTERNAL ADMINISTRATION OF SALICYLATE OF SODIUM.—By A. G. Auld, M.D.—But few drugs, old or new, have escaped trial in the special treatment

of chronic and subacute articular rheumatism. The effect of the salicylate of sodium (as sometimes prepared) in the following two cases is interesting in view of certain recent experiments: J. M. had been under treatment for subacute rheumatism for six months, in another part of the country, without deriving any benefit. On May 1st, 1889, I prescribed for her 100 grains daily of salicylate of sodium. On the 4th, she complained of giddiness, confusion of ideas, and weakness. On the 5th the giddiness was excessive, and the patient was unable to get out of bed. The next day, having now taken 600 grains, there were delirium and prostration. The drug was now stopped, and when the patient regained her faculties the joint symptoms had disappeared, and did not return. H.C. had for years suffered from articular rheumatism, chiefly in the lower extremities. On May 24th, 1889, I prescribed 100 grains daily of the salicylate of sodium, which was supplied by the same chemists as in the previous case. On May 30th, I was summoned at midnight to the patient, who was said to be dying. Briefly stated, his symptoms were—great and stridulous dyspnœa, extreme slowness of the pulse, and general paralysis, the patient being unable to speak. Delirium was not so marked, however, as in the other case. After appropriate treatment, he recovered, and his malady was considerably relieved for a time. I think it worth while notifying these cases, as the symptoms present such a striking similarity to those experimentally induced in the rabbit, by Professor Charteris, recently described in *The Lancet* and elsewhere. It was shown in these experiments that an element of high toxicity could be isolated from the artificial compounds commonly in use. Professor Charteris has kindly given me further information on the matter, and has shown me various specimens of the purified drug. Since then, I have had opportunities of witnessing the exhibition of much larger doses of the drug so purified, without any untoward results.—*Lond. Lancet.*

OVARIAN CYST REMOVED DURING PREGNANCY.—At the sixth Congress of the Italian Surgical Society, held in Bologna, in April, Dr. Angelini related the details of a case in which he removed an ovarian cyst from a woman five months pregnant, whose pregnancy was learned for the first time during the operation. The pregnancy ran a normal course from the time of the operation, and delivery took place fifty-five days after. With the exception of a somewhat slow involution of uterus, the puerperal period was quite normal. At the time of the communication the woman was quite healthy.

Loreta's Operation.—At the same Congress, Prof. Loreta, of Bologna, communicated the details of two cases of narrowing of the cardiac and pyloric ends of the stomach, on whom he had operated according to his own method. The first case was one of stricture of the pyloric end of the stomach, with gastric pain, which had been going on for eight years. The patient used to vomit seven hours after meals. The vomited matters presented the three layers described as characteristic by Loreta. On examination, dilatation of the stomach was found, with gurgling noises, but no tumor on the palpation. The abdomen was opened in the median line, the stomach incised, and first one finger, then two, were introduced into the opening, and passed in the direction of the pylorus. The stricture was stretched by the fingers. The patient recovered, and to-day enjoys good health. The second patient suffered for twenty years from a stricture of the cardiac end of the stomach, with the formation of a large sacculated dilatation of the œsophagus above the stricture. The walls of the abdomen and stomach were incised, a dilator was passed across to the cardiac end, the stricture was dilated, and an œsophageal bougie was passed down from the mouth. The patient recovered, and is now (two months after the operation) in good health.—*Dr. Johann Baaz, of Graz, in Medicinisch Chirurgisch, Rundschau, June 1st, 1890.*

UTERINE VOMITING INDEPENDENT OF PREGNANCY.—Much has been written of late years on the subject of vomiting of pregnancy, and its most aggravated form, hyperemesis gravidarum, or uncontrollable vomiting. Dr. P. Lamy has recently written on cases in which troublesome vomiting has been observed as associated with other phenomena of the female generative system besides pregnancy. He began with a case of vomiting at puberty. A girl, aged fourteen, suffered severe pain before her first period. After that period the pain ceased, but an attack

of vomiting followed every meal. No drugs were of any avail, and the patient had to be fed with a drachm of beef-tea every half-hour. When the menses became regularly established the vomiting ceased, and did not return during the first pregnancy, six years later. Dr. Lamy related two obstinate cases of vomiting during the period in adult women. In one, vomiting invariably followed sexual intercourse. The patient became pregnant, but after she bore a child, the vomiting always returned under the same circumstances as before. Treatment proved unsatisfactory. Lastly, Dr. Lamy noted a case of vomiting at the climacteric. The patient was fifty years old, the period was becoming very irregular, and occasional disturbances of the alimentary canal, especially vomiting, set in. Treatment, as in ordinary dyspepsia, gave relief. This last case might be explained by many physicians as simple gastric catarrh, due to errors in diet or other causes, rather than to changes in the uterine functions. It is clear that the vomiting of pregnancy is very common and almost normal, in the sense that a certain amount of hemorrhage at delivery is normal. On the other hand, vomiting at puberty, during menstruation, after coitus, or about the menopause, must be considered abnormal.—*Brit. Med. Jour.*

A CASE OF EXTENSIVE DROPSY DURING PREGNANCY.—The following case is reported because of its comparative rarity: A primipara, seven months pregnant, was suffering from dropsy of the lower extremities, and of the external genital organs. The legs and feet were swollen to an enormous size. The vulva was extremely œdematous, particularly the labiæ minoræ, which were as large as a hand, translucent, and were extremely tender on pressure. The urine was scanty and albuminous. Rest in bed and the internal use of Epsom salt and cream of tartar rapidly reduced the effusion in the legs, but had not the slightest effect on the swollen genitalia. After persisting for a few days, I punctured the organs, with excellent results, the labiæ diminishing to almost normal size. Patient was then put upon tincture of the chloride of iron, and was apparently doing well. About five days after this I was summoned, found her in labor, and delivered her of twins, one of which died in a few hours; the other is still living. The patient made a rapid and complete recovery. Lusk speaks of six cases of dropsy in pregnant women treated by him, in which miscarriage followed puncturing the labiæ. Whether labor was brought on by the reflex effects of the operation, or by the condition that caused the œdema, is a question on which I desire an expression of opinion.—*J. E. Covey, M.D., in Med. News.*

