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CANADA

MEDICAL & SURGICAL JOURNAL

MARCH, 1884.

Original Communications.

ON A CASE OF EMPYEMA.

BY J. G. SCOTT, M.D., HAZELDEAN, ONTARIO.

(Read before the Ottawa Medico-Chirurgical Society.)

MR. PRESIDENT AND GENTLEMEN,—The case I am about to bring under the notice of this Association is, I think, of sufficient interest to warrant me in asking your attention for a short time.

Mrs. J—, aged 20 years, has been married for two years.

Family History—Tubercular history in her father's family, her aunt and grandfather having died of phthisis.

History—Never had any serious illness, but always robust and healthy up to April, 1882, six months after her marriage, when I attended her in a miscarriage, being about three months pregnant; the cause of such miscarriage I could not ascertain. She made a good recovery, nothing occurring to prolong her illness.

In the latter part of July of the same year she was again threatened with a miscarriage, but this time, fortunately, it was averted, but she lost considerably during the attack; however, she went on to full time, and was delivered of a fine, large, healthy-looking boy, Feb. 17th, 1883. Patient lives 10 miles from my office, and although engaged to attend her during her accouchement, I was unable to do so, and a neighboring physician was called in attendance. On the 4th of March, or fifteen days after labor, I was summoned in great haste to the case, when I elicited from her mother a full account of her accouchement and illness up to the time of my attendance. Labor pains came on

about 12 p.m., Feb. 16th, and she was delivered about 3 p.m., Feb. 17th, before the accoucheur arrived. The placenta being adherent, he removed it by manual interference. On the eleventh day she had chills, with headache, thirst and violent pains over the womb; the lochia, which had been scanty in amount, and very offensive, were suppressed, and the secretion of milk to the breasts was arrested. The baby was not applied to the breasts at all.

On examination, I found her with a temperature of $104\frac{3}{4}^{\circ}\text{F}$.; pulse 140, small and very weak; complexion sallow; features pinched; tongue dry and coated; partial delirium; abdomen soft; uterus enlarged and very painful on pressure. I washed out the womb with 1-40 carbolic acid, when some shreds came away; applied hot applications, and gave internally Quiniae Sulph. grs. ii, Morphia Sulph. gr. $\frac{1}{4}$, to be repeated every three or four hours as required. Ordered liquid nutritious diet, with brandy.

I gave an unfavorable prognosis and left, to return March 6th, when I found her much more comfortable; temperature 100°F .; pulse 90, and much stronger. I now put her on calomel and opium, and requested to hear from her next day. Living so far away from the office, it was impossible for me to attend her daily. On March 7th, her husband reported that she was doing well. On the 9th, I found her temperature up to 103°F ., pulse 120, weak and easily compressible, and delirious. I again washed out the womb, and some more shreds came away. I now put her on quinine and morphia again, with the same dietetic treatment. She improved rapidly, and on March 21st she had no pain, no tenderness over the womb, appetite pretty good, slept well, but the abdomen was slightly distended, and her temperature was 103°F ., pulse 90. I examined her lungs carefully, and there was absolutely nothing abnormal either on percussion or auscultation; her heart was also normal, but weak. I could not account for the rise in temperature and the frequency of the pulse, but I feared some unforeseen trouble was about to set in.

March 23rd.—I was requested to visit her immediately, which I did, and found that she had oppression of breathing,

pain in the side, short hacking cough, temperature 104°F., pulse 120, full and bounding. Percussion revealed wooden dullness from apex to base of left lung; normal note over right. I at once suspected pneumonia. Auscultation revealed no crepitation, no friction, no blowing-breathing, but a peculiar sound louder than normal vesicular murmur, but not so loud as bronchial breathing. Puerile breathing over right lung. There was no bulging of the intercostal spaces. I did not examine the two sides by comparative measurement with the tape-line. Apex beat of the heart was a little to the right of the sternum, and on this I rested my diagnosis of fluid in the left pleural cavity. I introduced a hypodermic needle in order to confirm my diagnosis and ascertain the character of the fluid, which I found to be serous. Not having an aspirator with me I returned home, secured one next day, and on the 25th returned, aspirated and drew off three quarts of serous fluid, which was streaked in some places with opalescent matter. She felt much relieved, respiration became more tranquil, the temperature fell, and the pulse became slower and not so full nor bounding, all of which we might expect after the removal of such a quantity of fluid. I then put on a fly-blister, painted the chest with a mixture of iodine and belladonna, and gave internally alterative and tonic treatment, and ordered poultices to be applied after the blister had risen.

During my subsequent visits, I found that the fluid was again accumulating; that the heart, which had assumed its normal position, was again being pushed over to the right; that the temperature had risen; that the pulse was again accelerated, full and bounding; that respiration was becoming more and more labored, and that she was restless and very irritable.

April 3rd (eight days after I had aspirated).—I called my friend and preceptor, Dr. Church, in consultation, when we decided to aspirate, which we did under chloroform, and removed over two quarts of opalescent matter. But let me note here that when I introduced the needle of the aspirator (using the largest) no fluid escaped, so I withdrew it, ran the stilet through it, and discovered that the first matter that entered the needle was a

clot of pus, which clogged the needle and prevented any matter escaping. I then reintroduced it, with the above result. Again the fluid accumulated; she became very irritable, appetite failed, refused both nourishment and medicine, objected to another operation, and said she would die in peace; and now, for the first time, a fistulous opening into the bronchi was established, and mouthfuls of greenish purulent matter were coughed up, which was very fetid.

April 18th, or 15 days after the last operation.—I was summoned with the announcement that she was dying. When I reached the house she was in a state of furious delirium. Shortly after my arrival she calmed down, and I took her temperature, which was 105°F., pulse 140. In a few moments she again became furious, when I put her under the influence of chloroform and aspirated, this time drawing off over three quarts of purulent, greenish, very fetid matter—in fact so much so that the odor was almost intolerable. I found great difficulty in administering the anæsthetic on this occasion, as it seemed to induce coughing, and she would gulp up mouthfuls of matter that had entered the bronchi, and as I was alone, I had to attend to everything unaided. Having previously determined on introducing a drainage tube, I now decided to wait the result of the fistulous opening, hoping that the matter might be expectorated and a cure thus effected; but in this I was disappointed, as the pleural cavity again began to fill up.

During this time I myself became unwell, and my friend Dr. Small kindly visited the patient for me, and aspirated, removing 45 ozs. of matter of a similar nature to the last removed. Not being satisfied with the general results of drainage in empyema by means of rubber-tubing, knowing that it easily becomes blocked up, and that if there was much retraction of the chest, resection of a rib would be a necessity in order to drain, I hesitated before resorting to it. Being still unwell, and needing a few days' recreation, I visited Montreal, and while there, called on Dr. Ross, to whom I gave a brief history of the case, and solicited his advice, which he freely gave, and for which I am deeply indebted. The substance of that advice was: that I

should procure a silver drainage tube, such as they use of late in the Montreal General Hospital, and, with antiseptic precautions, introduce and drain the cavity. That advice I followed out to the letter, with the exception of the antiseptic precautions, and with what result you will presently hear.

July 14th.—I administered chloroform with difficulty, and with a scalpel made an opening in the intercostal space, below the inferior angle of the scapula, and introduced the tube, when over three quarts of very fetid matter escaped. She coughed considerably, and with each cough the matter was ejected to a distance of at least three feet through the tube. I gave a hypodermic of morphia, which allayed the cough and eased the patient. When fully recovered from under the influence of the anæsthetic, I had her assume the sitting posture, and then washed out the cavity with a warm solution of carbolic acid (1-40), and continued to do so until the fluid returned quite clear, being careful at the same time to have the air of the chamber both warm and moist. I then applied lint over the tube, followed by a layer of cotton batting, and over this a bandage to keep the dressing in place. Her usual weight had been 145 lbs., but now she scarcely turned the scales at 90 lbs. Next day I visited her, and washed out the cavity again, a good deal of matter having drained away. I instructed the nurse how to wash out the cavity and dress the side, insisting on her using the solution warm and repeating twice daily. When I returned in two days I found her cheerful and bright, and her temperature now for the first time during my attendance was below 100°F. Not nearly so much discharge. I washed out the cavity and dressed as before, this time using plain tepid water for the injection, and left instructions as before; but using tepid water now instead of the acid solution. I visited her tri-weekly, and each time found her improving rapidly, her temperature never going above 99°, and pulse never above 80. She weighed every week, and reported an increase each time. The discharge became less and less in amount, and on August 31st, or 48 days after the tube had been introduced, no matter appeared on the dressing, and on washing out the cavity, the fluid returned quite clear. I now

closed up the tube, and left it *in situ* until Sept. 9th, when I removed it, no matter having accumulated, and none appearing in the fluid injected. I now applied adhesive straps in such a way that the edges of the wound were brought into pretty close apposition, and then dressed with whiskey dressing; and on Sept. 18th the wound was completely healed, there was little or no retraction of the chest, and the lung had expanded fairly well.

She continued to gain in strength, and in the latter part of November she began to do her own housework, and continues to do so up to the present time. Her husband reported a few days ago that she never felt in better health, and that the only visible difference in the two sides is the scar left where the incision had been made, and that her menses had appeared regularly for the last two months.

In examining the reports of cases of empyema by different authors that I had at hand, I find in nearly every case that strict antiseptic precautions are advised. In the *Medical Times and Gazette* a case operated on by Dr. Goldammer is mentioned, using antiseptic precautions, resulting in a perfect cure; and it goes on to say that a few years ago such a case would be considered miraculous, but now, thanks to the antiseptic method, we scarcely wonder at it. Dr. Cheadle, of St. Mary's Hospital, says that full antiseptic precautions in paracentesis and dressing afterwards had been disappointing. He says they were adopted in three cases, and all ended fatally. The same writer merely requires carbolyzed instruments and dressing of carbolyzed tow. In the case I have just reported, you see that no antiseptic precautions were used, and no case could have a more favorable termination; but from the result of one case alone we cannot draw definite conclusions, still it proves that antiseptic precautions are *not absolutely necessary* in order to insure success in every case.

In the rural districts it is almost, if not altogether, impracticable to follow out antiseptic treatment to the letter, for many of our patients reside miles away from our office, and to attend them daily during a long illness is impossible, and to have the nurse faithfully carry out such treatment in our absence is equally

impossible ; besides, many of us have no spray-producers at all. I look on antiseptic surgery as the æsthetic treatment of the day, but not at all absolutely necessary, and that the *strict* Listerian routine practice will, in the near future, have lost many of its admirers. Dr. Campbell of New York arrived at the following conclusions in a report published in the *Lancet* for Jan., 1879: "That to operate early is absolutely necessary in order to insure a *possibility* of recovery. To make a free incision to insure thorough drainage. Not to allow the wound to close until the discharge ceases, and to keep the cavity cleansed and disinfected."

