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Original Communications.

**EXCISION OF THE SHOULDER AND
ELBOW JOINTS OF THE SAME
ARM FOR TRAUMATISM.***

BY ARCHIBALD E. MALLOCH, M.D.

Mr. Chairman and Gentlemen:

I have brought the following case before you on account of the rarity of an injury requiring excision of the shoulder and elbow joints of the same arm, and as an example of how useful a limb may be obtained after such extensive mutilation. The case reported to the Medico-Chirurgical Society of London, in 1872, by Wm. MacCormac, F.R.C.S. (now Sir William MacCormac), and published in Vol. 55 of its transactions, is the only similar one I have found on record.

D— S—, male, æt. 12, well-developed, was admitted into the Hamilton City Hospital on the 31st July, 1890, for a railway injury to the shoulder and elbow joints. He was seen by me two hours after his admission, when I found him suffering slightly from shock, with the limb, which had been thoroughly cleansed, bound up in towels soaked with 1 to 100 corrosive sublimate solution. Under chloroform it was found that the elbow was extensively injured, several pieces of loose bone being felt, and that a wound on its posterior aspect connected with the joint. The olecranon and all the condyloid surface of the humerus, and a portion of the shaft of that bone, were removed

in seven pieces, which were lying almost loose in the soft tissues; this portion of the limb was then wrapped in an antiseptic towel and attention directed to the other injury.

The shoulder and pectoral regions were much swollen, and fluctuation could be felt over a considerable area; the direction of the shaft of the humerus was to the inner side of the coracoid process, and below the clavicle its sharp, rough end could be felt; a hard, round mass could be indistinctly felt under the acromion. All our efforts to bring down the humerus failed. The patient then showed such signs of depression that I decided to wait before making further attempts to dislodge the humerus. The radial and ulnar arteries were found beating at the wrist. A drainage tube was passed into the centre of the elbow space and the wound closed and dressed antiseptically; with the forearm semiflexed, the elbow was supported by two narrow, thick pads of gauze reaching well up on the humerus and down to the tips of the fingers, and kept in position by a bandage. A reversed wedge-shaped pad of gauze was placed in the axilla, and the arm bound to the side. It would be too tedious to note the subsequent dressings to the elbow; at no time did the lad suffer from it, and antiseptically it was a success. Passive motion was made for the first time on the 19th of August. On August 5th it was found that the hand, forearm and arm were swollen; the elbow was exposed and found free from heat and redness, and not more swollen than the other parts of the limb; the fluctuat-

*A paper read before the Ontario Medical Association.

ing swelling of the shoulder and pectoral regions is more marked and presents a soft spot in its centre.

August 7th: Under chloroform this soft spot was opened into by a free incision and a quantity of dark fluid blood let out; the bare, rough upper end of the shaft was then felt, and posterior to it, and lying in a direction at right angles, another piece of bone. Extension on the humerus, assisted by all the pressure I could make from above through the wound with fingers, instruments failed to move the bones; the wound was then enlarged downwards, as if for excision, and the head of the humerus exposed. Further attempts at reduction having failed, the head of the humerus, which was fractured transversely at the surgical neck, was removed; the shaft was then brought into line; a posterior opening was then made for drainage and the wound stitched and dressed. Outside the dressing a large pad, hung from the neck, was placed in the axilla and the arm bound to the side. The shoulder wound did very well on the whole, though we failed to keep it perfectly aseptic. Some days subsequent to the operation the slight discharge which came from the posterior drainage tube smelt, and the protective was discolored; in all probability the sling of the pad in the axilla had worked under the dressings.

Sept. 20th: He moves the arm slightly, and can flex the forearm; passive motion to be continued daily.

Oct. 1st: A small fluctuating spot at the extremity of the elbow; scar incised and a drop or two of pus let out.

Nov. 21st: On my return from a three weeks' holiday, I found him in bed with a side splint controlling the elbow, and learnt that when playing on the stairs he had fallen and wrenched the elbow. Flexion and extension, with pronation and supination, could be fully made, but the power was feeble. He uses the deltoid much better than when last examined. There is still a little oozing of purulent matter from the sinus at the lower angle of the shoulder wound. Under chloroform the shoulder wound was opened, the shaft of the humerus exposed, and an inch of soft reddish bone removed. From the medullary canal thus opened a loose piece of necrosed bone three-quarters of

an inch in length was extracted. The medullary tissue was soft and red, and mixed with small particles of necrosed bone, which gave a gritty sensation to the scoop with which the canal for three inches was cleared out. After antiseptic flushing and filling the medullary canal with a 10 per cent. solution of iodoform in glycerine, a drainage tube was passed down the canal. The wound was dressed in the ordinary way.

The drainage tube was shortened from time to time as the discharge diminished.

Dec. 26th: Small piece of loose bone removed through the elbow sinus.

Jan. 21st, 1891: Two small loose pieces of bone were removed from the shoulder.

Feb. 10th: Discharged. A small sinus exists at lower angle of shoulder wound. The elbow is solidly healed.

During his six months residence in the hospital, the highest temperature recorded at night was 101° F., thirty hours after the shoulder excision. On only two occasions subsequent to this does the chart show an evening temperature of 100° F., and one of these corresponds with the date of his fall.

March 16th: Seen at office. There has been no discharge from the shoulder for three weeks. The right humerus is two and a half inches shorter than the left.

May 24th: I found that the old sinus at the elbow had reopened, the probe showing bare bone at the lower extremity of humerus. As notice had been given to the society of my desire to report the case, I determined to do so notwithstanding.

So far from the limb being flail-like and useless, as was predicted, the boy has a very useful member in his right arm. He dresses and undresses himself, cuts his meat, and has been working for some weeks in the cotton mill at his old job and earning the same wages. The shoulder motion is not so great as I would have liked, but improvement in this respect is still going on. Abduction is limited to an angle of 30° to 35° F. The forward and backward movements are good.

He can completely flex and extend the forearm, and pronation and supination are perfect, as was to be expected. The attempt to flex the forearm gives a pull of 16 lbs. on the spring

balance with the excised, and 22 lbs. with the sound arm; or, roughly speaking, the excised arm in flexion is a quarter weaker than the other.

In extending the forearm from the semiflexed portion a pull of $7\frac{1}{2}$ lbs. is indicated with the excised and 20 lbs. with the sound arm; or, roughly, in extension the excised arm is two-thirds weaker than the sound one. A comparison in excisions of the elbow in this way gives, I think, a better idea of the result obtained than by reporting it as "a useful limb," "almost as useful as ever," "very useful," etc., and would enable one to note the improvement from month to month after active motion has commenced.

SHORT NOTES ON CARCINOMA OF THE LARYNX AND INJURIES OF THE SKULL.*

BY W. BURT, M.D., PARIS, ONT.

CARCINOMA OF THE LARYNX.

Mr. President and Gentlemen:

In reporting to you a case of this disease, I do so more especially for the purpose of the statistician. I intended to record the case sooner, but let the opportunity go by. I do not know that there is anything of importance to the surgeon in the general history of the case. The symptoms at first were those of a chronic catarrhal laryngitis, with a suspicious carcinomatous formation on eighth vocal chord. These were in progress about a year before spasmodic symptoms developed. Tracheotomy was performed November 2nd, 1885. Death took place Nov. 20th, 1886. A short time before operating our patient had been examined by specialists. The diagnosis was confirmed and tracheotomy impressed upon him. The operation would have been performed somewhat earlier but for our patient procrastinating. A severe spasm setting in, from which he thought he would not recover, caused him to procrastinate no longer. My patient was a robust-looking man, and it is little to be wondered at that one in this full vigor of manhood, with but little embarrassment of the breathing and free from anything like a severe spasm, should,

under the circumstances, postpone an operation that would certainly remind him of a not far distant fatal issue. At this crisis he decided to give himself the benefit of the palliative treatment of tracheotomy. Laryngectomy was carefully explained to him—as well as I could do so at that time—but he banished all thought of it. In reference to the operation of laryngectomy, my own views, in the light of the literature of the subject, have not changed. I certainly have not favored the operation. In this case I left my patient to choose for himself, to sum up for himself, presenting him simply with the record of the operation so far as I could up to that time. Tracheotomy was performed in this case at the last moment, and, from a surgeon's point of view, should have been performed earlier. At the time of the operation our patient, as mentioned, was in the full vigor of manhood, and but little prepared, physically, to leave this world. During his post-tracheotomy life, although he did his speaking mostly by slate, being scarcely able to utter any audible sounds, his life was fairly comfortable. He would ride to town, a distance of seven miles, with a considerable degree of pleasure. During the last two months, however, he became greatly emaciated. His expectation was distressing, and his latter days have no redeeming feature except the presence of kind friends. He was prepared to leave this world physically. The danger of impending suffocation being removed, his system was left to the dire disease.

Whether excision of the larynx, with its record of deaths within the first few weeks, with its good results comparatively in a few cases, will take the place of the palliative treatment of tracheotomy, with immediate relief to all, and as a rule for some months at least, is a question which will no doubt at some distant day be answered. It is no doubt a most fascinating, if not almost a miraculous, thing for the surgeon to see one who, if left to himself or to a tracheotomy, can live but a short time, have all danger well-nigh removed and be able to speak intelligibly for years with an artificial larynx. But the question is: Which will give us, upon the whole, the largest sum of human comfort?

INJURIES OF THE SKULL.

I wish to present you simply with the outlines of three cases of injuries to the skull, and

* A paper read before the Ontario Medical Association, June, 1891.

direct your attention to the points of practical interest. I am sure the details would not interest you, and I am not sure that any new facts will be presented, but a few points in connection with them may be of interest to those who are workers in brain surgery.