THE COLOR OF NEGRO INFANTS.—Several histologists of authority, including Kolliker, have taught that the skin of the negro infant is not pigmented at birth, although the color, distinctive of the race, is rapidly developed in the course of the first few weeks of extrauterine life. In Europe the chances of observing a large series of pure-bred negro infants are rare. In the United States it is otherwise. Dr. Morison, of Baltimore, has made use of his opportunities of observation, and has shown, in consequence, that the current opinion as to the complexion of the negro at birth is quite erroneous. He examined the skin of the arm of an eight months' fœtus, whose father was a negro, and mother moderately dark-complexioned. Pigment was found in the lowest layers of the rete mucosum. He also detected pigment in the skin of a mulatto child, who had died about thirty-six hours before birth. Dr. Bowen, writing in the *Boston Medical and Surgical Journal*, on Dr. Morison's researches, adds a notice of his own observations. A few years ago he enjoyed the opportunity of inspecting, at the Boston Lying-in Hospital, a considerable number of negro and half-caste children at, or soon after, birth. The color of the skin was found to vary within a wide range. The pigmentation was marked from the first in all cases where the skin of the parents was very dark. The old, or European, opinion is true of infants with a considerable infusion of white blood. They are white-skinned at birth, but pigment is deposited in the rete mucosum within a few days.—*Brit. Med. Jour.*

THE CREMATION QUESTION IN AUSTRIA.—The Supreme Sanitary Council of Austria had the cremation question brought before it for the first time at a recent meeting. The family of a

man, whose body had been cremated in Italy, had applied to the authorities for leave to keep the ashes in their house. Such a petition being altogether without precedent, the authorities were greatly perplexed how to deal with it; they had ordinances and regulations of all kinds as to burial, and as to the preservation of bodies or parts of bodies for scientific purposes, but the forethought of legislators had made no provision for the disposal of the ashes of cremated ancestors. The question was accordingly referred to the Minister of the Interior, who thereupon asked the opinion of the Sanitary Council as to the hygienic aspect of the matter. That body, after due deliberation, passed a resolution to the effect that the ashes might be kept in the house without danger to health. This is the first public pronouncement of the Austrian Sanitary Council in any way relating to cremation. Though it was careful not to commit itself officially on the general question of the expediency of cremation, individual members expressed their approval of this way of disposing of the dead, from a sanitary point of view, while leaving the legal and religious aspects of the question to be dealt with by the proper authorities.—*Brit. Med. Jour.*

HÆMATEMESIS IN A NEW-BORN INFANT.—Mr. H. C. Hodges, of Watton, has published the notes of a case, under the care of his father, of hæmatemesis in a new-born child. The child, after a perfectly natural and easy labor, was born at 5 a.m. At 11 a.m. a very urgent message came that the child had hemorrhage. It was found to be blanched, and the pulse very feeble, and the clothes were saturated with bright blood, which had been vomited. Absolute quiet was enjoined, and ten minims of hazeline every two hours were ordered. There was no more hemorrhage, but about a tablespoonful of blood-stained mucus was vomited at 5:30 p.m. Hiccough had been constant since the morning. There was also one rather copious evacuation of blood, besides meconium. The next day the hiccough was less. There was a slight serous discharge from the left ear, and subconjunctival hemorrhage of the left eye. On the second day after birth there was internal strabismus of the left eye. After the third day, the symptoms rapidly disappeared, and the child got quite well. Mr. Hodges was disposed to think that there had been some injury to the vessels at the base of the skull.—*Lond. Lancet.*

SULPHO-CALCINE IN DIPHTHERIA.—A case of diphtheria came into my hands recently, which had been resigned as past hope by the former physician. The event fully justified his opinion. This case presented a difficulty sometimes met with, where the preparation of iron and nascent chlorine, upon which I usually rely, proved too strong for the child's mucous membranes, while it could not destroy the diphtheria when diluted. The day before the child died, her brother, 18 months of age, was seized with the same disease, in a malignant form. Knowing that it would be useless to rely on the chlorine mixture, a trial having shown the same effect as in the older child, I determined to employ sulpho-calcine, Dr. Love having reported favorably upon it. The liquid was applied in full strength to the false membranes, while the mouth, throat, and nose (which began to discharge ominously) were washed out hourly with as strong dilutions as they could bear. The child recovered, although slight epistaxis occurred, showing how grave was the nasal affection. The remedy deserves a further trial.—*Philadelphia Times and Register.*

GONORRHŒA OCCURRING IN A BROTHER AND SISTER AGED RESPECTIVELY SIX AND EIGHT YEARS.—Dr. T. M. Bull reported the cases to the New York Academy of Medicine. The first patient, a boy aged six, was brought to the clinic February 6, with a urethral discharge dating from about Christmas. Pus flowed from the urethra which, on examination, was found to contain numerous gonococci. Five days after the visit of the boy, the sister, aged eight years, was brought to the clinic, with a discharge which had been discovered about January 8. There was considerable swelling of the vulva and flow of pus from the vagina, which was found to contain gonococci in numbers. Both cases were completely cured by March 1. It was probable the boy had got gonorrhœa from his uncle, with whom he slept and who had the disease, and later the sister got it from the boy, since intercourse was acknowledged by both

parties. The boy was strong, active, rather large for his age, and unnaturally intelligent regarding matters which boys of his age should know nothing about.—*Archives of Pediatrics.*