To operate early by making a single free incision I believe to be the most judicious treatment ; say after having aspirated once or, at most, twice, the matter again accumulating. And if I had introduced the drain-tube earlier in my case, I have no doubt but that I would have had a similar result at a proportionately earlier date. To *operate early*, though the better treatment, is not *absolutely necessary* for the *possibility* of recovery ; but to keep the wound open until all discharge ceases I believe is.

I chose the intercostal space immediately below the angle of the scapula, as necrosis would less likely be produced in this position if much retraction of the chest occurred. Dr. Cheadle objects to this position, giving as his reason that there is often swelling, suppuration, and local abscesses due to injury of the muscles with the friction, heat and pressure caused by the patient lying on his back. None of these conditions occurred in my case, and I think such could be avoided by following the plan I adopted, viz., to inject slowly all the fluid the cavity will contain while the patient is in a sitting posture ; allow it to remain there for a few moments, the patient changing position, and when you wish to empty it, let him lie on his back and immediately the fluid injected escapes through the drain-tube ; repeat until the fluid escapes quite clear. Dress the side, and the patient can now assume any position he may please, and thus obviate the necessity of constantly lying on the back in order to establish free drainage, for when this is repeated twice daily very little matter can accumulate, even if the patient does not assume the dorsal position at all.

ON PUERPERAL FEVER.

By T. JOHNSON ALLOWAY, M.D., L.R.C.S. & P., EDIN.,

Consulting Physician Montreal Dispensary; Attending Physician Department for Diseases of Women, West-End Free Dispensary, Montreal.

(Read before the Medico-Chirurgical Society of Montreal, Feb., 1884.)

Nomenclature.—At the last meeting of the British Medical Association, Dr. Thorburn endeavored to impress the profession with the necessity of changing the old and time-honored name “Puerperal Fever” to that of “Metria.” He said that the old term did not cover the ground, for it was impossible to include epidemic puerperal fever under the same classification, or the more sporadic forms. Matthews Duncan and others, it is well known, do not include zymotic diseases with septicæmia as etiological factors; they wish to make puerperal fever a disease *sui generis*. Yet it is also well known that the poisons of scarlatina, erysipelas and typhoid fever may sometimes cause in the puerpera symptoms scarcely distinguishable from those of puerperal fever. In this case the woman has simply scarlatina, not metria; but a woman who has rigors, high temperature, intense tympanites, and rapidly dies, with subsequent clear proof of scarlatinal infection, has died of puerperal fever or metria caused by scarlatina.

I do not intend to defend Dr. Thorburn in his views, but merely place them before you. Neither do I feel that they are devoid of sound reasoning, and I think, as he does, that there would be no difficulty in conceiving how a tolerably definite train of symptoms ensuing from the action of septic or zymotic germs in the hyperfibrinated blood of a puerpera may take on a uniform character and epidemic virulence.

In a recent paper read before the New York Academy of Medicine by Dr. T. G. Thomas, the author pronounces emphatically against the change of name. He says, of the two names, “puerperal fever” is the least objectionable, but shows a decided leaning towards the term “puerperal septicæmia,” as indicating the more correct teaching from a pathological point of view, using the words of Barnes, “the blood of the puerpera is poisoned.”

Etiology.—At all the recent discussions on puerperal septic

fever, its etiology seemed to give rise to little diversity of opinion. All agree, I think, at present that it is due to those conditions pointed out by Dr. Lombe Atthill. First, that puerperal women are inoculated with septic matter conveyed to, and deposited in, the vagina by the hands of the attendants and other agencies; and, second, the patients may become victims of auto-inoculation, the poison originating within their own bodies from decomposition of blood-clots and placental remains after parturition. Dr. Atthill further contends that there may be a cause over which anti-septic precautions have no control. He says that there are instances of continued uterine relaxation where the uterus does not seem to permanently contract, but allows the formation of large clots to take place within the cavity, and that on their decomposition the disease is thus produced. Here it is clearly indicated we should employ ergot with an unrestrained hand, and continue its administration for several days after labor. Much difference of opinion has been expressed in regard to the prudence of practitioners or students attending puerperal women immediately after handling dissecting material or post-mortem cases. Löhlein and Fritsch are of opinion that if proper disinfection of the hands is practised, it is all that is necessary, and that fresh cases can be attended with impunity; but recent experiments have undoubtedly shown that micro-organisms are not so easily destroyed by antiseptics, and I doubt very much if merely washing the hands in antiseptic solutions will obviate the risks of inoculation after handling septic material.

Coexistent with these causes is a condition most favorable to the reception of poison-secretions into the blood of a puerperal woman—always a most prolific soil for sepsis and zymosis. I allude to lacerations of the genital tract. And I firmly believe that the strenuous opposition shown by a section of the profession to the immediate operation for lacerated perineum has a great deal to answer for in deaths from septicaemia. I have published cases myself of this disease which were undoubtedly traced to this cause, and which should never have occurred had these lacerations been attended to at the time of delivery, and proper antiseptic measures taken in their after-treatment. It is gene-

rally thought that fresh, healthy, non-offensive lochial discharge is harmless, and not capable of setting up a morbid state in the puerpera; but we find that as far back as 1843, Scherer found that secretions taken on the third day after delivery from a puerperal woman and injected into a healthy pup produced its death in two days. Examination showed extensive inflammation of the muscles and connective tissue, collection of hemorrhagic exudations, and intense inflammation of the kidneys. Rokitansky and Kehrer also arrived at the same result in like experiments. In a few days after delivery; the pure blood tended to diminish and the pus to accumulate, bacteria were found, chiefly of the spheroidal form.

When we are aware of such facts as these, and with solutions of continuity of the genital tract, we have, 48 hours after delivery, a rise of temperature, a slight chill, some abdominal pain with headache, the lochia have been normal, though irritating enough to produce a slight lymphangitis, but not sufficiently poisonous to produce erysipelas. Yet, as Thomas has pointed out to us, recovery from parturition is the rule, notwithstanding all these circumstances which are best calculated to ensure a bad ending. Now and then, however, the matter does not end with these symptoms of slight illness. The poison gains admission higher in the genital tract, increases in its violence, acts rapidly, as does yeast on dough, alarming phenomena follow, until eventually death takes place.

Pathology.—As regards the pathology of puerperal fever, I think it is fairly well accepted to be “a septicæmia” attacking the puerperal patient, and that the essence of the disease is absorption of poison into the blood through some breach in the genital tract. Lusk’s* definition is a good one: “The septic inoculation of wounds which result from the separation of the decidua and the passage of the child through the genital canal.”

It is, however, to be regretted that this clear and comprehensive view of the pathology of this disease is not wholly free from dissent. It is held that a certain form of the disease termed “sapræmia” is dependent upon the absorption of putrid

* Semmelweis and Hervieux.

matter independent of the influence of micro-organisms. The existence of such a condition I hold to be utterly impossible, and to be at variance with results derived from recent experimental research. Ogston's experiments on this point are of singular interest. He found that micro-organisms were present in all acute, but *not* in chronic, abscesses. Twenty experiments were made on guinea-pigs and mice by injecting pus from cold abscesses into the tissues of the back. "The invariable result was that no illnesses or abscesses ensued; that the pus was, within a week, dried up into a film pervaded by living cells; and that within ten days this film had become totally absorbed, so that no trace of it remained when the animals were killed, and the site of it was not discovered." But when pus from an acute abscess containing micrococci was injected in the same manner, symptoms of blood-poisoning ensued and lasted from two to five days, and after a few more days the animals recovered. And from other experiments it would appear that to have puerperal septicæmia, we not only require the presence of germs in contact with wounds of the genital tract, but also that there be a quiescent state of dilute albuminous fluids supplied for them to live upon, and increase in their virulence, by means of a process of fermentation. The principle of thorough drainage is based upon these truths; it prevents the occurrence of the very conditions above-named, so essential to the thrift of the septic organisms. It must also be remembered that whatever tends to disturb the equilibrium between absorption and excretion, so active in the puerpera, favors germ activity, and it was here that aconite, which obtained so much renown some years ago as a remedy in puerperal fever, exerted its good influence.

Treatment.—Of the different interesting points of this disease, there are none so interesting and important as the one which appertains to the prevention of the disease occurring, and its cure when it does occur. Herein lies the great battle-field of opinion. Extreme views, often diametrically opposed to each other, are held by our most experienced observers. The list of precautionary measures which Dr. Thomas gives us is almost impossible for ordinary men to carry out in detail. He views every parturient woman in the

light of one who has passed through a capital operation. Dr. Wylie treats the genital canal after labor as a punctured wound. And the question before us now is, how far the learned discussions of these gentlemen are going to help us, and how religiously are we to obey the demands of their creed. Dr. Thomas tells us the wall, floor and furniture of the room of every patient are to be washed with a 10 per cent. solution of acid. carbol., or 1-1000 of Hydr. Bichl. All curtains removed. Six or eight hours after labor he washes out the vagina with antiseptic solution, and introduces a suppository of iodoform. The injections are repeated every eight hours. If instruments have been used, inject every four hours, and keep up for ten days. Dr. Thomas lays special stress on the physician's attending to details himself, and giving ergot three times a day for a week at least to ensure proper contraction of uterus and expulsion of clots, etc.

During the discussion on Dr. Garrigues' paper there arose a storm of opinion. Dr. Garrigues does not use prophylactic vaginal antiseptic injections in normal labors. He simply washes the external parts after labor with $\frac{1}{2000}$ parts of Hyd. Bichl., and then uses antiseptic absorbent napkins, changed every four hours. It is, in fact, the nearest approach to antiseptic dressing as carried out by the surgeon in cases of amputation. In the discussion, Dr. Baruch claimed that in 15 cases in which three per cent. solution of carbolic acid was used as a vaginal injection twice daily, he had observed six cases of undoubted septic poisoning. This result, he claimed, was due to disturbance of patient, entrance of air, and infection by syringe, &c. Dr. Garrick cited 4,000 labor cases, with a mortality of two from puerperal fever, under strict cleanliness alone. Intra-uterine injections for prophylaxis were, of course, not entertained.