Case 1: E. B., æt. 17. On the evening of Feb. 14th, 1888, I found him in bed in a comatose condition, with his head and face covered with blood and bits of hay. His mother stated that he had walked, about 8 o'clock, into the house alone, went up stairs and threw himself upon the bed. She spoke to him, but he would only utter the names of two persons—his brother and a young man belonging to the town. His mother stated that he left home in the morning to go shooting. As one of the names mentioned was that of a farmer about a mile distant, the first impression was that his gun had burst and injured him, and that he had lain by some haystacks which were near the barns. The auricle of the right ear was lacerated, and a compound comminuted depressed fracture existed just in front of it, involving the squamous portion of the temporal just above its junction with the petrous. The wound was filled with seeds, bits of hay, and clots. Nothing of a sensible nature could be gotten from him. When disturbed he would say, "Let me sleep." Dr. Sutherland came to my assistance and anesthetized our patient. The wound was thoroughly cleansed, the depressed fragments elevated, and those becoming loose were removed. The membranes were found torn, the brain lacerated, and, when the operation was completed, bone to the extent of a fifty-cent piece was removed, exposing the middle meningeal artery. The wound was put in a condition that no injury was likely to accrue from the remaining portions. The projecting spicula were left, thinking they would help to fill in the opening. The result was satisfactory, the merest scale coming away before the healing of the wound. The wound was washed out, a drainage tube inserted, and the opening closed and dressed antiseptically. Before finally dressing the wound, however, the whole head was carefully examined and a large swelling detected in the left temporo-parietal region, and an open wound a little farther back. This swelling was laid open, the clot turned out, and the wound well washed.

The bone was found bare to a considerable extent, and a bevelled depression nearly three inches in extent was quite apparent, but not deep enough, I thought, to warrant interference, considering his youth and the free opening on the opposite side. The wound was well cleansed and dressed antiseptically, including a drainage tube. It was the presence of this left wound that caused me to think the lad had met with foul play, and I at once sent for a policeman, whom I acquainted with the facts and my suspicions. He set to work and next day got on the track of the assassin, who had fled to the States. It afterwards appeared that the boy had been hammered to death, as it was no doubt thought, about 11 a.m., in a hay loft. He remained there until about 8 in the evening, when, consciousness returning, he got down from the loft, crossed the street to his home, and went upstairs to bed as before stated. I will not trouble you further with this case than to state that he slowly recovered his senses, it being three weeks before he was at all manageable. The wounds were regularly dressed antiseptically. He came down stairs and took his meals on March 21st, and gave his evidence in court against his would-be destroyer on April 4th. The points of interest in this case were the readiness with which I was able, from the nature of the wounds, to put the police to work, the extent of the injuries, and the satisfactory recovery. He is now doing a man's work on the farm, carries his marks, but feels no ill effects from the injuries. In fact, it is thought that he is much wiser than before the accident. In this case a trephine was not used; a pair of bayonet root tooth forceps and a pair of scissors proved exceedingly satisfactory. I only took the precaution that every source of irritation was removed and thorough antiseptics carried out.

Case 2: M. J., æt. 4, a victim of a railway accident, Feb. 27th, 1889. This little girl, it was thought, was thrown forwards and struck her head in the left parietal region, at the upper and posterior part, on the corner of a stone. The result was a compound comminuted depressed fracture, with slight injuries to the membranes, one of the fragments being driven underneath the sound bone. A large movable fragment, the lower portion of the parietal, was

left in place. Four fragments were removed, all sources of irritation taken away, and the wound dressed antiseptically. Contrary to my expectation, the wound was long in healing, not closing until about the middle of June, on account of necrosis of some projections of apparently sound bone. It would, perhaps, have been better to have removed these projections at first, but the readiness with which they helped to cover in the vacant space in the case of No. 1 induced me to leave them here. The large loose fragment may, however, have been the chief cause of the necrosis. The child was unconscious at the first a very short time, and no seriousness at any time presented itself.

Case 3: E. S., æt. 4, was injured July 3rd, 1889. The brother of this little girl had just left a horse and cultivator standing to go for a wrench, when she ran up behind the horse, drawing a tin box containing pebbles. The noise frightened the horse and caused it to kick the child, striking it high up on the forehead, on the left side, making a gash down to the bone two inches long. This happened about 11 a.m. Saw her about 2 p.m. Had three convulsions in the meantime, one lasting about an hour. I found a compound depressed fracture three-quarters of an inch in extent. A tuft of hair and bits of straw were fast between the depressed and sound bone as in a vice. The depressed portion had evidently been driven farther when the hair and straw were kicked in, and the depressed portion, returning, grasped the hair and straw. I chiselled away a portion of the sound bone the length of the depressed part, removed the hair, straw and dirt that were imprisoned, and elevated the depressed part. In this case the dura mater had been separated from the sound bone, so that the chiselling was a very easy matter, and the readiness with which it was accomplished, and the simplicity, removing just what was required, being able to view every stage, commended itself to me in preference to the trephine. I make mention of this case to show that for injuries of the skull the chisel would seem to take the place of the trephine. There is very little hammering required when operating on a child's skull with a good sharp chisel dipped in hot water. I feel that we are much less likely to injure parts we wish to avoid. I drained this case with carbolized silk, dressed

antiseptically, and the child made an uninterrupted recovery. The wound healed kindly without suppurating.

A CASE OF RUPTURE OF A DEEP VEIN IN THE LEG.*

BY GEO. A. PEIERS, M.B., F.R.C.S. ENG.

The patient is a female, æt. 43. She has varicose veins in both legs. Some are superficial and large, others are small and "dendritic." She has suffered from sensations of fatigue and aching in the legs on walking or standing. While walking on the street one day she felt something give way suddenly in the calf of her leg. She does not recollect having stumbled at or before the accident. The pain and loss of power were so great that she had to be driven home. She states that nothing could be seen at the affected spot at the time.

April 25th. Four days after occurrence she came to see me. Found there was still some pain and stiffness with tenderness on deep pressure. The leg tired easily. Circumference at middle of leg increased $\frac{3}{4}$ of an inch. There was no superficial œdema. There was an irregular patch of extravasated blood under the skin at inner and front part of leg about middle. This patch was about $1\frac{1}{2} \times 2$ inches in extent. A similar patch, but darker in color, occupied the concavity of the arch of the foot and below inner ankle. There was no erosion of skin and no superficial tenderness at either of these points. These patches did not appear until the third day after the pain was felt, and they were growing slowly larger.

Diagnosis: Rupture of varicose vein in back of leg between superficial and deep layers of muscles, or possibly in one of the muscles. The extravasated blood had gradually made its way forward to the front of the leg, and also downward in the line of the tendons of the deep layer of muscles.

Treatment: Rest and elevation.

Boyer asserted many years ago that varicosities affected the superficial veins alone, and this misstatement, like so many others, was accepted as fact by subsequent authors without further investigation, until Verneuil in 1855 showed its

*Reported at the Toronto Medical Society.

fallacy. This surgeon was able to show that varix is as often a disease of the deep as of the superficial veins, and that not infrequently superficial varicosities furnish an indication of the presence of deep ones. Verneuil indeed describes a plexus of veins between the superficial and deep muscles of the calf, which he believes to be more often the seat of varicies than are the superficial vessels. He also claims, moreover, that the intra-muscular veins are sometimes varicose, and Callendar has shown that the six chief veins which pass from the soleus muscle alone have a united diameter of not less than one inch, though he is unable to sustain Verneuil's statement in regard to their becoming varicose. It would appear probable that varix commences most often at the points where the deep join the superficial veins, since at these points three forces meet: (1) The pressure of the superincumbent column of blood acting from above; (2) the resistance offered by the next valve below the point of entrance of the deep vein acting from below; and (3) the force with which the blood is driven by the contracting muscle from the deep to the superficial vein, acting at an angle to the first two forces.

The case is interesting from the fact that it seems to be unique. No doubt other cases have occurred, but they do not seem to have found their way into the annals of surgery, as I am unable to find any reports of cases. The hemorrhage in such a case probably continues until the extra- is equal to the intra-vascular pressure, when it will cease. The opening in the vein will soon heal—probably with obliteration of the vessel at that part, and the clot will be gradually absorbed. It is scarcely likely that, even if a large vein were ruptured, the results could ever be very serious. The consequences from the bursting of a vein are less serious than from the rupture of an artery of equal size, in proportion to the difference in blood-pressure in the two vessels. The subcutaneous rupture of a considerable sized artery may lead to interference by pressure with the venous circulation to such an extent that gangrene may result, but such a calamity could scarcely follow the bursting of even the largest vein. The symptoms are, however, sufficiently painful and alarming, but the prognosis is favorable and the treatment simple.

Selections.

RESTORATIVE TREATMENT OF VARICOSE VEINS.

BY WILLIAM TAYLOR, M.D., F.R.C.P. EDIN.

Eight years ago I had my second—and, I trust, final—attack of gout. I then realized to the fullest extent the accuracy of the description of that complaint given by an Edinburgh gentleman to his medical adviser: "At eleven last night I went to bed as hale and hearty as you are, doctor, and at two o'clock this morning I awoke with my foot in hell." Unfortunately my case presented an unusual aggravation, for both feet were affected. My left foot, although swollen and strained, was unable to accommodate the whole of the torturing elements, and the locked-out residue held an overflow meeting in my right, where, owing to the crush, the usual boundaries were again overstepped, and the heels encroached upon, in addition to the toes.

Fortunately my head was clear, and my sympathies perhaps brightened, for I thought of the many poor men the pain of whose single feet I had so often tried to alleviate; and as the phantom procession glided past, I endeavored to remember the applications which seemed to give most relief to the different individuals, and I determined to try them in turn on my own poor feet—a different one on each, so that I might the better judge of their comparative efficacy. On the third day my right foot was in heaven, but the left remained in the old place. However, I had discovered the remedy, and speedily applied it to the left foot, but, alas! it was vain. I had expected too much; and, forgetful of metastasis, I had attributed the cure to the wrong cause. The relief given to the right foot was simply the result of an adjournment of the fiendish meeting. My left foot remained obdurately insensible to the slightest alleviation from any or all of the anodynes employed. I shall therefore not enumerate them, for they are utterly useless. The complaint dragged its slow length along, and convalescence at last set in. My left foot regained its normal form and color and freedom from pain. One of the remedies applied to this foot was a fly blister, which was meant to relieve the pain in the heel; but did not. Some weeks afterwards the site of the blister

continued to be marked by a white patch, which, appearing in the midst of a mottled area of minute varicose veins, was somewhat conspicuous. I examined it carefully, but could not find any distended vein within it. Why not blister the remainder of the mottled area? I said to myself; and being very much at leisure, and utterly sleepless at any rate, I at once proceeded to do so. The blister rose, the mottling disappeared. I then continued the blistering process in the course of the internal saphen^y, which had for twenty years and more been in a prominent and painful varicose condition. This vein also disappeared. The raised blue distorted outline was no longer visible.

