

Technical and Bibliographic Notes / Notes techniques et bibliographiques

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

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

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

Continuous pagination.

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

The Canada Medical Record.

Vol. XX.

MONTREAL, JUNE, 1892.

No. 9.

CONTENTS.

ORIGINAL COMMUNICATIONS.		Chewing Gum as the Nucleus of a Vesical Calculus..... 496	Electrostatic Treatment of Strangury. 501
Arterio-Sclerosis..... 481		Fatal Suppuration of Ovary during Measles..... 496	Dermatol..... 501
Valedictory Address..... 487		Inequality of Pupils in Epileptics... 496	Petroleum in Diphtheria..... 504
Annual Meeting of the Ontario Medical Association..... 489		Treatment of Abscess of the Liver... 496	Labor Complicated by Cicatricial Atresia Vaginae..... 501
PROGRESS OF SCIENCE.		The Eye Symptoms of Brain Disease. 497	Neuritis and Poliomyelitis from Dys- toccia..... 501
Hypertrophic Cirrhosis of the Liver.. 492		Linear Craniotomy..... 497	
Tetany of Gastric Origin..... 492		Stitch-Abscesses in Ovariectomy..... 497	EDITORIAL.
Basedow's Disease..... 493		Treatment of Lupus by Excision..... 497	A Coroner's Physician..... 502
Pulmonary Tuberculosis..... 493		Antikamnia in Headache..... 498	Province of Quebec Medical Associa- tion..... 503
Paralysis of the Brachial Musculo- Cutaneous Nerve..... 493		Disturbed Equilibration in Tumors of the Frontal Lobe..... 498	
Cerebral Syphilis..... 494		Fatal Hæmoptysis in a Child..... 498	
Illumination of the Stomach..... 494		Leukæmia..... 498	
Caloric Epilepsy..... 494		Adeno-Gyposis..... 499	
Restoration of the Osseous Border of the Orbit..... 495		Angio-Neurotic Œdema..... 499	
Rephining the Frontal Sinus..... 495		Intubation..... 499	Personals..... 504
Resection of Sternum..... 495		Primary Fibro-Sarcoma of the Nasal Fossæ..... 500	
		Solanine in Painful Diseases of the Stomach..... 500	Book Notices .. 504
			Announcement..... 504

Original Communications

ARTERIO-SCLEROSIS.

By G. T. ROSS, M.D., *Professor of Physiology in Bishop's College, Montreal.**

On the 24th of last month I was called at 1.30 a.m. to see Mr. A. B., a wholesale merchant of this city, who was taken suddenly ill. When I reached his house, fifteen or twenty minutes later, he was dead, and I received the following history: He had attended to business as usual that day, but feeling some indefinite pains in his chest, had called upon an M.D. on the way home, who prescribed a nerve tonic, not noticing anything serious in the superficial examination made at the time. The same evening he had enjoyed more than ordinarily the company of friends and relatives, retiring, in apparent good health, at 1 a.m. Some twenty-five minutes later, his brother in the next room

was attracted by a peculiar noise, and on entering found a dying man. Breathing ceased within two or three minutes from the time he was thus discovered. A month and a half before this occurred he was laid up with what was called Grippe, while visiting London, Ont. He never recovered his usual spirits after this attack, but told his wife frequently that he felt as if death were impending. His temper became irritable, and a marked loss in weight was noticeable after the sickness mentioned. His depressed state of mind was not seriously regarded, as his disposition naturally was to exaggerate any illness he might have. Notwithstanding his wife's persuasion, he refused to consult an M.D. until the day he died.

With the exception of two or three days sickness in January last, from which he fully recovered, his record of health seemed remarkably good for many years past. No specific history could be elicited, but about ten years ago he was said to have used alcohol excessively for a time. The chronic illness of a brother to whom he

* Read before the Medico-Chirurgical Society of Montreal, May 13, 1892.

was attached, who had frequent attacks of hemorrhage during the past thirteen or fourteen years, gave him great anxiety at times. This, in addition to business cares and worries, to which he had been subjected, more or less, were the only factors which could be made out as bearing on the case. He was a man of powerful build, medium height, and forty years old. In closely questioning his wife, she said she had sometimes noticed a dark red discoloration of his ears, finger nails and back of neck, but it always passed off.

REPORT OF AUTOPSY.

Autopsy, April 24, 1892, twelve hours after death. Body well nourished and muscular. Rigor mortis well marked. A considerable amount of yellow fat in subcutaneous tissues and omentum. The fat is increased to a moderate extent on the surface of the heart. The organ is of normal size. The right side contains a considerable amount of dark colored fluid blood; the left, a small quantity only. A small dense fibroid patch is present on the ventricular septum just below the aortic valve. This patch is irregular in outline, about half an inch in diameter, and extends irregularly into the wall of the septum to about half its depth. The mitral valve presents slight fibroid thickening on its auricular aspect, and there are a couple of small yellow plaques on the anterior cusp. The orifice of the left coronary artery is slightly narrowed, and on dissection both coronary arteries are thickened and their lumens narrowed by numerous yellow plaques throughout their whole extent. The branch running in the anterior inter-ventricular groove is almost obliterated near its origin, and just below the fibroid patch already referred to. The arch and descending aorta present a number of small yellow raised plaques, and these extend into the great branches of the arch and to the iliac

arteries. The weight of the heart is 260 grams.

The left pleural cavity is obliterated by organized adhesions, which are readily broken down. Both lungs are hyperæmic and œdematous. The abdominal organs are normal. (The left testicle is considerably smaller and the right rather larger than normal.) The brain was not examined.

Microscopically the fibroid patch in the heart is mostly composed of a granular looking structureless tissue, with a small quantity of fibrous tissue, but no small round cells. The arterioles of the liver and kidney are normal. The renal artery showed distinct endarteritis.

Atheroma, arterio-sclerosis, or endarteritis deformans was first conceived as an independent affection by Messrs. Gull and Sutton.

Atheroma, a term meaning pap or pulp, is described as a variety of fatty degeneration, affecting especially the large arteries and valves of the heart. The disease is important as leading to certain grave accidents and lesions pertaining to the parts affected. It consists primarily of a deposit beneath the lining membrane of the arteries, or the endocardium investing the valves of the heart, of a substance which presents a yellowish or whitish color and is of a cheesy consistence. Microscopically it is composed of fatty granules, with crystals of cholesterol in abundance and certain earthy ingredients (Flint). The disease presents three tolerably well defined stages: (Little) (a) In the first stage we notice, when the vessel is slit open, greyish patches by which the membrane is irregularly thickened; these patches seem to lie on the surface of the membrane, but this is deceptive, the endothelium lies between them and the blood stream, and is, at least at the beginning of the morbid process, unaffected. The material of which the

patches are formed is really situated between the tunica intima and the tunica media; it is semi-cartilaginous in consistence, and is formed by an abnormally rapid multiplication of the deeper cells of the intima, the new growth pushing up this tunic with its super-imposed endothelium, and so causing a bulging into the interior of the vessel. The process is of the nature of an inflammatory change—that is, it consists in the proliferation of cellular elements, in consequence of some influence which has excited them to unnatural growth. (b) In the second stage, the cellular elements of which the new growth is composed, undergo a process of fatty degeneration; and in consequence it becomes yellowish in color and pasty in consistence; this pasty appearance caused the name atheroma to be originally given to the disease. It not infrequently happens that the whole of the internal coat with its endothelium is involved in the softening, and gives way under the pressure of the blood, leaving an excavation, the so-called atheromatous ulcer, the floor of which is formed by the media and adventitia. (c) In other instances, the pasty mass, instead of being washed away, becomes the seat of calcific deposit; this being the so-called third stage of the process. The appearance of a vessel in which atheromatous disease has reached this stage is very striking; plaques which present to the naked eye the appearance of bone, but do not show its minute structure, are observed at intervals on the walls of the vessel, and their comparatively sharp spiculae project into the interior; in the aorta it is not uncommon to find such plates an inch long and half an inch broad, and in the smaller arteries the calcific deposit sometimes forms a ring round the vessel. In the latter the calcareous particles appeared to be deposited in the patch while it is still firm, so that the second stage of the process is wanting.