Judging from the foregoing, I am inclined to think that the difficulty in arriving at a definite and unanimous conclusion in regard to the advisability or otherwise of using prophylactic vaginal injections is based upon the fact that inert antiseptics are generally used in such cases. I am convinced, from the results of a fair trial of many of the ordinary so-called antiseptics in general use, that they are uncertain; troublesome from the

necessary frequent repetition of them ; dangerous from the careless way in which they are used by ignorant nurses, and through second hand and infected syringes ; and that they should never be resorted to unless under the following conditions :—

1. No solution should be used as an injection but that of Hydr. Bichl. $\frac{v\bar{v}\bar{v}}{v\bar{v}\bar{v}}$ strength.

2. A perfectly new fountain (No. 2) syringe should *only* be used in each case ; better none than a second-hand one, no matter how apparently perfect.

3. No injection should be given until the day after the confinement, and one injection daily is sufficient ; sometimes one every second day will be consistent with safety of patient.

4. The physician should perform the operation himself ; on no consideration trust a nurse ; better leave it undone.

5. See that the syringe is playing before introduction of nozzle, to prevent entrance of air.

6. A convenient solution of corrosive sublimate can be made by dissolving one drachm (5i) of the salt in one ounce (ʒi) of alcohol. One teaspoonful (ʒi) of this solution added to one quart of warm water will give almost to a fraction one part in two thousand $\frac{v\bar{v}\bar{v}}{v\bar{v}\bar{v}}$ and will be sufficient for each injection. This injection can be continued for almost any length of time, the absorbent power of the vaginal mucous membrane being very low.

7. Provided there is no cause for *intra-uterine* decomposition—which every careful physician should satisfy himself of before leaving his patient at time of confinement—my experience has led me to think, that it is not possible to have a patient attacked with puerperal septic fever in private practice while observing the above indications.

In the treatment for cure, when the disease has set in, Dr. Thomas uses the intermittent *intra-uterine* injections of carbolic acid solution (2 per cent.), or solution of corrosive sublimate 1 in 2000 parts. (Cannot continue injections of solution of Bichloride (*intra-uterine*) for more than three or four days, one injection each day, without producing constitutional effects from absorption of drug. I have produced slight salivation upon two

occasions on the fifth day.) Dr. Thomas looks upon constant irrigation as a mistake. To control temperature he uses Townsend's rubber-tube coil, extending from the ensiform cartilage to the symphysis pubis, with ice-water flowing through it. He also gives quinine in full doses night and morning.

In considering the curative treatment, it will be remembered that last year I brought before this Society the record of three cases of puerperal sepsis, in which I had used suppositories of iodoform, each containing gr. x Iodoform in Ol. Theobroma, *made by pressure*, with very marked success.* I have now to present to you three more cases treated in a similar manner, with the exception that to the suppositories of iodoform *was added an equal quantity of boracic acid*, and which I have every reason to believe increased the efficiency of this particular form of treatment. Boracic acid, I think, may be placed close to the salts of mercury and silver as a non-irritant germicide. I have kept meat-extract perfectly pure for months in a solution as weak as three grains to the ounce of water.

The first of the three cases I shall speak of was a woman of about 30 years of age; had had five children. She was confined on the 19th of last March without instrumental aid. She objected to have vaginal injections, saying that she never used them, and did not think she now should deviate from her old customs. All went well until the morning of the 22nd (the third day after confinement). She was then seized with violent pelvic pain and a succession of rigors, intense headache, temperature 104°F., pulse 120. On examination, I found that a prune-juice-looking discharge was oozing from the cervix, but was non-offensive. I administered a hypodermic of Battley's solution, and washed out the uterus with about two quarts of 5 per cent. solution of carbolic acid and passed up two suppositories; also ordered gr. xx of quinine to be given that afternoon. She did not change much during the day towards improvement, so I injected the uterus again that night and passed two more suppositories.

*"On the treatment of Puerperal Septicæmia by a new method—*intra-uterine suppositories of iodoform.*" *Can. Med. & Surg. Journal*, April, 1883.

The following morning her temperature had fallen to 101°F. and pulse to 100. She had no more pain since yesterday, and was feeling well, with exception of some pelvic tenderness on pressure. Washed out uterus again with solution of carbolic acid, and two more suppositories were passed. Temperature and pulse that evening same as in the morning. Did not wash uterus out, but passed two more suppositories. For the following two days she had no other treatment than the introduction of two suppositories night and morning. Her temperature and pulse were normal, and I concluded all was over. For the following two days nothing whatever was done, beyond keeping her quiet in bed, and, to my great dismay, on the morning of the next day she was seized with a violent chill; temperature 105°F. and pulse 140; no pain. This was on the fifth day from first inception of sepsis, and was a relapse due to accumulation of fresh poison. She was now terribly reduced in strength, and like anything but a woman who could survive so severe a storm. However, I again thoroughly washed out the uterus with a very strong solution of carbolic acid, and passed up two suppositories. The same was again done that night. The following morning her temperature and pulse were much reduced, and she continued to improve from this time, the suppositories being used night and morning for some time, and the injections only occasionally. I did not, however, discontinue the treatment until I was quite satisfied a relapse would not be likely to occur again. I may state that this patient was a miserably-nourished woman at beginning of labor, and on its completion the uterus became extremely anteflexed, producing a kink at the cervix difficult to overcome, which may have had something to do with retention of clots.

The next case was that of a strong, healthy French-woman. She was confined, also without instrumental aid, on the 20th of March, the very day following my attendance upon the previous case. Vaginal injections of carbolic acid were here used from the outset. On the third day she was seized with a severe chill and pelvic pain, high temperature and rapid pulse. The same treatment was followed as in former case, with the exception of

the uterus being washed out *only once*. The suppositories were used night and morning with good effect, but though she improved during the following week, still she did not have a decided fall of temperature and pulse as I was accustomed to see in former cases. On the sixth day, a large fetid clot of blood was expelled, which was causing all the trouble, and which was probably infecting the placental site with fresh poison as fast as the suppositories were destroying it. From this out she rapidly improved, the treatment being continued for some days afterwards. It may here be of some interest to state that I had been, the day previous to attendance upon the first of these cases, for over an hour in the room of a patient dead of malignant disease of the kidney and peritonitis, on whom a post-mortem was being performed. This circumstance may have formed a link in the chain of causation, or it may not. It is, however, a very nice point for discussion, and will, in future, be a good lesson to me to avoid a like risk.

The third case was a young, powerfully-built primipara. I attended her on the 28th August last, and delivered her with forceps of a very large child. She was treated during the puerperium with vaginal carbolized injections, and made a very good recovery. She left her bed as convalescent on the ninth day. She began house-work immediately, and on the 11th September, fourteen days after labor, was seized with violent pelvic pain, severe rigors, intense headache, high temperature, and rapid pulse. On examination, I found a stellate laceration of the cervix, with blood oozing from each little radiating fissure. I washed out the uterus with a solution of corrosive sublimate *only once*, and used the suppositories as before. This was done again the next day, when all symptoms of a serious nature began to subside. The treatment was continued, however, for six days, after which she became again convalescent. This was really the most troublesome case I had ever had, from the fact that she was very ignorant, and possessed the most vile temper I ever experienced in a woman under such circumstances. However, I turned all her relations out of the room, and fairly subdued her into allowing me to perform the necessary operations. To act otherwise, I felt she would almost surely have died.

The method of introducing the suppositories is very simple. The perineum is retracted with a Sims' speculum in Sims' position, and the suppository passed up to the fundus uteri on a stilette sponge-tent inserter. I have been in the habit of introducing two suppositories night and morning, equal to 40 grains each of iodoform and boracic acid, daily. I see, however, that Ehrendorfer of Vienna has lately been using much larger doses of iodoform in similar cases, after my method, without evidence of absorption of the drug. I believe it to be quite immaterial what excipient is used to form the suppository. I like cocoa-butter and pressure, and find, by the experiment of dropping one of such suppositories in a glass of water at blood-temperature, that its disintegration is almost instantaneous. In conclusion, I would recommend that no time be lost in putting into practice the method above described, after the first onset of untoward symptoms. And it should not be forgotten, amid the foggy confusion of conflicting views regarding what is septicæmia and what is not in any given case, that Burdon Sanderson has shewn us by direct experiment the certainty of increasing virulence of successive inoculations. The inference is here obvious.

QUARTERLY RETROSPECT OF SURGERY.

PREPARED BY FRANCIS J. SHEPHERD, M.D., C.M., M.R.C.S, ENG.,

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Catheter Fever.—At a meeting of the London Medical Society, held in December last, Sir Andrew Clarke read a paper on "Catheter Fever," which excited considerable discussion amongst the surgeons present. By *catheter fever*, Sir Andrew means a low form of fever (often fatal) which follows the habitual use of the catheter in men about middle life, who are perfectly healthy, and with no discoverable evidence of disease, except a low density of the urine and a local condition of the bladder, which has given rise to the necessity for catheterization. When these cases prove fatal, Sir Andrew asserts that oftentimes no sufficient structural change is found in the kidneys to account for death. Sir Andrew Clarke, however, was only able to give the results of

one such necropsy observed by himself, but he quoted from Velpeau and Marx evidence in favor of his views. He held that the fact that this form of fever may arise in what seems to be good health is not well known among surgeons, and had no adequate place in English surgical literature or English surgical teaching of the present time.

“This fever,” the reader of the paper says, “is neither distinctly uræmic nor distinctly pyæmic, and probably first begins in the nervous system; that the disturbance of the nervous system reacts, in the first place, upon the general metabolism of the body, and, in the second instance, upon the secretory organs, beginning with the kidney; that the effect upon the kidney may consist either in structural alterations in the kidney, invisible by the aid of our finest instruments of research, or (as seems more probable to Sir Andrew) in alterations of the constitution of the blood, that dynamic condition of its constituents in the renal vessels essential to the elaborative action of the excretory cells thereof; and, lastly, that the concurrence of these conditions may be, and often is, enforced by septic reabsorption into the blood.” This definition is certainly vague enough, and may mean anything or nothing.

The prevailing healthy condition which the subjects of this fever suffer from is only apparent, as Sir Andrew Clarke admits there is low density of the urine, which means deficient excretion of solids, and the need of the habitual use of the catheter (or as Sir Andrew puts it, the entrance upon “catheter life”) indicates the presence of some chronic urinary trouble. To put the matter plainly, the apparently healthy patient has been for some time suffering from enlargement of the prostate, with, probably, atony of the bladder. Sir Andrew asserts that where narcotics or anæsthetics are used in these cases, no catheter fever follows, and advises their use in persons entering upon habitual catheterism. Quinine, he says, has signally failed in controlling this fever, and he asks: What are the things to be employed on such occasions? and what is the sort of hygienic management to be followed, especially in respect to food and alcohol, which are so variously used on such occasions?