CASE OF VISUAL DISTURBANCE CAUSED BY A TAPE-WORM. By Dr. G. Guiot (*Année Méd. de Caen, February, 1890, Alleg. Med. Central Zeitung*).—A young woman exhibited nervous disturbances for more than a year connected only with the sense of sight. Although on inspection the eye appeared to be quite normal, the patient complained of a feeling as of a foreign body in the conjunctival sac, of burning sensations, rubbing, etc. If she attempted to do the simplist work (reading, sewing), she became dizzy and complained of a violent headache; artificial light was borne with difficulty. The acuteness of sight seemed rather below the normal. Examination of the fundus revealed nothing abnormal. There was no trace of hysteria. The above mentioned symptoms were constant and not intermittent as in hysteria. After the patient had passed a tape-worm, two metres long, all the disturbances disappeared, and the patient was completely and permanently cured.—*Medicinisch Cherurgische Rundschau, June 1st, 1890.*

THE EFFECT OF OPIATES ON GASTRIC SECRETION.—According to the *Lancet*, Dr. Abutkoff has examined the effects of opium and two of its alkaloids on the digestive functions of healthy people. He found that the three substances experimented with—viz., opium, morphine, and codein—all exert a retarding action on gastric digestion by diminishing the general acidity of the gastric juice. Neither the quantity of pepsin nor the absorbent power of the stomach appeared to be affected by any of the three substances. As to their relative effects in such doses as can be given medicinally, opium had decidedly the most marked influence, and codeine the least. Dr. Abutkoff suggests that in the case of patients with weak digestion, due to deficiency of acid in the gastric juice, opiates should be given some hours after a meal, but that where the hydrochloric acid is excessive, they may be given with meals.—*Medical News.*

A NEW AND RAPID TEST FOR SUGAR.—A simple and ingenious test for saccharine in urine, by Dr. Becker, of Cairo, was brought before the Surgical Society of Vienna at its last sitting, by Professor Nothnagel. Ordinary visiting cards contain a considerable quantity of potash. Such a card is dipped with a solution of oxide of copper and dried. Sulphate of copper is then to be seen on the paper in minute crystals. Paper so prepared can be carried in the pocket. When urine has to be tested, a point of wood—match end—is dipped into it, or two or three strokes are made with it on the prepared paper. The paper is then passed two or three times over a lamp, and immediately the marks scored will take on a more or less distinct brown color if sugar be present. Normal urine does not cause any change if marked on the paper in the way described, and it is a useful way of confirming the proof, to test a sample of urine known to be free from sugar at the same time as a counter test.

SUTURE OF THE SOFT PALATE WITHOUT SECTION OF THE MUSCLES.—Muscular tension has been considered the great difficulty in uniting the two portions of the *velum palati* in cases of cleft palate. To overcome this difficulty the muscles on either side have been divided by incision, or, as Billroth has proposed, they have been cut at the point of their insertion. Jules Wolff, at the Berlin Medical Society, stated that this mutilation was unnecessary. Since October last he has operated upon nine cases of congenital cleft palate, without resorting to this procedure, and his results have been most satisfactory. The operation is not only simplified, but by leaving the muscles of the *velum palati* intact, the function of this organ returns more promptly, and is more nearly perfect.—*Le Bulletin Médical.*

MENORRHAGIA.—J. F. Purviance, M.D., in *Medical Summary.*

℞ Fl. ex. ergot.....℥ ss.
Tr. catechu.....℥ iss.

Misce—S. Teaspoonful in sweetened water every 1 to 3 hours, as needful.

If undue irritability exist, causing urine pain and febrile action:

℞ Pulv. opii.....grs. v
Plumbi. acet.....grs. xx.

M. Ft. ch. No. x. One to be given every second to fourth hour with preceding.

After a long experience with catechu, I place more dependence upon it in these uterine flows than any other astringent.—*Archives of Gynæcology.*

TREATMENT OF HAY FEVER.—Dr. Rixa, of New York, has been fortunate enough to have a patient willing to be experimented upon for this complaint. The list of remedies used is a formidable one, and includes analgesin, internally and locally, boric-acid spray, cocaine spray, morphine, atropine, cauterization with pure carbolic acid, eucalyptus, solution of menthol in olive oil, and acetanilid. Many of these gave temporary relief, but no treatment was satisfactory until peroxide of hydrogen spray was used. Since then the writer has employed it in other patients and with the same success.—*Ralph W. Lelftwich, M.D., in London Medical Record.*

ANTISEPTIC APPLICATION FOR DIPHTHERIA.—The following antiseptic mixture is recommended as an application to diphtheritic patches:—

℞ Borate of sodium,
Chloride of Calcium, of each, 75 grs. (4.25 grammes).
Carbolic acid, of each, 3½ grs. (0.25 gramme).
Glycerin, of each, 2½ drachms (10.0 grammes).
White honey, of each 3½ ounces (45.0 grammes).—M.

Sig: To be applied by means of a soft brush.
—*Internationale Klinische Rundschau.*

SPECIAL BERLIN CLINICS FOLLOWING THE CONGRESS.—A correspondent informs us that many of the professors and *Docenten* of the university intend to hold special courses of from three to four weeks' duration immediately on the close of the Tenth International Congress. He adds that strangers will find the various announcements on the bulletin-boards of the Charité Hospital and the University Clinics.—*New York Medical Journal.*

SIR JAMES GRANT, of Ottawa, took a trip to the Pacific coast.

