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CONTENTS.

ORIGINAL COMMUNICATIONS.

Home and Foreign Climates in Consumption.... 217
A Plea for Efficient Legislation Regulating Medical Practice. 218

SOCIETY PROCEEDINGS.

Montreal Medico-Chirurgical Society...... 221
Large Interstitial Uterine Tumor, with Great Development of the Uterine Wall and Moderate Increase of the Uterine Cavity...... 221
Cholecystenterostomy from the Use of Murphy's Button 221
Four Cases of Extra Uterine Pregnancy.. 222
Uterine Fibroid...... 226
Dermoid Cyst 226
Foreign Body in the Bladder 226
The late Dr. E. E. Duquet. 227
Perforated Gastric Ulcer 227
Gall Stones 229
A Case of Multiple Carcinomatous Growths in a Cirrhosed Liver 229
On Two Different Conditions of the Mitral Valve giving rise to Presystolic Murmur 230

PROGRESS OF SCIENCE.

Persistent Urethral Discharges due to Seminal Vesiculitis 232
The Treatment of Stricture of the Œsophagus... 232
A New Operation for the Radical Cure of Hernia 233
A New Method of Shortening the Tendo Achillis...... 233
Diagnosis and Treatment of Appendicitis 233
The Neatest Circumcision.. 233
Local Electrolysis and Zinc-Amalgam Cataphoresis in Malignant and Non-Malignant Tumor 234
Class Notes 235

EDITORIAL.

The Advantages of Private Hospitals 236
Canadian Medical Association... ... 236
The American Electro-Therapeutic Association 238
Selection.. 238
Class-Room Notes.. 238

BOOK NOTICES.

The Care of the Baby...... 238
Pocket Formulary and Table of Doses, and also Therapeutics of Children's Diseases 239
Le Moyen-Age Médical...... 239
Maladies Internes et Maladies des Enfants 239
La Mort Apparente du Nouveau-Né. 239
La Prostitution dans l'Antiquité, dans ses rapports avec les maladies vénériennes...... 239
La Cure de Barèges 240

Pamphlets received 240

Publishers' Department 240

Original Communications

HOME AND FOREIGN CLIMATES IN CONSUMPTION.*

Doctor Playter contributed a paper on "Home and Foreign Climates in Consumption," mostly extracts from a book on consumption now in the printers' hands, in which he contends, and quotes authorities to prove, that, in the present state of our want of knowledge of the effects upon the human functions of the various atmospheric conditions, change of climate is an empirical remedy having no theoretical foundation, and that acclimatization is a process, the possible injurious effects of which will often outweigh any benefit derived. In hardly one case in a hundred is such a change desirable, although change of locality is often essential.

A warm climate sometimes gives more comfort and prolongs life in advanced cases; and occasionally in the early stage, a young man indifferent about his health may be sent to an elevated climate.

Theory and practice have taught us that what the consumptive needs, first, last and always, is more pure air, more oxygen, and this in its best, most invigorating form. This cannot be best supplied by a warm nor by a thin atmosphere. The consumptive, whether from heredity or habit, is an imperfect breather. In the development of the soil for the tubercle bacillus imperfect respiration plays the chief part; all other causes are but remote and contributive to this one—an imperfect respiratory function, which clogs the entire organism with the degree of imperfect tissue metabolism from want of oxygen.

In the decomposition of this accumulated effete matter, not only are inorganic, substances formed which constitute food for the bacilli, but possibly also organic toxines, which transform simple saprophytic bacilli into poisonous or virulent pathogenic organisms or infections, the analogue of

* Abstract of paper read before Ontario Medical Association.

which we sometimes have in the transformation of the bacillus coli communis by intestinal toxines.

In the rarified air of high mountains with the climbing, there is great and forced expansion of the lung membrane. The subject actually gasps widely for breath in order to compensate for the thinness of the air. The whole function of respiration is aroused and improved, and the body purified and invigorated, but altitude is not necessary. This function can be more readily improved at lower levels with the richer air of Canada by suitable lung gymnastics, if the patient will only persevere in the exercises; and more safely too in hemorrhagic cases, in which there is considerable risk in going somewhat suddenly to a much elevated climate.

Dr. Playter refers to the benefits of compressed air, and of the dense air at sea, where the mortality from consumption has been shown to be sixteen times less than on land ; results not attributable alone to the purity of the sea air.

The purer air of great elevations is an important condition. Yet we have in many parts of Canada a practically pure highly ozonous atmosphere at all seasons while over our snow-covered expanses during several months of the year is air probably as germless as on sea or high mountain. The colder the air breathed, the more oxygen it contains, and the more too it expands in the air chambers on becoming warmed to the lung temperature. Consumptives in Canada in nearly all cases have acquired the predisposition by means of indoor occupation, or a habit of housing in close, over-heated rooms, and they may be, the most susceptible of them, gradually habituated back again to an outdoor life, even in the coldest season, by proper attention to the skin,—suitable clothing and especially the cool bath. The sudden changes in temperature in Canada, although trying, are invigorating and often less marked and sudden than on high altitudes. At Davos the thermometer has shown a drop of 150° F. (from 166° to 16°) between the midday sunshine and the following night.

Dr. Playter contends that we have in Ontario and Quebec some of the best localities for consumptives on this planet. Muskoka has a reputation as a good one. It is sufficiently elevated, has a dry, pure and invigorating atmosphere and a large proportion of sunny days. The ideal place, the doctor thinks, is on the Gatineau mountains, a few miles from Ottawa, in about the same latitude as Muskoka. With a pure and highly bracing air, and a large number of sunny days, it has a south-eastern aspect, and protection on the north-west by a much more elevated wooded ridge, and is hence suitable for all seasons. It has a delightful outlook, with a view of about 4000 square miles of beautiful country,—the Ottawa, Rideau and Gatineau Rivers, their valleys, windings and waterfalls, and the beautiful capital of the Dominion at the meeting of three waters.

A PLEA FOR EFFICIENT LEGISLATION REGULATING MEDICAL PRACTICE.

By Perry H. Millard, M.D., of St. Paul.

(*Concluded*)

Having submitted satisfactory evidence of preliminary fitness, only such persons should be admitted to undergo the professional test as have received their courses of professional education at schools of medicine whose curricula of requirements are acceptable to the respective boards. A minimum of requirements, both as to time and teaching facilities, are as essential in measuring professional fitness as it is for similar purposes in universities, colleges, and our public school system. A school should not be recognized unless it is working under a minimum that will assure the graduation of a class of persons that can safely be entrusted with the care of the sick. In arriving at a conclusion upon this most important function I desire to particularly impress upon the members of these boards the fact that medicine as at present understood and practised is radically different from that of a few years ago. To comprehend requires years of study and a training in laboratory methods and surgical technique that can only be grasped when afforded by a person

trained in methods of medical pedagogy. The clinical and laboratory facilities of many of our schools are shamefully inadequate, several colleges known to the writer having operated for years with substantially no assets. It is the duty of each board to enquire fully into the facilities of each school represented by graduates who are applicants for degrees.

Having determined upon the fitness of the school to afford satisfactory courses of medical instruction, applicants holding degrees from such institutions should be admitted and a further test of fitness demanded by requiring an examination upon all the recognized branches of medicine. These examinations should be conducted by number, be scientific, and of sufficient severity to assure the public a thoroughly educated profession. Students from the respective schools of practice should undergo an examination upon the same questions, no necessity existing for questions not primary in character.

Licenses should not be refused or revoked for other than gross unprofessional or dishonorable conduct. In criminal cases it is not well to anticipate the processes of criminal law. The latter feature of our legislation has been instrumental in protecting the people from the professional charlatan in several states. Its provisions should be incorporated in all statutes regulating medical practice.

Owing to the difficulty in securing indictments and the consequent tardiness of legal processes, the penalty for violations of the provisions of this form of legislation should be by penalties imposed by a justice or a municipal judge; the latter method has given satisfaction as far as I am aware. Reasonable efficiency upon the part of the officers of these boards have been awarded by a full compliance with the provisions of this form of statute in all instances. The Governor should have the appointing power, being responsible for the successful operations of the different state boards. Experience satisfies us that the so-called mixed boards are doing satisfactory work and operating in perfect harmony. Seemingly no excuse exists for the duplicate boards operating in a very few States. At present approximately thirty States possess legislation regulating medical practice. Seventeen States have a form of statute that fails to recognize the diploma as evidence of fitness to practice; consequently they may be classed with those States operating under efficient acts. In the latter class of States I particularly desire to call your attention to the results of work thus far accomplished. In a paper read before this learned body, at Detroit, Michigan, in 1892, I suggested the future influences of these boards as most important in shaping the future medical education in this country. I submit data at this time confirmatory of the position then taken, and reaffirm my former suggestion that future legislation will in a great measure determine and govern the work of the teaching bodies of the country.

I am deeply indebted to the officers of the various boards for courtesies extended, and regret that space forbids reference to many suggestions and conclusions arrived at in the work of the different boards.

Data have been obtained from the following named States: Alabama, Minnesota, Maryland, North Dakota, North Carolina, New York, New Jersey, Virginia, and Washington.

The subjoined table indicates briefly the work of these boards:

State.	Examined.	Licensed.	Rejected.	Per cent.
Alabama......	647	558	89	0.862
Maryland.....	150	105	25	0.806
Minnesota.....	641	499	142	0.778
New York......	967	797	170	0.824
New Jersey....	447	417	30	0.955
North Carolina.	615	508	207	0.71
North Dakota..	81	76	5	0.938
Virginia.......	835	613	222	0.734
Washington....	207	167	40	0.806
Totals....	4670	3740	930	0.822

It will be observed that of four thousand six hundred and seventy persons examined, but eighty-two and two-tenths per cent. were successful in securing a license. The nine hundred and thirty unsuccessful applicants have, we doubt not, principally located in States not protected by this form of legislation.

I am pleased to direct your attention to the good work of the Minnesota board. The first act regulating medical practice in this State became operative in March, 1883. It was the form of legislation at present in force in Illinois. It was in operation five years, being supplanted by the present law. The present act requires an examination of all persons commencing the practice of medicine, and, as amended by the last legislature, the minimum of requirements is changed, demanding that all graduates of later date than 1898 furnish satisfactory evidence of having attended at least four courses of lectures in different years, of not less than six months duration each.

We have in Minnesota a practical illustration of the position taken in my former paper: "that in medical legislation we have the only solution of the problem of higher medical education." Having drafted these bills, and by force of circumstances been somewhat conspicuously aggressive in urging their enactment, I have, in consequence, witnessed their operations with some concern and interest. The result is all that the most sanguine could have anticipated. In a period of twelve years the proportion of physicians to the population in Minnesota has been reduced from one practitioner to every six hundred and fifty in 1883 to one to every one thousand in 1895.

The State has been substantially rid of the travelling charlatan. The present able Secretary, Dr. McDavitt, informs me that the Medical Census just completed is accurate, and that the present operation of the law is quite faultless. We therefore conclude that in one State at least the number of physicians have been reduced to a number commensurate with the demands of the peop.e.

The work of the New York Board is attracting considerab'e attention. Notwithstanding pronounced opposition and many embarrassments, the act is destined to strengthen the character of the profession in this State. From advance sheets kindly furnished for use in this paper, I observe the following verification of a position taken by the Secretary, James Russell Parsons, in his 1893 report. He reiterates that the records of the past year conclusively prove the position taken in his 1893 report : "That the new law proves a barrier to the ingress of the incompetent, has operated to raise the standard of preliminary education, improve the methods of teaching and terms of study of the different schools of medicine."

The following resolution from the President and Secretary of the Board to the State Medical Society is significant, and should meet the approval and support of every member of the profession of this great State : "*Resolved*, That in the opinion of this Board the best interests of the public and medical profession would be materially advanced by gradually increasing the minimum of requirements as to general preliminary education, till no candidate be entitled to matriculate in 1897 at a degree-granting medical school in this State that has not completed at least a full high school course."