I had, like others, frequently had occasion to notice a great improvement in the condition of a varicose vein after an attack of phlebitis; and bearing that in mind, I felt that my present procedure was something like producing an artificial phlebitis, both in its appearance and results. I also thought of the contraction which shrivels up cutaneous structures after burns, and I felt that I was making use of a modified kind of burning, which was followed by similar contractions beneath the skin, and that these formed a kind of subcutaneous vitalized bandage which served to keep the vein within its proper limits. No doubt this is in some measure what did happen, but how? What are the changes involved in the process? In order to find assistance in determining this, I exhibited my leg to an eminent anatomist and physiologist in Edinburgh, and to an equally eminent surgeon and pathologist in London, but neither of them would venture to give an explanation of the anatomical condition then existing. The surgeon's remark was characteristic, and is almost enough to reveal his identity: "I don't know what has taken place in that leg, because I have not yet dissected that vein. The treatment and its results are to me entirely new."

A correct theory seemed, therefore, hopeless, without a foundation of anatomical fact on which to build it; and as no opportunity of dissection presented itself, I had to wait for more light, and content myself with the reflection, that whereas I once suffered from varicose veins, these sufferings are now relieved.

Meantime, being satisfied as to the absolute safety of the treatment, I lost no opportunity of

giving my patients the benefit of it, and the results have been in every way satisfactory. This was peculiarly noticeable in aged persons, say of sixty and upwards, for they were, of course, the least promising class. In them the veins are more distended, thinner, and more relaxed than in the young, and the vitality of both the vessels and the neighboring textures correspondingly diminished. Yet in every case the treatment has been successful, so that it is well entitled to be considered as eminently *restorative*.

Before such a society as this I deem it unnecessary to enter into elaborate historical details regarding the various modes of treatment adopted for the cure of varicose veins. These are all familiar to you under the designations of Radical and Palliative. So far as I can see, the plan of blistering partakes of the merits of both without the danger of either.

The *Radical* treatment, which consists in the operation for obliteration, carries in its train such an array of misfortune as to entitle it to the designation, hazardous. It is often only partially successful in obliterating the vein, but when completely so it only results in a mutilation, for it removes an organ whose increased usefulness had in the first instance led to hypertrophy and distension of its walls. Its natural functions had been strained by overfeeding from the increased supplies yielded by the surface of the overworked muscles of the calf. Hence the greater frequency of varicosity in those who have to stand and lean forward over a counter or a wash-tub. The removal of the vein, therefore, without removal of the conditions which give rise to the disease is unscientific, for the deligation of the superficial vein throws increased work upon the deep-seated intermuscular veins, whose functions are already proportionately strained, and which are themselves often simultaneously involved in the primary diseased action.

The *Palliative* treatment is invariably represented by that most deceiving of all deceivers, the elastic stocking. In theory, it is good; in practice, it is bad. I speak from a prolonged personal experience, but this is not necessary to make its defects apparent. I had abandoned it long before I was cured, and had substituted a well-knitted, well-fitting woollen stocking, which was always clean, always comfortable, afforded a sufficient and consistent support, and did not

deceive me into a belief in security which was fallacious. I never encounter an elastic stocking without ordering its immediate removal. In hot days they are too tight, and irritate the skin; in cold days they are too slack, and pucker into unequal folds. If you walk much, they gravitate towards the ankle and become irregularly hardened with perspiration. If you walk little, the ankle swells and the stocking becomes an obstruction to the circulation. This all applies to new, well-fitting stockings. What shall we say of old ones?

I have made use of the word *restorative* in preference to the term palliative; and although I have assumed that what takes place is the formation of crossing bands of connective tissue over the vein, constituting a subcutaneous binder, I do not by any means think that this is all—for if so, the analogy with phlebitis would not be complete. There is good reason to suppose that the coats of the veins themselves participate in the restored vitality, for their restored functions continue unimpaired for years. They are in no case obliterated; and this is best proved by the fact that after a limited number of years they again become distended and require a renewal of the treatment. This is not to be wondered at; for we cannot pretend that the restored vein is made better than it was originally, and if the sound vein gave way in the first instance, it is only reasonable to expect that under similar conditions the restored vein will also yield. This restorative treatment has the additional advantage of being applicable in regions where the ordinary palliative measures cannot be used, as in the walls of the abdomen and elsewhere. It is also suitable for dispelling the effusion and solid œdema which so often accompany the varicose condition.

The timely application of a series of blisters disperses this, and averts the almost certain sequel of hideous, intractable ulcers. The cure of these ulcers is most successfully accomplished—as pointed out by Mr. Syme—by the application of blisters to the surrounding œdema. I always feel that in anticipating the formation of these ulcers and preventing it by dispelling the nidus of solid œdema where they form, I am acting consistently with the teaching of that great master.

Details of Treatment.—I first ascertain, and,

if possible, remove the cause. I then prescribe such remedial measures as obviate a tendency to renewal of the cause. Third, I place the patient recumbent, with the affected part elevated on pillows, for twenty-four hours, or such period as may be necessary to enable the limb to regain, as nearly as possible, its normal calibre. I then blister from the foot or sound part of the vein upwards along its course, say six inches daily, always watching for the first symptom of disturbance in kidney or bladder. This does not occur so readily as one would expect from the proximity of the blistering agent to the surface of the veins. This may probably arise from these having in a great measure lost their absorbing power, or from the suction necessary to absorption being absent. Still the bladder does sometimes become affected, and when this occurs we must suspend operations for a day or two. Certain of the blistering liquids contain camphor, and this is said to prevent strangury.

In order to make sure of this safeguard, it is well to begin by a coating of Rubini's tincture, allowing it a minute or two to dry, and then applying the blistering liquid over it, with which it amalgamates. When the blistering liquid has had a minute or two to dry, I apply a coating of flexile collodion. This serves the double purpose of preventing evaporation and contracting the skin over the vein, and does not prevent, but rather aids the action of the blister. The blister *must* rise and the serum be withdrawn, but the action of the blister continues for days after, so long as any redness remains. The rising of the blister is useful in a secondary way, because the pain connected with it tends to reconcile the patient to the recumbent posture, which is absolutely necessary to success. When the whole of the affected vein has undergone blistering, the part should be carefully strapped with strips of adhesive plaster, two or three inches wide. This gently stimulates the whole surface of the leg, and assists the veins to resume their suspended functions. When the plaster begins to pucker, it should be renewed and fresh strips applied. Two weeks after the strapping has been applied it may be removed and the veins tested by placing the patient in the erect position. If the vein bulges anywhere, that part should be again blistered and the process renewed. If not, fresh strapping should be applied, and the patient al-

lowed to take gentle exercise for a couple of weeks, when the leg should be again examined and the strapping renewed. Sometimes, if the avocations of the patient compel him to walk earlier than is indicated, a solid coating of colodion over the affected surface may advantageously take the place of strapping. Thereafter, with renewed precautions as to avoiding any probable cause of obstruction, we may take leave of our patient with the parting advice, that he should daily practise walking on tiptoe until he acquires the habit of putting the toes down first. This saves the vein from the distending effects caused by the checked momentum of the contained column of blood which results from the jerk of placing the heel down first.—*Edinburgh Medical Journal*.

TREATMENT OF FISSURED NIPPLE AND ENGORGED MAMMARY GLAND.—In the treatment of fissured nipple, when the cracks are at all extensive, the ordinary remedies recommended from time to time have been found more or less unsatisfactory. Painting with tincture of benzoin, for instance, while an excellent procedure for small superficial cracks of the nipple, is perfectly worthless in more advanced cases. The writer has found in hospital and private practice that excellent results can be secured in bad cases by the application of an ointment made up of equal parts of castor oil and subnitrate of bismuth. This mixture makes a very smooth, soft ointment, which relieves the pain, and is an excellent protective to the part. Before application, the nipple and surrounding skin should be carefully cleansed and disinfected, and then the ointment should be smeared on plentifully. If it is necessary for the child to nurse from the affected nipple, it can be allowed to do so without the necessity of removing the ointment from the nipple, as must be done if tannic acid or the salts of lead are used. This is a serious disadvantage of many forms of treatment recommended for fissured nipple, for the irritation of removing the substance employed as a local sedative neutralizes its action. For the engorgement and pain in the mammary gland itself, which so often accompanies fissured nipple, the writer has had excellent results from the use of an application of lead water and laudanum, which is applied by means of a

cloth covering the whole breast, renewed at frequent intervals, and kept in place by a suitable mammary binder, either that recommended by Richardson or the Murphy bandage. This not only retains the dressing, but supports the breast and exercises even pressure upon it. With this treatment the development of mammary abscess is a rare event. If the child can be nursed from the other breast alone it is safer, I think, to draw the milk from the affected gland by means of a breast-pump until the cure is almost complete. If it is necessary that the child should nurse from the cracked nipple, a glass nipple shield with a rubber tip must be employed.—*Barton Cooke Hirst, M.D., in University Medical Magazine*.

A CASE OF REMARKABLE SURGICAL INTEREST.—The following case was communicated by letter from Dr. W. W. Stennett, of the Chicago and Northwestern Railroad, to Dr. Edward H. Williams, of the Baldwin Locomotive Works, and is well worthy of being recorded in the *University Medical Magazine*: "A switchman, in a retired part of one of the yards of the Chicago and Northwestern Railroad, picked up the arm of a man which had been crushed off at the shoulder-joint, and having on it a shirt-sleeve. Diligent search was made for the owner of the lost member, but nowhere could he be found, nor could any clue to the accident be discovered. Five days after the accident the police found the man at Clyborn, five miles from the scene of the injury, exhibiting his mutilated shoulder in proof of his arm having been cut off by a train. This exhibition he had made in twenty or thirty saloons for the purpose of obtaining whiskey. During all the time no dressing had been applied, or any vessels tied. He was sent to a hospital, and recovered perfectly. On examination, it was found that the arm had been torn out of its socket, leaving the other elements of the shoulder, the clavicle and scapula, intact." The forcible ablation of an arm has often occurred by machinery without any serious loss of blood, but the shock usually renders the patient helpless, and the surgeon invariably feels it his duty to ligate the crushed vessels. The marvel, however, in this case was in the ability of the man to travel about for five days, realizing neither shock nor bleeding. It

is not improbable that had one or two days more elapsed without a dressing, fatal bleeding would have ensued from sloughing of the crushed vessels, such sloughing often being delayed as late as the seventh day.—D. Hayes Agnew, M.D., Emeritus Professor of Surgery, University of Pennsylvania.—*University Medical Magazine*.