Some authors have divided cases of arterio-sclerosis into nodular, senile and diffuse forms. The macroscopic appearances of the nodular variety are quite characteristic. The aorta presents in the early stages, from the ring to bifurcation, numerous flat projections yellowish or yellowish white in color, hemispherical in outline, and situated particularly about the orifices of the branches. In the early stage these patches are scattered, and do not involve the entire intima. In more advanced grades the patches undergo atheromatous changes. The material constituting the patch softens and breaks up into granular material consisting of molecular debris. Here the primary alteration consists in a local infiltration in the media and adventitia, chiefly about the vasa vasorum, the affection being really a mesarteritis and a periarteritis. These changes lead to weakening of the wall in the affected area, at which spot the proliferative changes commence in the intima, particularly in the subendothelial structures with gradual thickening and the formation of an atheromatous patch of nodular arterio-sclerosis. The researches of Thoma show that this is really a compensatory process, and that before its degeneration the nodular patch, which post-mortem projects beyond the lumen, during life fills up and obliterates what would otherwise be a depression of the wall in consequence of the weakening of the media. This condition is one which may lead to dilatation or aneurism in the early stage before the weakened spot is thickened by the internal changes. In the second of this division, viz., *Senile Arterio-Sclerosis*, the larger arteries are dilated and tortuous, the walls thin but stiff, and often converted into rigid tubes. The subendothelial tissue undergoes degeneration, and in spots breaks down, forming the atheromatous abscesses. The greater portion of the intima may be occupied by

rough calcareous plates. The heart may not be enlarged. In the third form, viz., *Diffuse Arterio-Sclerosis*, the process is widespread in the aorta and branches, and may be associated with the nodular form. The subjects of this variety are usually middle-aged men, say forty to forty-five years; but it may occur early.

The affection is very prevalent among negroes. It is met with in strongly built, muscular men, and they rarely present on the autopsy table signs of general oedema; or if this exists, it has come on during the last few days of life. In this group the heart shows the most important changes, the weight being increased. Fibrous myocarditis is often present, particularly when the coronary arteries are involved.

The cause of this disease is now generally conceded to be overstrain of the vessels. The onset of arterio-sclerosis depends (Osler) in the first place upon the quality of arterial tissue which the individual has inherited, and secondly upon the wear and tear to which he has subjected this tissue. That the former is the more important is shown in cases where the disease occurs in early life where none of the recognized causes have existed. For example, a man of about thirty years may have arteries of sixty years, and a man of forty years may have arteries as much degenerated as they should be at eighty years, and this was found in the case which I bring before your attention to-night.

Entire families sometimes show this tendency to early arterio-sclerosis, a tendency which cannot be explained in any other way than that in the make-up of the machine bad material was used for the tubing. More commonly this disease results from the bad use of good vessels, and among the causes of this condition are the following:—

1. Chronic intoxications (not clear).
2. Over-eating (over-filling vessels, as fat people having no exercise).

3. Over-work of the muscles (raising blood pressure).

4. Renal disease (secondary or primary, not sure).

5. A cachectic state of the system, or some cause that alters the constitution of the blood and weakens the heart's action, such as prostrating illness and the mental conditions of anxiety and grief.

The dangers to which atheromatous arteries expose the person in whom they exist are varied. The stream of blood is retarded by the projection of the new growth into the vessel, and still more by the destruction of the elasticity of its coats; and hence ensues a failure in the nutrition of the organ which depends for its supply on the diseased vessel—this is said to be a cause of cerebral softening. When the paste-like mass is washed away, it sometimes happens that the blood insinuates itself between the coats of the vessel, producing a dissecting aneurism; or the portion of the vessel which has been weakened by the removal of the internal coat yields to the pressure of the current, and a sacculated aneurism is originated; sometimes the diseased vessel bursts. Cerebral vessels, probably on account of the thinness of their walls, are especially liable to rupture when they are the seat of atheromatous change, and occasionally a diseased coronary artery has given way, filling the pericardium with blood. Arteries have been completely occluded by fibrin on the spiculated edges of calcareous plates, causing senile gangrene. Embolic plugging of distant vessels at times results from the detachment of such fibrinous clots and the washing away of atheromatous debris. Rigidity of the larger arteries from this disease is a frequent cause of hypertrophy of the left ventricle, on which increased work is imposed, owing to loss of elasticity in the vessels.

Osler says that in this disease many patients never come under observation

during life, but are seen for the first time on the post mortem table, having died suddenly from blocking of a coronary artery, cerebral hemorrhage or rupture of an aneurism. Among important symptoms of arterio-sclerosis are the following :

Hypertrophy of Heart.—In consequence of the peripheral resistance and increased work the left ventricle increases in size. The chamber may be little if at all dilated. The signs pathognomonic of arterio-sclerosis are: increased arterial tension, a palpable thickening of the arteries, hypertrophy of left ventricle and accentuation of the aortic second sound. For years the patient may maintain good health; there may be no renal signs, or perhaps transient albuminuria. The subsequent history will depend on the accidents which are so liable to happen, and may be cardiac, cerebral, renal, etc.

Increased arterial tension has been mentioned as an important sign. It may be difficult to estimate how much of the hardness and firmness is due to the tension of the blood within the vessel and how much to the thickening of the wall. If, for example, when the radial is compressed with the index finger, the vessel can be felt pulsating beyond the point of compression, its walls are sclerosed (Osler).

At the heart, the involvement of the coronary arteries may lead to some of the symptoms already referred to, viz., thrombosis with sudden death, fibroid degeneration, aneurism of the heart, rupture and angina pectoris. Angina is almost always associated with arterio-sclerosis. Dilatation ultimately following hypertrophy may give us dyspnoea, scanty urine and serous effusions. The existence of a loud blowing murmur at the apex may lead the M.D. erroneously to suppose the existing distress is due to chronic valvular disease, if he is seeing the patient for the first time.

The cerebral symptoms are important and varied. Transient hemiplegia, monoplegia,

or aphasia may occur in advanced arterio-sclerosis. Recovery may be perfect. It is not clearly known upon what these attacks depend. *Renal symptoms* are found in many cases. It is difficult to decide clinically whether the arterial or the renal disease has been primary.

Respiratory symptoms are often found, particularly bronchitis.

As to the treatment of this disease, it is mainly preventative, in avoiding those influences which act as causes of the disease, viz., indulgence in alcoholic beverages to the extent of bringing about a gouty state of the blood; excessive muscular efforts, particularly in constrained positions; postures which involve the long continued contraction of muscles surrounding arteries; and, as far as the brain and heart are concerned, all those states which favor overfullness of their respective arteries—*in the brain*, excessive mental application, deficient sleep, prolonged periods of sexual excitement (Little), grief, or prolonged anxiety; *in the heart*, efforts which involve holding the breath, causing distension of the right cavities and preventing free return of blood from their walls. This is what causes the life of the pearl diver to be a precarious and short one. Some of these men die from the effects of disturbed blood pressure in a few months, while deafness and incipient paralysis are commoner features. Could we prevent syphilis and the abuse of alcohol, could we ensure everybody against excessive bodily and mental strain, we should go far to obviate the necessity for trying to treat these arterial changes and their allies, concomitants and results, at least, until a late period of life. Plumbism is, according to English writers, another cause of a preventable kind.

The chief means of prevention is a strictly hygienic manner of life. Although there is reason to believe that arterio-sclerosis may be a matter of inheritance;

yet the tendency can be effectually combated or delayed by temperance and moderation in all things—food and drink, work and play—and by the cultivation of an equable temper. The arteries which are the favorite seat of syphilitic changes are those of the brain. As it is impossible to be sure whether a syphilitic arteritis has gone beyond the point up to which retrogression may take place, under the use of Pot. Iod. and Hydrg. the patient should be given the benefit of the doubt by full anti-syphilitic measures. Apart from syphilis, the treatment of this disease varies with the presence or absence of compensating cardiac hypertrophy. If this be present we should maintain it by careful regulation of the diet and exercise. The nutrition of the heart muscle is assisted by simple, nutritious, easily digested food, pure air, sufficient sleep, proper graduated exercise, bathing and careful clothing of the body, it being remembered that the kidneys are seldom perfectly sound in these cases. The retention of excrementitious products being believed to cause arterial tension, careful attention to kidneys and bowels is imperative. In general, atheroma, over-exertion, or sudden exertion must be avoided. In many cases there are no certain means of knowing the exact condition of the cerebral or coronary vessels, for these may be the seat of advanced disease, while the radials and temporals may appear healthy, while, on the other hand, autopsies have shown the reverse condition may exist. It is notorious that individuals whose peripheral arteries are calcareous to the last degree not infrequently enjoy a life of surprising length and comfort. Drug treatment is always of secondary importance, except in syphilis, when Pot. Iod. is given, improvement or iodism being the indications of dosage. No drug can materially influence endarteritis other than specific origin. Bartholow and some others claim that

salts of gold control the formation, cause absorption of connective tissue growth, and hence indicated in this disease. It is given in the form of double chloride of gold and sodium 1-20 to 1-10 gr. p. cib. In persistently high arterial tension, nitroglycerine (i.m. of 1 per cent. sol.) is indicated. This is put up in tablet triturates for convenience and accuracy. The nitrates relax unstripped muscle fibre remarkably. Diuretics, diaphoretics and purgatives are useful when indicated. If compensatory hypertrophy is failing, the treatment is quite different. Rest is imperative, except in obesity with fatty heart, when Oertels' treatment, carefully supervised, will be applicable. Alcohol may be useful for impaired appetite and digestive power, with the other many aids in this direction. If it be true that digitalis increases arterial tension while strophanthus does not, the latter is to be preferred in this class of cases; some authors maintain that this difference is, however, somewhat theoretical. If digitalis be useful, Balfour's suggestion to give it with an interval of twelve hours between every dose enables us to give the drug without the danger of accumulation. Sleep is of the utmost importance, and morphia is one of the best hypnotics, apart from its usefulness in angina. In cases of great tension in muscular subjects a striking relief is afforded by the abstraction of 15 to 20 ounces of blood.