I am pleased to note that this bill has already passed the Senate in New York, and is in a fair way of becoming a law. If it becomes operative it will operate to improve the character of matriculates in New York schools, and will be followed by similar legislation in other States. Greater co-operation is necessary between different state boards, as it is essential that harmony of policy exist as far as practicable. As in foreign countries their relations to the profession and teaching bodies is most important, their functions being that of professional censors of the conduct of the members of the profession, and guarding at the same time the avenues of entrance to professional work. It being the duties of these boards to protect the people from professional incompetency and charlatanry, the duties are briefly comprehended in the performance of the following duties : 1. In establishing a minimum curriculum for all colleges whose alumni apply for a license to practice. 2. The individual examination of all perons wishing to practice medicine in the commonwealth. 3. A professional censorship granting the right to refuse or revoke a license for incompetency and gross unprofessional or dishonorable conduct.

As this form of legislation becomes more fully understood and appreciated by the better class of schools, it will be observed as one of the most certain and reliable avenues of placing before the profession of the country the character of work being done in all colleges whose alumni apply for a license. A school doing honest work has little to fear at the hands of these boards : upon the contrary, as suggested in my former paper, it will be found that the proportion of applicants able to pass successful examinations will be a certain index of the character of instruction afforded students in the respective schools.

While the proportion of applicants successful is only eighty-two per cent., it will be found that from the schools heretofore operating under a high grade of requirements that, thus far at least in the work of these boards, nearly all graduates are successful in obtaining a license upon examination. In substantiation of this conclusion I again submit data, using therein the same schools as in my former paper.

The following table indicates the proportion of students successful on examination from alumni of schools heretofore operating under the three years curricula.

Colleges.	Examined.	Licensed.	Rejected.	Per cent.
Harvard..........	31	31	0	1.000
Columbia........	123	118	5	.952
Univ. of Penna....	126	123	3	.976
Univ. of Michigan..	83	78	5	.940
Northwestern Univ.	26	22	4	.846
Univ. of Minnesota.	149	148	1	.992
Totals......	538	520	18	.964

I cannot but conclude, gentlemen, that efficient medical legislation will operate to bring about the following results, as applied to the profession and public.

1. It will protect the people by affording a profession of greater intelligence.

2. It will suppress charlatanry.

3. It will reduce the number of persons practising medicine to a number commensurate with the demands of the people.

4. It will reduce the number of medical colleges, at present far above legitimate demands.

5. It will raise the general standard of professional fitness, assuring us a professional prestige in the future, becoming the most important of the learned professions.

In conclusion, we appeal to the profession to renew their efforts in securing efficient medical legislation, believing its operations will result most beneficially to both the public and profession.

Society Proceedings.

MONTREAL MEDICO-CHIRURGICAL SOCIETY.

Stated Meeting, January 25, 1895.

DR. G. P. GIRDWOOD, PRESIDENT, IN THE CHAIR.

Large Interstitial Uterine Tumor with great Development of the Uterine Wall and Moderate Increase of the Uterine Cavity.—Dr. WM. GARDNER contributed this specimen and said that it appeared to belong to the variety of myoma, designated as lymphangiectodes; and, roughly speaking, was composed of intersecting bands or filaments of pearly white tissue bounding spaces containing a clear straw-colored fluid.

The case was interesting from its rarity, its rapid growth, its consistence as felt through the abdominal wall, and otherwise in some respects presenting difficulties in diagnosis. The patient was aged thirty-two, and married eight years, sterile, menstruation regular till three or four months ago, the flow being copious and painful. Otherwise her complaints were of pain in the left lumbar region and in the legs, and of abdominal enlargement. The patient said that previous to a year ago there was scarcely any enlargement. The abdominal tumor resembled much in feel and in other characters the gravid uterus of seven months, presenting at intervals the painless contractions so valuable a sign of pregnancy, as insisted upon by Dr. Braxton Hicks. The fact, however, that this sign is occasionally met with in the softer varieties of uterine tumors, was demonstrated by the late Dr. Matthews Duncan. This consistence of the tumor and marked purplish discoloration of the genitals, with pigmentation of the linea alba, and areola about the nipples, had given rise to the suspicion of pregnancy; a suspicion which was shared by a member of the profession. The operation was done a fortnight ago, and the method chosen was supravaginal amputation after ligature of the ovarian and uterine arteries, and intraperitoneal treatment of the stump. The recovery had been absolutely without unfavorable symptoms.

Cholecystenterostomy from the use of Murphy's Button.—Dr. SHEPHERD at a meeting held September 21st, 1894, reported a case of cholecystomy in which a fistula remained, and he stated then his intention of doing a cholecystenterostomy should the fistula not close within three months. She returned to the hospital November 28, 1894, looking well and healthy, and having gained considerably in weight. She, however, said the continued discharge of the bile was unbearable, and asked that an operation be performed for relief. So, on December 3rd, she was placed under ether, and an incision was made a little internal to the first one, and the fistulous opening thus avoided. The gall-bladder was seen attached firmly to the abdominal wall. On examining the site of the supposed gall-stones found at the last operation in August, he came down on a large mass, the size of an orange, which apparently involved the head of the pancreas and duodenum. Being convinced that the case was one of malignant disease, and that all measures for relief could only be temporary, it was decided to unite the gall-bladder to the colon by means of a Murphy button, the duodenum being fixed and not easy to get at. The button was introduced without much difficulty, the purse string suture being first applied; owing to the thickness of the gall-bladder, there was some puckering, and it was difficult to get the folds to lie flat. The thinness of the colon was remarked, and the button when pressed home could be seen distinctly through the walls of the gut, so a few Lembert's sutures were introduced. As the patient had malignant disease, it was not considered very important to close the fistulous opening, as it was felt that this would gradually diminish in size when there was free communication between the gall-bladder and the gut. On dropping back the bowel and gall-bladder the parts seemed to lie quite comfortably without tension. The abdominal wound was now closed with two layers of sutures.

The patient went on excellently well for three days, very comfortable, with no pain and no discharge of bile from the fistulous opening. On the evening of December 6th, she complained of chilliness, and bright red blood began to ooze through the fistulous opening which led to the gall-bladder, and large clots of blood could be squeezed out. The bladder was packed with iodoform gauze, but in a few hours the blood began to force its way through the abdominal wound, and the pulse began to fail, so it was decided to reopen the wound and examine the source of the hæmorrhage. On opening that, however, the parts were free from any peritonitis or sepsis, but there was a considerable amount of clotted blood in the abdominal cavity in the neighborhood of the stomach, besides a quantity in the gall-bladder. On examining the anastomosis, it was seen that the button had cut through the gall-bladder, and from this cut there was free bleeding. There was no gangrene of parts in contact with the button. The button was immediately removed and the wound in the colon and that of the gall-bladder sewed up. In the latter, owing to its great friability, this was a difficult matter. Blood still came, and so the gall-bladder was packed with iodoform gauze and the wound closed as the patient was getting much weaker. Next morning the dressings were found to be soaked with blood

and all efforts to stop it failed. She died that evening. A hurried examination was made after death, and carcinoma of the head of the pancreas and duodenum was found, which pressed the common duct. The gall-bladder was full of blood, the suturing having failed to arrest the hæmorrhage. Dr. Shepherd remarked that such cases as this rather damped one's enthusiasm for Murphy's button, but still the case was one of cancerous disease, and such cases were more liable to hæmorrhage than others.

Dr. JAMES BELL had listened with great interest to the result of this operation. He never had occasion to apply the Murphy button in the operation of lateral anastomosis in the human subject, although he had done so experimentally in the dog. However, he had often thought that a cholecystenterostomy, especially uniting the gall-bladder to the first portion of the duodenum, must be a good deal more difficult operation to perform than it is described as being. The difficulty of suturing the gall-bladder was in his mind while Dr. Shepherd was describing his case. Since his three cases reported a few weeks ago, he had performed another end to end anastomosis with every prospect of a satisfactory result so far. There was a very chronic obstruction, the ileum was much dilated, the muscular coat of the walls greatly hypertrophied, being perhaps 2½ inches in diameter at the point of section. On the other hand, the distal portion was perhaps smaller than usual. In puckering up the purse-string suture over the end of the proximal portion of the bowel, which was also greatly thickened, he found difficulty in getting the edges evenly turned in, and after uniting the button he noticed some mucous membrane protruding. He then cut the string, unscrewed the button, made another section, and applied the button a second time with better success. The question of hæmorrhage in Dr. Shepherd's case was a little difficult to understand. There were no large vessels to bleed in the substance of the gall-bladder itself, as it is not a vascular structure under ordinary circumstances. His first impression, upon hearing of the hæmorrhage, was that it came from some portion of the meso-colon. It was certainly difficult to understand what combination of circumstances could make the gall-bladder bleed so profusely. He could well understand that an experience of this kind would not predispose a man to repeated operations with the Murphy button. He thought that it had been used oftener than advisable in cholecystenterostomy. The plea is, that in a certain percentage of these cases, a fistula remains permanently. On the other hand, he believed opening the duodenum to be a great element of danger. Then the history of the earlier cases, those done before the Murphy button was introduced, of establishing a communication between the gall-bladder and some portion of the intestines, was a very unfortunate history all through. Many cases of inter-communication of the contents occurred, setting up disastrous, if not fatal results.

Four cases of Extra-Uterine Pregnancy. Dr. SPRINGLE read this paper, as follows:—

I shall not attempt to enter into a consideration of the subject of this condition, for it may be found occupying chapter upon chapter in any modern text of gynæcology or abdominal surgery, and medical literature teems with it. Still, I think you will agree with me that one or other of these cases possesses more than one point of interest.

This paper is more properly a series of four case reports of extra-uterine gestation, which present so many differences in their history and clinical course and effect, that I thought perhaps their relation might be of interest to you.

Two of these cases were advanced, one to a little over six months, the other somewhat less. The other two were early pregnancies not advanced more than three months. Again, one of each of the two was operated upon and the others recovered with equally as good results.

CASE I. I first saw at the Metropolitan Dispensary in June, 1893, and ordered her to the Western Hospital, where she was admitted on the 15th of that month. Her age was 28 years, and she had been married nine years, and had had nine children and no miscarriages. Her youngest child was then 18 months old. She had never, so far as she knew, suffered from any menstrual or other disorder bearing upon her condition at the time. When first seen at the dispensary she was complaining of great abdominal pain and enlargement of the abdomen, due to a tumor, she had been told by her physician.

While in the hospital she gave the following history in addition to that stated above:

On February 28, 1893, she became unwell, and continued to be so until March 29. The flow was accompanied with more or less pain, which she had not experienced before, and at no time had she noticed shreds or pieces of tissue to lead one to suppose that a decidual membrane had been shed. She continued to exercise her household duties, but experienced always more or less pain of a lancinating character and situated more in the lower abdomen, accompanied by nausea, vomiting, fainting attacks and frequency of micturition. These symptoms continued up to the time when seen, and patient suspected, but was not quite sure, that she was pregnant.

The mammæ and areolæ were in a condition corresponding to the period of pregnancy that she was supposed to have been in. The abdomen was enlarged, tender, and with some

slight difficulty an ovoid in contour tumor could be felt reaching to the umbilicus and enlarging below where its outline to palpation became lost in the depths of the pelvis. The tumor was dull on percussion, very tender, no contractions to be felt, no fœtal movement (although the patient thought she had felt these), and no heart sounds to be heard at the time. A well-marked souffle was heard.

Per vaginam the uterus was found to be crowded to the right and front of the pelvis, but its exact position and location with the tumor could not be ascertained accurately. It was raised slightly and measured by the sound slightly over 70 m.m. The remainder of the pelvic cavity was filled by a large fluctuating tumor continuous with that observed above. It was thought at the time that a solid movable body could be detected, but the extreme tenderness precluded thorough manipulation. Dr. Fisk, then house surgeon of the hospital, detected fœtal heart sounds upon the day of operation.

When the cavity of the peritoneum was examined, it was found that the pelvis was roofed by a tumor which had a projection upwards. It completely filled the pelvis from the brim. The uterus and right appendage were easily felt in the position partially ascertained by the examination previously mentioned About one inch of the left tube could be felt close to the uterus, the rest of the tube appeared to be lost or spread out upon the tumor. Here and there small and recent clots of blood entangled in omentum and lying in between the folds of bowel were to be seen. These had evidently come from the sac or cyst wall, in which more posteriorly several small oozings were observed. Shreds of fibrin attaching the cyst wall to the surrounding parts were quite numerous, and evidently but a few days old.