THIOL IN DISEASES OF WOMEN.—Gottschalk (*Centralblatt f. Gynakologie*, March 21st, 1891) has used thiol in inflammations of the uterus and its appendages for nine months. He treats para and perimetric exudates with vaginal tampons impregnated with a ten or twenty per cent. glycerine solution of the drug. At the same time he has the abdomen rubbed once daily with a salve containing the same remedy. After the tampon has been placed, the patient, as a rule, feels a "drawing up" of the belly, and there is a free flow of vaginal secretion. The tampon is removed in twenty-four hours, and the flow ceases. The local effect of the drug on the skin of the abdominal wall is much the same as that of tincture of iodine. After six or eight days' application, it is well to intermit this part of the treatment until the skin has regained its normal condition. Under this treatment, which will eventually be supplemented by the internal use of the drug, large pelvic exudates have disappeared in a few weeks. Up to the present time, Gottschalk has not failed to cure any case of this kind by this treatment, which has passed through his hands. Baths and massage are very useful adjuncts to the treatment. Inflammatory erosions about the vagina are treated with equal success by dusting them with a dry thiol powder. Acute and chronic endometritis also yield readily to the remedy applied in solution on an applicator. The application is painless and without danger. The uterine colic which follows the use of iodine is not met with. No serious irritation has been observed to follow either the vaginal or intra-uterine applications. At times a slight blood discharge is seen to follow immediately after the treatment, due to the local irritating action of the drug upon the uterine mucous membrane. The mucous membrane is exfoliated after many applications.—*University Medical Magazine*.

TURPENTINE AS A GERMICIDE AND ANTI-SEPTIC.—Although the oil of turpentine (*Oleum Terebinthinae*, U.S.P.) is not unknown as an antiseptic and germicide, its insolubility in water and its irritating properties have hitherto made its use impracticable. That it has its special uses, however, in this connection, I have had abundant testimony. It is a well-known fact among naturalists that if the air of a cabinet be impregnated with the vapor of turpentine, the specimens are safe from the ravages of moths and other intruders, so long as this condition of the air of the cabinet remains. Having learned the advantage of turpentine in preserving entomological specimens, I concluded to try its germicidal properties in the cases containing surgical instruments. A bacteriological examination of the cases, made four weeks afterward and compared with the examination of cases not provided with turpentine, convinced me of its efficacy, and I soon afterward applied the same principle to drawers containing towels, gauze, bandages, etc. The method is simple. The turpentine is placed in flat large-mouthed bottles at the bottom of each case or drawer, the volatility of the turpentine causing the vapor to impregnate the surrounding air. Of late I have also placed my surgical instruments, the night preceding an operation, in a flat dish containing oil of turpentine. The instruments are completely sterilized, are not injured by the submersion, and are easily dried by a piece of sterilized gauze or towel. The characteristic odor of turpentine can be removed by ether. The cheapness of turpentine and the ease with which it may always be obtained, added to its special adaptability in preserving the aseptic condition of instruments, bandages, etc., by its vapor, may make it a valuable addition to the list of our antiseptics and germicides. I have also used benzole in the above manner. Its greater volatility gives it a more rapid germicidal action than turpentine, but its great inflammability admonishes caution in its use.—*Medical News*.

ST. LOUIS MEDICAL COLLEGE has been made the Medical Department of Washington University.

SOME German physicians propose that the coachmen of medical men wear white hats.

THE
Canadian Practitioner

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

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

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TORONTO, JULY 1, 1891.

A FIVE-YEARS' COURSE IN MEDICINE.

The most important part of the recently amended curriculum of the Medical Council is the requirement of a five years' course of study from students after matriculating. This journal has always done its share in advocating higher standards of medical education in this province; but with reference to this radical change, we are placed in this position: we must either follow those who have passed us in the race, or oppose their recent enactment. We have considered the matter carefully, have consulted many friends of higher medical education, and have arrived at a definite conclusion that we will loyally support the Council in its new departure.

It is well known that Dr. Bergin has been for years the sturdy champion of the five years' course. He has also advocated making a degree in arts the standard for matriculation. We have frequently been compelled to differ from him on certain points, and especially with reference to his views on the arts course. Such a course does not of necessity furnish a good preliminary training for the study of medicine. Raise the standard for matriculation, if you like; but choose with care the subjects most suitable for the purpose instead of demanding something so indefinite as a degree in arts without any restrictions.

In our last issue we gave a summary of the main points in the now celebrated report. Its reading caused considerable surprise, and even alarm. We are told that Dr. Bergin in his advocacy of the proposed changes made one of the ablest speeches that has ever been heard in

the Council. The other members of the committee supported him on every point. The big fight was on the five years clause. The opposition was vigorous and able; the discussion was prolonged and spirited; the resulting majority in favor of the adoption was small. On the first vote in the "committee of the whole," the clause was carried by the casting vote of the chairman.

There is a general consensus of opinion that the new requirements will prove a serious blow to the medical colleges; but as the supplies from the schools in recent years have considerably exceeded all legitimate demands, the general profession can view that aspect of the case with equanimity. We have no desire, however, to see the schools which have done good work in the past seriously injured; but we have an idea that the numbers will not be so much diminished as is expected in some quarters. After all, our educational institutions should take pride in the quality of their students rather than the quantity.

It is generally conceded in all parts of the world that the tasks imposed on students in medicine have been greatly increased in recent years. As a consequence, the pupils in all the schools have been kept at high pressure during their whole course. A large portion of them have very crude and ill-digested ideas on many if not all the subjects of the various curricula. This fact is duly appreciated by a large and increasing number of graduates from year to year, as is shown by the fact that so many make it a rule to take some sort of a post-graduate course before commencing active practice. Unfortunately it has happened in the past that many of the weakest graduates have not recognised their deficiencies, but have considered any post-graduate work as entirely superfluous, and have commenced their life's work without a sufficient definite knowledge to guide them in the serious emergencies which occur in medical, surgical, and obstetrical practice.

The new requirements will compel the weaker to adopt a course which is so necessary for them, while it will do no harm to the stronger. Law students are required to take a five years' course, and yet there is no alarming deficiency in their ranks. On the contrary, law, like

medicine, is full to overflowing, and our own profession is unlikely to suffer much from diminished numbers. That the general standing of the medical profession will be materially raised under the new régime is beyond doubt. In the future it will be a grand thing to be able to say that the physicians of our fair and prosperous province are second to none in the world from either a practical or scientific point of view.

BURLINGTON AND HOME ELECTION FOR THE MEDICAL COUNCIL.

The decision of the committee of the Council, with reference to the protest of Dr. Miller against Dr. Shaw's return has caused much comment. Dr. Shaw was declared elected by a majority of four. In the first place, the disputed ballots, seventeen in number, were all counted. There was no question as to intention or identity in any case, and, therefore, there can be little doubt as to the justice of this decision. Dr. Miller had a majority of two on these "spoiled" ballots, and Dr. Shaw's four were reduced to two.

Various votes then came up for consideration. The vote of Dr. E. B. O'Reilly was thrown out because it was considered that he was not a resident of the division. We must confess that we cannot understand the reasons for this. Dr. O'Reilly was born and reared in Hamilton. While a student of medicine in Toronto his home was in Hamilton. Sometime after graduating he was appointed superintendent of the Winnipeg Hospital. He left there a year ago, and since last September has been living and practising in his old home—Hamilton. He has, however, expressed his intention to leave that city, and on this account the committee considered him a non-resident. If he does not live in Hamilton, he certainly lives nowhere; and while we acknowledge the element of doubt, we question the justice of his disfranchisement.

The vote of Dr. Rannay, of Georgetown, was thrown out because, at one time, he refused to pay his fees to the Council on the ground that he had been registered by another party without his knowledge or consent. Still we know that Dr. Rannay does practise to a limited extent, and he is legally a registered practitioner, resid-

ing in the division, notwithstanding his indefensible conduct with respect to the non-payment of his fees.

The vote of Dr. Robinson, Jr., of Brampton, was thrown out because he was in New York and was not practising in the division, although Brampton, where his father lives, will, in a sense, be his home until he finally locates. In this case we are inclined to agree with the committee. Dr. Shaver made the singular mistake of voting for both candidates. This vote was allowed to Dr. Shaw, but we think it should have been thrown out altogether.

The vote of the returning-officer, which went to Dr. Shaw, was thrown out. There have been many discussions with reference to the right of the presiding officer to vote, some contending that he should only be allowed the right in case of a tie, others maintaining that he should vote as an ordinary elector and have a second vote in case of a tie. If the result of this protest were accepted by all, it would remove the doubts which exist. In the last general election for the Council, we thought the majority of returning-officers voted in the ordinary way. The recent decision surprised many, and may not establish a thorough precedent because the members of the committee were not unanimous in their opinions.

Although this contest was conducted with considerable vigor, if not bitterness, we are glad to know that both candidates were considered above reproach; and consequently, as far as professional weal or woe is concerned, it is a matter of little consequence whether Dr. Shaw or Dr. Miller represents the division. At the same time, it will generally be conceded that Dr. Shaw has had rather "hard luck."

WILLIAM AINSLIE GOODALL, described as of Montreal, and registered as L.K.Q.C.P.I., 1885, has, for disreputable conduct, had his name removed from the British Register. His name had already been erased for the same reason from the Medical Register of the Province of Nova Scotia, and from the Roll of Licentiates of the Royal College of Physicians of Ireland. Goodall had offered to practise gratuitously and to guarantee cures, and had issued objectionable and disreputable advertisements to the public.

Meeting of Medical Societies.

THE ONTARIO MEDICAL ASSOCIATION.

(Continued from page 292).

Thursday morning, June 4.

MEDICAL SECTION.

Dr. A. B. Osborne, Hamilton, read a paper on

"PATHOLOGICAL WEEPING,"

which appears at page 275 of THE CANADIAN PRACTITIONER.

Dr. Birkett, of Montreal, emphasized the statement concerning the necessity for the examination of the nose in seeking for the cause of epiphora. He had seen cases due to contact between a hypertrophied middle turbinated bone and the septum.

Dr. Trow, of Toronto, believed that the dilatation of the stricture often proved unsuccessful because no attention was paid to the catarrhal condition of the mucous membrane, which, unheeded, kept up the disease.

Dr. McWilliams, of Thamesford, read the history of five cases of

PHLEGMASIA DOLENS,

treated chiefly by salicylate of soda, in which recovery had occurred more quickly than usual.