Personal.

DR. G. E. FENWICK, of McGill Medical College, Montreal, has resigned his position as Professor of Surgery, on account of ill-health. Dr. T. G. Roddick will take his place. Dr. Fenwick is one of Canada's most eminent surgeons, and the many friends of McGill will regret his resignation, and especially the cause thereof. No one doubts that Dr. Roddick will prove a worthy successor.

DR. E. H. HORSEY, a graduate of the Royal College of Physicians and Surgeons, Kingston, Ontario, in 1860, and for fifteen years resident physician at the Palmer House in Chicago, died suddenly on Tuesday evening. He had been suffering for some time, and on Monday submitted to an operation. He was left in charge of a man known as S. W. Nicholas, of Covington, Ky., who is said to have not only neglected his duty, but has mysteriously disappeared. When last seen he appeared intoxicated, but sent a despatch to his home saying he was insane. There seems to be a measure of mystery surrounding the case that no one has been able to satisfactorily solve.

The catalogue of the New York Polyclinic shows an attendance for the session of 1889-90 of 422. The following extract shows that the Faculty have resolved to exclude all but graduates of regular medical colleges from matriculating at this school: "Practitioners who are graduates of a regular medical college, or who, having attended one or more courses of lectures at such college, have a legal permit to practice, will be admitted."

A GOSSIPY Philadelphia paper says (which we quote for the encouragement of any blue young reader) that "many years ago, after he had worked in vain for two or three years to get enough medical practice to support him, Dr. D. Hayes Agnew dropped physic in disgust and went to 'keeping store' at Newton, Delaware county. There, in a small shop, he sold tarred rope, sickles, sunbonnets, molasses and rakes, nails and flour and fish-nets. But his passion for surgery and medicine made storekeeping galling; he gave it up, risked starvation in a desperate battle with fortune again, and won."—*Boston Medical and Surgical Journal.*

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, SEPTEMBER 1, 1890.

THE USE OF THE CURETTE IN CONNECTION WITH THE TREATMENT OF ABORTION.

At a recent meeting of the Philadelphia Obstetric Society, Dr. Joseph Hoffman reported the following very interesting case of perforation of the uterus with a curette. Patient suffering from a delayed miscarriage with certain putrid matters retained. Cervix dilated under ether with a Molesworth instrument. Interior of uterus curetted. After removing some debris the curette suddenly appeared to be too far, and it was found that it had passed through the uterine wall. The curetting was continued for a time, when something was noticed protruding from the os, which was supposed, and afterwards proved to be, omentum. This was pulled down with a tenaculum, to control hemorrhage and keep putrid matter out of the peritoneal cavity. Four hours afterwards the patient was again etherized and the abdomen opened. The abdominal cavity contained bloody fluid and clots. Incision enlarged to four inches to get proper view of uterus. A ragged rent was found on antero-lateral surface and sutured. The uterus was peculiarly soft. The abdominal cavity was washed out and drained for seven days. In five weeks patient was comfortable and able to go out for a ride or walk in fair weather.

There is something brilliant about such a case as this, when the ordinary accoucheur becomes transformed into a bold successful abdominal surgeon. The old-fashioned plan would have been somewhat as follows: Patient kept in bed; cervix dilated with finger if possible, or by the more dangerous tent; contents of uterus removed by the *clean* finger, using bimanual method; if such matters be offensive, cavity washed or swabbed out; patient kept in bed one to two weeks; medicine—a mixture containing ergot, quinine, and aromatic sulphuric acid, or something of the sort; patient able to ride or walk in fair or fine weather in considerably less than five weeks. This may seem tame and unattractive after a perusal of the more showy method. It wouldn't certainly be considered worth reporting to a learned society; but, we fancy, if the whole truth were known, it would prove sufficiently satisfactory to the patient and her friends. But some say—all your hum-drum cases don't turn out so well, some are very tedious. Yes! but the bad results generally arise from the fact that the *finger isn't clean.*

What we wish particularly to refer to in this connection is the use of the curette in such cases. The curette will frequently be found very serviceable, but its use is accompanied by grave dangers. So highly do we fear these perils that we believe the hard inflexible metallic instrument should never be used in obstetric practice. It is used by some men of undoubted ability, especially in the United States. In their skilled hands the dangers are minimized, but not absent. The uterine wall may not uncommonly be punctured by the curette or sound without much danger; but, all the same, we had better avoid such accidents. If we must use a curette in such cases, let it be a flexible one, and let it be used with the greatest possible care.

In the discussion which followed the reading of the report (*Buffalo Medical and Surgical Journal*), Drs. W. H. Parrish and J. Price took the proper and safe stand in condemning the routine use of the curette in such cases. Dr. Hoffman in reply urged, first, the use of the placental forceps, and, second, that of the curette to remove what the forceps had left, and concluded by saying—"of all methods, I think that of gouging away the early placenta with the finger nail the most bungling and unskilful." With all due deference to Dr. Hoffman, we may state our opinion, that if any one thing has been conclusively proved in the history of

obstetrics, it is the fact that, for the removal of the contents of the uterus in delayed abortions, no instrument that has ever yet been devised is nearly so safe or effective as the clean, educated, and intelligent finger tip.

TENTH INTERNATIONAL MEDICAL CONGRESS.

The great medical gathering which has been held in Berlin during the present month has been attended with remarkable success. The international character of the meeting was its most interesting feature, and the opportunity of seeing gathered together many of the greatest men in medical science of the civilized globe was in itself a grand experience for all who had the good fortune to be there.