This serious disease, affecting, as it does, the seat of life itself, demands from a practitioner the exercise of the utmost skill and mature judgment which a careful painstaking study of a given case enables him to apply. The elucidation of the many problems which arise in such cases has occupied the attention of the brightest intellects of the profession, and yet the insidious onset of the disease, giving no note of warning to the patient; the impossibility of procuring, after the

disease is recognized, precise and positive data regarding the condition of the internal organs primarily or secondarily affected; the impossibility of judging with certainty in some cases as to whether death is imminent or remote; and the utter unreliability of any known drug in simple arterio-sclerosis, leave much to be desired in the further explanation of what has long been a *terra incognita*.

VALEDICTORY ADDRESS

to the Graduating Class of the Medical Faculty of the University of Bishop's College, at the close of the

SESSION OF 1892,

By FRANK R. ENGLAND, M.D.,
Professor of Diseases of Children.

Mr. Vice-Chancellor, Ladies and Gentlemen, Gentlemen of the Graduating Class,—The honor of addressing you on behalf of the Faculty on this important and to you commemorable convocation day has fallen upon me.

The very name Convocation impresses all as being the students day; a day of rejoicing, when they have a right to lay aside text and note books, and receive their well-earned reward and the congratulations of their friends. As it is a recognized day of rejoicing, so has it been from time immemorial a time for the giving of advice by a Faculty through one of its members to a departing class of students. That this time-honored custom may be continued, I shall more particularly address my remarks to you, gentlemen of the graduating class; and in giving advice I will endeavor to be brief lest I bore you, for we must remember the hour belongs to them and not to us. And here at the very beginning of my remarks I wish to extend to you on behalf of the Faculty our congratulations on your success in passing your examinations so creditably as to be worthy of the degree of C.M.

M.D., of the University of Bishop's College. Gentlemen, your success to-day is no surprise to us, for we have watched you faithfully and with deep interest during the past four long years of your professional education. We have noticed the attention you have given to the various branches prescribed in our curriculum. We have followed you day after day through the wards of the different hospitals, and observed your constant and painstaking work in prying into the mysteries of disease. We have learned to have confidence in your ability, and realize that your knowledge of medicine and surgery did not spring up in a night, to fall from your minds a few days after your examinations are over. During the long four years now at an end which you have passed with us, the responsibility of giving you a solid grounding of principles and a practical knowledge of medicine and surgery has been upon your professors. To-day when the parchment certificate entitling you to dispense and treat the many ills that affect the human race is conferred upon you, our responsibility ends and yours begins. We therefore in the same breath bid you farewell as students and welcome as practitioners. The Medical Faculty of the U. B. C., like most young schools, has had her struggles and difficulties from her very beginning; at times her classes have been small and her future not very encouraging, nevertheless those actively engaged on her teaching staff have always been hopeful, and determined to give the young men under their care, however few in number, a thorough and practical training, not only to discharge their duty to them, but in the full belief, that if they sent out men well instructed and equipped for the practice of their profession, their *successes* would certainly reflect credit on their Alma Mater, and improve her position. The size of our classes this session proves the wisdom of

making *thoroughness* our motto. Yes, gentlemen, you are to be congratulated on your attainments, and no institution can feel more pride in her graduating class than exists here in these exercises to-day. But where, and how, and at what, are you to use the knowledge which you have acquired? Remember there is no standing still for a scientific medical man. Day by day you are growing larger or smaller. Day by day you will develop or degenerate, and you alone have the shaping and building up of your character and personality. From this very hour you start upon a new life, and I trust you will consecrate yourselves wholly to it, for the privileges and responsibilities to which you are introduced are not found in any other profession. That you are a properly qualified physician is a passport into the first society of any community, for the profession which you have chosen is the grandest and most noble calling to which the energies of man can be devoted. It has from the earliest age numbered among its ranks men whose characters were models of perfection. Call to mind from that noble army of investigators who have placed medicine upon a truly scientific basis such names as Virchow, Koch, Pasteur, and Lister, and endeavor to realize the honor we have a right to feel in being associated however humbly with such giants among men. The relationship which a physician bears to the public is a peculiar one. He is many times made the confidante of his patients, and appealed to for advice when they are in trouble of whatever nature. He must be the friend of all, acting always in the cause of justice, studying to injure or favor none. To keep securely professional secrets, and whenever possible to aid in settling difficulties among his fellow-men is his bounden duty. The highest duty the modern physician has to perform is the relief of human suffering and the prevention of disease. It devolves upon

him not only to administer a medicine or an antidote, but he should be a sanitarian and an instructor of the people in the laws of health. The masses should be instructed in the dictates of Nature, and taught to obey her demands, that health may be secured, and when the cycle of life is completed, death rendered as free from dread and pain as is one's birth. This purely painless process of natural physical death is the true Euthanasia. If we are to make progress in bringing about this happy state, we must look far into the recesses of nature and expose to view the hidden secrets. Hygiene or the science of the prevention of disease come to us at this time with fair promises to accomplish much in the prevention of contagious diseases which we now know through the faithful labors of the bacteriologist to be due to micro-organisms developing within us producing disturbances.

It is through a knowledge of these germs and how to combat them by antiseptics that surgery holds its present proud position in medicine. As surgery has recently made such grand achievements, so other departments of medicine are daily making progress, and much remains to be accomplished. I need but direct you to the mysterious field of electricity, where there is certainly much remaining to be discovered and employed in the interest of humanity. For how many *empirics* are there to-day making use of this important therapeutic agent to one apostle? It remains with you, gentlemen, to be among those to bring about these advances, thus becoming true benefactors of humanity, elevating yourselves, and throwing lustre upon your Alma Mater.

That you may be successful physicians in the true sense of the word, I would warn you against *making* money the main object of your life. To the medical man the love of money is the root of all evil. Cling to the thought that medicine is not

a trade, but the noblest profession, and practice your calling for the relief of poor human suffering, and in the pursuit of science for its own sake and not from any lower view, and you will be sustained. Make it a rule of your life to be punctual at all professional engagements, and let order about your work be one of your characteristics. As you are thus just to yourself be careful to be just to others, especially to your confrères. The golden rule is the true code of ethics. If you respect the rights of others yours will be respected, and you have nothing to fear if your health is given you and you maintain your honor and industry. In conclusion, gentlemen of the graduating class, I bid you, in the name of the Faculty, with every wish for your health, happiness and prosperity, farewell.

ANNUAL MEETING OF THE ONTARIO MEDICAL ASSOCIATION.

BY OUR OWN CORRESPONDENT.

The twelfth annual meeting of this Association was held in the Hall of the Education Department, at Toronto, on the 1st and 2nd of June, under the presidency of Dr. Richard A. Reeves, the celebrated ophthalmologist. The first vice-president was Dr. F. Le M. Grasset, of Toronto; second vice-president, Dr. A. Groves, of Fergus; third vice-president, Dr. H. J. Saunders, of Kingston; and fourth vice-president, Dr. G. T. McKeough, of Chatham. A good deal of the success of the meeting was due to the untiring efforts of Dr. Z. Gibb Wishart, a rising oculist of Toronto. During the two days of the meeting an immense amount of work was done in the way of reading and discussing papers. Dr. Reeves made an excellent president, saving a great deal of time that is usually lost at these meetings by his punctuality in opening the sessions and his promptness in conducting them. There was consequently no dragging in the proceedings. Each reader of a paper was followed by three gentlemen who had been notified beforehand to discuss it, so that anything omitted by the reader of the paper was supplied by those who discussed it. The meeting opened with a general session, at which there were present over two hundred members and guests, the latter including Dr. Birkett

and Dr. Laphorn Smith, of Montreal, and Dr. Marcy, of Boston, who was on his way to the American Medical Association at Detroit, of which he is the president. The visitors were made heartily welcome, not only at the meetings, but also at many of the private houses of the Toronto profession. After the reading of minutes and reports of committees on papers, business and arrangements, and the reception of guests and delegates, there was read a most masterly and interesting paper by Dr. A. Wright, of Toronto, on "The third stage of labor," in which he recommended his hearers not to be in too great a hurry in extracting the placenta, but, on the other hand, never to leave the patient until it had been removed. In his experience it generally came away of itself in fifteen minutes; but if it did not, the hand might be kept on the fundus with a firm but gentle pressure for even an hour longer, after which time it might be considered an adherent placenta, and the hand introduced with due aseptic precaution into the uterus to remove it. He thought the hand was introduced too often when a little patience would enable the accoucheur to avoid doing so. He was opposed to giving ergot, because he thought it caused spasmodic contractions of the uterus. Neither was he in favor of the routine employment of douches, as they were not altogether without risk of introducing infection into the uterus, and even of separating lacerations of the cervix which would otherwise have healed. He was not in favor of removing clots by the hand. If there was a rise of temperature or chill he then used bichloride of mercury injections—1-4000. He was followed by Dr. H. S. Griffin, of Hamilton, who recommended removing the placenta as soon as possible and clearing out clots with the hand carefully cleaned. He was in favor of douching the vagina with weak bichloride solution. Dr. J. M. Cotton and Dr. N. W. Meldrum also agreed with the reader of the paper.