Dr. Adam Wright, of Toronto, also read the history of a case of

PHLEGMASIA DOLENS.

The salicylate, he thought, was useful, but the weakness and depression of septicæmia contra-indicated it. He had found it one of the most difficult drugs to administer, because the patient was so soon nauseated by it. The pain makes the patient worse and prolongs the disease. Opium he thought, for that reason, to be the best drug. Purgation by epsom salts in small doses, and support in the form of quinine and other tonics, formed the treatment he would recommend.

Dr. Barrick, of Toronto, believed that opium should be the mainstay.

Dr. Cronyn, of Buffalo, said that the salicylate might be made very acceptable by combination with the aromatic spirits of ammonia, and Battley's solution.

SURGICAL SECTION.

Thursday morning, June 4th.

Dr. Primrose read a paper on

FATTY TUMORS IN THE INGUINAL CANAL.

He stated that the origin of fatty tumors in this neighborhood was often somewhat obscure, and it had been suggested that they were derived from the extra peritoneal fat. The subserous fat bears to the peritoneum a relation very similar to that borne by the subcutaneous fat to the skin. Lipomata in the latter situation are very common, and we are not surprised to find like developments in connection with the subserous fat. Lipomata have been described by Mr. Bland Sutton occurring in connection with the colon, developed from the subserous fat of the visceral peritoneum. Dr. Primrose has in his own practice found a fatty tumor lying on the rectus muscle, pedunculated, the pedicle passing through the abdominal wall, and apparently continuous with the subperitoneal fat. This tumor was under the deep fascia, was lying in a very thin capsule, which presented septa passing between the lobules; there was no peritoneal covering. The tumor had been looked upon as a ventral hernia, and possibly this error in diagnosis is not infrequently made, the subserous fat being mistaken for omental, until the true condition of affairs is revealed at the operation. If, therefore, we have instances of tumors developing from the subserous fat both in connection with the parietal and visceral peritoneum, we are not surprised to find a like condition in the inguinal canal. Dr. Primrose then described a specimen which he had dissected in the anatomical rooms of Toronto University. A fatty tumor was found projecting from the external ring, lying on the anterior aspect of the constituents of the cord and within the coverings of the cord; it was entirely devoid of peritoneal covering, and a careful dissection from within the abdomen demonstrated the fact that there was no hernia and no pouching of the peritoneum, whilst the tumor was attached to a pedicle which lay in the inguinal canal and was continuous with the subperitoneal fat in relation to the internal ring. Fatty tumors in the inguinal canal may of course be omental, and a case was described in which an omental hernia, the size of a duck's egg, was found within the

inguinal canal associated with an imperfectly descended testicle. In the neighborhood of the canal, although not within its coverings, we occasionally have tumors developed from the subcutaneous fat. The sources from which fat tumors in this neighborhood may be derived are, therefore, (1) omental, (2) subserous fat, (3) subcutaneous fat.

Dr. Grasett then read a paper on

LITHOTOMY.

The question arises as to whether or not the suprapubic method affords an easier means of entering the bladder than the lateral operation. Gasron demonstrated the effect of dilating the bladder and rectum, the fact that by so doing the bladder can be raised up behind the abdominal wall. The operation is undoubtedly easy, as there are no vessels of importance in the way; the dangers are that of wounding the peritoneum and septic infection, the latter favored by disturbance of the cellular tissue in front of the bladder.

In Toronto the results obtained by the lateral method have been most encouraging. The dangers in the lateral operation seem to be exaggerated; only one case of damage to the rectum has been seen by Dr. Grasett, and he has never seen a case terminate fatally. With the good results recorded, we must look upon the lateral operation as a safe procedure. Perineal lithotomy in boys has been an extraordinarily successful operation. In boys, of course, by the suprapubic route we avoid any possible danger to the vesiculae seminales and we cannot open up the recto-vesical pouch, things possible in the lateral operation. In the aged, the suprapubic method may afford some special advantages in cases of enlarged prostate. In the cases of large calculi we have more room afforded by the suprapubic method, but stones are recognized now much earlier in their formation than formerly. The prospect seems to be that in the future the suprapubic operation will supplant the lateral, although in Toronto the lateral method is still the favorite.

Dr. Holmes, of Chatham, stated that he had never done the suprapubic operation, and that he has hitherto been satisfied with the results of the lateral method. He narrated a case of lithotomy in which the blades would not close

after crushing, and with great difficulty he removed the instrument from the bladder, the blades being separated about a quarter of an inch. The cause of the difficulty was because of a defect in the making of the lithotrite. The smaller blade fitted the shoe accurately, but the shoe had no perforation in it, so that the debris could not fall out.

Dr. Eccles, of London, referred to two cases of suprapubic lithotomy. One in a girl, *æt.* 7; the stone was so large (726 grains) that the high operation seemed indicated. The child made a good recovery. Another case in a man, *æt.* 62; there were twelve stones in the bladder. The bladder was distended, and there was no difficulty during the operation. The stones were round, and about the size of a filbert. After the bladder closed a small abscess developed in the subpubic fat, but this soon healed. The recent advance in abdominal surgery has done much to develop the operation of suprapubic lithotomy.

Dr. J. F. W. Ross presented a note on the

DIGITAL EXPLORATION OF THE FEMALE BLADDER,

which will appear in full in the columns of this paper.

Dr. Kelly stated that he has practised this method for many years. The little finger, as suggested by Dr. Ross, is preferable to the index. If the index finger be introduced with the pulp down the second finger strikes against the pubic arch, and is limited in that way; the little finger, however, introduced in the same way will permit of invagination of the soft tissues by pressure of the other fingers, and thus length is added to the digit. The tactile sense seems sufficiently acute in the little finger. Dr. Kelly often uses two small lateral clean incisions at the meatus, subsequently closed by suture. The bimanual method should be used in exploring the bladder.

Dr. Dame mentioned a case in which there was retention of urine, relieved by dilatation of the urethra, but the lumen narrowed down again in a few days, and symptoms recurred. The case was obscure, as no cause was discovered.

Dr. McFarlane referred to the extent to which the urethra could be dilated without causing in-

continence. He has removed stones of considerable size without ill effect.

Dr. Price Brown read a paper on

DEVIATIONS OF THE NASAL SEPTUM.

This paper will appear in full in THE CANADIAN PRACTITIONER.

Dr. B. E. McKenzie exhibited four cases of

TALIPES REQUIRING OPERATION.

The method of Phelps, of New York, was referred to. First, correct the varus so that the foot is in the axis of the leg; subsequently correct the equinus. Phelps' operation of incision on the concave surface of the foot was described; it is better than removing bone on the convex surface. The foot should first be brought into a position of over-correction, and retained there by fixation apparatus, *e.g.*, plaster.

GENERAL SESSION.

Thursday afternoon, June 4th.

Dr. F. R. Eccles, of London, read a paper on

MYOMA OF THE UTERUS.

This paper will be published in full in THE CANADIAN PRACTITIONER. In the discussion which followed, Dr. A. A. Macdonald remarked that the term "fibro-myoma" was more suitable than "myoma"; this he argued to be the case from the histological characters of the tumor. Treatment must vary according to the position of the growth—subperitoneal, submucous, or intramural. The submucous shows a greater tendency to bleed than the others, and the condition often demands operative interference because of repeated hemorrhages. They, too, tend to become pedunculated, and may be removed through the vagina; occasionally they become strangulated, and a spontaneous cure results. Of medicinal treatment, ergot alone is useful; it must be used in large doses, and continued for a long time. Curretting is sometimes useful where there is endometritis. When it is proposed to use electricity, we must make sure of our diagnosis; the treatment is useless in the subperitoneal forms. In submucous varieties electricity is only useful for the purpose of controlling hemorrhage, and the treatment is always tedious; the patient may tire of it, and may go to another practitioner, who removes the uterine appendages and effects a rapid cure! Electricity

proves of the greatest value in intramural tumors. The strength of current varies in different patients; some stand a much stronger current than others; we must begin with a weak current. Electricity employed in unsuitable cases and in a careless way may lead to untoward results; thus Dr. Joseph Price remarks that very many cases present themselves now with extensive adhesions, the result of previous treatment by electricity. In view of this fact, we must proceed with great caution and watch the degree of tolerance exhibited by the patient. Many men have abandoned older methods and have instead used electricity, this, too, with great success, as in the hands of Keith, for instance. We must remember that many cases may be safely carried to the menopause, and the growth then diminishes; we are sometimes warranted in bringing on the menopause prematurely by removal of the uterine appendages. In certain cases, where the woman is a constant sufferer, pain severe, and hemorrhage profuse, there may be nothing left to afford hope of relief but hysterectomy.

Dr. Howard A. Kelly, of Baltimore, then read a paper on

INJURIES OF THE VAGINAL OUTLET OCCASIONED BY PARTURITION.

The support to the vaginal outlet has been erroneously viewed; the anatomical features have been allowed to overshadow the physiological factors in considering the subject. If we examine a virgin and introduce the finger into the vagina, the individual lying on her back, we find the rigid pubic arch above and in front, the rami on either side, and a rigid band posteriorly, stretching from one side to the other behind the vagina. The vaginal outlet is tucked up under the pubic arch by this band, which is not always rigid but relaxes occasionally. Here then we have something which exercises a tonic contraction, and this is due to the fibres of portion of the levator ani muscle. The tissues of the fourchette are lax and not capable of affording any support. The anterior fibres of the levator ani muscle therefore supports the vaginal outlet; it also passes back to and around the rectum, being related, however, more especially to the *sides* of the rectum.

With rare exceptions injuries to the vaginal outlet occur during parturition; the vaginal

outlet is subject to sudden enlargement, it forms the mouth of a funnel through which a large and irregular body (the child) is to be propelled.