A trocar withdrew a quantity of unmeasured slightly tinged with blood fluid from the cyst. The puncture bled so freely that a finger was introduced to explore the contents, and which was found to be a living child. The opening was quickly enlarged and the fœtus extracted. This was followed by the most awful hæmorrhage I have ever seen, and was only controlled by aortic compression. The cord was attached about one and a half inches to the left of the median line to the roof of the cavity. The placenta was wholly attached above, and the thickness of the placenta and cyst wall in parts did not measure more than one-fourth of an inch, and seemed to be but peritoneum and placental tissue.

Any attempt at hæmostasis by ligature, force-pressure or cautery seemed to increase the hæmorrhage. The sac was sewn by its opening to the abdominal opening, pressure on the aorta being maintained in the meanwhile and the cavity tightly packed with iodoform gauze, as were also the united openings. This stopped any active hæmorrhage. The child after delivery made a few feeble respirations and died No attempt was made to extract the placenta.

The patient recovered well from the effects of the anæsthetic considering the amount of blood lost.

For several dressings in which the gauze packing was removed it was found necessary to compress the aorta, and any attempt in detaching the placenta was followed by profuse hæmorrhage.

She continued to improve for ten days, after which symptoms of thrombosis appeared in the left femoral vein, septic in nature. This was followed by pyæmic abscesses. She recovered, however, but did not leave the hospital until October 18th, and is now in fair health.

I am indebted to Drs. McConnell and Perrigo for their able assistance in this case and its after-treatment.

CASE II. This case is of much interest, for it is believed to be now a case of retained fœtus. The patient was 30 years of age and had been married for six years. There is a history of a probable miscarriage (of about three months) five months after marriage. Since this she had been attended by a gynæcologist for some uterine disorder. She had enjoyed fair health otherwise and menstruation had always been regular.

On the 12th of September, 1893, she was seen for the first time and complained of pain in the lower region of the abdomen, syncopal attacks and vomiting. There was a slight rise of temperature and pulse rate. She had menstruated during the last week of March, nearly six months previously. About the end of the following May she noticed a slight flow of blood and pieces of skin, as she called them. This was accompanied by violent cramp-like pains, vomiting and fainting. Her friends thought she was dying. She recovered from this attack, but had more or less pain in the abdomen and occasional attacks of syncope until she came under the writer's care.

She was poorly nourished, complained of nausea and vomiting. Pulse was 100 and weak, temperature 100 1-5°. Pressure over the abdomen elicited much pain, and a smooth immovable, rounded mass was felt in the median line and to the left and in the pelvis. The breasts were hard and tender and the areolæ dark.

By bimanual examination the mass in the pelvis could be felt; it was semi-fluctuant, tender, and was harder in consistency in some parts than others. The uterus was apparently to the right and front of this mass, and could not be definitely separated from it. No fœtal

movement or heart sounds were detected, nor had the patient experienced any sensation of motion. No attempt to introduce a sound into the uterine cavity was made. She was kept under observation for a few days, during which time she improved.

She was admitted to the Western Hospital on September 24th, a little over six months from the date of her last menstrual period. On admission a slight amount of dark fluid blood was seen coming from the vagina ; this flow ceased after six hours.

The hospital records state that fœtal heart sounds were to be heard. This, however, could hardly have been the case. She suffered from labour-like pains from time to time ; these, however, passed off. During the first week of October a large amount of pus was passed from the rectum, and has continued to be discharged up to the present time.

Dr. Perrigo advised operation before this occurred, but was not supported by the rest of the hospital staff in consultation. She left the hospital some two weeks later somewhat improved. She was seen at her home shortly afterwards and the condition of the pelvic contents was as follows : The uterus is pushed to the right side and front and its outline can be more easily felt ; it is more moveable. To the left of and behind the uterus a large mass the size of a full term fœtal head may be felt. This is harder at some parts than others and particularly so close to the uterus. Here a rounded nodule or body is situated. Towards the left of the pelvis the mass became more irregular in outline. No crepitation or grating can be elicited on palpitation. Pus is discharging from the rectum, from exactly what part cannot be ascertained, but the sinus must be high up.

This patient was seen quite recently and her condition is the same. The mass is hard, nodular and somewhat contracted. She suffers more or less pain constantly in the pelvis. The rectal discharge continues, but is less in amount. She has not menstruated since March, 1893.

This case was looked upon when first seen as one of extra-uterine gestation. Although perhaps a dermoid tumor might simulate or resemble such a condition, yet the history past and subsequent is that to be expected in the diagnosis formed.

Case III. This and the following case are instances in which the primary rupture of the tube also caused the death of the embryo. Both were less than three months pregnant.

In one the condition immediately endangered life, in the other the symptoms were masked. Indeed the condition of affairs was not suspected before operation.

In the first of these cases, a young healthy looking woman of high complexion, 25 years of age, was sent to the hospital by Dr. Tatley, complaining of pain in the right iliac region, and was supposed to be due to some chronic, probably gonorrheal, inflammation of the tube and ovary on that side.

She was admitted on May 23, 1894, with this history : She has had four children, and in September, 1893, twelve months after the birth of her youngest child, she first complained of pain on that side. This had been continuing up to the past few weeks, when it became worse.

Two days before admission she felt a sudden sharp pain in the side ; this was accompanied by vomiting and she had to go to bed. There was no marked history of concealed hæmorrhage to be elicited. The pain continued for a few hours and ceased.

When first seen she was in good condition, color and pulse normal, temperature half a degree above normal. There was slight resistance to and pain on pressure over the part complained of.

I had omitted to state that she had been regular and did not suspect that pregnancy existed. However, she is not very positive as to the occurrence of menstruation or not, and I hardly like to accept her statements as correct. On examination per vaginam an enlarged ovary and tube was thought to be present on that side, and to be accompanied by adhesions.

On May 28, five days after admission, the abdomen was opened and a large amount of clotted blood was found filling the pelvic peritoneal cavity. The tube on the right side was enlarged and ruptured on its posterior aspect. The rupture was large, and an ordinary pencil could be inserted through it. It was ragged, and a mass of chorion, etc., protruded through it. Villi were found in abundance. The left tube presenting signs of old inflammation was removed also. Recovery was uneventful.

Case IV. In this case the internal hæmorrhage must have been great. The patient was 34 years of age, had had five children and no miscarriages. Two years before, at the time of her accouchement, she had a severe post-partum hæmorrhage. Menstrual history negative.

She was seen for the first time on February 19, 1894, and was then about eleven weeks pregnant, as she thought. Three-quarters of an hour before, while engaged in her housework, she felt something give way on the right side and she fainted with pain. Vomiting set in and she became so bloodless and weak that the last rites of the church were administered.

On examination she was without color to the lips, buccal mucous membrane almost bloodless, sighing and gasping for breath. The pulse attained a rate of 150 per minute when first seen and was hardly perceptible at the wrist.

Speech was hardly audible. She had frequent hiccough and complained of slight pain over right iliac region, where some fullness was to be felt on palpation and dullness on percussion. Some slight fullness was also felt here bimanually. However, but little attempt at thorough examination was made, and the patient was disturbed as little as possible. Her condition improved slightly that night, but next morning she again collapsed and was even in a more serious condition than at first and felt more pain.

Dr. Perrigo saw her with me on the second day and concurred in the necessity for immediate operation. This was declined, and she again gained strength and again had a fit of collapse on the third day. After this she slowly and surely gained, and on the fourth day had slight intermittent pain, followed by a discharge of blood and decidua. There had been no flow of any kind for the preceding eleven weeks. A large mass occupied the pelvis, fixing the uterus, and it was thought that the ovary and part of the tube could be felt on the right side.

She made a tedious but complete recovery, and nothing more than an induration and slight enlargement is now to be felt about the broad ligament.

Comment.—In the first case is an example of the most dangerous form of extra-uterine pregnancy that could exist. It has been said by many a writer that the rupture of a gravid tube is one of the most dreadful calamities to which women can be subjected, and anyone who saw the loss of blood in this case will agree with the saying.

Women have been known to collapse and die so suddenly that poisoning has been suspected and the case only cleared up on autopsy.

Could this case have gone to full term, this would have been impossible; rupture was impending at the time of operation. In any case in which a diagnosis can be made, or even if the condition be suspected, the only logical and humane treatment is operative, and that as soon as possible.

If another case of like nature be encountered by the writer the sac would be opened by the cautery knife, with the hope of less hæmorrhage.

The compression of the aorta was most effectual here, and it is to be regretted that this means has not been more employed, especially in controlling post-partum hæmorrhage. It was recommended by Bishop in the *Lancet*, 1893, and for the past three years the writer has used it with invariable results.

The removal of the placenta is advised when attached above. In this case it would have taken with it the roof of the sac.

In the second case it is to be regretted that an early operation had not been resorted to. The present condition of the sac communicating with the bowel would complicate the usual state of affairs greatly, and it is hardly to be expected that the patient in her present condition can enjoy perfect health and be free from further danger. However, the result might have been worse.

Whether this case had a primary rupture into the layers of the broad ligament or into the peritoneal cavity is mere conjecture, but the history would incline me to favor the former situation.

In the third case the history of cessation of menstruation is wanting, but this might occur in any case, and would perhaps be misleading to the attending physician. Another feature of this case is the absence of the marked state of collapse usually seen in this accident.

The interesting points in Case IV. lie in the extreme collapse observed, the occurrence of further hæmorrhages with eventual recovery, and the absorption of the greater amount of clot.

Dr. HINGSTON said that some years ago Dr. D'Orsonnens, a very distinguished accoucheur in Montreal, mentioned a number of cases in which no operation was performed, and where the patients ultimately made good recoveries. He (Dr. H.) saw two of the cases to which Dr. D'Orsonnens alluded, where the fœtus came away, piecemeal, through the abdominal wall in one case, and through the rectum in the other. Dr. D'Orsonnens' experience in the Maternity and in private practice went to prove that in extra-uterine pregnancy rupture did not necessarily follow, and that when rupture occurred, death did not necessarily take place. Sometimes nature was sufficient to bring the child into the world. He (Dr. H.) had an instance of this four years ago. He was asked by a medical gentleman of this city to see a lady for the purpose of removing what was considered an ovarian tumor. He saw the lady, examined her carefully, found the uterus perfectly free; depth of cavity normal, yet there was a large swelling, more to the right side than to the left, and on close examination he came to the conclusion it was not a tumor, but partly interstitial, partly tubal pregnancy. He advised the operation to be put off till the seventh month. The lady was again seen at the seventh month, and being in excellent health, the operation was deferred till the eighth month. About the time when the operation was to take place, being in the neighborhood, he called on the lady, and while talking to her something like labor pains came on. On examination he found the os uteri dilated, and the membranes projecting from the side of and into the uterus. He suggested that an accoucheur be sent for and left. He learned afterwards that the child was born without

difficulty in the natural way. Both parent and child were alive to-day. He merely mentioned this case to show that, in some instances, exceptional, no doubt, interference was not necessary, and that especially when fœtation was partly interstitial and partly tubal. Dame Nature may, and does, sometimes dispense with our art.

Uterine Fibroid.—Dr. LAPTHORN SMITH exhibited a fibroid uterus which he had removed fifteen days previously from a German woman at the Samaritan hospital. The patient was thirty-five years of age, but looked much older, and was very anæmic from menorrhagia, the flow being very profuse and lasting fifteen days. Although this had been going on for five years, it was only during the last three years that she had noticed the tumor which, when she came under observation, made her appear the size of a woman seven months pregnant. The method employed was that followed by Bantock and Price and Tait, by serre-nœud and the extra-peritoneal treatment of the stump. The tumor weighed, when fresh, about fifteen pounds, was symmetrically oval, smooth and dense, and had two small subperitoneal fibroids on top of it between the ovaries, which latter were large. The serre-nœud had been removed on the 6th day, and the stump cut away on the 12th day. The patient was eating well, and pulse and temperature had hardly gone above normal, 100½ for one night only. She was now sitting up a little every day. While admitting the many advantages of the new method by which no stump at all is left, he felt safer with the extra-peritoneal method, and still employed it whenever he was particularly anxious for the patient to recover, or, in other words, in every case.

Dr. HINGSTON thought there were some cases where the operation must necessarily be intra-peritoneal, and when it could be performed it was also the better; but there were cases where the extra-peritoneal was the better operation. He had operated by both methods, and while he gave the preference to the intra-peritoneal method, he found that each had advantages in certain cases. Much depended upon the length of the cervix, the nature of the tumor, and the facility or otherwise with which the stump could be drawn through the abdominal wound.