Sir Henry Thompson, in an able speech, described several forms of urinary fever which follow the use of the catheter, and are familiar to all surgeons. First, four or five hours after catheterism, and after the first passage of urine, the patient experiences a rigor, followed by fever, pains in back, and then sweating; these symptoms pass away slowly, no recurrence takes place, and the patient, in two or three days, is as well as ever. This Sir Henry calls an "acute transient attack," occurring in persons who have the most healthy renal organs, and occurs occasionally from a simple absorption into the blood-vessels of some small portion of the urine. The phenomenon above described, he thinks, may also arise from purely nervous causes. Another form of urinary fever is the acute recurring form. The patient has, as a rule, four or five attacks of fever, and always recovers with rest and care. There is also a third class of cases where death occurs from 24, 36, to 48 hours after the attack, evidently from shock of some kind. A shock, Sir Henry said, sometimes follows the simple passing of a bougie on a young man who has never before had an instrument passed, and we cannot but be struck with the close sympathy that is established between the urinary organs and the nervous system; and it is therefore not surprising that in a very few and exceptional cases, with no obvious disease existing in the organs, the passage of the catheter may sometimes bring about a fatal result in 24 hours, and no special lesions be found to account for it. These latter cases, Sir Henry says, have no right to be included under the name of catheter fever.

In cases of true catheter fever, when ending fatally two or three weeks after catheterizing has been commenced, Sir Henry Thompson has invariably found, at the autopsy, advanced disease of the kidneys and ureters. Sir Henry pertinently remarked that it is not the attack of any catheter fever, but the want of a catheter at an early stage, which has placed those individuals suffering from enlarged prostate, with retention, in their dangerous condition. Where the residual urine is considerable, catheterizing mostly involves serious consequences, and Sir Henry insists on the necessity, in these cases, on the commence-

ment of catheterism, of keeping the patient in a warm room, without exercise, perfectly quiet, and on simple diet.

Quoting from the results of University College Hospital, Mr. Berkeley Hill said that out of thirteen necropsies made on men dying after the relief of retention due to enlarged prostate, in eleven there was interstitial nephritis, and in the other two the condition of the kidneys was not clearly stated.

Mr. Savory said the urinary organs were very delicate tests of reflex action, especially if any morbid condition were present. The passage of an instrument may be followed by a rigor, and this was of two kinds—physiological and pathological. The latter attended by rise of temperature ; the former not. He said that the cases to which Sir Andrew Clarke particularly alluded were cases in which constitutional disturbance or fever or pyrexia is produced by local irritation through the nervous system. He also dwelt strongly on the necessity, before operations, of examining the condition of the kidneys, especially as to the quantity of urea they are separating from the blood ; and with regard to serious operations, he would rather have thoroughly sound kidneys on his side than even a sound heart or lungs. He also remarked that in some of these cases which were said to have no appearance of mischief after death, the kidneys have still been at fault. In another class of cases where the kidneys are perfectly sound, Mr. Savory thinks we undoubtedly get blood-poisoning and septic inoculation after the use of instruments.

Mr. Harrison (Liverpool), in withdrawing residual urine in cases of enlarged prostate, substitutes an antiseptic fluid for the urine withdrawn. He said that English surgery was not only cognizant of, but prepared to meet, such cases as those to which Sir Andrew Clarke referred.

Since the discussion, the various English journals have been full of the subject of catheter fever, and one good has been to direct surgeons more particularly to this form of urinary fever, and to more widely make known its proper treatment. The opinion of most surgeons is that Sir Andrew Clarke has not told them anything new, that the disease about which he raised such a discussion was one that every experienced surgeon was

perfectly familiar with, and that his assumption of the *role* of surgical preceptor has been quite unnecessary.

Mr. Henry Morris (*Lancet*, Dec. 22nd, 1883), referring to the fever which follows catheterism in persons suffering from enlarged prostate, says it is to the state of the kidney prior to surgical treatment, and not to the state of the bladder after the commencement of catheterism, that we ought to look for an explanation. The granular kidney, or the kidney which has been changed by chronic interstitial nephritis, becomes the seat of acute suppurative inflammation, perhaps throughout, but more likely in areas. Two conditions are requisite—(a) a pre-existing degeneration of the secreting structure; (b) an alteration from obstruction, in the intra-renal pressure, whereby the ureters, pelvis and calyces of the kidney become dilated. When these two conditions exist, a state of active congestion of the kidney is brought about by the release of the distension by means of the catheter, the elasticity of the kidney having been destroyed by previous disease, this increased flow of blood cannot be controlled or checked, and acute pyelo-nephritis sets in upon the top of chronic interstitial fibrosis. Mr. Morris, in such cases, advocates the recumbent position for some days after the commencement of catheterism, as that posture may favor the gradual change in the renal pressure. The diet should also be restricted, and ergot of rye given in moderately large doses.

Treatment of large Bronchoceles.—The removal of large bronchocele by the knife has, since the introduction of antiseptic surgery, become much more common. Billroth holds that simple primary thyroid cysts may be radically cured by puncture and injection of iodine. Larger bronchoceles, which cause dyspnoea, had better be removed by the knife. These, when even very large, if situated in the middle line of the neck, can usually be easily and successfully removed; but deep-seated substernal or unilateral bronchoceles are much less favorable cases for operation. Every bronchocele is encapsuled, and if care be taken, and the large vessels entering the tumor tied before division, removal can be complete. Mr. Thorniey Stoker has lately reported a case of removal of an enormous bronchocele to the

Irish Academy of Medicine (*Dublin Med. Journal*, Sept., '83). The tumor occurred in a boy, and extended from ear to ear, and hung down as low as the navel. Two-thirds of the mass comprising the right lobe and isthmus was removed in March, 1882, and the remainder on the left side a year later. Complete recovery followed the first operation, but the patient died five days subsequent to the second from pulmonary thrombosis.

Mr. Henry Smith (*Lancet*, Jan. 5, 1884) reports two cases of bronchocele successfully treated by the seton. The first case was that of a man who had a great enlargement of the right lobe of the thyroid, which caused cough, dyspnoea, and general weakness, so that he could not attend to his duties. He was advised to have the tumor removed, but refused, so Mr. Smith, after puncturing the tumor with a small trocar, passed a needle around by a double hempen thread through the opening, carried it deeply into the substance of the swelling, and brought it out on the other side. The threads were tied together and left to act as a seton. Great local irritation was produced, accompanied with a free purulent discharge. As there was considerable fever, the seton was withdrawn and a drainage-tube introduced. The tumor gradually decreased, and the man left hospital still wearing the tube. After a time it was taken out, and when the man was exhibited to the students, there was no appearance of the tumor, beyond a very slight thickening, and the man was in perfect health. The second case was that of a woman, aged 68, who had suffered from bronchocele for 16 years. The tumor involved the whole gland, and produced much distress, with dyspnoea. A seton was introduced and left in for 16 weeks; free discharge ensued, and the tumor rapidly decreased in size. The difficulty of breathing disappeared, and when shown to the students, there was hardly any trace of the tumor.

Although bronchoceles have been frequently removed, still, notwithstanding the greatest precautions, the operation is always a formidable and frequently a fatal one, so that the method advocated by Mr. Smith deserves trial.

There is still another method, which has only lately been introduced, for the removal of the grave dyspnoeic symptoms often

produced by these large tumors, and it has lately been tried with success by Mr. Sidney Jones, of St. Thomas' Hospital, London. (*Lancet*, Nov. 28, 1883.) This method also involves an operation, but one which is much less serious than that required for the removal of the entire gland. The method is one which has been practised on the Continent for some time, and is the removal of the isthmus of the gland only. In Mr. Jones' case there was severe dyspnoea, and the structures in front of the isthmus were carefully divided, the veins being tied before division, and the isthmus was detached by the finger and director from the front of the trachea. An aneurism needle, armed with a double ligature, was made to perforate the junction of the isthmus with each lateral lobe, and the double ligature on each side was tied as with an ovarian pedicle. The isthmus was then cut away and the ligatures left hanging out of the wound for drainage; a drainage tube was also inserted, and the wound dressed antiseptically. A month after the operation, the thyroid was scarcely perceptible, and the difficulty of breathing had entirely disappeared. In other cases of removal of the isthmus, a similar atrophy of the lateral lobes has been noticed. The late Dr. G. D. Gibb many years ago advocated the division of the thyroid isthmus to relieve the severe dyspnoea which occurs in large bronchoceles.

Prof. J. L. and Dr. A. Reverdin (*Revue Med. de la Suisse Romande*, 1883) give an account of 22 extirpations of the thyroid gland performed by them on 21 patients, 12 of whom were women. The size of the tumors varied from a hen's egg to that of an adult's head. In 17 cases total extirpation was performed. Two cases died. The average time in hospital was sixteen days. The Messrs. Reverdin were able to examine their patients several years after the operation, and then discovered certain remarkable alterations of the general health that showed themselves several months after operation in five patients, three of whom were women. There was first weakness and coldness of the limbs, then loss of appetite, slowness of speech, diminution of memory, and progressive anæmia, accompanied, in two cases, by a peculiar œdema, most marked on the face, and very anala-

gous to that which occurs in myxœdema. These symptoms partially disappeared after three years. Messrs. Reverdin say they appear after total extirpation, and are produced by a lesion of the vaso-motor nerves, and by a mucoid infiltration of certain tissues in consequence of the removal of the gland. The Messrs. Reverdin recommended extirpation of the thyroid when there are symptoms of imminent danger, such as attacks of suffocation, and also in cases of retro-sternal or rapidly-growing goitre, when ordinary treatment has proved useless.—(*Condensed from Brit. Med. Journal*, Sept. 29, 1883.)