The communications made before the Congress will be read with great interest, from the eloquent address of welcome by the illustrious president, Professor Virchow, down through the long list of valuable contributions made by such men as Koch, Lister, Bouchard, Cantani, and Meynert. We quote the following from a British journal, regarding the manner in which the guests were entertained in the metropolis of the German empire: "Nothing could have exceeded the overflowing hospitality, the generous and cordial welcome, the thoughtful courtesy, and the minutely elaborate preparations with which the social and scientific needs of the invading hosts were met. All were alike made to feel this welcome; so that whether for its remarkable assemblage of the most eminent representatives of cosmopolitan medical science, or for its endless round of scientific and social activity, the Berlin Congress must be pronounced to have far exceeded any which has preceded it, and it will certainly be difficult in the future for any capital to surpass the feat that Berlin has accomplished."

A number of Toronto men attended both the Berlin Congress and the meeting at Birmingham of the British Medical Association. Drs. Graham, Cameron, Reeve, Peters, O'Reily, Nevitt, MacFarlane, Covernton, Allan Baines, and Prof. R. Ramsay Wright, were among the number. The next meeting of the Congress will take place in 1893, at Rome.

THE BRITISH MEDICAL ASSOCIATION.

The fifty-eighth annual meeting of the British Medical Association has recently been held at Birmingham. A series of interesting papers were read, which will afford matter for study and criticism for a long time to come. The views expressed by the president, Dr. Wade, in his address on the practechnical stages of medical education, and the remarks made by Mr. Lawson Tait on the subject of surgical training, have already aroused considerable criticism. Dr. Wade's opinion is that we should raise the standard of preliminary examination sufficiently to insure that the student's knowledge is such as cannot have been obtained by cramming.

Professor Osler, in proposing the toast of the British Medical Association at the annual dinner, referred to the suggestion of the president, that Latin should not constitute part of the education of the doctor. This, Dr. Osler thought, came particularly hard upon those teachers who came from America, for they were struggling hard to get a proper system of elementary education, and they wanted above all things some classical training for their medical students. One of the striking features of this meeting of the British Medical Association was the development of the pathological section, which is only of recent institution. The proceedings in this section took the form of practical demonstration instead of the tedious reading of papers; a series of demonstrations on the screen, by Woodhead, Watson Cheyne, Bruce, and others, were greatly appreciated. In the section of anatomy and physiology valuable contributions were made by such men as Gaskell, of Cambridge; Cunningham, of Dublin; and Symington, of Edinburgh. In all the sections excellent work was done.

The meeting was one of the most successful of the Association, and was largely attended by members, not only from different parts of Great Britain, but from the colonies.

THE CANADIAN MEDICAL ASSOCIATION.

The annual meeting will be held in Toronto, on the 9th, 10th, and 11th of September, in the hall of the Normal School, St. James' Square. Every effort will be made to make the session a

success, and already a somewhat extensive programme has been arranged. The list of papers (published elsewhere in this journal) will doubtless be considerably extended before the date of meeting.

A dinner will be given by members of the profession of Toronto to the visitors, at the Queen's Hotel, on the 11th September, at 7:30 p.m. The owners of the yachts "Oriole," "Aileen," and "Abeona," have placed their craft on Toronto bay at the disposal of the committee of arrangements for the afternoon of the 10th, and the managers of the Industrial Exhibition have arranged for the special entertainment of the members of the Association during one of the days of the meeting. The president for the year is Dr. James Ross, of Toronto; and the secretary, Dr. James Bell, of Montreal.

Hospital Reports.

REMOVAL OF OVARIAN CYST—HÆMATOCELE OF BROAD LIGAMENT—LOOSENING OF LIGATURE—SECONDARY HEMORRHAGE — REOPENED IN TWELVE HOURS —NERVOUS SYMPTOMS —RECOVERY.

UNDER THE CARE OF DR. J. W. ROSS, IN THE TORONTO GENERAL HOSPITAL.

Mrs. R., æt. 28. Referred by my friend Dr. Verner, of Toronto. Married 10 years. Has had three children; youngest one 8 years of age. Three miscarriages. The last time pregnant, five or six years ago, had a miscarriage; menses came on last time two weeks ago and lasted three or four days as usual; has not missed a month; noticed enlargement of abdomen two years ago; has been in poor health for five years; no family history of tumors of any kind; suffers from frequent and painful micturition; on examination a tumor is to be felt rising from right ovarian region about the size of a child's head; uterus found in front of tumor between it and the bladder and inclining toward the left side; fluctuation present; tumor diagnosed as ovarian cyst; operation June 6th, 1890; chloroform; removed a multilocular cyst of the right ovary; pedicle very broad; tied with the Staffordshire knot after transfixion; tied as tightly as hands could tie it; tissues of pedicle very dense; omentum adherent to right broad ligament; ligatured and cut off; no drainage-tube used.

1.30 P.M. Temperature, 97°; pulse, 82; face pale; feels cold.

3 P.M. Pad changed; a little oozing from wound had discolored the pad.

5.15 P.M. Pulse 100; pain in abdomen.

5.30 P.M. Pulse 110; patient almost crying with pain.

7 P.M. Retched once.

7.15 P.M. Patient retched again.

8.15 P.M. Patient retched again and blood gushed from the wound and stained the pad. I was at once informed.

9 P.M. Reopened abdomen; found it filled with clots, and after clearing them out as quickly as possible, found a small vessel spouting in the pedicle and a general oozing from the stump; a small perforation was found in the broad ligament below the ligature, as if an hæmatocele had formed in the layers of the broad ligament and had burst into the abdomen; tied the pedicle with four chain ligatures below the old ligatures and found the hemorrhage effectually controlled; washed out the abdomen; drained.

12 P.M. Pulse 138; tube emptied of clots, and a little fresh blood probably from the broad ligament and parts to which omentum had been adherent; patient retched frequently; pulse dropped to 114; temperature 100°.