Dermoid Cyst—Dr. LAPTHORN SMITH exhibited a dermoid cyst of the right ovary, which he removed a week before at his private hospital, from a lady, fifty-six years of age, who was suffering great pain, as well as from profuse menstruation. On examination, the uterus was found to be enlarged, there being several small fibroids in its anterior wall, and the cervix was badly lacerated, while a solid tumor, the size of a small orange, occupied Douglas cul-de-sac. She was very weak from these hæmorrhages, which began ten years before and had gradually increased. The periods, however, had never ceased at the usual age for the menopause. The uterus was curetted, the cervix repaired, and the dermoid cyst and the other ovary removed. She suffered so little pain that she did not even require the hypodermic injection of a ¼ grain of morphia, which he always allowed, while she declared herself to be absolutely free from pain the day following the operation. The object of removing both ovaries was to put a stop to the menorrhagia. On cutting open the cyst it was seen to contain an outside layer of pure white sebaceous matter around a central ball of hair; but it contained no teeth. The operation presented no difficulties, and illustrated the importance of recognizing and removing the tumors while they were yet small.

Foreign Body in the Bladder—Dr. HINGSTON exhibited a wax candle which he had removed from the bladder of a lady who had been using it for purposes of sensual gratification. On the last occasion, which to her would be a memorable one, it slipped from her finger and was seen no more. She suffered intense pain in consequence, and finally was compelled to seek surgical aid. After successively examining the vagina and rectum and bladder, Dr. Hingston located the foreign body completely within the latter organ (the patient only knew it had gone "somewhere down there"). He removed portions of it with bullet forceps, but owing to the softness of the wax those portions were inconsiderable. He therefore ordered the patient to the hospital, where, after chloroform had been administered, he succeeded in removing the whole of the candle, the longest piece measuring five and a half inches in length, the last and largest piece having been removed with a lithotomy forceps, such as is used for children. The most interesting feature in the case was, Dr. Hingston remarked, the facility with which he could manipulate his finger, and an instrument upon it, through the urethra. It probably did not take more than ten or twelve minutes for him to gain an entrance to the bladder with the lithotomy forceps and the finger to guide it. There was very little suffering experienced afterwards from the operation, and no incontinence of urine resulted from it.

Dr. F. W. CAMPBELL mentioned several somewhat similar cases which had occurred in the practice of the late Prof. Syme, during his attendance at the Royal Infirmary, Edinburgh. He also described a case which he had seen at the Montreal General Hospital, where the late Dr. Thomas Walter Jones removed from the urethra, by perineal section, a carpenter's lead pencil. One case which occurred in his own practice some years ago, was that of a young man who came to his office and said that he

had been waylaid and two large pins pushed into his urethra—the heads downwards. It was impossible to remove them *via* meatus, so the points were pushed through the sides of the penis and a small incision made to liberate the heads. The present case was the first the speaker had heard of where the female urethra was used for such a purpose, although those in which the vagina was used were not very rare.

The late Dr. E. E. Duquet—The following resolution was moved by Dr. HINGSTON and seconded by Dr. BURGESS :—

"That this Society desires to record its sense of the loss sustained by the profession generally, and mental science more especially, by the recent death of Dr. Duquet, who, in a quiet and unobtrusive manner, had secured the respect and confidence of his professional brethren in Montreal, and the esteem and consideration of the more eminent alienists elsewhere.

Stated Meeting, 8th February, 1895.

Dr. G. P. GIRDWOOD, PRESIDENT, IN THE CHAIR.

Perforated Gastric Ulcer—Dr. KIRKPATRICK brought before the Society a patient on whom he had operated for this cause.

As this case is one of more than usual interest, I bring the patient before you to-night to show how perfectly recovery has taken place. The history is as follows, and for it I am indebted to my house-surgeon, Dr. Byers.

Fanny R., aged 24, native of Ireland, servant girl by occupation, was admitted into the Montreal General Hospital on Nov. 17th, complaining of "pain in the abdomen and shoulders."

Patient gave the history of having been seized on Thursday morning (2 o'clock), Nov. 15th, with severe pain in the epigastrium and lower substernal regions, which caused her to suffer intensely, and along with this she vomited "dark-colored" material for several hours. The condition, except for additional pain felt in the shoulders, continued thus unabated in spite of treatment, and she entered the hospital on Saturday afternoon, Nov. 17th. Was uncertain when asked as to the condition of her bowels during this time.

In addition to the above, patient gave an indefinite history of having been under treatment two years before for shortness of breath on exertion, pallor, headache, amenorrhœa, etc., symptoms of chlorosis, and of having had during the month previous to the onset of her major illness, pain in the region of her stomach, sometimes severe, and coming on immediately after eating, and sometimes felt between the intervals of taking food. Walking, particularly upstairs, rendered the condition worse, and the pain seemed to have grown more severe during the few days preceding the attack of Thursday, Nov. 15th. Occasionally, the patient said, she had "felt sick at her stomach," but she never had vomiting of blood, nor did she at any time notice anything peculiar about her motions. Of late, also, her appetite had been very poor and capricious, and her strength and general health much impaired.

When seen first after admission, patient was lying in bed in the dorsal position, with her legs drawn up, moaning and in great distress.

Her face was pallid, and lips dry. She complained of pain in the abdomen, particularly in the epigastric region, and in the shoulders, especially the left. The tongue was brownish, fissured and dry in the centre, whitish and moist at the edges. Sordes present in the teeth.

She complained somewhat of being thirsty, but was not sick at her stomach, and had no inclination to vomit.

The abdomen was prominent and rounded, and evenly distended.

Tenderness general, but particularly marked in the epigastric and innermost portion of the hypochondriac regions. Tenseness of the abdominal walls was not great, and not more marked in any special region. No evidences of tumor in any situation. Percussion revealed a general tympanitic note, which mounted up and completely obscured the liver dullness. The urine was high-colored, with thick cloudy deposit, spec. grav., 1.032; reaction acid; albumen present in appreciable quantities; casts and leucocytes found on microscopical examination. Respiratory and vascular systems normal; temp. 101.5; pulse, 120; respiration, 44.

As the patient did not improve during the night, it was decided, after consultation with Dr. Armstrong, that the condition was one of perforated ulcer of the stomach, and that the only hope was immediate operation. Accordingly the operation began at 2 o'clock in the afternoon; the details are as follows:

An incision was made from the ensiform cartilage to within a short distance of the umbilicus. On opening the peritoneum a small quantity of gas escaped and the anterior wall of the stomach presented. This was found to be attached to the parietes by slight adhesions, which were easily broken down by the fingers.

On disturbing the viscera thus, more gas escaped from the abdominal cavity, and while assisting me to break down the adhesions, Dr. Armstrong's finger slipped into the hole in the stomach. Gauze pads were immediately packed around the opening in order to prevent escape of the stomach contents, and then Dr. Armstrong withdrew his finger. The stomach

was drawn up through the wound and examined. The ulcer was situated in the anterior wall of the stomach, a little to the right of the œsophageal line, and more toward the superior and inferior gastric border. The opening was a little larger than a five cent piece, and was closed with a continuous Czerney-Lembert suture after trimming the ragged edges with a pair of scissors. The Lembert suture was continued for about half an inch toward the median line, in order to invert a portion of stomach wall that looked as if ulceration might be going on inside. The abdomen was then sponged out, a rubber tube inserted into the right flank and the edges of the incision brought together by through and through stitches of silkworm gut. Irrigation of abdomen was not used.

During the operation the patient's pulse became very weak, but on being put back to bed she came quickly out of ether, with little pain or vomiting. The pulse improved quickly, stimulation being required on only one occasion when strych. gr. 1-50 was given. Exudation was very slight, only ℥ i ss. clear fluid coming away, so that the drainage tube was removed on the following morning, after 20 hours. All food by mouth was prohibited at first, patient's strength being maintained by nutrient enemata of beef tea and peptonized milk. On the third day small quantities of milk were given by the mouth. The patient was dressed on Nov. 23rd and again on Dec. 3rd, when the stitches were removed. The wound healed by first intention. Slight suppuration occurred in the upper part of the incision, and a small sinus appeared five weeks after the operation.

This appeared to be due to the working forward of a bit of deep gastric suture, which could be felt as a rough body at the bottom of the sinus. The patient sat up, out of bed, on Dec. 19th, and since then her general health has been improving steadily. The temperature was normal on the thirteenth day following the operation. The sinus has now healed and the patient is perfectly well.

The operation has been performed a numbe of times, but so far very few successful cases have been reported. At the meeting of the British Medical Association last summer (*British Medical Journal*, October 20, 1895), the subject came up for discussion, and at that time only five successful cases had been reported. The operators were Taylor, Kriege, Morse, Maclaren and Gilford. M. P. Michaux, of Paris (*Bulletin Med. Oct. 24th*, 1894) reports a successful case and mentions another, that of Roux, of Lausanne. Lastly, R. H. Bourchier Nicholson reports a case (*Brit. Med. Journal, Nov. 3 and De . 22*, 1894). This makes a total of nine cases reported up to date.

Dr. ARMSTRONG congratulated Dr. Kirkpatrick, and thought it was a credit to the Society for one of its members to have recognized this condition and performed operation. He believed that this promised to be a field in which a great deal of useful surgery might be done; and physicians should be stimulated to the early recognition of such cases. Although ulcers were more common on the posterior wall, rupture or perforation was more apt to occur on the anterior, which was fortunate, as of course it was more easy to reach the anterior wall of the stomach.

Dr. GURD said that he had been attending the girl for about a week before sending her to hospital. She had been suffering from the usual symptoms of anæmia with gastralgia. The pains in the stomach came on periodically about four or five o'clock every afternoon, and appeared to shoot up to the upper part of the chest. She was able to attend to her duties, those of housemaid, when suddenly in the night she was seized with severe pains in the epigastrium. Dr. Gurd was asked by her employer for something to relieve her. He sent a ¼ grain of morphia. The next day he found the pain not very great, but much increased on pressure, temperature about 101°. The following day all the symptoms were rather worse, and an attempt to get her into the hospital was made, but without success. Two days went by before she could be admitted, during which time she had been growing worse, so much so that few who saw her before the operation thought she could recover.

Dr. ENGLAND said this case recalled to his mind a case reported by Dr. Armstrong, about 3 years ago, to whom he administered the ether. The case was that of a young lady, 22 years old, who was suddenly seized, while at a social party, with severe abdominal pain. Her previous health had been fairly good, though she had at times been troubled with indigestion, and was rather anæmic. The pains continued in spite of treatment by the local physician and peritonitis developed. Seven or eight days after the onset of pain, Dr. Armstrong saw the case and recommended operation. Laparotomy was performed, the incision was made in the middle line below the umbilicus. General peritonitis was found to exist. The appendix vermiformis was located and removed, also the uterine appendages, the latter not being healthy, and the wound closed. The patient died, he believed, on the following day, and the autopsy revealed two large ulcers which had perforated the walls of the stomach, the perforation probably having occurred at the onset of pain, allowing the contents of the stomach to escape into the peritoneal cavity. On opening the abdomen it was found that firm adhesions had formed at about the level of the umbilicus, dividing the abdominal cavity into

two zones. Into the upper the contents of the stomach continued to escape from the time of perforation until death. The lower zone showed signs of more recent and severe inflammation. His object in alluding to this case was to show that peritonitis, following perforation of a gastric ulcer, was not so virulent in character as was peritonitis from perforation of an inflamed appendix or other intestinal ulcer. Peritonitis in both these cases was slow in its development and of a subacute character; so different from the peritonitis which one expects to find when the bowel is ruptured or a pus tube breaks, and its contents escape into the peritoneum.

Dr. ARMSTRONG remembered the case referred to by Dr. England, and it was owing to that and one or two similar experiences that he acquired sufficient knowledge to recognize the condition and its seriousness in Dr. Kirkpatrick's case. In this way even our mistakes prove beneficial to mankind. He thought that it was these cases without any distinct history which were apt to rupture. The girl alluded to by Dr. England had been dancing when the rupture occurred.

Gall Stones.—Dr. ARMSTRONG showed two lots of gall-stones. The first bottle passed around contained, according to a count made by one of the students, 637 stones. This was a large number, but of course much larger numbers had been removed. The chief interest of the case was in the clinical history.