Dr. Laphorn Smith was called upon to make some remarks, which he did to the effect that he agreed with the reader of the paper in every respect. He thought that we were often a little too much in a hurry about removing the placenta, and that, consequently, there were frequently cases of *post partum* hemorrhage and even inversion of the uterus. For if the placenta is pulled out instead of being expelled by uterine contractions, a non contracting uterus, such as we have after the administration of chloroform, is left with its sinuses unprotected and unclosed, the result being a terrific *post partum* hemorrhage. In nearly every *post partum* hemorrhage he had heard of in the practice of others, the placenta had been removed forcibly by introducing the hand. He had never had a case of *post partum* hemorrhage in his fourteen years practice, and he attributed

his good fortune to his generally leaving the placenta until it was forced out by uterine contraction, or could be squeezed out with the hand on the fundus by Credé's method. But this latter must be done with gentleness, as cases of death, supposed to be due to septic metritis, had occurred in which the real trouble had been found to be general peritonitis, due to the rupture of a pus-tube or ovarian abscess, owing to violent squeezing of the uterus and appendages. He thought that leaving the placenta for a few hours was utterly devoid of danger, although it would be considered rank heresy to say so. Winkel in his book says distinctly that this is frequently done at the Munich Maternity without any bad effect, the placenta being almost always expelled by the unaided efforts of the uterus. He had frequently waited two or three hours, at the end of which time it was nearly always found lying in the vagina, and could be easily removed. He deprecated pulling hard upon the cord, as this led to irregular contractions of the uterus. Another reason why he had never had a case of *post partum* hemorrhage was because he always took care to have an ounce of the very best extract of ergot at every case. Whenever he used chloroform he was in the habit of giving one dram of ergot to counteract its relaxing effects. And in any case he generally gave a dram as soon as he was sure that there was no obstacle to the birth of the child, either at the cervix, or in the pelvis, or at the perineum. He employed douches of plain hot water for the first three or four days in every case, simply for cleaning purposes, because the patients told him that this afforded them so much comfort. He never used bichloride now, because he had seen several cases of severe poisoning from its use. As regards clots, he had always found that they would come away by allowing the woman to sit up on a chamber to pass water and motions, instead of keeping her on her back. The hand should not be introduced into the uterus unless both it and the vagina were first rendered perfectly aseptic. In closing the discussion, Dr. Wright differed from Dr. Smith as to leaving the placenta for so long as two or three hours. He was in favor of a pad and binder, as it afforded great comfort to the patient, and perhaps guarded against hemorrhage. He never used ergot until the placenta had been delivered, because he had found it in one case cause the uterus to grasp the child so firmly that delivery was retarded, and he was obliged to use the forceps.

The report of the committee on Necrology was then read, after which the session adjourned.

By the invitation of the Hospital Trust, the members of the Association were cordially invited to inspect the Victoria Hospital for sick children, of which many availed themselves at one o'clock.

At two o'clock the president, Dr. Richard A. Reeves, delivered his annual address, which was an interesting résumé of the year's progress, most of the points of which have already appeared in the RECORD.

The discussion on Medicine "Diphtheria" was opened with a paper by Dr. A. S. Fraser, of Sarnia, followed by Dr. W. Britton of Toronto, and Dr. T. S. Harrison of Selkirk, who proved an excellent speaker, giving the history of the pathology of the disease up to the present day. He showed that the disease was distinctly local, not going beyond the mucous membrane, and that the constitutional symptoms were due rather to the poisonous excreta of the bacilli being absorbed by the lymphatics. This poison was evidently a powerful depressant of the nervous system. The disease must be attacked locally and as early as possible. There were many different varieties of diphtheria bacillus, some causing mild attacks and others very severe attacks.

Dr. J. A. Williams, of Ingersoll, president of Ontario Medical Council, then delivered a splendid speech on "Recent Medical Legislation and its effects," in which he showed all the advantages which the medical profession in Ontario attained through the Medical Council. Among them were the following: 1st. The standard of the profession was being constantly raised, so that medical men were taking a higher and higher position in the estimation of the public.

2nd. The members entering the profession were at the same time restricted, so that the competition was much less than it would otherwise be. 3rd. Inspectors and detectives were employed to hunt down quacks and charlatans who would otherwise flourish in great numbers, to the great injury of the regular profession. 4th. An accurate register of all the practitioners in the province was kept with their addresses. Eventually, 5th, a building had been erected at a cost of seventy thousand dollars, which was now worth one hundred and twenty thousand, and which, while furnishing a habitation to the Council for holding examinations and keeping appliances for the same, was no expense to the members, the rent from a portion of it being sufficient to defray the interest on the whole building.

The receipts from this source would be sufficient to defray all the expenses, and then the profession would be relieved of even the trifling charge of two dollars a year. In the meantime, all must pay these two dollars who wished to practice, and all alike derived the benefits which the Medical Council afforded the profession of Ontario.

Anyone failing to pay before the first of January would have his name removed from the register, and would become an illegal practitioner, although he could at any time have it replaced simply by sending his arrears to the

Registrar. He explained that the Medical Library Association has no connection with the Council beyond renting a room from it. His remarks were listened to with great attention, although there was strong feeling among many against the Medical Council and the powers it had acquired by recent legislation.

Dr. Raikes of Midland read a paper on Puerperal Eclampsia, attributing the great frequency of the disease in his locality to the amount of lime in the water, an opinion, however, which was not generally shared. When the question of treatment came up, the general opinion was that premature delivery at the seventh month was the best, while bromide and chloral were found to be the best palliatives.

Dr. McCallum read a paper on chloroform inhalation, and Dr. Greig of Toronto one on disinfection after infectious disease. Dr. Z. T. Duncan read a paper on the nervous methods of treating whooping cough.

Dr. Wolfred read a very interesting account of a case of club foot which he had cured by operation. Dr. Z. Olmstead of Hamilton then followed with the report of a case of brain injuries, of which he also exhibits the case. The young man had a staggering gait and strabismus, there was also double optic neuritis. There was no history of syphilis. His diagnosis was a tumor of the cerebellum. Dr. Graham of Toronto agreed as to the diagnosis, although it was difficult to understand why a tumor so far back should cause inflammation of the optic nerve. He believed in iodide of potassium, although after a time it lost its effects. The next paper was by Dr. Groves of Fergus, Ont., entitled "The Dressing of the Wound after suprapubic cystotomy." A very interesting paper was one by Dr. A. B. Atherton, of Toronto, on "Suturing of The External Popliteal Nerve," of which he exhibited a case. A discussion on the present status of Antiseptics in Surgery was then opened by Dr. R. B. Nevitt, of Toronto, followed by Dr. J. K. Holmes, of Chatham, A. Powell, of Toronto, and Dr. Geo. A. Peters, of Toronto. The general opinion was that aseptics were more important than antiseptics, and wherever the steam sterilizer could be employed it was best to use it. Some of the speakers having complained that boiling steel instruments caused them to rust, it was shown that this could be prevented by the addition of a teaspoonful to the gallon of washing soda, or, equally well, by wrapping the instruments in a towel. As far as the hands were concerned, what is generally known as "Kelley's" method of blackening them in a saturated solution of permanganate of potash, and afterwards bleaching them in a saturated solution of oxalic acid, was recommended. As far as the patient was concerned, this was more difficult, as it had been shown that colonies of bacteria existed below the surface of the skin.

Another interesting point that came out in the discussion was, that it was not the bacteria themselves which did the mischief, but the ptomaines or albuminoses, excreted by the bacteria, and which were thrown out in an advancing circle, killing the tissues before them. It was on this killed tissue that the bacteria flourished. It was shown that microbe organisms of disease had no effect on healthy tissue; but when the vitality of the tissues was lowered by injury or by the destructive action of the excreta above mentioned, the phagocytic powers of the organism were lost.

A recent paper by Dr. Carr, of Washington, which appeared in last month's RECORD, goes into this subject very fully.

One of the greatest treats of the meeting was an address by the silver-tongued orator of Boston, Dr. Henry O. Marcey, on the anatomy and the surgical treatment of Hernia. He convinced his audience that the radical cure of inguinal-hernia was one of the surest operations in surgery, and could be done with almost no risk. He employed the buried kangaroo tendon, which owes its adoption so largely to his persuasive advocacy of it.