June 7, 3.30 A.M. Discharge of blood from tube continues; ℥ ii. every half hour.

9 A.M. Serum only from tube.

6:45 P.M. Temperature 99°; pulse 100; retching very severe.

June 8, 2.15 A.M. Retching continues; breath offensive; red discharge from vagina.

June 8. Champagne and brandy enemata; vomiting continues; temperature normal; pulse 118.

June 9. Vomited matter like coffee grounds; after taking seidlitz powder sweetened with cane sugar (not by my order) vomited matter looked bright red like blood, but no clots or streaks were to be seen. I attributed this color to chemical action of the bile and cane sugar in presence of small quantity of some acid.

12 P.M. Pulse 116; temperature 100°; patient wandering for a little while; nervous symp-

toms set in; looks flushed; severe headache; potass. bromide and chloral by enema.

June 11. Restless and noisy; delirious; talking during sleep; looks wild; vomiting continues; no iodoform or carbolic acid has been used.

June 12. Tea and bread retained; buttermilk returned; slight diarrhœa; expression better.

From this on patient convalesced very nicely, and went home on the 20th July quite well.

Remarks.—In this case, and one reported in the last issue of THE PRACTITIONER, hemorrhage occurred subsequent to operation. In one case it was free for one hour but ceased, and the abdomen was not opened. In the other it was giving rise to great pain, and telling rapidly on the pulse, and the abdomen was reopened; no doubt large quantities of blood can be absorbed in the peritoneum. The nice point is when to reopen and when to leave the patient alone. In the second case the patient remarked several times that she could taste blood in her mouth when there was no evidence of blood in the vomited matters. I at first associated the tightness with which it was necessary to tie the broad ligament in No. 2 with the severe and long continued retching, but afterwards found out that the patient had become a slave to the morphine habit for several months before coming under my notice.

PLEURISY, WITH EFFUSION.

A CASE IN TORONTO GENERAL HOSPITAL, UNDER THE CARE OF A. M'PHEDRAN, M.B.

The following case is of interest chiefly on account of the very large amount of effusion present. The fluid filled not only the right chest but extended over into the left over an inch beyond the sternum. Of course the danger is great in such cases, and death may occur suddenly, so that aspiration should be done quickly. The final aspiration was not sufficiently large, the house physician being fearful of drawing off too large an amount at once. He was directed to repeat the operation on second day after, and tried several times, but could obtain no fluid, as the instrument did not work properly. The amount of fluid drawn off on the seventh was very large, might, in fact, be considered too large, but the effect of the aspiration was closely watched, and as he showed no signs of disturbance, the fluid was allowed to run slowly. The chief danger that the future has for him now is probably from phthisis, which so often follows serious pleurisy.

The following notes were taken by my clinical clerk, Mr. W. A. Barnhart:—

H. A., æt. 24; farm laborer; has previously enjoyed good health; family history good. On Saturday, June 14th, 1890, he caught a cold while washing sheep; he felt several chills, which, in a few days were followed by severe pain in right side of chest, not referred to any particular region; his respiration became hurried and troublesome; he still continued his work, but felt very unequal to it. On Wednesday, 25th June, was obliged to remain in bed; his sister applied poultices and mustard to the affected side, which relieved him some. On Friday following he went to a physician, who told him he had fluid in his side; he applied a fly blister to it and told him to go to the hospital as his room was too small and poorly ventilated.

Came to hospital on Sunday, June 29th; temperature 102.5°; pulse 105; respiration 65 per minute: his appetite was fair, his tongue very little coated, and his bowels regular.

June 30. Physical examination: the right side was full and rounded; the location and direction of ribs was not visible; a total absence of respiratory movement; vocal fremitus absent; dulness on percussion amounting to flatness in front and behind, extending from apex to base of lung and about an inch to left of sternum except over tracheæ and right bronchus; there was also a very marked feeling of resistance to the pheximeter finger; there was complete absence of breath and voice sounds in the region of flatness: there was increased movement, hyperresonance and puerile breathing in left side; the cardiac impulse was displaced outward one inch and upward about an inch; the chest was aspirated, thirty ℥ of fluid being drawn off, after which his dyspnœa was somewhat relieved.

July 1st. Slight expansive movement in right side; flatness on percussion to almost the same extent as previous day.

July 2nd. Temperature rose to 103°; pulse 105; respiration 60 per minute.

July 4th. Temperature 103°; pulse 110; respiration 55 per minute; no change in dulness; patient prefers to lie on affected side.

July 7th. His condition has remained much the same for last few days. Aspirated and withdrew eighty ℥ of fluid.

July 21st. Patient has improved every day since last operation; his appetite is better and he sleeps well; respirations are now reduced to 28; pulse 80 per minute; temperature 100°; the fluid still remaining is being slowly absorbed.

Aug. 15. Discharged; his general health good; still quite decided dulness with weak respiratory murmur over lower part of chest.

Clinical Notes.

REPORT OF A CASE OF ADDISON'S DISEASE, WITH NOTES OF AUTOPSY.

BY JOHN CAVEN, M.D., L.R.C.P. LOND.

A. F., fisherman; residing at Peak's Island, Maine. Family history, good; nothing noteworthy.

Personal history previous to illness.—The only facts worthy of notice in the history of the patient prior to his present illness are: (1) That he served as a cavalryman in the late American war; was wounded in the back and arm, and lay bleeding on the field for over three hours; was then taken prisoner, and left without food or treatment for a considerable length of time (the only treatment he ever received was washing of the wounded arm with cold water). (2) That his life since the war has been an exceedingly hard one, he being exposed to a great degree of wet and cold, and that often without proper food; and that he suffers from piles.