Three grades of tears—1. Begins at the fourchette and breaks down the lax tissue; it does not in any way affect the supporting structures of the vaginal outlet, this is, therefore, unimportant as far as the support goes. 2. A tear running up one of the sulci of the vagina, tongue-shaped, into the vagina. This is the result of the head and shoulders of the child tearing up the tissues at the side of the levator ani. The important part of the tear lies within the vagina. This injury, which often escapes notice, should be sought out and treated at once. Bring the patient to the edge of the bed, and get a thorough exposure of the wound. Silk sutures are best, the first one passed must be in the upper angle of the wound; one or two sutures within the vagina will be sufficient, and they must be passed so that the lowest and deepest part of the suture will be nearer the operator and the vaginal outlet than will be the point of entrance or exit; this tucks up the tissue in the proper manner. The common method is apt to leave a pocket or sac in the vagina, and the outlet is not properly supported. The old method also was to pass the sutures on the outer or skin surface first; this gave a good skin perineum, but a great well is left within the vagina for secretions to collect. 3. A degree of tear which involves the integrity of the bowel, the rupture passing through the sphincter and up the recto-vaginal septum to a variable extent and involving a tear of the levator ani fibres. We must close this in two stages—suturing the bowel first, either by continuous or interrupted cat-gut suture, deeply placed. Then pass one or two silk sutures, passing them well back so as to afford good support. Cat-gut is excellent, but will not stand pressure, therefore silk must be used in addition. Then complete the operation by the superficial sutures as described, then the skin sutures. A well-performed immediate operation always succeeds in the absence of puerperal fever. It is always to be preferred; the patient is relieved from the discomfort of a second operation.

There are two important secondary operations where we have to deal with (a) a complete tear through the sphincter; (b) where we have re-

laxation of the vaginal outlet. It is difficult to find the ends of the divided sphincter. If the tear be a shallow one, although just through the sphincter, still the ends of the sphincter may be so held together by the tissues in which it lies, and eventually in cicatricial tissue, that there is not incontinence of feces afterwards. When we have a case in which the sphincter has been torn across, we wish to make the condition as much as possible like the recent tear. This is done by denudation and then suture as in recent tear. The tear may go up one sulcus or both, or up the middle line of the posterior vaginal wall.

The condition known as *relaxation of the vaginal outlet* is the most important of the injuries here. This condition is often not recognised. In this condition we notice that the anus and the vaginal outlet have dropped back. The perineum is frequently deep and the skin perineum, measured with a tape-line, may be found to be extensive; nevertheless the support of the vaginal outlet may be lost. The walls of the vagina may pouch, and we may find a cystocele, or a rectocele, or both. If we place the patient in Sim's position, the absolute lack of support becomes very evident. Palpation also aids us, the skin perineum can sometimes be picked up between the fingers and thumbs and carried forward over the clitoris. The anterior, posterior, and lateral vaginal walls look as if they might afford support, but to the simple touch they yield, showing that they fill up without supporting the vagina. What has become of the loop of muscular fibre which affords support? The fibres of the levator ani are found lying parallel to and alongside the vaginal walls, their transverse continuity severed and their support gone. The characteristic "rolled out" appearance of the relaxed vaginal outlet can be developed by placing the thumbs on either side of the outlet and pushing upwards and backwards. Another test is by introducing the fingers and pulling downwards and outwards, when the cervix uteri can actually be seen under such conditions. The relaxed outlet may sometimes be concealed, such women are under a more or less constant strain, a constant effort to draw up the muscle, and the result often is reflex nervous symptoms. Relaxation suspected is developed on putting the patient under an anæsthetic. The hymen in

some cases remains intact, the laceration passing down one or both sulci. The rational treatment in such cases is as follows: Denudation is carried on so that two triangular areas are mapped out within the vagina, one extending towards the fornix of one side, the other towards the fornix of the other side, the apex being high up, the base abutting against a crescentic surface, which lies between the hymen and the fourchette. The first suture passed is of silk worm-gut, passed in the manner before described for recent tears, the deep part of the suture being nearer the operator than the point of entrance or exit. Above this, higher up within the vagina, a few points of cat-gut suture may be necessary to bring the edges together. The operation is completed by passing a suture in a circular course around the crescentic surface, beginning posteriorly and passing it around and out again near point of entrance, in such a manner that, when drawn tight, there is a puckering up of this crescentic area. A few superficial sutures will be necessary to complete the accurate apposition of the edges. This form of treatment yields most excellent results.

Dr. Temple had formerly looked upon the perineum as a support for the uterus, but now he looked upon it more as a support for the rectum and bladder. In repairing a recent perineal tear, his practice has been to pass the sutures from without inwards. The object in view has always been to carry the curved needle as far outwards as possible, in order to get hold of the end of the divided muscle. So far his results have been satisfactory. The operation described by Dr. Kelly, the bilateral one, is an old method. If possible, remove very little tissue, as we have no more tissue than we want to restore the normal condition of the parts.

Dr. Kelly stated that whereas the genius of the whole method of operating comes from Emmet, yet recent modifications of original methods have proved of considerable value. He does not agree with Dr. Temple concerning the removal of tissue; in relaxed outlet we have more tissue than we have in the normal condition, and this must be removed.

MEDICAL SECTION.

Dr. H. A. Macallum, London, read a paper on

SOME POINTS IN THE PATHOLOGY OF KIDNEY DISEASE,

which will appear in full in THE CANADIAN PRACTITIONER.

Dr. John Caven wished to support the main statements of the essayist, and in particular those which were contrary to generally accepted beliefs. In his experience in the dead house he had found but few normal kidneys. In nearly all were to be found, just beneath the capsule, small wedges of inflammation. He agreed that the classification of kidney diseases, as used at the bedside, was nonsensical, for interstitial inflammation affects eventually the parenchyma, and *vice versa*. He had found the capillaries of the tuft denuded of their endothelium, but still perfectly clear in outline. This membrana propria must be directly derived from the elastic tissue of the artery. In no other capillary does this occur, and this might be the reason why the leucocytes were not seen within the capsule. Endothelium might be found, but not leucocytes. Cysts, he believed, were often produced by plugging of the urinary tubules by albuminous material; more frequently they were caused by localized interstitial nephritis. Mucous cylinders, he thought, were most easily recognized under the microscope by the fact that they were frequently divided at the end. This distinguishes them from hyaline casts.

Dr. McPhedran did not believe in the existence of a physiological albuminuria. He was in accord with the views expressed as to the classification of kidney disease.

Dr. Sheard said that the transudation of leucocytes was still believed in, notably by Klein. He did not think the mucous cylinders could be distinguished from the hyaline cast, which was always to be found in albuminuria. He did not think a large white kidney became a contracted one, because the patient dies too soon. A large white kidney was easy to discover; a contracted kidney, difficult. Classification was necessary for the sake of clearness. The term, Bright's disease, might mean anything.

Dr. J. E. Graham drew attention to the deduction to be drawn from the statements of the paper, that patients with fatty casts in the urine seldom recover. This is an important point in prognostic. In his opinion physicians were too

apt to think that because the urine contained albumen and casts that the patient was doomed. This was not necessarily the case. Our prognosis should be made rather from the symptoms than from the urine. He thought that although it was quite possible for a large white kidney to become a contracted one, still the classification usually adopted was too useful to be dispensed with.

Dr. Macallum, in reply, objected to the slipshod way in which, at *post mortems*, simply because the capsule peeled off readily, the kidney was declared healthy. Nothing but a microscopical examination could determine that positively. As there is but one kind of inflammation, he failed to see how there could be a classification of kidney disease. Clinically it is impossible to tell anything more than that the inflammation is acute or chronic. An illustrative case was cited in which microscopical diagnosis had been surgical kidney, clinical diagnosis contracted kidney, while the *post mortem* had revealed one surgical, one contracted kidney. Classification might be useful for prognostic purposes, but symptoms were far more so. Dr. Klein had recanted his views. Physiological albuminuria he believed in. The albuminuria consequent upon a cold bath could not be pathological; it must surely be physiological. The mucous cylinder was best recognized under the microscope by the aid of the reflector, or by the use of the aniline dyes.

SURGICAL SECTION.

Thursday afternoon, June 4th.

Dr. A. E. Malloch, of Hamilton, read a paper on

EXCISION OF THE SHOULDER AND ELBOW JOINTS OF THE SAME ARM FOR TRAUMATISM.

This article appears on page 293, in this issue of THE CANADIAN PRACTITIONER.

Dr. Geo. A. Peters, of Toronto, read a paper on

ACUTE NECROSIS OF GROWING BONE.

This title is perhaps the best that has been proposed for this disease, although it has been described under many other names, as acute infective osteo-myelitis, necrosial fever, bone-typhus, etc. It is an exceedingly malignant disease, and its early diagnosis is attended by such

difficulties that Holmes remarks, that it is more frequently recognized at the *post mortem* table than at the bedside.

The symptoms were illustrated by the narration of the history of a typical case. A girl, æt. 9, who had always been delicate, was attacked suddenly with pains in the right knee, which rapidly spread to other joints. Two days later, pain and tenderness were complained of over the lower end of the right femur. At first there was no swelling, but in a short time this thigh was observed to be larger in circumference than the opposite one, and the diagnosis of acute necrosis as a complication of rheumatism was established. Before consent to operation could be obtained, the patient developed double pleurisy and pericarditis, and sank so rapidly that it was decided that operation would be of no avail, and the patient died on the ninth day of the disease. Only a partial *post mortem* could be obtained. On making an incision over the lower end of the femur, pus gushed out as soon as the periosteum was reached. It was found that the periosteum was totally separated from the femur throughout its lower half, the separation, however, stopping abruptly at the epiphyseal cartilage. On making a section of the bone, the cancellous tissue on the shaft side of the epiphysis was found to be acutely inflamed, and separation of the epiphysis from the shaft was in progress.

Through the kindness of Mr. Mackenzie and Dr. Shaw, cultures were made from the pus, and typical colonies of the staphylococcus pyogenes aureus were found. An inoculation of this culture in a white mouse caused death in thirty-six hours, with symptoms of septicæmia, and cultures were again made from the blood of this mouse, and found in a commencing abscess which was forming on the right axilla.

The remarkable virulence of this germ when growing in bone was attributed to the peculiarity of the circulation in such structures, which affords peculiar facility for the lodgment and growth of the virus, and for the entrance of the morbid products into the circulation. The diagnosis from rheumatism, typhoid fever, the eruptive fever, and cellulitis, was dwelt upon; the principal point to be relied upon being the acute pain and tenderness on pressure over the affected part.