Another very pleasant feature of the first evening's session was a magic lantern demonstration of bacteria by Drs. R. Spencer and W. R. Shaw, of Toronto. The next morning's session was taken up with a symposium upon the pneumonias of children, including the diagnosis of lobar from lobular pneumonia, and of pneumonia from bronchitis, from Dr. Machell, of Toronto. The diagnosis of lobular pneumonia, acute and chronic, from tuberculosis, by Dr. G. M. Shaw of Hamilton; and the diagnosis of pneumonic consolidation from pleural effusion, by Dr. W. H. Henderson of Kingston; and the prognosis in pneumonias generally by Dr. Allan Baines, of Toronto. There was also a paper on the treatment of pneumonia by Dr. J. J. Brown of Owen Sound, and a case of acute suppurative pleurisy, by Dr. H. S. Clerke, of Lucan. Dr. Saunders of Kingston read a paper on Herpes, and Dr. C. K. Clark of Kingston reported two cases of lethargy. In the surgical section there was a paper by Dr. Sterling Ryerson on "Otic Cerebral Abscess," and one on Angina Ludovici by Dr. G. L. Mackelcan of Hamilton. This was followed by a symposium upon hip joint disease, in which the general opinion was that if there was pus it should be let out and the diseased surfaces curetted and disinfected, although some were in favor of an expectant treatment and others of mechanical treatment; those who were in favor of the latter advocated a splint which would allow the patient to go about. Dr. Meek of London read a paper on "Ventral Hernia," in which he advocated a flap splitting operation, similar to that employed by Lawson Tait in lacerated perineum. Dr. Dupuis of King-

ston reported a great many cases of cure of inguinal hernia by the methods somewhat similar to Dr. Marcey's, to whom he paid a high tribute of praise for his original work with the animal tendon.

Dr. A. B. Welford, of Woodstock, read an interesting paper on Hay Fever, which showed that the disease was due to a pollen, and the best way to avoid it was to go to a high altitude or on an ocean voyage. A curious point which he noted was that the disease stopped within twenty-four hours after the supply of pollen was cut off.

Dr. Jas. F. W. Ross, of Toronto, read a critical review based on clinical histories of hysterectomy without a pedicle, which gave rise to a sharp discussion by Drs. Marcey of Boston, Laphorn Smith of Montreal, and Atherton of Toronto. The general opinion was, that although the removal of the uterus entire was the ideal operation, yet the extra peritoneal treatment of the stump was the safer operation.

Dr. Ross reported the death of one of his patients some weeks after the operation, owing to an adhesion of a knuckle of intestine to the abdominal incision, which caused obstruction of the bowel. Dr. Laphorn Smith maintained that the advantages of fixing the stump to the lower angle of the womb were: first, giving support to the arch of the pelvic roof; second, if any hemorrhage occurred, it took place where it could be seen; third, there were no raw surfaces left to which the bowels could adhere; and fourth, there were no ligatures left in the peritoneum.

One of the most interesting and complete papers was one by Dr. J. C. Mitchell, of Enniskillen, Ont., on the "Therapeutics of Constipation," which called forth a lively discussion from Drs. McKinnon of Guelph, J. J. Farley of Belleville, Achison of Toronto, and Laphorn Smith of Montreal, the last named pointing out the importance of habit in treating this condition. He was very particular in insisting upon his patients having a regular hour and minute for going to stool. He thought that constipation was not only directly to blame for a great many diseases of women, but was also indirectly the cause of a great many more, by interfering with the circulation of the uterus.

The meeting on the whole was a most successful one.

The President entertained over a hundred guests at dinner on the first day, and the profession of Toronto entertained the whole Association to lunch on the second day. In addition to these, a great many of the individual members were invited to dine with their friends. But the social part of the meeting was entirely subordinated to the scientific, and promptly at the hour the members proceeded from refreshments to labor.

Take it altogether, the Ontario Medical Association is a credit to the Province, and cannot fail to be of the greatest benefit to the profession. The example of the Ontario physicians should be imitated by those of the sister Province of Quebec.

Progress of Science.

HYPERTROPHIC CIRRHOSIS OF THE LIVER.

MEREDITH (*Medical News*, January 2nd, 1892) says that some writers dispute the separate existence of this form of cirrhosis. The first stage of atrophic cirrhosis is also accompanied by hepatic enlargement, but in the hypertrophic form the enlargement is progressive up to the patient's death. The degree of portal obstruction, well marked in atrophic cirrhosis, is the chief distinguishing point, whereas in the other disease the jaundice is early, intense, and permanent. Owing to the deposit of fibrous tissue about the radicles of the portal vein in atrophic cirrhosis, the nutrition of the lobules is interfered with and the liver cells atrophy, but the interlobular bile ducts survive and carry off the bile. The cell destruction in hypertrophic cirrhosis is small, and the total amount of blood in the liver is not diminished. The bile, owing to the obstructed interlobular ducts, remains in the lobules until absorbed into the blood and deposited in the tissues. Thus the enlargement of the liver in hypertrophic cirrhosis as against the atrophic form is brought about by the increased connective tissue with diminished cell degeneration and a lessened diminution in the amount of blood in the organ, as also by the greater accumulation of bile in it. A typical case occurring in a woman, aged 69, is given in detail. The author says the early stages of the two diseases cannot be distinguished from each other, but in the hypertrophic form, as the enlargement progresses, a destructive train of symptoms is produced. The disease runs its course in from two to five years, terminating in asthenia, or not infrequently in the typhoid state, with convulsions due to the toxæmia.—*British Medical Journal*.

TETANY OF GASTRIC ORIGIN.

BOUVERET and DEVIC (*Rev. de Méd.*, February, 1892) give the details of 23 cases (including 3 of their own) in which tetany was associated with dyspepsia due to gastric hypersecretion. This hypersecretion is characterized by the following symptoms: Gastralgia occurring two to five hours after food, acid vomiting at the end of the attack, the relative preservation

of the appetite, the long duration of the disease, wasting resembling that of malignant disease, and dilatation of the stomach. This gastralgia and vomiting are not met with in atonic dilatation of the stomach with absence of hydrochloric acid. In 12 of these 23 cases there were ulcers or cicatrices present in the stomach. In one case hypersecretion, ulcer, and cancer were traced successively. It is now known that hypersecretion represents the ordinary pathogenic condition of ulcer of the stomach, and that gastric ulcer sometimes provokes cancer. In 3 cases there was duodenal ulcer. Three forms of tetany were noted: (1) contracture of the extremities, lasting for several hours, and recurring—this is the most common form; (2) a more or less generalized form (tetanismus) of grave import; and (3) a form with clonic as well as tonic convulsions resembling epilepsy. Only 3 of the 23 cases belonged here. The spasm is painful, and is often preceded and accompanied by vomiting. Dyspnoea is present if the tetany is generalized. The pupils are small, the temperature raised at times, and the intelligence disturbed. Tetany is a serious complication of gastric dilatation. In the 23 cases death was caused by it in 16. There are three theories to account for the disease: (1) dehydration of the blood illustrated by the cramps of cholera; (2) reflex irritation; and (3) intoxication due to the retention of the stomach contents. This latter is the most likely theory. Tetany is thus a complication of dilatation of the stomach, with permanent gastric hypersecretion.—*British Medical Journal*.

BASEDOW'S DISEASE.

MENDEL (*Deut. Med. Woch.*, February 4th, 1892) says that *post-mortem* investigation in cases of Basedow's disease has been at times negative, and at times of such doubtful significance as to be almost useless. He relates the case of a man, aged 48, who had a previous attack of the disease three years before, but recovered from all the subjective symptoms. On the second occasion, in addition to the usual symptoms, there was oedema of the legs and of one arm, and a blood-stained pleural effusion. He died of syncope. At the necropsy the brain and cord so far as examined were healthy to the naked eye. There was a considerable goitre of a white greyish red appearance, and lobulated structure on section. On both surfaces of the pericardium there was a fibrinous exudation. The cardiac valves were healthy. In the upper cervical ganglion there were some atrophied cells, but only such as may be found in animals and man not suffering from Basedow's disease, as White has also pointed out. The left restiform body was atrophied, and did not stain well with Weigert's method. On the right side the

solitary bundle was alone affected. The vagus nerves were healthy. Filehne, Durdufi, and Bienfait have succeeded by section or removal of the restiform bodies in producing the chief symptoms of exophthalmic goitre. There is no reason to suppose that any other part of the restiform body, other than the solitary bundle, could produce symptoms of this disease. The relation between the affection of the vagus and the atrophy of the solitary bundle can hardly be denied in view of the connection of this bundle with the vagus nucleus. The theories of this disease are: (1) that it is a neurosis, and (2) that it is due to a perverted function of the thyroid gland. Against the first view is the discovery of changes in the nervous system, and against the second the healthy condition of the gland tissue as in the case reported here.—*British Medical Journal*.

PULMONARY TUBERCULOSIS.