History of present illness.—The patient, who is 45 years old, had noticed for the last three or four (his wife says five) months that his strength was leaving him, though very gradually. He also noticed that his hands and face were becoming very dark in color, although less exposed to sun than usual. The weakness he attributed to bleeding piles, and the coloration of hands and face to sun-burning. He persisted in attempting to work, and on several occasions became very faint as a result. Three weeks before death, the patient was seized one night with purging and severe pain in the bowels. This continued all night. He was seen next day by a doctor, and enteritis suspected. Diarrhœa and pain yielded to treatment, but he was unable to retain anything on his stomach. From this on to the time of his death, which took place on August 12th, he gradually sank, there being no signs of any acute disorder. At all times, his pulse was exceedingly small and feeble, and during the last five days of his life was inappreciable, except in the larger vessels. During the last five days of his life, he complained of vague pains in the abdomen, not being able exactly to locate them, and was unable to lie on his left side. The morning of his death he became delirious, and for the last few hours convulsive twitchings, especially of the left side, were present (The clinical notes are necessarily imperfect, since the case was not in the hands of the reporter).

The autopsy, which was made for Dr. Thayer, of Portland, by the reporter, showed that the case was one of Addison's disease. Only the abdomen was opened. The following conditions were found: The peritoneal coat of the small intestine was considerably injected; the mesenteric glands were enlarged, indurated, and blotted over with black pigment; spleen about five times its normal size, color and consistency normal; liver showed extensive adhesive perihepatitis, otherwise healthy; kidneys showed a few subcapsular cysts, but no signs of *general* interstitial inflammation; supra-renal capsules greatly enlarged in all diameters; section showed their central areas to be composed of large bean-shaped nodules of caseous material; no special affection of sympathetic ganglia or nerves could be made out with the naked eye; stomach and intestines healthy; bladder healthy; pancreas slightly smaller than usual, but healthy.

There are one or two points in connection with this case which seem to be worthy of special notice, namely:

(1) The limited area of the so-called bronzing, which was confined to the face, neck, hands, and wrists. There was absolutely none on the buccal mucous membrane, or on any other part of the skin, except that mentioned. Some small pigmented spots were found on one arm, but these the patient said were moles, and had always been present.

(2) The conjunctivæ were yellowish, as in jaundice; not pearly white, as usually found in such cases.

(3) The pigmentation of the lymph glands of the mesentery appears to be an unusual feature. This pigmentation showed on the outside of the glands and on section.

FOREIGN BODY IN ALIMENTARY CANAL TEN MONTHS.

BY W. D. T. FERGUSON, M.D., ROCKLAND, ONT.

On the evening of Oct. 4th, 1888, I was called to see Arthur Fairfield, æt. 7, who had a few moments previously swallowed a cent. Found the little fellow making violent but futile efforts to vomit. He was becoming rapidly asphyxiated, and I was afraid lest the foreign body had entered the respiratory tract, but on investigation found the asphyxia due to the convulsive efforts at vomiting. Felt sure the coin was lodged in some portion of the gullet, and that it had not yet reached the stomach. Failing to locate it by digital examination, both internally and externally, I introduced a soft bougie; my intention being to first locate it, and then contrive some means of extracting it, as I had not a coin extractor with me. After passing bougie some seven or eight inches it became arrested, but hardly had its tip touched foreign body when a convulsive effort was made to swallow, and bougie passed on. The patient immediately experienced a sense of relief, and told me that the cent was gone. Satisfied of its arrival in the stomach I felt easier regarding patient's immediate safety, and as he was soon taken with another violent fit of vomiting, looked eagerly for the return of the cent, but in vain.

Shortly before, patient had eaten a large meal of bread, potatoes, etc., this was all thrown up in an undigested state. As this vomiting soon gave place to retching, the little fellow became much exhausted, and despairing of having the cent brought up, I administered an anti-emetic with very little hope, I must confess, of its accomplishing much, aware of the constant presence of the cause. All that night and next day patient could retain nothing on his stomach, and complained of pain and oppression in this region, also dribbled copiously of a watery fluid from mouth. Towards next evening the stomach having, no doubt, become accustomed to its new tenant, or tired out by its useless efforts at eviction, become passive, and he fell asleep. The following morning, in consultation with Dr. Robillard, of Thurso, Quebec, we concluded to keep patient in bed, and feed him on a constipating diet for a few days. Thick soups, eggs, etc., were freely given, and at the end of two days a purgative dose of castor oil. Oil operated nicely, but without desired effect. Then I resorted to constipating diet alone, the idea being by this means to dilate any constricted portions of canal, and thus allow passage of the cent.

At the end of two weeks, as patient was feeling tolerably well, with only slight oppression and slight soreness in stomach, and cautioning himself and parents to watch the motions carefully, I allowed him to join his playmates, and from that time on he was quite hearty. As a preventive a gainst the stomach acids dissolving the metal and causing copper poisoning, I put him on an alkaline mixture. Saw patient occasionally for several months, and for at least four months felt quite positive that the cent was still in the stomach—pylorus end. At the end of that time patient could give no information, nor could I on careful examination elicit any signs of its presence, so concluded that he must have passed it unnoticed.

On the 6th of June, 1889, was called to see patient suffering from severe intestinal colic in region of ilio-cæcal valve. Immediately thought of foreign body, gave enema, hot application, and opiates, with prompt relief of colic. Again concluded that coin could not be present.

Heard nothing further till the morning of 10th August, when I was informed by the little fellow that he had found the cent. On enquiring from his mother, found that the previous evening as he was about retiring he was seized with very severe pains in lower part of abdomen. His mother endeavored by means of hot applications to allay the pain, but failing to do so was about sending for me when his bowels moved, and examining the motion the coin was found imbedded in a mass of hard fæces tinged with blood. Relief from pain was instantaneous. Patient's bowels had not moved during the three or four previous days.