In the treatment stress was laid upon the importance of early incision down to the primary focus of the disease, whether that was to be found in the periosteum, as held by English writers; in the medulla, as asserted by the Germans and French; or in the cancellous tissue adjacent to the epiphyseal cartilage, as maintained by Tubby and endorsed by the author. The shaft of the bone should be opened freely by the trephine or chisel, and thorough irrigation with a strong antiseptic should be practised. Where the medulla was affected throughout the whole length of the shaft, multiple incisions should be made, and the whole of the affected medulla should be scraped out with bent scoops. It should be remembered in the after treatment that all bare bone was not necessarily dead, and the bone should not be removed until nature had decided how much of the affected part might recover. Then the ordinary operation of sequestromy could be performed, and the hiatus filled with Senn's decalcified bone chips, desiccated sponge or blood clot. The limb should be placed upon a splint early in the disease, in order to prevent pathological fracture or separation of the epiphysis.

Dr. N. A. Powell stated that the fact that the condition sometimes follows some of the exanthemata has been recently fully dealt with by Keen. Dr. Powell has seen three cases in the lower end of the femur; several have come under his notice in the tibia. A case occurring in the tibia was mentioned in which a persistent high temperature, 105 F., continued with obscure symptoms. There were thoracic complications and parotid suppuration. An operation was performed and necrosed bone from the tibia removed. The patient recovered. The onset of the symptoms is often abrupt. In the treatment an error is often made in removing too little bone. Except in the time saved in the healing process there is no advantage in the use of Senn's chips here.

Dr. Peters, in reply, emphasized the statement that these cases are often not recognized until it is too late.

GENERAL SESSION.

Thursday Evening, June 4th.

Dr. Reeve opened the discussion in ophthalmology and otology. He dealt entirely with

points of general interest in otology. His paper will appear in full in the columns of THE CANADIAN PRACTITIONER.

In the discussion which followed, Dr. Osborne, of Hamilton, stated that he prefers the chisel to the drill in opening the mastoid. If the ear be examined as a matter of routine practice in every case by means of the tuning fork, we would be struck by the frequency with which the internal ear is implicated in middle ear disease. The nasopharynx should be treated antiseptically because of the frequency of the passage of micro-organisms up the eustachian tube to the middle ear. Eight cases out of ten of deafness in children are due to the morbid condition of the nasopharynx. Dr. Osborne has used peroxide of hydrogen, or alcohol; the latter he prefers.

Dr. Moorhouse warned against the error of delay in opening the mastoid, so frequent a source of failure in treatment.

Dr. Birkett, of Montreal, referred to the fact that cases may exist without any of the classical symptoms of mastoid disease. He had seen two cases in which there were no symptoms save discharge and headache. He urged the importance of surface thermometry of the mastoid and auditory canal in such obscure cases.

Dr. Ryerson spoke of the necessity of careful inquiry in cases of supposed foreign bodies in the ear. He had known a case in which the drum-head and auditory ossicles had been removed as foreign bodies.

Dr. Reeve, in reply, stated that he now uses the chisel in preference to the drill in operating on the mastoid. Alcohol he considers an excellent antiseptic, and peroxide of hydrogen a valuable cleansing agent.

Dr. G. S. Ryerson read a paper on
THE PRACTICAL BEARINGS OF COLOR-BLINDNESS.

He held that the examinations as conducted for the purpose of testing for color-blindness were often inefficient, because such conditions of the atmosphere as fog, steam, mist, etc., obscure vision and lead to considerable variation in the powers of perception in different individuals. The test ought, therefore, to be applied under these conditions. People should be examined repeatedly, because disease or injury may lead to impairment of the function in question.

TORONTO MEDICAL SOCIETY.

May 7th, 1891.

The President, Dr. Spencer, in the chair.

Dr. Gullen exhibited a patient, a man, æt. 24, suffering from

DIABETES MELLITUS.

He was in apparent good health until four months ago, when he consulted a doctor because he was losing flesh and strength, and suffered a great deal of pain in the chest. The urine had a specific gravity of 1050, and contained sugar. He was put on opium treatment, but this caused constipation; bromide of arsenic (gr. $\frac{1}{6}$ in the dose) was administered with good effect, the amount of sugar being reduced, but irritability of the stomach was produced, and even minute doses could not be borne; the specific gravity was reduced under this treatment to 1032. At present the patient's pulse is 96; he has exaggerated pulsation in the carotids, and is highly nervous; specific gravity now is 1042. He passes much more urine than normal; he has not had much thirst, but complains of dryness of the mouth; appetite is good. He has not been losing flesh recently; in fact he seems improved in health.

Dr. Macdonald finds a great deal of difference in the varieties of gluten food in the market. There is a large proportion of starch in many of them.

Dr. Machell thinks the patent foods are all right when first put on the market, when chemists analyse them and give their report, but the standard is not maintained, and the article is subsequently manufactured at a cheap rate. Nestle's food has been found bad in this respect. Dr. Machell has at present under his care in the children's hospital a girl, æt. 11. On admission, she was passing 140-170 oz. urine a day. A special formula for diabetic food was tried as follows: "Six eggs are thoroughly beaten, and then a teaspoonful of baking powder, or its chemical equivalent, and a quarter of a teaspoonful of salt are added, and again the eggs are beaten. This mixture poured into hot waffle-irons smeared with butter is baked in a very hot oven. For variety and to make the biscuits seem more like coarse bread, pulverized nuts, of those permitted, may be added. They may be eaten hot with butter and cheese, but

will remain good for a long time, and nobody would suspect that they were destitute of flour." Within two days the patient began to improve, and she now passes only 60-70 ounces urine per diem. The good results have been attributed mainly to the bread.

Drs. Spencer, Gordon, Macallum, and Thorburn also took part in the discussion.

Dr. Thorburn then read some notes on a case of

SUPPURATIVE DISEASE OF THE ANTRUM.

The case was that of J.G., æt. 27, captain in the Austrian army. There was a history of an empyema of the antrum, following the extraction of a carious tooth, lasting three years, without causing actual pain, although the pent up fluid was at one time great enough to cause a swelling of the face. The pus was greenish in color, and contained white flakes, which might have been due to the mucous membrane of the antrum secreting fibrin, which appeared as flakes in the pus. Examination for tubercle bacilli at different times yielded negative results. The mucous membrane lining the cavity of the antrum acts as a periosteum to the bone; this became thickened by inflammation and probably became loosened or partially detached from the bone. By means of a curved trochar an opening was made by Dr. Thorburn into the antrum through the thin plate of bone immediately below the inferior turbinated bone, one-eighth inch from its anterior extremity. The trochar was passed upwards, backwards and outwards. On withdrawing the trochar no pus followed. Re-introducing the trochar and giving it a firm push, it was passed one-half inch further into the antrum, and it felt as if it were piercing a bladder partially filled with fluid. Upon withdrawal of the trochar a copious discharge of putrid pus followed. The difficulty at first experienced in introducing the trochar was due to the fact that the thickened lining membrane was pushed before it but was not punctured. The cavity was washed out with creolin, and a vulcanite tube, with a plug at its external orifice, placed in position. Subsequently the cavity was daily washed out with creolin solution; after three weeks the discharge became clear and sweet, the patient's general condition, which had been much deteriorated, improved, and after four months he was discharged cured.

In discussing this paper, Dr. Powell referred to an excellent form of nasal speculum devised by Dr. Palmer, of this city.

Dr. Macdonald has found the use of iodine in washing out the antrum very beneficial; peroxide of hydrogen also. He thinks the cavity should be opened below.

Dr. Primrose referred to a case of Dr. Cameron's in the General Hospital, where suppuration in the antrum occurred combined with a malignant growth. He also referred to a case in his own practice where he had treated suppuration in the antrum occurring secondarily to caries of a molar tooth; this was cured by simply extracting the tooth. The mucous membrane which lines the antrum has been said by Dr. Thorburn to function as periosteum, by affording nutrition to the bone; like periosteum, it is occasionally raised from the bone; pus collecting under it, between it and the bone, leading sometimes to necrosis.

Dr. A. A. Macdonald presented some specimens showing

TUBERCULAR ULCERATION OF THE INTESTINE.

This occurred in a patient who exhibited symptoms during life of general tuberculosis. The ulcers are typical tubercular ones.

May 14th.

The President, Dr. Spencer, in the chair.

Dr. Greig showed a specimen of

CONGENITAL INTESTINAL OBSTRUCTION.

A woman, pregnant at the seventh month, fell down stairs and sustained a fracture of the fibula. Labor came on a few days after the accident, and the child was born apparently well developed. It was noted soon after birth that the abdomen was unusually large; the child vomited green mucous material, and refused to nurse at the breast. The vomiting continued, and became stercoraceous on the second day; there had been no movement of the bowels; intestinal obstruction was diagnosed, and the patient was submitted to operation. Littre's operation in the right groin was performed; a passage of bowel contents occurred. The child seemed comfortable all day after the operation, but the following morning the child suddenly became collapsed and died. On *post mortem* examination there were signs which indicated that there

had been intra-uterine peritonitis; at one point a thickened band of organized lymph extended from the stomach to the omentum; adhesions between adjacent portions of bowel existed here and there. Extending from the stomach there were two feet of intestine of normal calibre; this ended below in a *cul de sac*. From the rectum there extended up a portion of intestine three feet in length of normal calibre; beyond this and connecting it with the normal bowel above was a portion of intestine not thicker than a lead-pencil; it seemed solid, but on examination was found to have a very small lumen.

Dr. A. A. Macdonald read a paper on

AMENORRHOEA.

He spoke of two classes: (1) Those in whom the menses had not appeared; (2) where the menses, having appeared, were subsequently suppressed. The most common cases occurring in practice are, perhaps, those of young girls sent into the city for educational purposes; the tendency is for over-culture without due regard for the necessity for recreation and healthful exercise. The result is often a cessation of menstruation or a delay in the appearance of the menses; the general health suffers, and many of great mental brilliancy are of necessity compelled to give up their studies because of ill-health. Among those in the second class we find girls who are engaged in the higher class of female labor, e.g., telephone girls, stenographers, etc.; these, as a rule, have more pluck than enduring power. Then there is the working girl—employed at the sewing-machine, or at the bench or counter. Other causes are, derangements of nervous system, sudden shock; prolonged mental strain, etc. In considering the treatment, the indications are in most cases to remove the patient to healthy surroundings—tonic treatment, with rest and recreation; there should also be special attention paid to the regulation of the bowels. In difficult cases the application of electricity over the back and in the ovarian region does good; the vaginal electrode should not be used except in older patients. Superinvolution of the uterus and appendages is another cause of suppressed menstruation. In a case in which there was suppressed menstruation for nineteen months, the negative galvanic electrode produced a slight discharge, which, however, Dr. Macdonald considered to be altogether of a local origin.