R. W. PHILIP (*Edin. Med. Journ.*, May, 1892) gives an analysis of 1,000 cases of pulmonary tuberculosis which have attended as out-patients,—64 per cent. were males, 36 females. The well-known influence of certain occupations in causing phthisis is well shown; most of the cases occurred between the ages of 20 and 30; the disease seems to be always slower in the male than in the female; there is no evidence that tall people are more liable to phthisis than short ones. The most important part of the paper is that which treats of contagion. Philip has obtained irrefutable evidence of this in 67 cases; in some the wife infected the husband, or *vice versa*, children infected parents, companions sleeping together infected each other, parents infected children, and brothers and sisters infected each other; 2.3 per cent. of the cases were instances of basal phthisis. The influence of influenza in determining phthisis was shown in 4.4 per cent. of the cases, and there was much evidence that many attacks of pleurisy supposed to be simple are really tuberculous. Alcoholism was traceable in 1.4 per cent. The larynx was affected in 10.5 per cent. Valvular affection of the heart was present in 2 per cent. Fistula *in ano* was present in 1 per cent., and they were all males. Of these cases that were observed for six months, 24.94 per cent. did well, 34.75 per cent. improved, 24.1 per cent. remained *in statu quo*, and 16.2 per cent. died.—*British Medical Journal*.

PARALYSIS OF THE BRACHIAL MUSCULO-CUTANEOUS NERVE.

WINDSCHEID describes (*Neurol. Centralbl.*, April 1st, 1892) the case of a man who noticed a sensation of numbness in his right thumb and part of the front of the forearm, with partial inability to bend the elbow a few hours

after carrying a heavy marble slab on his right shoulder, a sharp edge of the slab having pressed deeply into the supraclavicular fossa. At examination a fortnight later, the forearm could be voluntarily flexed, but, when bent, the biceps remained flaccid and uncontracted; numbness and formication were felt in the volar portion of the thumb and the radial side of the fore-arm; in the same regions analgesia was also complete, though contact impressions were fairly well perceived; there was no ordinary reaction of degeneration. Indirect faradic stimulation of the affected biceps elicited "Rumpf's traumatic reaction" very clearly. On cessation of the tetanising current a wave of short contractions appeared in the muscle. This phenomenon was discovered by Rumpf in cases of traumatic neurosis, and was considered by him to be an important objective indication of that affection. He observed it in various nerve territories besides that of the nerve primarily excited. In Windscheid's case it was limited to the biceps, and was not obtained on direct stimulation of the muscle. The sign, in Windscheid's opinion, has not the value accorded it by Rumpf; it partially resembles Ritter's opening tetanus. In the case above referred to it could only be regarded as an indication of increased excitability of the nerve below the injury. After three months treatment with electricity, the biceps contracted well, the sensory disorders were diminished, and Rumpf's reaction was less distinct.—*British Medical Journal*.

CEREBRAL SYPHILIS.

CNOFF (*Münch. med. Woch.*, March 15th 1892) relates the case of an infant 13 weeks old, which, in addition to the ordinary symptoms of intestinal catarrh and atrophy, had severe attacks of pain, during which the neck and back muscles became rigid. Eight days before death there were convulsions. At the necropsy there was a circumscribed greyish-red gelatinous mass in each corpus striatum. On the left side the centre was yellow and breaking down. The occipital lobes were sclerosed. There was external and internal hydrocephalus (*hydrops e vacuo*). There was no change in the vessels. The other organs were healthy. The author shows by statistics that cerebral syphilis in children is rare. He has only been able to find twelve recorded cases. In one half there was disease of the arteries and in one-half gummata. These gummata occurred mostly in the base of the frontal lobe, partly as yellowish centres of softening and partly as calcified masses. In one case the brain was atrophic and sclerosed. Only four of the twelve cases occurred under 1 year of age. Although the parents of the infant appeared quite healthy, it was ascertained

that the father had syphilis eight years previously, for which, however, he was thoroughly treated. Most of the twelve cases had external manifestations of syphilis as well as cerebral symptoms. Among the latter were noted nystagmus, dilatation of one pupil, diplopia, optic atrophy, swelling of the optic disc, choroiditis, loss of smell and hearing, hemiplegia, anæsthesia, paralysis of single nerves, mental symptoms, and fits. In the author's case there was no external evidence of syphilis, and no symptoms which could be put down exclusively to cerebral disease. The author then refers to the difficulty of diagnosing cerebral syphilis from other forms of cerebral disease, and yet the diagnosis is essential owing to the importance of early treatment.—*British Medical Journal*.

ILLUMINATION OF THE STOMACH.

RENVERS (*Münch. Med. Woch.*, April 12th, 1892) recently demonstrated to the Berlin Medical Society an apparatus which consists of a small Edison's lamp fixed to the end of a bougie, and covered by a small glass case filled with water. The electric current is obtained from a battery of twenty cells. If the stomach is full of food, illumination is impossible; but if it is quite full of water when the lamp is passed into the stomach, an illuminated area is seen, which corresponds exactly to the limits of the organ. The apparatus can only be used in the erect posture, when the greater curvature is usually seen a little below the level of the umbilicus. Abnormal dilatation of the stomach can be readily detected, and a case of carcinoma of the organ has been diagnosed by the use of the apparatus, the diagnosis being confirmed by *post-mortem* examination. The tumor appeared as a dark spot in the light field.—*British Medical Journal*.

CALORIC EPILEPSY.

BENEDIKT (*Intern. klin. Rundschau.*, No. 46, 1891) communicates the following case: A slim lad, aged 15, was seized with rigors. For eight days his temperature ranged from 39° to 41° C., headache was severe, and on one occasion he had brief loss of consciousness. He then appeared to recover. In a week or two, rigor, cephalalgia, and feverish sensation returned; the temperature quickly rose to 42.5°. This lasted about two hours; sudden crisis to 36° then followed, appetite returned, and the patient felt well. More or less similar attacks occurred once or several times daily, until the patient could tell with much precision what degree of pyrexia existed. Whenever the temperature reached 42.4° to 43° the patient lost consciousness, had a starting expression, and invariably murmured "Rauber

After careful cleansing of the exposed parts, including the antrum of Highmore, which had necessarily been opened, the soft tissues were replaced and carefully sutured. Union by first intention was obtained, and the patient recovered without any unpleasant symptoms.—*British Medical Journal*.

TREPHINING THE FRONTAL SINUS.

E. LAMPHEAR (*Kansas City Medical Index*, April, 1892) records the following case: A woman, aged 28, after having faced wind and rain for some hours, suffered from "cold in the head." This was followed by frontal headache, which resisted all treatment, and became steadily intensified till the pain was almost unbearable. Examination of the nose gave a negative result; the retina presented nothing abnormal beyond slight congestion. Signs of cerebral pressure beginning to show themselves, Lamphear made an incision along the eyebrow to the root of the nose, dissecting the tissues back sufficiently to allow the use of the gouge; he then opened the frontal sinus at a point $\frac{1}{4}$ inch above and internal to the inner angle of the orbit. As soon as the chisel penetrated the skull, pus poured out in considerable quantity. The opening was extended across to the right side, and about an ounce and a half of pus escaped. Exploration with the probe failed to detect necrosed bone. The sinuses were thoroughly washed out with a weak solution of bichloride of mercury, and afterwards with peroxide of hydrogen. A drainage tube was inserted, and the wound closed, iodoform being freely dusted on it, and a dressing of bichloride gauze applied. The pain ceased immediately after the operation, and in less than four weeks the patient was discharged in perfect health.—*British Medical Journal*.

RESTORATION OF THE OSSEOUS BORDER OF THE ORBIT.

GAYET (*Arch. d'Ophthal.*, April, 1892) describes an operation designed to remove the deformity resulting from destruction, by injury or disease, of the lower margin of the orbit. Such a measure is only necessary in the worst cases, for the relief of which none of the ordinary plastic operations are sufficient. His case was that of a man, aged 32, who had been struck by a block of wood on the left side of the face, four months previously. The deformity was very marked, the lower lid being everted and drawn downwards by cicatricial tissue adherent to the bone, with evident fracture and displacement of the lower orbital margin. Judging that no operation limited to the skin and subcutaneous tissues would remove the deformity, Gayet determined to endeavor to replace the bony border, and the following is a brief description of the operation, which is reported to have been most successful. The tissues of the cheek were dissected up in a crescentic flap, the incision reaching from the root of the nose to a point outside the external angular process of the frontal bone, and extending as low as the ala nasi. The flap being turned up on to the brow, and the periosteum carefully separated from the bone, the superior maxillary bone was drilled with a dentist's drill in a series of closely set holes extending in a crescent from a point just below the lachrymal tubercle to another close to the external angle of the orbit. The piece of bone between this line of drill holes and the floor of the orbit was then levered from its position, as shown in the drawings given by Gayet, and maintained in its new situation by small platinum rivets in shape like those used in repairing broken china. The detached piece of bone was raised from 12 to 14 millimetres.

RESECTION OF STERNUM.

YVERT (*Sem. Méd.*, May 4th, 1892) reports the case of a soldier, aged 21, who, in addition to general bronchitis, had cold abscesses in the wrist and foot, and one over the manubrium of the sternum. On opening the latter collection, the upper part of the sternum was found bare, carious, and covered with fungus. The body of the bone was displaced

CHEWING GUM AS THE NUCLEUS OF A VESICAL CALCULUS.