Patient, a female, æt. 64, was admitted to the Montreal General Hospital complaining of pain in the right hypochondrium. The pain was so severe that morphia was given hypodermically to relieve it. She had had a little jaundice, lasting a short time, some three months before admission. The patient had the appearance of a woman suffering from malignant disease. She was pale and cachectic.

The operation was begun as an exploratory incision, with the idea of removing gall-stones if they were found, and if malignant disease, the patient would be none the worse.

On opening the abdomen, the gall bladder containing these stones was readily found, and fortunately for the patient, no evidence of carcinoma about this organ, liver or pancreas was discovered, with the exception of one enlarged freely movable lymphatic gland. As he could not bring the edges of the gall-bladder to the edge of the abdominal incision, and there was evidence of the patency of the cystic and common duct, Dr. Armstrong closed the opening of the gall-bladder and dropped it back. He then passed a glass drain down to the suture line in the gall-bladder as, if any bile had escaped from the gall-bladder, the condition would have been the same as if the gall-bladder had not been sutured. The patient made a perfect recovery. An additional reason for operating for gall-stones in elderly people, was that the injury and local irritation caused by their presence might be an exciting cause of malignant disease. The association of gall-stones and malignant disease in the neighborhood of the gall-bladder had long been noted.

The second bottle contained a lot of gall-stones which had been removed post-mortem by Dr. Stenning, of Coaticooke. Their interest was in the fact that there were 3 pretty large stones, with 78 small ones. Mr. Tait had drawn attention to the fact that as a general rule gall-stone cases were divided into two distinct classes. In the first, there was one, two, or three, seldom more, large stones, and in the second a large number of small stones. This was the first instance coming under the notice of Dr. Armstrong in which the small and large stones were found together in the same case.

Dr. ADAMI agreed that it was very unusual to find large and small gall stones together in one case. With reference to what Dr. Armstrong had remarked concerning the etiological relationship between gall stones and hepatic carcinoma, he reminded the Society that during this session he had exhibited a case in which this relationship appeared to exist, a case in which the bladder, full of gall stones, had become the seat of a suppurative inflammation, and cancer of the liver substance developed immediately outside the chronically inflamed bladder.

A Case of Multiple Carcinomatous Growths in a Cirrhosed Liver.—Drs. FINLEY and ADAMI brought forward this case, which was of interest both from a clinical and anatomical standpoint. Dr. Finley read the following history of the case:

C. D., aet. 50, an Italian laborer, was admitted to the Montreal General Hospital, December 24, 1894, complaining of swelling of legs and abdomen.

Personal History—He has always been extremely temperate, and has not had any venereal disease. He has enjoyed good health up to the onset of the present illness. The family history is unobtainable as the patient speaks but little English. The present illness began on the 25th of October, with severe pain in the right hypochondrium radiating over the abdomen. A month later the abdomen began to swell and the pain disappeared. He has lost much flesh and strength.

Present Condition—He is much emaciated, the cheek bones are prominent and the muscles small and soft. A moderate degree of jaundice is present, the conjunctivæ being yellow and the skin brownish-yellow in color. The tongue is heavily coated, the bowels constipated and the appetite poor. The temperature ranges from 97° to 99°, pulse 88 and of good volume. The abdomen is much distended, and enlarged veins are seen in the flanks and over the right

hypochondrium. The presence of a large quantity of free fluid is indicated by movable dulness and fluctuation. There is distinct fulness in the hepatic region, both in front and behind about the angle of the scapula. Hepatic dulness extends from the fifth rib to a hand's breadth below the costal margin and measures six inches. The edge of the liver can be felt through the fluid. Spleen is not palpable. The fæces are colored, the urine very dark, with a deposit of amorphous urates; acid, S.G. 1020; no albumen, no sugar. Urobilin with Huppert's test. Tested for bile with nitric acid only a purple ring on filter paper.

December 26, 8½ oz. of clear yellow fluid withdrawn with the aspirator. After paracentesis the lower end of the spleen is distinctly felt. The hepatic enlargement involves the right lobe only, its border passing beneath the ribs at the right parasternal line. The surface is slightly nodular and hard. Early in January nourishment was refused and rectal tenesmus with small clay-colored stools set in. Death occurred on January 6th, being preceded by delirium, involuntary evacuations of urine and a semi-comatose condition.

The diagnosis lay between cirrhosis and carcinoma of the liver, the former being specially suggested by the enlarged spleen. The rapid emaciation, together with enlargement of the liver, an enlargement which it will be noted involved only the right lobe, was, however, strongly in favor of cancer, as was also an absence of an alcoholic history. Obstruction to the portal system evidenced by ascites would also explain the splenic enlargement. Urobilin and not biliverdin was constantly present in the urine, a fact which has been specially noted by Jaksch in the jaundice of hepatic disease.

Dr. Finley stated that at the autopsy performed by himself and Dr. Williams the body was found deeply jaundiced. The abdomen contained a large amount of fluid.

The liver weighed 4140 grms; its right lobe was greatly enlarged, extending below the costal border, and it was thickly studded with yellow nodules varying in size from that of a small shot to that of a walnut. The larger nodules were friable and caseous in the centre. The left lobe had a roughened cirrhotic surface, was firm and somewhat diminished in size. Both externally and on section it presented the appearance of an atrophic cirrhosis. No nodules were discovered in it.

The spleen was greatly enlarged (1060 grms.) and firm. To the naked eye the condition resembled that of cancer of one lobe and cirrhosis of the other, and sufficed to explain the symptoms which, as above noted, were those both of cancer and cirrhosis.

Dr. Adami described the microscopical appearances of the liver. The right lobe on section had the appearance, observable in cases of extensive cirrhosis, of sharply marked-off small islands of liver tissue, many of them of pale yellow color standing out sharply from the surrounding tissue. In addition there were the larger yet paler nodes of cancer. On microscopical examination the extensive cirrhotic change of monolobular type was well observed. The nodes or masses of new growth were sharply encapsulated. He felt some hesitation in describing them as fully developed carcinoma, for there was a tendency to preserve the type of liver tissue. In parts the cells tended to be arranged in columns resembling the relationship in the lobules of liver tissue, and judging from the amount of bile pigment deposited in some of them (as in cells of the surrounding functional tissue) they were not so far removed from the normal as to have lost all specific action. Again, the growths were not infiltrating, but were sharply defined and encapsulated. But in general the evidence of regular growth had been lost and the cells were massed together without regular order, while degenerative processes had affected the centres of many of the masses. Perhaps the term adeno-carcinoma would express this transition from simple to cancerous overgrowth. Frequently in cases of primary growths in the liver this difficulty is met with. Sections taken from the left lobe showed nodules of overgrowth, rare and small compared with those in the right. Here the cirrhosis was extreme. Dr. Adami compared this development of multiple overgrowths of gland tissue in the cirrhotic liver to the more frequent development of adenomata in the cirrhosed kidney. In both organs there occurred a cutting off of portions of the gland by bands of interstitial fibrous tissue followed by proliferation of the gland tissue and the development of adenoid neoplasms.

Thus microscopical examination fully confirmed the conclusions arrived at by Dr. Finley in his study of the case during life, and explained the clinical history which he (Dr. Adami) had heard that evening for the first time.

On Two Different Conditions of the Mitral Valve giving rise to Presystolic Murmur.—Dr. Adami exhibited two hearts. The first case was one of mitral stenosis from a patient in Dr. Stewart's wards at the Royal Victoria Hospital. The patient gave the frequent history obtainable in cases of mitral disease, namely, that of attacks of acute rheumatism. Here there had been an attack fifteen years ago and another in January, 1892. There had been a premature labor at the eighth month six years ago, with evidences of albuminuria and dropsy. From this there had been only partial recovery, the slightest cold sufficing to bring on swelling anew in the lower extremities. In August last pul-

monary trouble supervened and œdema became constant. There was dyspnœa and profuse expectoration. The condition became more severe, and the patient was admitted into hospital upon January 6th.

On admission, not to enter into full details, the pulse was of fair tension and regular, the arteries felt a little sclerosed. There was a diffuse impulse in the fourth and fifth spaces, and a strong impulse was felt in the fifth interspace at the nipple line. First sound rather muffled, second fairly clear. Both systolic and presystolic murmurs were heard traceable towards the axillary line, with a diastolic blowing murmur at the apex, heard, however, much better along the left border of the lower half of sternum. As the autopsy showed, this murmur probably originated in the right heart.

The heart was of great size, 450 grm., right auricle greatly distended, passing well (4 cm.) over the middle line. The distended right ventricle formed the whole anterior surface of the heart below and to the left, the left ventricle being completely out of sight, and the apex lying close upon the seventh rib in the anterior axillary line. Evidently, therefore, the impulse felt during life in the fifth interspace at the nipple line must have been due to the systole of the right ventricle.

There was, as the specimen showed, extreme stenosis of the mitral valve with thickening and sclerosis of the aortic valves, but by the usual test these last showed themselves still competent.

The stenosis of the mitral was so extreme that the slit-like opening was only one centimetre in length. The valves were markedly fibroid. The aorta showed patches of atheromatous degeneration that had not passed the fatty stage, most frequent in the abdominal region. The patient was only 36 years old.

The second heart was from a youth of 16 years of age, also an occupant of Dr. Stewart's ward. In this case the history was more especially one of chorea. There was one attack at the age of seven which lasted for two years, another of a month's duration when he was twelve. The only rather doubtful indication of acute rheumatism obtainable was that the last illness began in May, 1894, with pain and stiffness in the joints and marked swelling of the finger joints lasting for one day; with this there was shortness of breath, which steadily became accentuated.

On admission on January 22nd the patient was extremely anæmic, poorly nourished and feeble. The cardiac impulse raised the whole side of the chest, extending for five inches from the third to the seventh ribs. The apex was recognizable at the seventh rib, four and a quarter inches from the mid-sternal line. There was a roughish systolic murmur at the apex heard all over the anterior aspect of the chest and back. At the back it could be heard as low as the line joining the crests of the ilia. At the fifth space there was a rough presystolic murmur not transmitted. Presystolic thrill plainly felt at the level of the fourth rib.

On opening the chest the heart was found to extend 5.5 cm. to right of median line and 10 cm. (four inches) to the left. The apex in the sixth interspace. The right auricle was greatly distended. The anterior aspect of the ventricular region was formed about equally of right and left hearts. Left auricle fairly flaccid, but had evidently undergone so much previous distension that the auriculo-ventricular groove was almost eradicated and the walls almost parchment-like and fibroid rather than muscular, the appendix appearing not so much as a prolongation, but as a diverticulum off at right angles to the auricular cavity. With this the mitral orifice was found much larger than normal. In the adult this orifice should admit roughly three fingers; here in a boy of sixteen it admitted five, and was 11.75 cm. in circumference at the narrowest part. The valve flaps were moderately sclerosed with very slight roughening and vegetation. The chordæ tendineæ were thickened, the papillary muscles large and fibroid at their apices. The left ventricle presented extreme dilatation.

The aortic cups showed small wreaths of old vegetations below the line of apposition. They were, however, quite competent. Thus this case differed from those of Dr. Austin Flint. (*Lancet*, Jan. 27th, 1883.) The right heart presented no great abnormality. Contrary to what was the case in the previous heart, here the tricuspid orifice was above the normal capacity.

Commenting on the cases Dr. Adami said: " In these two hearts, apart from other points of interest, we have the history of well-marked presystolic murmur associated with the diametrically opposite conditions of extreme stenosis and of dilatation of the mitral orifice. In the one case the stream of blood pouring through from the left auricle into the ventricle at the end of ventricular diastole must have been peculiarly fine and have passed through with considerable force; in the other there must have been a large stream passing slowly. In the former the wall of the auricle was distinctly of a muscular type; in the latter the muscle was thinned and weakened. The edges of the mitral orifice in the case of stenosis were smooth, in that of the dilatation were slightly roughened.

" These two cases then, so far as they go, show that the presystolic murmur is not dependent upon the absolute size of the orifice, and I would go so far as to say that with such extremes it cannot be dependent even on the relative size. They show also that the condition of the edges of the orifice, through which the stream of blood pours, must only play a second-

ary part; and, in short, if we accept the view that the presystolic murmur is auricular systolic, due to the pouring of blood into the ventricle in consequence of the contractions of the auricle, they make it extremely difficult to assign a cause for its development. The one point in common in the two cases is disease of the mitral valve. That, so far as I can see, is the only common ground."

Progress of Science.