Dr. Spencer concurred in Dr. Macdonald's remarks; the school girl is victimized. Iron is good, and permanganate of potash is said to be beneficial, but the latter causes griping, which is so persistent that Dr. Spencer has given up its use; a large amount of water combined with it does not prevent the griping.

Dr. Dame has had some encouragement in the results he has had from the use of electricity in superinvolution with suppressed menstruation. Dr. Harrington believes tincture of capsicum to be of special efficacy in these cases. Dr. Noble finds strychnine, arsenic and iron in combination very beneficial. Dr. Machell stated that the treatment must vary according to the cause and according to the individual peculiarities in the constitutions with which we have to deal. Dr. Cane considers that the amenorrhœa causes a good many cases of insanity. In all such cases, if taken early enough, treatment is successful, and they recover their mental condition.

Dr. Macdonald, in reply, emphasised the statement that the constant current proves of considerable benefit in cases of superinvolution.

Dr. N. A. Powell narrated the following cases of

HEMIPLEGIA DURING THE PUERPERIUM.

Case 1. Woman, æt. 27, in her third confinement; labor was tedious, but normal, and she made a fair recovery. The only thing noted was a rapid pulse, 120 per minute; there was no apparent cause, the temperature was normal. Fourteen or fifteen days after she had right hemiplegia she became comatose, and died in twenty-four hours after the onset of the attack. The heart had been examined, but with negative results.

Case 2. Woman, attended by Dr. Harvie, a former pupil of Dr. Powell's. She was all right for two weeks after labor, when she became aphasic, then right hemiplegia. Examination of the heart revealed nothing abnormal; she died soon after the onset of the attack.

The question is, does the puerperal condition stand in causative relation, or is it a mere coincidence? The straining and excitement during labor might lead to the laceration of a cerebral vessel. The evidence, however, seems to show that the rupture of a vessel does not occur, but rather plugging of a vessel by an embolism. The

age of a woman during the child-bearing period would militate against rupture. Some cases recorded are merely aphasia, others hemiplegic. Flint ridicules the idea of administering any kind of drug with the purpose of affecting the clot in the vessel. Richardson, however, advised the administration of ammonia with the object of causing an absorption of the clot. These cases do not seem to be connected in any way with rheumatism.

Dr. Graham has seen hemiplegic patients who dated their hemiplegia from a confinement.

Dr. Cotton exhibited a patient, a man, suffering from

EPITHELIOMA OF THE TONGUE.

There was an enlarged gland under the jaw for two weeks. Dr. Cotton has been using electrolysis; the tumor has diminished one-fourth, and is more circumscribed.

Correspondence.

ASEPTIC BONE-FILLING.

Editor of THE CANADIAN PRACTITIONER:

SIR,—In your last issue I notice a report of a case presented by me at the recent meeting of the Ontario Medical Association. The President having inadvertently declared an adjournment before I had an opportunity of closing the discussion, I would ask you to allow me to make a few remarks.

The advantage derived from the bone-filling in this case was that the cavity filled with new bone in four months (plus one week) instead of taking a very much longer period. The whole of the lower end of the tibia, down to the cartilage, was removed, and the cavity, about $1\frac{1}{2}$ inches deep, extended up to the upper fourth. The period which would be required to fill up so large a cavity was estimated by Dr. Senn as from seven to twelve months, if the aseptic filling had not been used.

I cannot agree with the statement that the trephine is now, or that it should be, "an obsolete instrument." In this case I found it more expeditious and neater, with a very long cavity detected by the probe and an involucre nearly three-quarters of an inch thick, to make two trephine openings and saw from the one to the other, instead of chiselling the whole length

of dense, thick bone. Of course the chisel and gouges were also freely used, as also was the sharp spoon for thoroughly scraping the cavity. The latter was rendered thoroughly aseptic; and owing to this and the antiseptic filling, the discharge which subsequently occurred remained inoffensive; and it was not until after the sloughing of integument that the discharge became purulent. The precaution referred to by Dr. Senn, of drawing the edges of the periosteum together, was of course attended to; and the "partial failure"—not getting union by the first intention—was due, as he surmised, to destruction of integument.

It might be worth while to correct a slight inaccuracy which has crept into the history. The patient came down immediately after the injury suffering from severe sprain and much pain. Periostitis, with suppuration, supervened, the first incision being made within a week of the time of the injury, and the bone necrosis manifesting itself within two or three weeks.

The advantages of obtaining, by the method described, an aseptic and antiseptic stage-work to support the subsequent work of repair are so apparent that I thought it desirable to bring the subject more prominently before the attention of members of the Association.

Yours, etc.,

WM. OLDRIGHT.

Reviews.

Medical Symbolism. By T. S. Sozinsky, M.D. Philadelphia: F. A. Davis, Publisher.

Like an oasis in a dry and dusty desert of medical literature, through which we wearily stagger, is this work devoted to medical symbolism and mythology. As the author aptly quotes, "What some light braines may esteem as foolish toys, deeper judgments can and will value as sound and serious matter."

Fever; its Pathology and Treatment. By H. A. Hare, M.D., Demonstrator of Therapeutics in the University of Pennsylvania. Philadelphia: F. A. Davis, Publisher.

This is an essay which was awarded the Boylston prize of Harvard University in 1890. It is valuable chiefly as a contribution to our knowledge of the action of coal-tar products on pyrexia.

Pamphlets and Reprints.

Seventeenth Annual Report of the Secretary of the State Board of Health of the State of Michigan, 1890.

Time Reckoning for the Twentieth Century. By Sanford Fleming, LL.D. From the Smithsonian Report for 1886. Washington, 1889.

Sitzungsberichte und Abhandlungen der Naturwissenschaftlichen Gesellschaft Isis in Dresden, 1891.

Causation of Influenza. By H. B. Baker, M.D., Secretary of the State Board of Health of Michigan.

Personal.

SIR JOSEPH LISTER recently lost \$90,000 through the failure of a London broker to whom he gave his money for investment.

DR. J. C. SMITH (For '91) has entered into partnership with Dr. A. R. Harvie, of Orillia.

DR. C. B. LANGFORD, of Blenheim, has entered into partnership with Dr. Samson of the same place.

Therapeutic Notes.

APPLICATION FOR DIPHTHERIA.—According to *L'Union Médicale*, Simon recommends the following application in cases of diphtheria:

R.—Salicylic acid . . . 7 to 14 grains.
Alcohol, a sufficient quantity to dissolve acid.
Glycerin 1½ ounces.
Infusion of eucalyptus 2 ounces.

A small piece of absorbent cotton is to be wet with this mixture and applied to the throat and false membranes. The application may be made every three to eight hours during the day, and once or twice during the night. If the false membranes are very adherent, they may be touched up two to four times a day by a solution composed of perchloride of iron and glycerin, of each three drachms. It may also be ad-

visible to irrigate the nostrils and throat with boric acid solution in the strength of four per cent. Internally, he advises the administration of tincture of chloride of iron, in the dose of ten to twenty drops every twenty-four hours, according to the age of the patient. One drop may be given each hour in a little wine or broth.—*Med. News.*

SUMMER DISTURBANCES OF CHILDREN.—In fermentative disorders of the alimentary canal in the young, middle-aged, or old, Listerine has given most satisfactory results. In the summer diarrhoea of children, Dr. I. N. Love, of St. Louis, speaks very highly of it, given in combination with glycerine and simple syrup. A formula that I have time and again used—in fact, it has almost become routine with me of late years—is as follows:

℞. Bismuth Sub. Nit. . . . half a drachm.
Tr. Opii. twenty drops.
Syr. Ipecac.
Syr. Rhei Arom. . . . aa two drachms.
Listerine half an ounce.
Mist. Creta one ounce.

M. Sig.—Teaspoonful as often as necessary, but not more frequently than every three or four hours. This for children about ten or twelve months old.—D. J. ROBERTS, M. D., in the *Southern Practitioner.*

[NOTE.—“Listerine contains the antiseptic constituents of thyme, eucalyptus, baptisia, gaultheria, and mentha arvensis, with two grains of benzo-boracic acid in each drachm.”]

FOR HAY ASTHMA.—

℞.—Cocainæ hydrochlor. . . 1½ drachms.
Glycerini 3 fl. drachms.
Aquæ destil. 5 “

Sig.: At the outset of the attack make two applications, with an interval of five minutes, by means of a brush, to the accessible nasal mucous membrane.

℞.—Cocainæ hydrochlor. . . ½ drachm.
Benzoini, pulv. 1½ drachms.
Sacchari, pulv. ½ drachm.

Sig.: Use as a snuff.—*L'Union Méd.—Med. News.*

SOLUTION FOR THE REMOVAL OF FRECKLES:

℞.—Chloride of ammonium . . 1 drachm.
Hydrochloric acid 1 “
Glycerin 1 ounce.
Fresh milk 2 ounces.

Dissolve, and apply night and morning to the part of the skin which is affected.—*Med. News.*

FOR HERPES GENITALIA (Besnier).—

℞.—Acidi tannici ½ drachm.
Bismuthi subnitratis . . . 6 grains.
Pulvis amyli 12 drachms.

Sig.: Dust locally the region the seat of the herpes, after washing with diluted carbolized water. If ulceration exists, astringent dressings should be used. If the skin is dry, inunctions of vaseline should be used.—*L'Union Méd.—Med. News.*

Miscellaneous.

CHICAGO PASTEUR INSTITUTE FOR THE PREVENTIVE TREATMENT OF HYDROPHOBIA.—Since the opening of the Chicago Pasteur Institute in the Rush Medical College Building (July 2, 1890), fifty-five persons have received treatment. Thirty-one came from Illinois, ten from Iowa, four from Indiana, two from Ohio, two from Minnesota, one from Missouri, one from Tennessee, two from Kentucky, one from South Dakota, one from Arizona. Thirty-six were male and nineteen female. The youngest patient was two and a half years old and the oldest fifty-six. Fifty-one were bitten by dogs, three by cats, and one by a skunk. Thirty-one persons were bitten in the hands and arms, three in the face, and twenty in the body and legs. Twenty-four had their wounds cauterized with chemical agents, and thirty one had not. Thirty-three persons were bitten by animals recognized and ascertained of being rabid, by experiments made upon rabbits, by the death of persons and other animals bitten by the same, or by symptoms shown during life; and twenty-two persons were bitten by animals strongly suspected of being rabid. All these treated are said to have been cured.