It is now twenty-two months since the little fellow swallowed the coin, and one year since exit per rectum. Coin was an old fashioned one, larger than the modern cent; diameter, 1 1/8in. It was only slightly corroded. Patient is to-day quite healthy.

The above is the unvarnished history of the case, and I report it not as an example of judicious medical treatment, but because I have not yet heard of a foreign-body remaining so long in the digestive tract with so little apparent harm.

Correspondence.

LODGE PRACTICE.

Editor of CANADIAN PRACTITIONER:

SIR,—I think your editorial on this subject in your issue of the 16th inst., will meet with the cordial approval of the majority of your professional brethren in all parts of the province, and particularly in the towns and cities. Perhaps in the densely populated centres of European countries some show of reason can be given for medical men accepting such practice. But in a young country, as Canada is, no man need want, except he be improvident or intemperate. It may be assumed that no medical man has the right to agree to attend the men who are members of many of these societies at a nominal sum. Why, sir, I know men, members of these societies, who are in very comfortable circumstances, and who are not ashamed to receive medical attendance from their "lodge-doctor" for the miserable dollar a year they pay for membership fee. Is it not a great wrong that medical men should treat as paupers those who can well afford to pay, and who, for that matter, live in a much better way than some of our struggling fellow-practitioners?

It is a fact that some of these societies offer as an inducement to persons to become members, that they will receive free medical attendance. Can a lawyer be found who would give his service to clubs and lodges in such a way? What grocer, for the honor of being appointed grocer to the "Grand Knights of the Maccabees," would permit each of the said Knights for the nominal sum of a dollar a year to obtain from his store all the goods he personally needed? If it be right, why do not these societies try to get everything else free, as well as medical attendance?

I do not wish to be understood as desiring to limit the charitable work of any member of our profession. Everywhere will be found the widow and the orphan, often left all but destitute after the lingering illness and death of the husband and father. To them let every brother render his charitable service without stint. But in attending the well-to-do members of these societies as paupers, in giving his name, his time, and his service in enlarging the membership of these so-called benefit societies, he degrades his calling, does wrong to his professional brother, and inflicts a real injury on the public at large.

Yours truly,

ANGUS MACKINNON.

Guelph, Aug. 23rd, 1890.

Pamphlets Received.

Identité de la Dengue et dé la Grippe-Influenza. Par le Dr. Jules Rouvier, Paris, Librairie Médicale, 23 Rue Racine.

Transactions of the American Pediatric Society, vol. 1, 1889. J. B. Lippincott & Co.

Twelfth Annual Report of the State Board of Health of the State of Rhode Island, 1889.

Rivista Clinica, Archivio Italiano di Clinica Medica. Francesco Vallardi, Milano.

Fact and Theory Papers. The Suppression of Consumption. G. W. Hambleton, M.D.

Miscellaneous.

THE CANADIAN MEDICAL ASSOCIATION.

The programme of the next annual meeting of the Association, which will be held in Toronto on the 9th, 10th and 11th of September, will include the following addresses and papers:—

Address in Medicine, by Dr. Prevost, Ottawa.
" " Surgery, by Dr. Chown, Winnipeg.
" " Obstetrics, by Dr. J. Chalmers Cameron, Montreal.
" " Materia Medica and Therapeutics, by Dr. W. S. Muir, Truro, N.S.

Papers :—

The Failure of the Removal of the Ovaries and Tubes to Relieve Symptoms—Dr. Jas. F. W. Ross, Toronto.

Abscess of the Brain—Dr. G. Sterling Ryerson.

Pernicious Anæmia (with report of two cases)—Dr. A. McPhedran, Toronto.

The Cardiac Complications of Gonorrhœal Rheumatism — Dr. R. L. MacDonnell, Montreal.

Pharmacology of Salicylamide—Dr. W. Beatty Nesbitt, Toronto.

Syphilis of the Spinal Cord—Dr. F. G. Finley, Montreal.

Cholecystotomy—Dr. F. J. Shepherd, Montreal.

Inhalation in the Treatment of Chronic Pulmonary Diseases—Dr. Price Brown, Toronto.

(*a*)The Local Administration of Bichloride of Mercury as an Alterative in Pelvic Exudations in Women ; and

(*b*)Why Apostoli's Method Sometimes Fails—Dr. A. L. Smith, Montreal.

Chronic Urethral Discharges : their Diagnosis and Treatment. With a Demonstration of the Electric Endoscope—Dr. Edmund E. King, Toronto.

(*a*)Electricity in Gynæcology. Report of Cases;

(*b*)Porro's Operation. Report of Case—Dr. Holford Walker, Toronto.

A Contribution to the Operative Treatment of Injuries to the Spinal Cord in the Cervical Region—Dr. Jas. Bell, Montreal.

Exhibition of Cases—Dr. B. E. McKenzie, Toronto.

Hydatid Growths—Dr. E. B. O'Reily, Toronto.

The Surgical Treatment of Fractured Spine—Dr. E. A. Praeger, British Columbia.

(*a*) Hemi-Atrophy of the Tongue.

(*b*) A New Method of Preserving Specimens of the Eye—Dr. H. S. Birkett, Montreal.

Abscess of the Anterior Mediastinum—Dr. John Campbell, Seaforth.

N.B.—Members will please note that certificates entitling them to reduced travelling rates will not be issued this year, as heretofore, by the Secretary, but will be obtained from the agent at the starting point of the journey.

JAS. BELL, M.D., *Secretary.*