Amputation in Senile Gangrene. —At a meeting of the Royal Medical and Chirurgical Society of London, held Dec. 11th, '83 (*Lancet*, Dec. 15th, 1883), Mr. Jonathan Hutchinson read a paper advocating the treatment of cases of senile gangrene by high amputation. He urged the safety and expediency of amputating in senile gangrene if the operation were done at a good distance from the disease. In the common form of gangrene of the toes and foot, the lower third of the thigh was the part suggested as the proper level of the amputation, and in the rare cases, in which the hand was affected, the middle of the upper arm. The author stated that the reason amputation had fallen into disrepute was because the disease returned in the stump owing to the amputation having been performed too low down. The calcification of the arteries on which, in the main, the disease depended, was usually greatest near the periphery, and hence the difficulty as to supply of blood to the flaps. This source of danger is not met with if the operation be performed sufficiently high. In a series of cases in very old persons, the reader of the paper had only seen recurrence of the gangrene in one. In three the stump had healed well; in a fourth, in which the patient, although not old, was prematurely senile and the calcification of the arteries extreme, the recovery had also been excellent. One of the patients in whom the stump had healed without a drawback was 70 years old. As to the time to be selected, the author thought that as soon as the patient was so ill as to be confined to bed, and the disease well established, it was best to operate. Spontaneous cure was, he urged very

exceptional, and a great majority of such cases ended in death, with much suffering. The thinner the patient the less was the risk of the amputation. In a few cases where the thigh was exceptionally fat and the tissues flabby, it might be wise to hesitate as to recommending it. In all Mr. Hutchinson's cases Lister's precautions had been carefully used, and in two or three the patient had never experienced the slightest pain from the day of the operation.

In the discussion which followed the reading of the paper, Mr. Rivington supported the views of Mr. Hutchinson, and said he had amputated successfully in two or three cases. Mr. Hulke had seen cases of spontaneous recovery after senile gangrene of the foot and lower third of leg, and his experience was in favor of conservative treatment. Mr. Cripps advocated amputation lower down than Mr. Hutchinson. Mr. Savory said the causes of senile gangrene were partly local and partly constitutional; when these reached a certain stage gangrene ensued, but in some the local causes were predominant, and in others the constitutional were most efficient, and as regarded treatment, the two classes could not stand in the same category. If the mischief depended chiefly upon the constitutional cause, amputation would not be successful; if upon local causes, it would. In typical senile gangrene, where the vessels are calcareous, a very trivial cause might start it; but in others, a considerable injury might originate it, and the same thing might occur in younger people, where the tissues were rotten. Where there had been a considerable amount of injury, he thought amputation would be useful; but in the typical form of senile gangrene, amputation, high or low, would be attended with disaster.

Mr. Hutchinson, in reply, said that he thought the abolition of shock by anæsthetics, the bloodless method of operating, and rapid primary healing of the amputation wounds, placed the question of such an operation in quite a different light from that in which it had previously been; however, if the spontaneous separation of the sphacelus were probable, and would leave a more useful limb than that made by a surgeon's amputation, he would, of course, prefer to leave the patient to the slower process of natural amputation.

Mr. James, of the Exeter Hospital, has reported a series of five successful cases of high amputation for senile gangrene in very old persons. I have at present under my care a case of senile gangrene of the moist type, where a line of demarkation formed about the middle of the right foot. The gangrenous part was separated at the tarso-metatarsal joint quite lately, and the case has progressed most favorably, a useful foot being left. At one time high amputation was thought of, but a line of demarkation forming, the idea of amputation was abandoned. The patient's arteries were very calcareous. Opium and stimulants was the principal treatment.

Radical Cure of Exomphalos.—Mr. Lawson Tait (*Brit. Med. Jour.*, Dec. 8, 1884) says that a hernial protrusion at or near the umbilicus is an exceedingly troublesome condition in the adult. In children, in the majority of cases, it can be cured by the careful use of a well-fitting truss. It occurs chiefly in fat women, or in those whose abdominal walls have been greatly stretched by many labors or by large tumors. In cases occurring in adults, trusses are of little service, Mr. Tait says, so he advises operative interference. He has had eleven cases, all successful. He opens the sac, frees all adhesions, removes redundant and irreducible omentum, pares the edges of the ring and stitches them together with continuous silk thread, which he leaves permanently there. He has traced three of the patients thus operated on, and finds that the cure of the protrusion is permanent after eleven, eight and five years respectively. All the patients operated on have been very fat, and the last one was pregnant. Mr. Lawson Tait, in conclusion, remarks that if he is ever called upon to operate in a case of strangulated hernia, he will proceed by abdominal section, and complete the radical cure of the protrusion at the same time that he relieves the obstruction.

New method of treating Psoas Abscess.—Mr. Frèd. Treves read a paper at the meeting of the Royal Medical and Chirurgical Society of London, held January 8th, 1884, on the *Direct Treatment of Spinal Caries by Operation*. He said (*Lancet*, Jan. 12, 1884) the gravity of spinal caries depends, not so much

on any special pathological features in the process, as upon the depth at which this disease is situated and its inaccessibility to the usual operative procedures applied to caries elsewhere. Diseased bone cannot be removed from the vertebral bodies, and the morbid products having to travel a great distance in order to be evacuated, are apt to induce immense purulent collections. These collections are usually opened at a point remote from the original seat of the disease. In the operation proposed by Mr. Treves, the anterior surfaces of the bodies of all the lumbar vertebræ and the last dorsal vertebræ can be reached from the loin; a vertical incision is made near the outer edge of the erectors spinæ, the sheath of that muscle and the quadratus lumborum are cut through, the psoas muscle is incised, and the vertebræ reached by continuing the operation along the deep aspect of that structure. By means of this operation the vertebræ can be readily examined, carious or necrosed bone can be removed, a ready and direct exit can be given to all morbid products, and an abscess situated in the psoas muscle or in the lumbar region can be evacuated while it is yet small, and before it has led to a large abscess cavity. If a large psoas or lumbar abscess exist, it can be evacuated at its point of origin, and at a spot that, in its recumbent posture, corresponds to its most dependent part. If Hueter's statement be true, that the two vertebræ most frequently attacked by caries are the last dorsal and first lumbar, the operation should be of frequent application. The author details three cases of this operation; all made a good recovery. In one of the instances, he evacuated at its point of origin a psoas abscess containing 40 ounces of pus, and removed from the body of the first lumbar vertebra a large sequestrum. The immediate improvement in this patient's condition was very marked. In another case, a psoas abscess had been opened in the thigh some months previously. By this operation, a counter opening was made at the point of origin of the abscess from the lumbar spine, and the entire abscess cavity was drained by a tube passing from the origin of the psoas muscle to its insertion. Mr. Treves added that, with regard to the last case in the paper, the patient did well, but the boy had chronic lung disease, the

drainage-tube had to be removed, and he died with extensive cavities in the lungs and amyloid disease of the liver and kidneys.

In the discussion which followed, most of the speakers agreed as to the value of opening a psoas abscess at its point of origin and so securing free drainage, but condemned the cutting down on the diseased spine for the purpose of removing carious bone.

Mr. Furneaux Jordan has recommended a somewhat similar operation for the treatment of psoas abscess if the ordinary method is unsuccessful. Dr. McEwen of Glasgow treats psoas abscess by cutting down on the diseased spine.

Dr. Norman Chavasse of Birmingham published a lecture in the London *Lancet* for December 29th, 1883, in which he advocates opening psoas abscess by a posterior incision. His mode of procedure is as follows: An incision is made immediately above the crest of the ilium, commencing at the edge of the erector spinæ muscle and carried three or four inches transversely outwards towards the anterior superior spine; the various structures are divided, as in colotomy, till the quadratus lumborum muscle is reached. The forefinger should then be passed downwards and forwards on the iliacus muscle till the tense and distended psoas sheath is detected. A scalpel should then be introduced along the finger and the abscess incised, the opening being enlarged by dressing forceps. A drainage-tube should be introduced, and the wound treated antiseptically. Mr. Chavasse reports two successful cases treated on this plan. He says that to Prof. Chiene of Edinburgh is due this method of treating psoas abscesses.

Treatment of Nævus.—Mr. W. Beatty, in the *Brit. Med. Jour.*, Nov., 1883, notes that he has had great success in the treatment of nævi by the local application of arsenic. The preparation used is the ordinary Liquor Arsenicalis of the Pharmacopœia, with which the nævus is to be painted night and morning until ulceration takes place. The cure is effected in from three to five weeks.

Treatment of Phagedænic Chancre.—For ordinal cases, Vidal (*Bull. de Méd. Gén.*, Nov., 1883) uses an ointment composed of pyrogallic acid 40 grammes, vaseline 120 gr., starch 40 gr.

When the ulcer has a very irregular surface and undermined edges, the best plan is to use a powder of pyrogallie acid 20 parts to starch 80 parts, which can be blown upon the part twice daily by means of a small pair of bellows.—(*London Medical Record*, Feb., 1884.)

Prevention of Bedsores.—Dr. H. Snow (*Brit. Med. Jour.*, Dec., 1883) recommends the use of the compound oil of hypericum in the treatment of bedsores. It induces healthy granulations, and does not produce any smarting. A bottle should be half filled with the flowers of St. John's wort, olive oil should then be added, and the bottle allowed to stand in the sunshine for some days till the oil becomes of a deep red color, then it is brushed over the sore two or three times daily.

Treatment of Chronic Urethritis.—Guyon says the internal treatment is very important, and differs (*Bull. de Méd. Gén.*, Nov., 1883) according to the constitution of the patient. Cod-liver oil, with creasote, arsenic, iodide of iron, sulphur, and the balsams are the best remedies. The local treatment consists in injections, instillations, cauterizations, or catheterism. Injections are too often valueless, as they do not always reach the bulbous part of the urethra. For instillation, Guyon uses a tube provided with a small syringe, and by which a solution (generally nitrate of silver, 1 in 20 or 1 in 50) can be brought in contact with the deep part of the urethra. Catheterism is only justified in very intractable cases, and a large metallic sound is the best; medicated bougies are valueless. In cases of gonorrhoeal cystitis, Guyon advises the injection into the bladder of 10 to 15 drops of a 1 to 2 per cent. solution of nitrate of silver. The injection must be repeated every day, and may be used in recent as well as old cases.—(*London Med. Record*, Feb., 1884.)

Conversion of Malignant Tumors into Innocent Growths.—In a clinical lecture delivered in Munich (*Wien. Med. Zeit.*, June, 1883), Dr. Nussbaum expressed a belief that he had discovered a procedure for the positive cure of cancer, by restraining the proliferation of the tissue elements of the disease. It appears to him that a total interruption of all peripheral sources of nutrition is the means best adapted to secure the result. He

accomplishes this object by the use of the thermo-cautery, with which instrument a deep channel is made quite around the malignant growth, thus cutting off entirely the supply of blood and other nutritive fluids from the surrounding tissues. The small vessels which ascend into the tumor from the parts beneath are sufficient to preserve its vitality, so that gangrene does not occur. He thinks the thermo-cautery far preferable to the ligature, and that it possesses many advantages over the knife. Prof. Nussbaum thinks that this method of circumscribing cancerous growths and cutting off every channel of peripheral nutrition has a brilliant future, especially in those desperate cases in which death is imminent from hemorrhage. In his hands this method has afforded satisfactory results.