E. E. DORR (*Vis Medicatrix*, April, 1892) records the following case, which he believes to be unique: A man, aged 21, had a piece of chewing gum introduced into his urethra without his knowledge. The foreign substance worked its way into the bladder, and the patient soon began to feel pain in passing water and in moving about. About three months after the occurrence suprapubic lithotomy was performed; the stone was easily found, but gave way when the forceps were applied, and had to be removed with a teaspoon. It was fully $1\frac{1}{2}$ inches long and inch thick, and on dissection it was found to be mostly composed of gum, with a phosphate incrustation of about 1-16 inch in thickness. The man made a good recovery. Dorr points out that if he had used the lithotrite he would have found himself in serious trouble, as would have been impossible either to have crushed the gum, which was still soft and sticky, or to have disengaged the jaws of the instrument.—*British Medical Journal*.

FATAL SUPPURATION OF OVARY DURING MEASLES.

GALLIARD (*Sem. Méd.*, April 27th, 1892) records the following case: A virgin, aged 21, was attacked with measles, and free metrorrhagia occurred. On the 12th day severe pain in the right iliac region, with rise of temperature, occurred. Symptoms of general peritonitis developed, and the patient died on the 25th day. At the necropsy, peritonitis was discovered, and streptococci were found. The complication was traced to rupture of a small abscess of the right ovary. The tubes were thickened and dilated. The pus inside the ovary contained streptococcus pyogenes in abundance, but no staphylococci, gonococci, or bacilli. The uterus and left appendages were healthy. The ovarian lesion was evidently recent, and there was no vulvitis. Galliard insisted that the lesion represented a secondary infection occasioned by the measles. M. Chantemesse noted that in typhoid fever

FONTAN (*Rev. de Chir.*, February, 1892) holds that a simple incision is not always sufficient, even when very large, to effect a cure of hepatic abscess. Scraping of the walls of the abscess was advocated as a desirable addition to incision. The scraping, it was stated, should be done with a blunt curette, guided by the index finger passed into the interior of the abscess. Two cases were reported in support of the author's opinion that such treatment is not likely to cause any serious hæmorrhage, and that it favors rapid and complete cure. In the discussion, Pozzi, whilst granting that the method might enable the surgeon to discover and open a second abscess, said this advantage would not compensate for such probable dangers as hæmorrhage and opening of the biliary passage. Monod considered the method not only dangerous, but also useless. He quoted cases to show that incision followed by drainage would suffice to bring about a cure of the abscess. In one of these cases, however, the ultimate result was not satisfactory. After three unsuccessful exploratory punctures, a fourth made in the seventh intercostal space revealed the presence of pus in the liver. Monod, after moving a portion of rib, made a free incision to the abscess, and drained the cavity. The condition of the patient improved for a time; it subsequently the temperature rose, the diarrhoea became more profuse, and death took place six weeks after the operation. The original abscess, which had been incised and drained, was found at the necropsy to be quite closed; but there remained two other collections—one near the convex surface, the other near the inferior surface of the liver. The presence of one or more other purulent de-

posits is usually the cause of failure of incision in the treatment of hepatic abscess. Unfortunately, Monod states, it is very difficult to determine the presence of such multiple abscesses.—*British Medical Journal*.

THE EYE SYMPTOMS OF BRAIN DISEASE.

C. ZIMMERMANN, in briefly reviewing some of the ocular affections associated with cerebral disease (*Transactions of the Wisconsin State Med. Society*, 1891), refers to the remarkable integrity of sight that is found in some cases of papillitis. If vision be impaired in this affection the loss occurs rapidly or slowly, never suddenly, and the visual fields are restricted in no constant manner. Sudden blindness coming on in the course of optic neuritis indicates retro-ocular mischief. As to the mode by which papillitis is induced by intracranial disease, augmented pressure within the skull appears to be inoperative so long as no pathogenic matter is present in the cerebro-spinal fluid which is forced into the optic sheath. Deutschmann and Zellweger have verified this point in the case of animals experimented upon by them. The purulent irido-choroiditis occasionally seen in cerebro-spinal meningitis is an

its greatest width $\frac{3}{4}$ inch, and it tapered at both ends to a point. The corresponding portion of periosteum was cut away with scissors; the wound was irrigated with sublimate solution (1 in 3,000), dried with gauze, dusted with iodoform, and closed with interrupted silk sutures, which were placed $\frac{3}{4}$ inch apart posteriorly to allow drainage. Antiseptic precautions were very carefully observed. To diminish shock the child was given 5 drops of tincture of nux vomica and a drachm of whisky a quarter of an hour before the operation, and during it the head was wrapped in a towel wet with hot bichloride solution, and rested on a bag full of hot water. The operation, which lasted half an hour, was well borne. The temperature reached 100.2 the same evening, but then declined. The wound was first dressed a week later; it had united by first intention, and all the sutures were removed. It was thought that some improvement had taken place in the child's mental condition.—*British Medical Journal*.

STITCH-ABSCESSSES IN OVARIOTOMY.

BUCKMASTER (*New York Journ. of Gynec.*, January, 1892) says that it has been shown that stitch abscesses may occur even when the most scrupulous cleanliness is used. Sublimates do not convey absolute immunity; germs can pass through them. Creolin is a good substitute, but its solutions are opaque. Iodoform is a new agent; in solution it is not opaque. It closely resembles creolin in appearance, but does not possess so strong an odor. A very common source of stitch abscesses is the use of a dirty nail brush. A surgeon and his assistants too often clean their hands with brushes in general use in the operating theatre. Buckmaster advocates Gerster's principle of boiling brushes in a solution of potassium permanganate or potash, one drachm and a half to the pint.—*British Medical Journal*.

TREATMENT OF LUPUS BY EXCISION.

RAMER (*Centralbl. f. Chir.*, No. 8, 1892) states that the present methods of treating lupus by caustics and by scraping are very unsatisfactory, and advocates excision of the diseased portion of skin. This is removed with the knife together with the subcutaneous tissue as far down as the muscular layer. After an interval of about twelve days, when granulations have formed, the defect is closed either by transplantation after Thiersch's method, or by a plastic operation. The author states that he has carried out this treatment in several cases during the past two years, and it has invariably resulted in permanent healing at the seat of operation. Although this method is more applicable to cases in

which a portion of an extremity or of the trunk is affected, it may be practised with good results in many cases of lupus of the face. In this region excision should be performed as early as possible; and even if the wound be an extensive one the surgeon will be able to close it, thanks to the improved methods of transplantation, implantation, and plastic procedure. The scar thus formed, though more apparent than that produced after other methods of treatment, has the advantage of being quite sound, and free from any remains of the disease.—*British Medical Journal*.

ANTIKAMNIA IN HEADACHE.

In the section referring to Antikamnia, Dr. Johnson says: "Its action as an analgesic appears from the best evidence to be central, and I do not doubt that its antipyretic action is of a central character, thereby depressing heat production.

"I ordered 8 grain doses in a case of Cephalalgia, to be repeated at the end of three hours until four had been taken, with gratifying results. It causes no excitation and no depression of the vital forces, and is best administered in liquid form. It is without disagreeable taste."—T. M. JOHNSON, in *N.Y. Medical Record*, 6th June, 1891.

DISTURBED EQUILIBRATION IN TUMORS OF THE FRONTAL LOBE.

BRUNS (*Deut. Med. Woch.*, February 18th, 1892) says that the so-called cerebellar ataxy has not the local diagnostic significance which is usually attributed to it, and that tumors in the frontal lobes will also produce it. He relates four cases of tumors of this latter region in which there was marked ataxy, the diagnosis being confirmed by necropsy. This disturbance of co-ordination is not observed in cerebral tumors in other situations—that is, if they are not very extensive. Recently it has been stated that cerebellar tumors only produce ataxy by a direct or indirect lesion of the medulla oblongata, a view which the author does not accept. The diagnosis between tumors of the cerebellum and frontal lobe is generally quite possible. In the latter there is hemiplegia or monoplegia if the growth is placed near enough the central convolutions. The author lays stress upon the pain produced by percussion of the scalp over the tumor, which circumstance would also seem to signify that the tumor is near the periphery. In three out of four cases this tenderness corresponded exactly to the situation of the growth. Bruns also draws attention to the tympanic note which he, with others, has observed over the growth. Choked disc is especially frequent, and appears early in cerebellar tumor, but is often absent in frontal

tumor. Bruns refers to the resemblance sometimes noted in the changes seen in the fundus oculi in cerebral tumor and albuminuric retinitis. Psychological symptoms are frequently seen in tumors of the frontal lobe. The ataxy is indistinguishable in character in the two cases, and its earlier appearance in cerebral tumor is of small diagnostic value. The ataxy in frontal tumor may be: (1) a direct focal symptom—Wernicke has referred the inco-ordination to paralysis of the trunk muscles, the centre of which Munk places in the frontal lobe; or (2) not a direct focal symptom. This would be the case if the ataxy is looked upon as the effect of a sort of chronic *contre-coup*. The author concludes that the so-called cerebellar ataxy is very often present in tumors of the frontal region, but is rare in other cerebral tumors, and that the accompanying symptoms permit of a differential diagnosis being made.—*The British Medical Journal*.