PERSISTENT URETHRAL DISCHARGES DUE TO SEMINAL VESICULITIS.

Dr. Eugene Fuller, in a study of the subject of persistent urethral discharges, advances the following conclusions:—

1. Seminal vesiculitis is the cause of chronic urethral discharges in a certain percentage of cases.
2. In about one-third of these cases the seminal vesiculitis is tubercular in character.
3. It is most important to differentiate between the simple inflammatory and the tubercular cases, owing to the difference in prognosis and treatment.
4. In the simple inflammatory cases the prognosis is good unless the subject is of an advanced age, the duration of the treatment depending largely on the chronicity of the case.
5. The treatment employed in these simple cases consists of stripping the vesicles, thereby squeezing out into the urethra their inflammatory contents by means of the forefinger introduced into the rectum. This treatment should be employed once in five to seven days, a long interval being allowed to elapse between treatments should signs of acute inflammation appear as a result of the manipulations.
6. The duration of the treatment may be all the way from a month or six weeks in subacute cases to many months, and possibly a year, in very chronic ones.
7. At the commencement of treatment the parts are usually very tender, indurated, and distended. If the case progress favorably, all these elements gradually diminish, and finally disappear as resolution takes place. The discharge customarily wholly disappears before a cure in the vesicles is attained.
8. In tubercular cases the tenderness in connection with the vesicles is not liable to be so great as, and the induration more than, in simple inflammations. In this form of inflammation the parts resent the manipulations, unless, indeed, they be most gentle, and even then it is a question if this form of treatment is beneficial. If the tubercular condition is not diagnosed at first, the manner in which the vesicles, when so involved, resent the ordinary manipulations by becoming more tender and indurated, thus aggravating the urethral symptoms, speedily renders the correct diagnosis apparent.
9. Many of these tubercular cases become quiescent under internal medication and hygienic measures.—*Journal of Cutaneous and Genito-Urinary Diseases.*

THE TREATMENT OF STRICTURE OF THE ŒSOPHAGUS.

After an exhaustive discussion of the various operative procedures in œsophageal stricture, Dr. Willy Meyer arrives at the following conclusions:

1. There are now three useful and reliable methods of gastrostomy at the surgeon's disposal. Of these, one (Witzel's) prevents leakage with absolute certainty. The two others, if properly carried out, promise the same good result. Thus the patient who had been submitted to this operation will not starve from regurgitation of the food alongside the tube.
2. In view of this fact, gastrostomy should be resorted to "early" in cases that will sooner or later need this operation.
3. In cases of burn of the œsophagus, primary gastrostomy and timely dilatation of the contracting scar will most probably prevent conditions which at present generally confront the surgeon in this class of cases, and are sometimes incurable. Witzel's method of gastrostomy deserves preference. The oblique canal produced by it will close spontaneously when the tube has been removed. Thus a secondary operation will not be needed.
4. In cases of cancer of the œsophagus a gastric fistula should be established as soon as the scales show a steady decrease of the patient's weight.
5. Further experience is needed with reference to Ssabanejew-Frank's method before an attempt can be made at giving each of the three operations its proper place in the treatment of cancerous stenosis. If future observations be favorable, Ssabanejew-Frank's operation seems to be destined to become the standard one for malignant stricture of the œsophagus. If unfavorable, Witzel's method should be done wherever it can be carried out.
6. Von Hacker's method should then be reserved for far-gone cases, and should, if the patient be very weak, be done under cocaine-anæsthesia, best at two sittings. If properly performed the outlook for making the fistula close tightly around the tube is good.—*Amer. Jour. of Med. Sciences*, October, 1894.

A NEW OPERATION FOR THE RADICAL CURE OF HERNIA.

The operation devised by Dr. C. A. L. Reed is as follows : Incision in inguinal hernia is made from a point two inches above Poupart's ligament, midway between the anterior superior spinous process of the ileum and the spine of the pubes, oblique downward and inward as nearly as possible consistent with the access of the inguinal canal to a point at the base of the scrotum. The dissection is then carried into both scrotal and pelvic cavities. The protruding viscera are then reduced and carefully inspected after being brought out above. The sac is then carefully dissected from its scrotal connections, and reversed by invagination. It is then opened by two incisions : one toward the pubes, the other toward the ileum, being thus converted into an anterior and a posterior flap. The cord is now dissected loose and placed in the canal and denuded of its peritoneum at its outer angle. The internal ring is closed by several interrupted sutures, animal or buried silk, these sutures being applied beneath the peritoneal flaps formed by splitting the sac, care being taken that in the closure of the ring undue pressure shall not be brought to bear upon the cord. The posterior peritoneal flap is now excised, the stump being ligated should there be any necessity for doing so. The anterior flap is carried across the now obliterated internal ring, and stitched by interrupted sutures to the posterior parietal peritoneum. The external ring is now closed by passing a number of sutures through its pillars external to the cord, which is now fixed in the internal (pubic) angle of the outlet of the canal. The incision into the abdomen is closed by an interrupted figure of eight suture, the internal loop embracing the peritoneum, the aponeurosis of the transversalis and of both oblique muscles, and the external loop embracing the superficial fasciæ, fat and skin. These sutures should not be more than three-quarters of an inch apart. The incision into the scrotum may be closed in the ordinary way. Drainage should not be employed except in the presence of marked oozing or obvious infection. —*Jour. Amer. Med. Assoc.*

A NEW METHOD OF SHORTENING THE TENDO ACHILLIS.

Phocas (*Amer. Med. Surg. Bulletin*) proposes the following operations :

A median incision five or six centimeters is made, over the tendon the sheath opened, and the tendon carefully denuded. It is then transfixed laterally at the upper end of the wound by a bistoury which is carried down the middle of the tendon by a sawing motion. The posterior flap is cut away above and below. The anterior part of the tendon is thin enough to be folded on itself, and this is now done, the freshened surfaces together, thus shortening it one-half the length of the incision, and the fold stitched together with cat-gut. The sheath is closed, and the skin also, separately. The foot is then put up in equinus in a fixed dressing.

DIAGNOSIS AND TREATMENT OF APPENDICITIS.

M. Monod discussed this subject, "Treatment of Appendicitis," at the Eighth Congress of, French Surgeons, held at Lyons, October 9-13, 1894 (*Allgemeine Medicinische Central Zeitung*, No. 102). In all his 22 cases surgical interference was resorted to, with brilliant results if done early. Five out of his 22 operative patients died ; in all cases pus was found in the abdominal cavity. The diagnosis should be made early, even before a tumor appears. The diagnostic points are : The sudden appearance of the symptoms ; the retraction of the abdominal walls ; and the spontaneous and violent pain, increased by the slightest external pressure. The afebrile course of some cases is noteworthy. The incision should be very similar to the one employed for ligation of the iliac artery. The appendix, if found, is to be exsected ; otherwise, the entire disease area is to be cleaned out, and drainage, not suture, employed. The technique is simple ; and the operation should be employed in doubtful cases to clear the diagnosis.

In the discussion M. Ricard agreed with Monod as to the necessity of early operation. In his 16 cases there were 4 deaths, all due to procrastination in operating from various causes. In one of them the appendicitis ran a mild course, and the patient was apparently getting well without interference ; but a sudden movement in bed caused rupture of the pus sac, and the patient died 36 hours later of general peritonitis. Ricard is therefore strongly in favor of immediate operation as soon as the symptoms of threatened perforation occur.—*Intern. Jour. of Surgery.*

THE NEATEST CIRCUMCISION.

In a paper read at the last meeting of the Miss Valley Med. Assoc., Dr. Bransford Lewis, of St. Louis, detailed a method of doing this operation. for which he claimed many advantages in celerity, ease and exactitude of performance and rapidity of healing. The operation was done with the assistance of two instruments presented by the author, a clamp and prepuce-tractor, which enabled the operator to carry out the following steps of procedure : 1, after cleansing the penis and encircling it with a small rubber band, the prepuce is drawn strongly forward, the action being applied to its inner surface by means of the serrated tractor mentioned ; 2, the glans penis being repressed, the curved fenestrated clamp is applied ; 3, with these as a

support and guide, 10 per cent. cocain solution is injected between the two layers of foreskin, anterior to the clamp—no danger of cocain poisoning occurring, since both clamp and rubber constrictor lie between it and the general circulation; 4, after effective anæsthesia has been secured, six double length (ten inch) catgut sutures are run clear through the clamp-fenestra and the four layers of foreskin; 5, with strong scissors the latter is cut off at one sweep; 6, tractor and clamp being removed, the double length sutures being divided, and two additional sutures being placed at the dorsal and frenal sites, previously occupied by the tractor; 7, the vessels are secured and sutures tied all around, making a circumcision that is at once symmetrical, precise and admirable, leading to prompt union and a satisfactory result.—*Jour. Amer. Med. Assoc.*

LOCAL ELECTROLYSIS AND ZINC-AMALGAM CATAPHORESIS IN MALIGNANT AND NON-MALIGNANT TUMOR.*

By G. Betton Massey, M.D., Physician to the Gynæcological Department of the Howard Hospital, etc.

Before reporting the three cases on which this new treatment of morbid growths is mainly based, I must explain what I mean by local electrolysis and zinc-amalgam cataphoresis, and also advance reasons for my belief that these methods, either separately or together, present important advantages over cutting operations in certain cases of benign vascular growths and incipient cancers.

Local electrolysis means simply that the electrical decomposition of the tissue salts is confined to a localized area by the approximation of the poles. If both poles of a galvanic current be placed in the morbid tissue, quite near each other, the bulk of the current will be concentrated within the portion of tissue immediately between them, and but little will traverse the outside healthy parts. In practice they should not be further apart than from a half to one inch, though this depends entirely on the strength of current to be used and the size of the growth. So placed, an enormous current may be employed to dissolve a morbid tissue without affecting surrounding tissues, the parts having been chilled by a spray, or otherwise rendered anæsthetic, if sensitive. The surgical possibilities of such currents are quite remarkable. All the salts and liquids of a given growth lying between the points become a prey to such a current, the watery contents being turned into oxygen and hydrogen gases, and the complex salts into solutions of acids and alkalies. This is, of course, attended with a material rise of temperature, but nothing like charring. If the tissue subjected to the process is soft and vascular, or juicy, there will be very little left between the poles after the gas has been given off. but the acids and alkaloids dissolved in a turbid liquid remainder. If the tissue is tougher and more fibrous, a gristly residue will be found which can be detached or left to be detached by nature.

The strength of current required to destroy tissue in this way depends altogether on its concentration at the active spot. A minute reproduction of the process occurs when we apply but two or three milliamperes to the papilla of a hair sheath, or to a mole on the skin; but to completely dissolve tissues between two or more needles a half inch apart requires at least four hundred to seven hundred milliamperes.

Whether this portion of my method has any advantages over a cutting operation in removing malignant or non-malignant external growth depends upon circumstances. It is clearly inapplicable to any growth within the body, unless it is situated in a drainable natural cavity, as a considerable quantity of detritus must drain away. It also presents the disadvantage of not permitting healthy tissues to be united at once over the seat of the removed growth, a procedure, however, that is often of doubtful utility, as it frequently covers up portions of the disease that failed to be removed. The advantages of the method over the knife are, on the other hand, by no means inconsiderable. It is absolutely bloodless, no matter where applied, thus enormously conserving strength after operations notoriously bloody; the edges of the undestroyed tissue remain non-absorbent, lessening risk of sepsis; and finally there seems to be some property in the galvanic current to cause a retrogression of the whole of a benign growth even when but a portion is directly acted on, as in the Apostoli treatment of fibroids and the ordinary treatment of moles and other small skin tumors.

If the growth be a benign one, the application described will probably cover the whole of the active treatment. If it be malignant, on the contrary, the second portion of the method—zinc-amalgam cataphoresis—is employed, a procedure of great value in radically removing all remaining traces of a still localized cancerous growth.

Zinc-amalgam cataphoresis is electrically monopolar, the single active electrode, which is always positive, being applied to the cavity left by removal of the greater portion of the growth, while the indifferent or negative electrode, in the shape of large conducting pads connected together, is placed on any convenient portion of the body. The active electrode is a freely-amalgamated zinc surface of one or two square centimetres area, which is held successively against all portions of the bottom and edge of the excavation. From 150 to 300 milliamperes are

* Read before the Philadelphia County Medical Society, Jan. 9, 1895.

sufficient, the pain being controlled by cocaine in solution placed in the excavation beneath the electrode to be conveyed into the tissues simultaneously with the nascent oxychloride of zinc and mercury which is dissolved from the electrode by electrolysis.