Reviews and Notices of Books.

The Operative Treatment of Intra-Thoracic Effusion.—By NORMAN PORRITT, L.R.C.P., Lond., M.R.C.S., Eng., Hardwich Scholar in Clinical Medicine. London: J. & A. Churchill.

Since it has become the recognized treatment with all physicians to remove effusions into the pleural cavity when such have gained any considerable dimensions, it behoves every one to be acquainted with all matters concerning the *technique* of this now little thought of, but still important, operation. This is a very carefully prepared essay, entering thoughtfully into all the questions which may arise in the consideration of a case of thoracentesis. The author advises the seat of election for puncture to be "the 7th and 8th interspace, about the junction of the anterior two-thirds with the posterior third of the chest-wall," although the lateral region is preferred by many writers. On this point, our own practice corresponds exactly with that laid down, and we think there are good reasons for it. As to quantity of fluid to be removed, he would "limit it to two pints and to a less quantity than this should troublesome symptoms come on." There may be good grounds for this limitation, but we have many times aspirated a larger amount than this from

even a small chest, and have never seen anything to contraindicate it. For removing serous fluids Dr. Porritt objects to the aspirator except for localized or firmly encapsuled collections, preferring in all ordinary cases a trocar with syphon attachment. We are not satisfied that his arraignment of the aspirator is sufficiently supported; and certain it is that many of the best operators still use it exclusively and with entire satisfaction. As long as it is believed to be quite safe, its numerous and evident advantages will prevent its being replaced by any other mechanism. Southey's trocars are only alluded to in order to be condemned. We agree with this, for we have seen a case in the practice of a *confrère* where they seemed to have been the cause of a fatal termination. The subject of free incision in empyema is treated of exhaustively and scientifically. There are only a few points which we shall have space to notice. It is a delicate question whether an anæsthetic can safely be given. It is certainly always advisable, if safe. Dr. Porritt says: "Without any misgivings, I advise the employment of ether to the 'surgical degree.'" Quite recently it happened to ourselves to give ether for operation upon an empyema. Just as the cutaneous incision had been made, the patient's condition became so alarming that we were compelled to desist and postpone the operation. We would advise great care in the anæsthetizing of these persons. The operative treatment of limited empyema, of pneumo-thorax, of pyo-pneumo-thorax, and of hæmo-thorax, occupies the concluding chapters. We have had much pleasure in the perusal of this book, and recommend it to the attention of all who are interested in the diagnosis and treatment of chest disease.

On Bedside Urine Testing, including quantitative Albumen and Sugar.—By GEO. OLIVER, M.D., Lond., M.R.C.P., Lond. Second Edition. London: H. K. Lewis.

Dr. Oliver has been introducing to the profession the idea of replacing the old liquid tests for albumen and sugar in the urine by various test-papers. The advantages claimed for these—very great if proven—are their portability and ease of applica-

tion, reliability and the rapidity with which they act, and especially the fact that they can be made to reveal not only the presence of these abnormal ingredients, but also their *quantity*. The tests recommended for albumen are Potassio-Mercuric Iodide, Picric Acid and Sodium Tungstate. For sugar the paper used is saturated with Indigo-Carmine, the principle of which is a reaction discovered by a French chemist that "when the Carmine of Indigo is heated with Carbonate of Soda and a solution of glucose or Saccharine Urine, the blue color is converted gradually into green, then into red, and finally into yellow." If further experience confirms the observations of Dr. Oliver, it is quite probable that this method of urinary examination will, in great measure, supersede the older and more tedious and uncertain procedures.

Students' Manual of Diseases of the Nose and Throat.—By J. M. D. KITCHEN, M.D., Asst. Surg. to the Metropolitan Throat Hospital, &c. New York: G. P. Putnam Sons.

This is a small, handy manual, professing to be "a digest descriptive of the more commonly seen diseases of the upper air tract, with the methods of their treatment." It is evidently written by one who is quite familiar with the subject. It is concise, and the explanatory matters seem very accurate and clear. It will no doubt be found useful by students who, when they become practitioners, soon realize how common these diseases are, and how little they know about them.

Typhoid Fever in Victoria.—By JAMES W. BARRETT, M.B., Ch. B., Resident Medical Officer to the Melbourne Hospital. Section I. George Robertson, Melbourne.

This essay upon the most important zymotic disease of modern times is interesting, as showing the character and fatality of the complaint amongst our cousins of the Antipodes. It has been evidently prepared with great care, and is furnished with numerous statistical tables and linear diagrams in explanation of the text. The author is clearly an enthusiastic and

hopeful sanitarian. He dwells strongly upon the preventive nature of typhoid; shows how even restricted sanitary measures in his district have been followed by marked diminution in the number of cases. He would reject the idea of origin *de novo*, believing that decomposing sewage matters must first be contaminated with the typhoid stool before they can breed the disease, and adduces facts in support of this view. This corresponds completely with our own convictions in the matter. The adoption of this theory in no way detracts from the importance of thorough sanitary work for, in either case, cesspools and foul sewers are admitted to be the nidus or breeding-ground for the poison. We shall be glad to receive Dr. Barrett's further contributions to this most important subject.

Chemistry, Inorganic and Organic, with Experiments.—By CHARLES LOUDON BLOXAM, Professor of Chemistry in King's College, London, &c. From the fifth and revised English Edition, with two hundred and ninety-two illustrations. Philadelphia: Henry C. Lea Sons & Co. Montreal: Dawson Bros.

This is one of the best and most complete of the modern text-books of chemistry. It is well known by students and physicians, and needs no special notice. It is only necessary to draw attention to the fact of the appearance of this new edition. It is handsomely printed and profusely illustrated.

A System of Oral Surgery: Being a treatise on the diseases and surgery of the mouth, jaws, face, teeth, and associate parts.—By JAMES E. GARRETSON, M.D., D.D.S., Dean of the Philadelphia Dental College; Surgeon in charge of the Hospital of Oral Surgery. Illustrated with numerous steel-plates and woodcuts. Fourth edition, thoroughly revised, with additions. Philadelphia: J. B. Lippincott & Co.

Of American books this is probably the best and most thorough upon a very important branch of surgery. After an extended description of the anatomy and functions of the

various parts to be found in the region of the mouth and jaws, the teeth claim the first attention, and an extended account is given of the defects and anomalies of teeth, their diseases, and the best means of treatment. This part, of course, necessarily deals with what falls almost exclusively within the domain of the dentist proper. But the latter half of the book makes it well deserving of being in the library of every practical surgeon, for it furnishes a very good account of the numerous affections of the maxillæ, the tongue, lips, tonsils, uvula and soft palate. It is profusely illustrated with woodcuts, and nine steel-plates, well executed, embellish it still further.

Cruise of the Revenue Steamer Corwin in Alaska and the North-West Arctic Ocean, in 1881.—
Washington : Government Printing Office.

We have been favoured with a copy of this interesting compilation of the notes and observations of the scientific staff who accompanied this expedition. They are divided into medical and anthropological, botanical, and ornithological. The first of these is prepared by Dr. Irving C. Rosse, who has carefully studied the physical peculiarities, the linguistic affinities, the artistic instincts, and the craniology of the native Eskimos, and gives us a paper of much interest thereon. Lithographic plates represent the forms of skull prevailing amongst them. The botany of this far-away region is fully detailed with explanatory notes, and the birds and fishes are very fully described, and the rarer kinds are shewn in very beautiful colored drawings.

Books and Pamphlets Received.

STUDENTS' MANUAL OF DISEASES OF THE NOSE AND THROAT. By J. W. M. Kitchen, M.D. New York: G. P. Putnam & Sons.

ON BEDSIDE URINE TESTING, INCLUDING QUANTITATIVE ALBUMEN AND SUGAR. By Geo. Oliver, M.D., Lond. Second Edition. London: H. K. Lewis.

SAN REMO: CLIMATICALLY AND MEDICALLY CONSIDERED. By Arthur Hill Hassall, M.D., Lond. With numerous illustrations. London: Longmans, Green & Co.

A TREATISE ON PHARMACY, DESIGNED AS A TEXT-BOOK FOR THE STUDENT AND AS A GUIDE FOR THE PHYSICIAN AND PHARMACIST. By Edward Parrish. Enlarged and Revised by Thos. W. Wiegand. Philadelphia: Henry C. Lea's Son & Co.

PRACTICAL PATHOLOGY, A MANUAL FOR STUDENTS AND PRACTITIONERS. By G. Sims Woodhead, F.R.C.P.E. Philadelphia: Henry C. Lea's Son & Co.

A PRACTICAL TREATISE ON SURGICAL DIAGNOSIS, DESIGNED AS A MANUAL FOR PRACTITIONERS AND STUDENTS IN MEDICINE. By Ambrose L. Ranney, A.M., M.D. Third Edition. New York: Wm. Wood & Co.

THE INTERNATIONAL ENCYCLOPEDIA OF SURGERY. A systematic treatise on the theory and practice of surgery, by authors of various nations. Edited by John Ashurst, jr., M.D. In six volumes. Vol. IV. New York: Wm. Wood & Co.

VETERINARY MEDICINE AND SURGERY IN DISEASES AND INJURIES OF THE HORSE. Compiled from modern and standard authorities, and edited by F. O. Kirby. New York: Wm. Wood & Co.

A MANUAL OF PRACTICAL HYGIENE. By Edmund A. Parkes, M.D., F.R.S. Edited by F. S. B. François de Chaumont, M.D., F.R.S. Sixth edition, with an appendix giving the American practice in matters relating to hygiene prepared by Fred. N. Owen. Vol. II. New York: Wm. Wood & Co.

THE FIELD OF DISEASE: A BOOK OF PREVENTIVE MEDICINE. By Benjamin Ward Richardson, M.D., LL.D., F.R.S., &c. Philadelphia: Henry C. Lea's Sons & Co.

A MANUAL OF OBSTETRICS. By A. F. A. King, M.D. Second Edition. Philadelphia: Henry C. Lea's Son & Co.

Society Proceedings.

MEDICO-CHIRURGICAL SOCIETY OF MONTREAL.

Stated Meeting, Jan. 25th, 1884.