FATAL HÆMOPTYSIS IN A CHILD.

JEANSELME (*Rev. des Malad. de l'Enfance*, February, 1892) has recorded another case of fatal hæmoptysis in a child, owing to ulceration from a cavity produced by destruction of an enlarged lymphatic gland.—*British Medical Journal*.

ADENO-GYPSOSIS.

ROBIN (*Bull. de l'Acad. de Méd.*, January 12th, 1892) says that calcification of the bronchial and mesenteric glands has often been described, but it has always been tuberculous in origin. In a patient, aged 79, dead of pericarditis, fibrous and calcified plaques were found in the left pleura. The mediastinal glands, both in front and behind the trachea (but almost exclusively on the right side), as also the right subclavian and axillary glands, were calcified. The mesenteric and some other glands in the abdomen were similarly affected. There was no lesion in the mucous membrane of the respiratory tract or alimentary canal, and no tubercle anywhere. During life no tubercle bacilli had been found in the sputum. The patient had been a *stuccateur* for forty years, and thus he had breathed in and swallowed sulphate of calcium in a fine state of division. This had been absorbed and deposited in the glands. M. Robin shows that there was nearly 20 per cent. of calcium sulphate in the glands from his case, whereas the analysis of ordinary calcified tuberculous glands shows no such constituent. The calcification was not the outcome of the calcareous diathesis, for then it would have consisted of the minerals ordinarily found, and not of sulphate of calcium. The author would look upon this case as an example of an occupation disease. He admits its rarity, and would explain its occurrence here by the fine subdivision of the stucco known to have existed in this instance. In conclusion, M. Robin says that very fine particles may pass through the epithelium without altering it, that the disease must be placed along with the pneumoconiosis, and that the clinical manifestations are due to pressure and functional disorders. In this case the bronchi were somewhat pressed upon, and the patient suffered from emaciation, dyspeptic troubles, and a liability to bronchitis. Hygienic precautions would no doubt be prophylactic.—*British Medical Journal*.

ANGIO-NEUROTIC OEDEMA.

BAUKE (*Berl. klin. Woch.*, February 8th, 1892) describes in detail two cases of circumscribed oedema of sudden onset and rapid disappearance occurring in individuals of neuropathic tendencies and without other signs of disease. The evidence in favor of the

nervous origin of this affection is (1) that most often the patients are neurotic; (2) that in this disease, as in other nervous diseases, heredity is often present; (3) that it frequently appears as a result of psychical disturbances and after such noxious agents as alcohol, which affect by preference the nervous system; (4) that it occurs with other nervous affections, such as neuralgia, etc.; (5) that some patients present signs of other vasomotor neuroses, such as Basedow's disease and urticaria; (6) that this oedema may appear on one side only, and also at such times (menstrual period, climacteric) favorable to neuropathic manifestations; and (7) that improvement is brought about by measures directed to the nervous system. The author says that the form accompanied by (local) rise of temperature and redness is due to local paralysis of the constrictors or reflex stimulation of the dilators, producing increased transudation, and that, in the other form without these accompaniments, an alteration in the lymph secretion takes place. If, in consequence of repeated and long-standing oedema, changes in the tissues supervene, then a tropho-neurosis may be correctly spoken of. Inflammatory or congestive oedema has nothing in common with this angio-neurotic form, either etiologically or clinically.—*British Medical Journal*.

INTUBATION.

BOKAI (*Jahr. f. Kinderhiknde.*, Bd. xxxiii, H. 3) gives the results of the operation of intubation in his hands in the Stefanie Children's Hospital in Buda-Pesth. He began to use the method in August, 1890, and between that date and August, 1891, he had to treat 310 cases of diphtheria and croup. There were 128 cases of pharyngeal diphtheria without laryngeal symptoms, 139 with laryngeal symptoms, and 43 cases of laryngeal croup. The 128 cases of diphtheria without laryngeal complication showed a recovery rate of 64 per cent. In the previous year there had been 170 such cases, with a recovery rate of 77.5 per cent., so that the epidemic of the year under consideration was not of a milder character, but rather the reverse. In the 139 cases of laryngeal diphtheria intubation was performed in 78, tracheotomy without intubation in 39, 16 recovered without any operation, and 6 died without operative interference. In the 43 cases of simple croup, intubation was done 31 times, and tracheotomy 6 times, and 6 recovered without operation. After January 1st, 1891, intubation was performed in every case of laryngeal diphtheria. Of the 78 cases of laryngeal diphtheria intubated, 24 recovered (30 per cent.). In the two preceding years during

which he was performing tracheotomy, the recovery rate of this group was 14 per cent. Of the 31 cases of simple croup intubated, 13 recovered (41 per cent.); with tracheotomy the recovery rate of this group had been 39 per cent. As to age, there were 5 cases 1 year or under, of whom 1 recovered; between 1 and 2 years there were 19 cases, with 3 recoveries; between 2 and 3 years, 23 cases, with 11 recoveries; between 3 and 4 years, 12 cases, with three recoveries; between 4 and 5 years, 7 cases, with 3 recoveries; between 5 and 10 years, 11 cases, with 2 recoveries; a case aged 11 died, and another aged 12 recovered. Of the croup cases, 2 were 1 year or under, both died; between 1 and 2 years, 11 cases, with 3 recoveries; between 2 and 3 years, 8 cases, with 4 recoveries; between 3 and 4 years, 8 cases, with 5 recoveries; 1 case aged 5 recovered, and 1 aged 6 died. The shortest time the tube was retained was ten hours, the longest seven and a-half days. In 6 successful cases the tube was retained for more than five days, which proves Escherich's opinion, that after five days a secondary tracheotomy must be performed, to be questionable. In 18 out of the 72 cases which died, the tube was found to have caused some ulceration, but in 16 it was slight. In one case there was a perichondritic tracheal abscess, in the other also the cartilage was involved; in both these cases the tube had been retained for more than three and a-half days. Among the 37 successful cases the tube was only introduced once in 12 cases; in one case it was introduced 7 times. In the 109 cases, which was the total intubated, tracheotomy was subsequently performed in 3; these 3 patients died. Bokai believes that in hospital practice, where skilled assistance is always at hand, intubation will replace tracheotomy in the majority of cases; in private practice the necessity for such supervision will, perhaps, interfere with the general adoption of intubation.—*British Medical Journal*.

ARONSON (*Deutsche Med. Zeitung*, No. 139 1892) has formed a much less favorable opinion as to the value of intubation. He made use of it in fifteen cases of diphtheria, with only one recovery. In one other case tracheotomy was subsequently performed, and the child recovered, and in another the dyspnoea was relieved, but the child died two days later of pneumonia. He thinks that intubation cannot become a routine treatment mainly on the two grounds that the necessity for tracheotomy, or for the withdrawal or reintroduction, may arise at any time, so that skilled assistance must always be at hand; and secondly, that there may be

generally, increasing obstruction of the left nasal passage, with profuse mucopurulent discharge and frequent hæmorrhage. On examination, the left fossa was found completely filled by a greyish mass with granular surface, painful, friable, and bleeding at the slightest touch. Posterior rhinoscopy showed vegetations of the growth projecting through the left choana. Examination with a probe showed that the tumor had a pedicle, and that it sprang from the cartilaginous part of the septum. The mass was removed with the galvano-caustic loop, but immediately showed signs of recurrence. Vigorous use of forceps and cautery being insufficient to check the process, an incision was carried round the left ala, and free access being thus obtained to the nasal fossa, the tumor was removed as thoroughly as possible, the site of implantation being scraped with Volkmann's spoons, and all suspicious points touched with the galvano-cautery; the fossa having been washed out and stuffed with iodoform gauze, the ala was replaced in position and sutured, the patient leaving the hospital on the seventh day. A fortnight later the growth had again recurred, this time perforating the septum and appearing in the right fossa. Forceps and cautery having again failed to stay the progress of the disease, both posterior nares were tamponed, and the whole growth cleared out under chloroform with forceps and sharp spoons, nearly the whole of the cartilaginous septum being removed in the process. When seen a year later there was no sign of recurrence. The growth was examined by Dr. Mendoza, chief of the laboratory of the Hospital San Juan de Dios, and pronounced to be a fibro-sarcoma.—*British Medical Journal*.

SOLANINE IN PAINFUL DISEASES OF THE STOMACH.

At a meeting of the Paris Academy of Medicine on March 22nd (*Sem Méd.*, March 23rd 1892), Desnos read a paper in which he recommended solanine as a useful substitute for morphine in painful diseases of the stomach. The drug is in a general way inferior to morphine, but it sometimes succeeds where the latter has failed, and it is likely to be of use where morphine is not well borne, or where the establishment of the morphine habit is feared. Desnos has used solanine in a large number

PAGE

MISSING

PAGE

MISSING

PAGE

MISSING

PAGE

MISSING