By this procedure we search out and destroy all remaining spurs and paths of infection in the contiguous unhealthy and healthy tissues, the current seeking vascular and cellular paths of less resistance by preference in its journey to the other pole; and to the lethal effect of the current we add the well-known lethal effects of nascent mercury and zinc compounds. The surface of the amalgamated zinc electrode is consumed in the process—the mercury as well as the zinc—producing a mixed infiltration of the immediate polar region that is readily detected by the eye. Low organisms in the immediate neighborhood of the electrode quickly succumb, and the antiseptic value of the procedure is shown in the correction of any odors that may have accompanied the cancerous discharge. That the action is not confined to the immediate neighborhood of the electrode was well demonstrated in one case in which the zone-like base of a cancer was observed to lose its induration, and shrink in places at least an inch distant from the contact point. The applicability of the first portion of the method—local electrolysis—to a benign growth was shown in the case of a large intra-uterine cystic fibroid, which was destroyed piecemeal by repeated applications of bipolar local electrolysis, resulting in a satisfactory cure; and two other cases were reported; one of sarcoma of tonsil and soft palate cured by electrolysis, followed by zinc-amalgam cataphoresis, was also referred to me by Dr. Hemminger, February 17, 1893. Five years before, he suffered from an abscess of the ear. Two years before being seen by me the left tonsil was found to be the seat of a tumor. He had recently been sent to the Hospital of the University of Pennsylvania, where, he says, malignancy was diagnosed and an operation was proposed, which he declined.

A tumor about the size of a goose egg filled the pharynx, involving the tonsil and soft palate and threatening suffocation. Liquids could be swallowed with much difficulty.

The patient was placed on monopolar negative punctures, 30 to 60 milliamperes, daily. But little progress being apparent at the end of a week, the parts were cocainized and subjected to bipolar local electrolysis with from 200 to 350 milliamperes, on two occasions. The separation of the eschar that resulted was accompanied by considerable pain and reaction, but as the place healed it was found that but little of the tumor remained. He did not return for further treatment until more than a year had elapsed, during which he seemed to be well. At this time, however, a renewal of the growth occurred, and it was about the size of a peach-stone when he was re-admitted to the Howard Hospital for further treatment. During this second treatment zinc-amalgam cataphoresis was mainly employed, the treatment lasting six weeks and being carried deeply into the base of the growth. A complete cure resulted, and at an examination of the parts six months later a healthy scar only was to be seen; the other, an inoperable carcinoma of the groin greatly relieved by zinc-amalgam cataphoresis, resulting in death from erosion of femoral artery and gangrene.

An estimate of the value of the method in these three cases must be comparative, as cases similar to each are usually subjected to other methods, removal with the knife being the favorite. Hysterectomy in the first case would, of course, have involved removal of the ovaries also. Both this and removal of the uterus itself were avoided entirely, no natural structures being even injured, and the time required in the treatment was probably not longer than that necessary to recovery from the effects of abdominal section. In the second case the bloodless removal of a sarcoma of the palate was followed by a treatment that I hope will render the patient less liable to a return of the disease. The third case was, of course, a failure to cure or to preserve life, yet it is thought that life was prolonged by the very evident curtailment of the growth and improvement of health. Comparisons were hardly possible, however, as an operation had been refused by one surgeon as useless.—*Coll. and Clin. Record*

CLASS NOTES.

Carcinomata of the testicles, œsophagus or tonsils, according to Prof. Keen, are very rarely benefited by operation.

Prof. Hare says that *Retrocedent Gout* is more apt to occur under the influence of colchicum than in cases where it is not employed.

Painting *Verrucæ* with the juice of the milk weed, with tincture of iodine or with a solution of the perchloride of iron, will sometimes cause them to disappear.

In *Cirrhosis of the Liver*, if ascites develops, the fluid should be drawn off as often as it accumulates. Frequent aspirations, Prof. Hare says, sometimes cause a permanent cure.

Prof. Wilson says that in children who are attacked with *Enteric Fever* the symptoms of the stadium prodromum are of a greater severity than in adult life.

According to Prof. Keen, *Perforating Ulcers of the Foot* result often from a thickening of the endoneurium, with a subsequent compression and destruction of the sensory nerve-fibres.

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MONTREAL, JULY, 1895.

THE ADVANTAGES OF PRIVATE HOSPITALS.

We notice in Dr. Skene's new book on the medical treatment of diseases of women, some remarks on the future progress of what he calls private hospital treatment. He says the order and government of such a hospital can be made agreeable to the suffering inmates both as regards quiet and cleanliness, which includes sewerage and ventilation; the diet also can be regulated according to the laws of health, and made agreeable and tempting to the capricious appetites of patients. When the sole object of the establishment is to improve the health of those who dwell in them, and where the physician and surgeon and their attendants have the controlling power, a condition of things is secured that is almost impossible in a private family. In such an establishment the doctor has great advantages; his patients being brought together, he can attend a larger number in a shorter time. We might add that he can devote to the patients the time which would otherwise be spent in useless driving about the city; he has also a more perfect control over all their doings. In this country and in Europe we find that the foremost men among specialists maintain private institutions for the care of their patients. That such institutions are both successful and advantageous to patients and physicians is a fact beyond all question. That more of them are needed is also a fact. The proof of this is in another fact, namely, the prosperity of institutions under the care of half-educated men who practically carry out but one idea in the treatment of diseases, like hydropathic and cancer-cure establishments, for example. For many years such places have been crowded by invalids in search of health. Rather than waste energy in declaiming against such places, it would be better for the profession to recognize the good that is in them, and direct institutions upon proper scientific principles to take the place of those which have for a long time been the only resorts open to sick people.

Coming from such an authority as Professor Skene, this testimony in favor of the private hospital must be considered above reproach.

CANADIAN MEDICAL ASSOCIATION.

You are invited to be present at the Twenty-eighth annual meeting of the Canadian Medical Association, to be held in Convocation Hall, Queen's University, Kingston, August 28, 29 and 30, 1895. Wm. Bayard, President, St. John, N.B.

HOW TO GET THERE.—Purchase a ticket for Kingston from the station agent at the place of departure, and get from him a standard certificate (*which is a receipt for one full single fare*), When registering at the meeting, leave the certificate with the Treasurer and it will be returned. signed by the Secretary, on the morning of August 30th. This certificate when presented to the station agent at Kingston will entitle the bearer to a ticket to his destination (1) for one-third of the single fare if there are 50 or more holding standard certificates, (2) free of charge if there are 300 or more holding such certificates.

N.B.—These rates refer to delegates and their wives.

HOTEL ACCOMMODATION.—*Special per diem rates*: Frontenac $2.00; British American $2.00; City $1.50. Rooms may be secured ahead by communicating with the proprietor.

MEMBERSHIP.—The fee for membership is Two Dollars ($2.00), and may be paid to the Treasurer, H. B. Small of Ottawa, at the opening of the meeting.

Members of the profession desiring to become members of the Association may hand

in their names, with the names of the mover and seconder at any time during the meeting, to the Secretary, who will provide forms for that purpose.

PROVISIONAL PROGRAMME.

The meeting will open at 10 a.m., on Wednesday, August 28th.

Addresses of welcome by the mayor, Fife Fowler, and M. Sullivan.

Report of Committee on Interprovincial Registration during morning session of first day.

The President's Address will be delivered at 2.30 p.m. on the first day.

The Address in Surgery will be given by I. H. Cameron, Toronto, at the evening session on the first day.

The Address in Medicine will be given by Edward Farrell, Halifax, at the evening session on the second day.

The Skin Clinic, in which J. E. Graham, Toronto, F. J. Shepherd, Montreal, and L. Duncan Bulkley, New York, will take part, will take place on the evening of the second day. There will probably be a Clinic on several nervous cases during the morning session of the third day.

There will be an excursion through the Thousand Islands by Steamer "America" at 2 p.m. on the 29th August; luncheon on board.

At 4 p.m. on August 30th the members will visit the Penitentiary and the Asylum.

Papers will be read in the order in which they are received by the Secretary. (*Not more than* 30 *minutes will be allowed for a paper.*)

1. Physical Training and Development as a Therapeutic Measure.—B. E. McKenzie, Toronto.

2. What is the Best Treatment for Retroversion of the Uterus?—A. Lapthorn Smith, Montreal.

3. A Tumor of the Medulla Oblongata.—J. E. Graham, Toronto.

4. Report on a Case of Acromegaly.—F. Buller, Montreal.

5. Notes upon Typhoid Fever in private practice.—W. S. Muir, Truro, N.S.

6. Objective Noises in the Head.—G. Sterling Ryerson, Toronto.

7. Some Practical Notes on Mental Depression.—J. V. Anglin, Montreal.

8.—The Operative Treatment of Injuries of the Head.—A. J. McCosh, New York:

Discussion by James Bell, Montreal, and Geo. A. Peters, Toronto.

9. Final results of Gastro-Enterostomy.—Robt. C. Kirkpatrick, Montreal.

10. Dysmenorrhœa, Report of a Case.—J. Campbell, Seaforth.

11. The Importance of Early Treatment in Cutaneous Cancers.—A. R. Robinson, New York.

12. The Anomalies of Albuminuria.—Jno. R. Hamilton, Port Dover.

13. Double Orchidectomy in Enlarged Prostate.—E. E. King, Toronto.

14. Experimental Cachexia Strumipriva.—Wesley Mills, Montreal.

15. Notes on some of the Newer Remedies used in Diseases of the Skin.—L. Duncan Bulkley, New York.

Discussion.

16. Acute Uræmia, followed by Gangrenous Abscess of the Lung.—A. McPhedran, Toronto.

17. Report of a case of Spina Befida, with treatment.—Jno. L. Bray, Chatham.

18. Thyroid Feeding in Cases of Stupor.—F. K. Clark (Rockwood), Kingston.

19. Syphilitic Manifestations in the Eye.—Alfred J. Horsey, Ottawa.

20. The Ophthalmometer.—R. A. Reeve, Toronto.

21.—Notes on a case of Brain Tumor, with an account of its removal.—J. Webster, Kingston.

22. A case of Placenta with Hydatids: Fœtus with Spina Bifida.—Alex. Bethune, Seaforth.

23. The Relation of Insanity to General Diseases.—E. H. Stafford, Toronto.

24. ....T. G. Roddick, Montreal.

25. ....J. L. Currie, Cambridge, Mass.

26. Notes on a case of Hernia of the Vermiform Appendix.—R. W. Garret, Kingston.

27. ....W. W. White, St. John, N.B.

28. Some unusual Forms of Hernia.—F. J. Shepherd, Montreal.

29. Cases in Practice.—W. G. Anglin, Kingston.

30. Operative Treatment in Moveable Kidney.—James Bell, Montreal.

31. Asthma.—H. J. Saunders, Kingston.

The above Programme is subject to change.

For further particulars, address, F. N. G. Starr, General Secretary, 394 Markham St., Toronto.

THE AMERICAN ELECTRO-THERAPEUTIC ASSOCIATION.

The fifth annual meeting of the American Electro-Therapeutic Association—Dr. A. Lapthorn Smith, Montreal, President—will be held in "College of Physicians and Surgeons of Ontario," corner of Richmond and Bay Sts., Toronto, on Tuesday, Wednesday and Thursday, Sept. 3rd, 4th and 5th, 1895. For the convenience of those who desire to attend also the meeting of the Canada Medical Association in Kingston the preceding week, the following arrangements have been made with the G.T.R. and C.P.R. A first class full rate one-way ticket to Toronto should be purchased, and a "Standard Certificate" to that effect should be procured from the ticket agent at starting point at time of purchasing ticket, and this must be signed by the Secretary of the Association in Toronto in order to secure reduced rates on returning. Holders of such are entitled to stop off at Kingston for Canada Medical Association. This applies to points east of Kingston. Information as to tickets from other localities may be obtained from Dr. C. R. Dickson, 159 Bloor St. East, Toronto, Chairman of Committee of Arrangements. These privileges apply to all who attend the Meeting, whether members or not. A most cordial invitation is extended to practitioners. All meetings are open to members of the profession. A very interesting programme will be presented, an exhibit of modern electrical appliances will be held, and ample entertainment provided for.