T. A. RODGER, M.D., PRESIDENT, IN THE CHAIR.

Case of triple birth at 7th month of gestation, in two of the fetuses development had been arrested at about 4th month.—

Dr. Beaumont Small, of Ottawa, sent down the above 4 months' fetuses along with the following history and remarks:—

The patient was a young woman of delicate health who had always been anæmic and troubled with menorrhagia. During the first four months of married life the prolonged menstrual periods continued without change. She then became pregnant, her general condition improved, but she persisted in performing heavy household duties. During the early months of pregnancy there is no history of any condition likely to cause injury to the contents of the uterus. During the last month before delivery there were marked signs of irritability of the uterus. Slight disturbances, such as driving over a rough road and jumping easily from a buggy were followed by pains and distress much

more severe than the causes would lead one to expect. About a week before delivery she fell upon her side receiving a severe shock, active pains ensued and continued until delivery. I was not able to find out if the membranes had been ruptured at the time of the injury. Upon my arrival labor was well advanced, the os fully dilated and waters discharged. During examination a loose body was detected projecting from the os which I endeavoured to recognise as an arm or leg. To my surprise it became loose and was easily withdrawn—proving to be foetus No. 1, in a black, shrivelled, flattened state, differing very little from its present appearance. The flattening was due to compression between the head and pelvic walls. No placenta was attached. In a short time a well-nourished but lifeless foetus of about seven months development was delivered: it had been dead for a day or two only. The placenta followed easily, there was no sign of its being a double organ, or of any attachment of the other foetus. Shortly after foetus No. 3 was removed with its placenta attached. This placenta was elongated and evidently foetus No. 1 had been joined to it. Convalescence progressed favorably and the patient regained her comparative good health. There is no instance of multiple births having occurred in her mother's family. The cause of this unusual condition, I think, can be traced to the impoverished physical condition of the patient. The burden proved too great for the enfeebled uterus—the single placenta proved the stronger and attracted the greater show of nutriment—the other was correspondingly weakened and ultimately destroyed. Such instances of the power of toleration possessed by the uterus are rare. At a recent meeting of the Obstetrical Society of London a similar condition was reported in a twin birth. One other member only had met with the same in his practice.

DR. KENNEDY had never seen a similar case. He thought that pressure stopping the circulation was the cause of death of the specimens exhibited.

DR. WM. H. HINGSTON read the following paper on *Certain Forms of Club Foot*:—It is precisely one hundred years since, as Adams says, the treatment of club foot was limited to

mechanical appliances, when Thilenius proposed the division of the tendo-Achillis by an open wound ; sixty-eight years since the division of the same tendon subcutaneously was performed—if Delpech's operation deserves to be so designated ; and fifty-three years since Strömeyer improved upon the operation of Delpech by puncture and subcutaneous division. The modification of the operation of Thilenius, so far, concerned the manner of dealing with the tendo-Achillis, for to that tendon alone was imputed all the blame of the deformity, until comparatively recently, when other structures—tendinous, muscular, ligamentous, bony—have received attention. I intend here to speak only of that inveterate form of club foot ; not of that simple form with which all are familiar, and which the nurse's, and, later, the mother's hand alone may remedy ; nor of that other form which mechanical appliances may easily correct ; nor of the milder form which tenotomy alone will cure ; nor of a still severer form in which tenotomy of certain tendons, aided by mechanical appliances, suffices to remedy ; but of that still severer form in which division of all the tendons and fascia commonly, or exceptionally at fault, followed by the use of the best mechanical contrivances, are powerless to remedy. One such case I exhibited to you last year, in the person of Emelie, aged 15 years, upon whom I had operated in the early part of 1881 for exaggerated talipes equino-varus. It may be in the recollection of some of you, that, when I showed to this Society the young girl in question upon whom I had performed the operation which had been introduced to the profession by Dr. Phelps, of Chateauguay, N.Y., based on the principle enunciated by Dr. Post, of New York, in dealing with wry neck, I mentioned that I had already, with the tenotome, divided, without much amelioration of the deformity, all the muscles usually at fault in this affection. There remained, to undo the excessive arch and shortening and doubling-in of the foot, excision of a portion of the tarsal bones ; but the additional shortening of the foot that would result, not to speak of the considerable risk to limb and life of opening into the inter-tarsal articulations, made me disinclined to resort to it. You saw the result of the operation in

a completely straightened foot, without any diminution, but with increase of its length, and with but temporary impairment of its strength. The operation, so far as the members of this Society knew, was a novel one, and one not without the apparent qualifications of rashness.

I shall give short notes of a second, third and fourth, and two photographs of the last.

J. McG., æt. 19 years, the subject of exaggerated talipes equino-varus, entered the Hotel Dieu on 12th February, 1883. He had been born with the deformity, but, as years rolled on, the deformity had become greater. The heel was drawn up; the foot very strongly inverted, and bent inward upon itself. The patient walked on the outside of his foot; and the usual cutaneous and tarsal thickness existed there. I could not undo, in the slightest, this exaggerated deformity. I divided subcutaneously the plantar fascia, tibialis posticus, and anticus, and the flexor pollicis and long flexor digitorum, and, lastly, *as is usual with me*, the tendo-Achillis. With the exception of bringing down the heel somewhat, the deformity, notwithstanding considerable force, was not relieved—the excessive arch remaining as before. I then adopted free open incision; swept the knife across the sole of the foot, dividing tissue after tissue till the bones were reached. The excessive arch was then in great measure, but not completely, remedied. Across the ball of the foot a padded splint was applied, and on this, adhesive plaster to which were attached cords which led over pulleys, and a weight of 12 lbs. was suspended. With the exception of looking after the foot-piece, and sliding it nearer to, or farther from, the open wound, no surveillance was needed. The dressing consisted of vaseline for the first two days, and afterwards carbolic lotion or red wash, as suppuration was more or less abundant. When the patient left the hospital, on 30th April, his foot was quite straight and supported his weight comfortably. I have since learned that the foot is in every respect like the other.

CASE III.—Is that of a boy, J. D., aged 10 years, who entered the Hotel Dieu under my care on 15th October, 1883, for double congenital talipes equino-varus. The deformity in

both feet, but chiefly in the left, was excessive, and no amount of force, even under chloroform, could diminish it. Subcutaneous division of the supposed faulty tendons of the left foot was performed, and in the order named in previous case; but, apart from giving greater freedom to the heel on the division of the tendo-Achillis, the rigidity and deformity remained. I then used the scalpel very freely to the sole of the foot, dividing all the tissues down to the bone, and gradually unfolded the excessive arch. This added most markedly to the length of the foot—the cut edges at their centre gaping apart to the extent of nearly two inches. I had difficulty in keeping up extension. The boy was a mischievous fellow, difficult to control. Pulleys were ineffectual, as they were tampered with either by himself or some other patient. But what was found to restrain him effectually was a quickly-setting plaster-Paris splint, with a fenestra opposite to the incision. Through this the gaping wound was filled with tow soaked in Peruvian Balsam and renewed once a day. Granulation went on with surprising rapidity to the end. (I may here say, by way of parenthesis, that Peruvian Balsam, used in this way, is, without exception, the best application with which I am acquainted, and fully merits the favor in which it is held by Sayre and others.)

CASE IV.—This subject was the same as the preceding, the foot this time being the right one. As the deformity was not so great as in the left I hoped, by free subcutaneous division, to remedy it in great measure; but the relief obtained by tenotomy was so inconsiderable that I proceeded at once to treat it as I had treated the left. The order of division was as in preceding case, with this difference, that structures already divided subcutaneously required no further attention by the open wound. The great difficulty in the treatment of the second foot, as in the first, was to keep up proper extension. Every additional day in the hospital added to the boy's cunning and to his desire to display it, regardless of consequences, to the admiring patients around him. During my absence of a couple of days from the city the boy manipulated things as he wished; and on my return, finding the old state of things partially restored, I

put him again under chloroform and forcibly extended the foot. This forcible tearing open of a partially healed wound, I may add, was followed by more suffering than was the original operation.

CASE IV.

(Before the operation.)



In talipes equino-varus, however exaggerated the degree, there is, there can be, no contraction of either the abductor or

of the short flexor of the little toe. The plantar fascia is almost always at fault, and its division remedies to some extent the deformity. The division of the flexor brevis muscle still further relieves the tension; the separation of the flexor longus digitorum still further; division of the tendon of the flexor

(After the operation.)



longus pollicis still more markedly; and that of the flexor accessorius still further. The lumbricales, as they are on the

phalangeal side of the incision, escape division—while division of the tendon of the tibialis posticus completes in a satisfactory manner the relief of the deformity, unless, as in Case I., the long calcaneo-cuboid ligament, a much longer ligament than its name implies, be also partially severed. The hemorrhage is not what might *a priori* be expected. The internal plantar artery, 'tis true, is divided; but the external plantar, much larger than the internal, escapes division, if the knife be not needlessly carried beyond, or in front of, the base of the fifth metatarsal bone. Leaving the large external plantar untouched, its numerous distributing branches suffice to keep the muscles, and the digits and their appendages, abundantly supplied with blood. In no case was the temperature of the foot on the distal side of the incision lowered, and granulations sprang up as abundantly on that as on the central side. The internal plantar nerve is divided early in the operation; and, if the incision be carried too far back, the external plantar suffers also; but this would be unwarrantable. Respect for the arteries prevents our carrying the incision too far forward; and respect for the nerve too far backward.

A question will now obviously suggest itself: Why not divide all these muscular structures subcutaneously? And in the answer to which lies the gist of the whole question: the skin itself is largely at fault, and must be divided; and the division of the artery necessitates an open wound. In Case II. every muscle and tendon were divided down to the bone, but the relief was not what I expected till the unfolding process had gone on for several days after division. In the third and fourth cases (those of the young boy) I was disheartened at the imp's devices with the aid of other patients in the ward to relieve his foot of restraint. The weight and pulley were not equal to him.

The quickly-setting plaster, to which a little salt had been added, applied under strong extension, suited admirably in one foot; and in the other a simple and inexpensive device, suggested to me by Dr. Phelps, and which I now show to you, was used with satisfaction. Most of you are familiar with the method of

applying adhesive plaster around the foot, and along the outer side of the leg; but in this plan the plaster so applied is divided between its two attachments on foot and leg, and two pieces of thick wire, like telegraph wire, and made into hooks or two buckles, are attached, and these are drawn together with strings and tightened as the plaster loosens. This device is a simple, inexpensive and efficient one, and is much better than the single piece of adhesive plaster which, when it slips, becomes useless.

What is 1st, the position of the operation; and what are, 2nd, the limits of its application? It is a most useful one, and one which, compared with excision of a wedge-shaped portion of the scaphoid—an operation which hitherto has not met with any considerable favor—is simple, safe, and requires no dexterity whatever in its performance.

What are the limits of its application? These appear to me clearly defined: 1st. Eliminate all cases in which, by hand or by mechanical appliances, or by both, deformity can be relieved. 2nd. Eliminate all cases which can be relieved by tenotomy. 3rd. Eliminate all cases where these, or any of these methods, or all combined, may suffice; for in all those cases would the operation by open division be totally unwarrantable.