SELECTION.

"The meanest man I know of lives in Kansas," said a St. Louis physician. "He is a farmer, worth a cool hundred thousand. His wife was taken suddenly ill, and he came to town to consult me about her case. I told him that I could not prescribe intelligently without seeing the patient, but he declined to incur the expense of a visit. I charged him $1 for the prescription, and he spent half an hour trying to beat me down to 90 cents. He made me write the prescription in English, then bought the drugs and compounded it himself to save the apothecary's fee. One of the ingredients was capsicum. He thought he had some at home, but was mistaken, and had to come back to town, a distance of four miles, for it. By this time he had succeeded in saving about 20 cents, and wasting $2 worth of time, his wife was dead and the medicine a loss on his hands. That so bore on him that he fell ill. He took the medicine prepared for his wife, but that only aggravated his malady. When he finally recovered he sued me for $10,000, and was beaten and had to pay costs. He then went before the Grand Jury and tried to have me indicted for malpractice." This man is about on a par with the fellow who takes a medical journal for several years, and when asked to pay for it drops back in the office and has it marked "refused."—*Times and Register.*

CLASS-ROOM NOTES.

—Prof. Longstreth says that *Menstruation* is usually interrupted, or sometimes the flow is delayed, by an oncoming attack of rheumatism.

—Prof. Wilson says that in cases of *Enteric Fever* sometimes a pink flush, not unlike the hectic flush, will develop; it will also be deeper during the latter part of the day.

—*Headache*, often of the most aggravated form, Prof. Keen says, manifests itself in cases of pressure on the brain; it is often so severe that the patient will moan constantly.

—As a rule, Prof. Longstreth says, if a joint swells very much in a case of *Acute Rheumatism*, fluid will be contained in the joint, but occasionally it will be found absent.

—Prof. Wilson says *Urticaria* occasionally makes its appearance in young people at about the time of the crisis or during the early part of convalescence from typhus fever.

—In cases of *Uterine Hemorrhage*, ergot and the oil of erigeron, Prof. Hare says, are both indicated; the oil being indicated for oozing and the ergot in cases of more active hemorrhage.

BOOK NOTICES.

THE CARE OF THE BABY. A manual for mothers and nurses, containing practical directions for the management of infancy and childhood in health and in disease. By J. P. Crozer Griffith, M.D., Clinical Professor of Diseases of Children in the Hospital of the University of Pennsylvania; Professor of Clinical Medicine in the Philadelphia Polyclinic and School for Graduates in Medicine; Physician to the Children's Hospital, to the Methodist Episcopal Hospital, and to St. Agnes Hospital, Philadelphia; Member of the American

Pædiatric Society and of the Association of American Physicians. Philadelphia: W. B. Saunders, 925 Walnut Street, 1895. Price $1.50.

The author has furnished a reliable guide for mothers anxious to inform themselves with regard to the best way of caring for their children in sickness and in health. There are in all nearly 400 pages.

The first chapter of the book discusses the hygiene of pregnancy, the method of calculating the date of confinement, and similar data. The characteristics of a healthy baby are considered in the second chapter, and the growth of its mind and body in the succeeding one. The chapters which follow relate to the methods of bathing, dressing, and feeding children of different ages, to the hours for sleeping, to physical and mental exercise and training, and to the proper qualities of the children's various nurses and rooms. A special effort has been made to emphasize details and to make them clear, complete, and thoroughly up to date.

The chapter upon the baby's diseases has been written particularly for those mothers who, through various circumstances, are unable to have a physician constantly within a moment's call. It contains a description of the symptoms by which we may know that disease is present; a consideration of the nursing of sick children; a concise *résumé* of the commonest diseases of infancy and childhood; and directions for the management of various accidents, including, among others, drowning and the swallowing of poisons.

The author's style is so natural that it is a pleasure to take up this book and read a chapter of it. It is well indexed, and the printing, paper and binding is a distinct improvement on any of this publisher's former productions; in fact he appears determined to take the lead in these departments. We congratulate Dr. Crozer Griffith on the admirable success he has attained in the production, and trust that he will not stop with this interesting and presentable work.

POCKET FORMULARY AND TABLE OF DOSES, AND ALSO THERAPEUTICS OF CHILDREN'S DISEASES. By Dr. H. Danchey, formerly Chief of Clinic of the Faculty, formerly House Surgeon of the Children's Hospital and President of the Medical Society of the 6th ward of Paris; Laureate of the Academy of Medicine, Paris. Société d'Editions Scientifiques, 4 Rue Antoine-Dubois, Paris, 1895.

This is a handy little pocket volume thoroughly up to date with all the newer remedies.

LE MOYEN-AGE MÉDICAL. Les médecins au moyen-âge. Les grandes épidémies. Démonomanie. Sorcellerie. Spiritisme. La médecine dans la littérature du moyen-âge. Historiens. Poètes. Auteurs dramatiques. Par le Dr. Edmond Dupouy, Ancien Interne de Charenton et des Asiles d'Aliénés, Lauréat de la *Société Médico-Psychologique.* Prix Esquirol et Prix Aubanel. Paris: Société d'Éditions Scientifiques, Place de l'École de Médecine, 4, rue Antoine-Dubois, 1895. Tous droits réservés

This is a book of unusual merit. Among the most interesting chapters is one on the early history of the University of Paris. Another interesting chapter is that which deals with the gre epidemics of Europe. It also shows that women occupied an important place in medicine is the middle ages. The author shows that he is a man of great learning, and must have spent many years in patient research to produce the volume of 350 pages.

MALADIES INTERNES ET MALADIES DES ENFANTS. Par C. J. Smith, médecin praticien à Moscou. Deuxième édition. Paris: Société d'Éditions Scientifiques, Place de l'École de Médecine, 4 rue Antoine-Dubois, 1895.

This is a very practical little volume of two hundred pages in paper covers, and is suitable for the coat pocket. It contains an immen e amount of information in very condensed form. For instance, the Weir Mitchell treatment with diet table and all only occupies two pages. The price is not stated, but we presume it would be about 50 cents.

LA MORT APPARENTE DU NOUVEAU-NÉ. Par le Dr. Demelin, chef de Clinique d'Accouchement à la Faculté de Médecine de Paris. (Mémoire couronné par l'Académie de Médecine, prix de l'Hygiène, 1894). Société d'Editions Scientifiques, 4 rue Antoine Dubois, et Place de l'École de Médecine, Paris. 27e volume de la Petite Encyclopédie médicale. Collection in-18 raisin cartonné à 3 fr.

This is a handy little volume, and contains full directions for the treatment of apparently still-born children. We notice that the opinion of the great American authority, Dr. Lusk of New York, is frequently quoted.

LA PROSTITUTION DANS L'ANTIQUITÉ, DANS SES RAPPORTS AVEC LES MALADIES VÉNÉRIENNES. Etude d'Hygiène Sociale. Par le Dr. Edmond Dupouy, Ancien Interne de Charenton et des Asiles d'Aliénés, Lauréat de la Société Médico Psychologique. Prix Esquirot et Prix Aubanel. Un vol. in-8 de 220 pages, avec figures, 4 fr. Troisième édition. Société d'Editions Scientifiques, 4 rue Antoine-Dubois et Place de l'Ecole de Médecine, Paris.

We cannot say much in favor of this work, It were better that it were never written. We must admit, however, that the author has shown an immense amount of erudition in compiling it,

and he must have had access to many ancient works which might otherwise be forgotten. This book may do good in one way, and that is by showing that, in spite of all the wickedness of the present day, it is as nothing when compared with the nastiness and filthiness of the manners and customs of antiquity. But we would prefer to know that such infamy was buried and forgotten with the past.

LA CURE DE BARÈGES. Le climat et les eaux minérales, indications et contre-indications. Par le Docteur I. Bétous, Médecin-Consultant à Barèges, Lauréat de la Faculté de Paris, Membre de la Société d'Hydrologie médicale, etc. Paris : Société d'Editions Scientifiqnes, Place de l'École de Médecine, 4 Rue Antoine-Dubois, 1895.

PAMPHLETS.

THE ENTRANCE OF WOMAN INTO MEDICINE. By J. C. Reeve, M.D., Dayton, Ohio. The Presidential Address to the Alumni Association of the Medical Department of the Western Reserve University, at Cleveland, Ohio, delivered May 22, 1895. Reprinted from Western Reserve Medical Journal.

BURNS OF THE CORNEA ; ELECTRIC-LIGHT EXPLOSION CAUSING TEMPORARY BLINDNESS; TRAUMATIC INJURIES TO EYES—HYPOPYON. By L. Webster Fox, M.D., Professor of Ophthalmology in the Medico-Chirurgical College, Philadelphia, Penna. Clinical Lecture delivered at the Medico-Chirurgical College, March 9, 1895. Reprinted from The Medical Bulletin.

EVISCERATION OF EYEBALL. By L. Webster Fox, M.D., Philadelphia. Abstract of a paper read before the American Medical Association, Ophthalmic Section, held in Baltimore, May 7, 1895. Reprinted from The Medical Bulletin.

AN ELECTRIC PRESSURE SOUND FOR THE DIRECT VIBRATION OF THE MEMBRANA TYMPANI. By John C. Lester, A. M., M.D., Brooklyn, Assistant to the Chair of Otology, Bellevue Hospital Medical College ; Assistant Surgeon to the St. Bartholomew's Clinic for the Eye, Ear, Throat, and Nose ; ex-Editor American Medical Digest; Fellow of the American Academy of Medicine ; Member of the Medical Society of the County of Kings. Reprinted from the New York Medical Journal for June 8, 1895.

SUPRA-PUBIC CYSTOTOMY FOR CALCULUS OF THE BLADDER. Trendelenburg's Transverse Incision—Transverse Division of the Recti and Pyramidalis Muscles—Incision of the Bladder without Inflation of the Rectum or Injection of the Bladder. Read before the St Louis Medical Society, Dec. 22, 1894. By A. H. Meisenbach, M.D., Professor of Surgery in the Marion-Sims College of Medicine, St. Louis, Mo. Reprinted from the *Journal of the American Medical Association*, March 16, 1895. Chicago : American Medical Association Press, 1895.

PUBLISHERS DEPARTMENT.

HEMATURIA.

James W. Osborn, M.D., of Bealton, Ont., Canada, writing to the Editor of *Medical World*, Philadelphia (July number 1895), says: "Regarding my obstinate case of hematuria, I told you in a previous communication of my patient's restoration to a fair degree of health after a siege of anemia, emaciation and prostration, but that the hæmorrhage, though more moderate, was still going on. I have now a still more favorable report for you. Having failed to obtain the tannate of soda recommended by Dr. Hutchins, San Francisco, from my druggist, or in the city, I ordered a bottle of Sanmetto, thinking by the time she had given it a fair trial I would be able to get the tannate of soda elsewhere. She had only taken the Sanmetto a week, in drachm doses three times a day, when the hematuria disappeared. This was about three weeks ago, and it has not returned unless within a day or two. This is certainly worthy of note, as the hæmorrhage, notwithstanding her great improvement, had never subsided entirely for more than a day, and that only once, in a period of about eight months. While we cannot be sure of the proper hoc from the post hoc, in a single instance, it certainly looks as if the Sanmetto has been of service to the vis medicatrix naturæ. I have just received a letter from an old friend in the profession, who has used Sanmetto with decided benefit to a patient afflicted with hematuria."

ANTIKAMNIA—QUININE—SALOL.

The well-known therapeutical properties of these drugs makes this combination desirable in such intestinal affections as Fermentative Dyspepsia, Diarrhœa, Dysentery, Duodenal Catarrh, Cholera Infantum, and Typhoid fever. The Antikamnia controls the pain as effectually as morphine, and yet is never followed with any of those undesirable effects so characteristic of opium and its derivatives. Freedom from pain saves an immense amount of wear and tear to the system, and places it in a much better position for recovery. The Salol acts as an antiseptic and removes from the intestinal canal the first or continuing cause of the affections just mentioned. The Quinine acts as a tonic, increasing the appetite, and thus contributing much to a speedy recovery. Hare says that Quinine is not only a simple bitter, "but also seems to have a direct effect in increasing the number of the red blood corpuscles." A tablet composed of Antikamnia two grains, Quinine Sulph, two grains, and Salol one grain, allows of the easy administration of these drugs in proper proportionate doses,