But in those cases of exaggerated club foot, as these now submitted, with excessive arching and shortening, and more especially with narrowing and rolling in of the foot upon itself, *which cannot be relieved by the usual methods*, operation by open division offers important advantages.

DR. SHEPHERD said that Dr. Hingston ought to be congratulated on the results obtained in the cases just quoted, and spoke of the success which Dr. Davies has in these cases, where he operates by removing a wedge-shaped piece from the scaphoid bone.

DR. HY. HOWARD asked Dr. Hingston if the wedge-shaped opening which fills with granulation tissue ever contracted later on, as he had seen operations on the eyelids, which, after healing, were perfect, become a source of trouble from contraction of the granulation tissue months after. In one of these cases,

that of a lad, it became necessary to perform a rhinoplastic operation. A bit of the cheek was transferred to the upper lid, and, later on, whisker hairs grew from this piece.

DR. HINGSTON said that in the face this was so—the tissue would contract; but in the foot, which, with each step, was stretched, this would not occur. In the girl operated on two years ago, there is no contraction.

DR. WOOD exhibited two *Albinos*, and gave the following particulars:—Two boys, aged respectively 9 and 6, with congenital nystagmus, the elder having also right convergent strabismus. They are both albinotic—white hair, eyebrows, skin, and choroid; also pink irides. The eyes are very sensitive to light, and the children are both myopic. They are now, and have always been, healthy. There is no other instance of albinism in family or in any of parental relatives. No parental consanguinity or chronic neurotic disease. Other children healthy; none dead. The children are perfectly intelligent, and the elder has learned to read, although he suffers from inability to bring about proper ocular fixation. The elder child has fair distant vision, though they both suffer from amblyopia. Excitement of any kind increases the oscillation of eyeballs. On examination by ordinary light, the interior of eye can readily be made out. The mother had nothing to say regarding prenatal impressions of any sort. There are four children in family, and these are second and third. Dr. Wood said the question was, how should their eyes be treated?

DR. KENNEDY thought colored glasses, by absorbing some light, would be useful.

DR. HY. HOWARD had seen several similar cases. He used to treat them successfully by using ordinary colored glasses covered with chamois leather, leaving a slit-like opening in the middle of the leather.

Double Nipple.—DR. CAMPBELL mentioned having lately seen a man with two nipples on his left side, and said that Dr. Howard of Lachine had recently seen a case of double nipple on each breast.

DR. SMITH had seen a similar condition in a woman.

Traumatic Delirium.—DR. HINGSTON mentioned that lately he had had an unusual complication follow several operations, viz., violent delirium, with high temperature, lasting four or five days, but never ending fatally. Some of these cases occurred in private practice, others in hospital, and all in temperate patients. He asked if any of the members had similar cases.

DR. TRENHOLME said he had seen several cases of high temperature, accompanied with delirium, follow delivery at the Western Female Hospital.

Condolence.—The following resolutions of condolence were passed :—

Resolved,—That the members of this Society have heard with deep regret of the death of Dr. John Reddy of this city, which took place in Dublin on the 23rd January. The Medico-Chirurgical Society of Montreal feels that in the death of Dr. Reddy, one of its former Presidents, it has lost a member of the profession who, in his entire work, proved himself to be devoted to its best interests.

Resolved,—That this Society extends to the family of the deceased its deep sympathy in the bereavement which has befallen them.

MCGILL MEDICAL SOCIETY.

The seventh regular meeting for the session 1883-84 took place on January 12th, 1884. Dr. Stewart read a paper on "*Some points in the Diagnosis and Treatment of the Neuroses of the Genito-Urinary Organs.*"

The eighth regular meeting took place on Jan. 26th. Dr. MacDonnell read a paper on "*The Human Hand,*" and Mr. W. G. Johnston reported a case of *Cardiac Dyspnœa*.

The ninth regular meeting took place on Feb. 16th. Dr. J. A. MacDonald read a paper on "*Renal Calculus,*" Mr. W. G. Johnston exhibited some pathological specimens, and Mr. Darey reported a case.

The tenth regular meeting took place on March 1st. Dr. R. J. B. Howard read a paper on "*Defœcation,*" and exhibited a specimen of an *os centrale* in the human carpus.

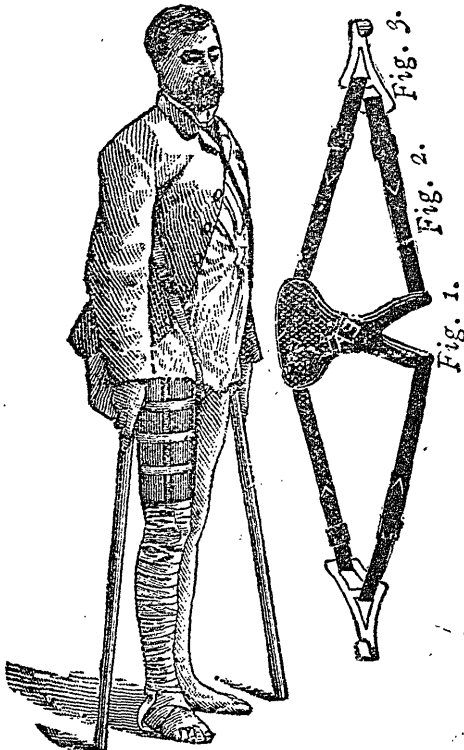
J. H. DAREY, *Secretary.*

Extracts from British and Foreign Journals.

Unless otherwise stated the translations are made specially for this Journal.

New Form of Saddle-Crutch.—We publish by request the following description of this new mechanical support, which first appeared in the *Journal of the American Medical Association*, September 1st, 1883:—

When the patient has recovered sufficiently to leave his bed, crutches are found to be necessary to enable him to move about for exercise and for other purposes; and if you look at the Plate
 Plate VI.



you will see a good representation of a saddle-crutch which I invented some time since, and which has given a number of

my patients a great deal of comfort and myself much satisfaction. The saddle and suspenders are worn inside of the clothing, the hooks alone coming out two inches below the axillæ. Ordinary sticks of proper length suit quite well for crutches if the top end is chiseled to fit the hooks of the suspenders, as they do not touch the axilla when the patient is suspended upon them. Thus the body can be maintained in a natural posture both while standing on the feet, while sitting on a chair, and while swinging in the act of stepping.* I will mention two cases :

Mrs. G., a lady of two hundred and ten pounds weight, came under my care last winter with fractured fibula. When the proper time had arrived I ordered crutches, as usual. Their use was attended with so much suffering, she being afflicted with prolapsus uteri, that she was indisposed to take necessary exercise. I then had a saddle prepared for her, and nicely padded to fit. This she used during the period of convalescence without discomfort, walking three or four hours every day. After she gave up using it, it was re-covered with soft leather and sent to me. It had proved such a pleasant support for her that when her limb was quite restored to usefulness she abandoned the use of the saddle with regret. I pass it round that you may see how it is padded to suit the circumstances.

Mr. B., a gentleman of two hundred and thirty pounds weight, with a similar injury. On the ninth day he procured a pair of crutches, but he got along rather poorly with them. I lent him a saddle, and from that time until he got quite well he used it constantly. It is not necessary for me to explain the advantages of carrying the weight of the body upon well-cushioned pelvic bones fitted by nature for the purpose. Neither do I feel called upon to point out the inconvenience and suffering imposed upon a patient when the doctor orders him to take exercise with ordinary crutches, with the weight of his body suspended upon cross-heads in the axillæ, where he is also in constant danger of injury to the vessels and nerves contained within their boundaries. These are obvious to you all without further mention. The saddle is of simple construction, and can be made very cheaply. I use a bit of steel cut to shape and

bended into the general form of a saddle. A few holes are drilled in to fasten the padding, and a little rivet on each corner, with a protruding head like a button, to fasten the suspenders to. The straps and hooks can be made of any material that is strong enough to carry the body and to suit the pocket or taste of the wearer. I use the boot-strap webbing one inch wide, with button-hole on one end and a buckle near the other end, so that they may be shortened or lengthened at pleasure. Leather straps answer the purpose. The hooks can be made of thick wire bended to suit. I use thin steel plate cut to shape and bended as required.

Torture and Sexual Excitement.—The relation between certain auto-mutilations and sexual excitement was long ago remarked by Montaigne, who said that “lust seeks self-stimulation even in pain.” It has been noticed that hebephreniacs often mutilate themselves, not from a sense of penance, but with obvious enjoyment. Dr. G. M. Cox (*Alienist and Neurologist*, April, 1883) cites an instance of the relation of these seemingly opposed agencies. The victim was a man—who had a wife and several children—of good character, and otherwise sound mentally, but who, at stated periods, displays certain peculiarities. He has never been known to cohabit with a lewd woman nor to speak an immodest word; yet he is a regular visitor and, in his way, a liberal customer of houses of ill-repute. He goes early in the afternoon, selects two of the largest girls in the house, repairs to a private room, and locks the door. He divests himself of all his clothing, except his trousers and boots. Then, lying on the floor, he commands his companions to walk over his naked chest, neck and face, taking care to stop and grind his flesh with their boot-heels. He then buys wine for his tormentors, but drinks none himself. This system of self-torture goes on for a couple of hours. It is said the ecchymosis thus produced soon disappears. The peculiar satisfaction experienced by the “flagellants” was evidently of an unrecognised sexual origin, and the subject needs investigation.—*Journ. of Nerv. and Ment. Dis.*

Antiseptic Puerperal Dressing.—Dr. Gargues says:—Having been asked by several practitioners how I arrange the details in private practice, I will give the particulars here. I carry powders of 15 grains of corrosive sublimate in my satchel, in order to be sure to have them on hand. After confinement I prescribe powders with $7\frac{1}{2}$ grains. I dissolve the 15 grains in a quart of hot water, stirring with a wooden spoon. This forms a solution of about 1 to 1,000, which, according to circumstances, is mixed with an equal amount of hot or cold water, thus forming a solution of 1 to 2,000, which is the strength used for all purposes. I dispense with the disinfection of the abdomen, thighs, and buttocks, deemed necessary in the hospital, but inject invariably a quart into the vagina, placing the patient on a bed-pan. If the latter utensil were not obtainable, it might easily be replaced by some contrivance which will present itself to the mind of the practitioner. In tedious cases I repeat this injection according to circumstances, at least once in three hours, in which case it serves both as a disinfectant for the vagina and as a stimulant for the uterus. When the presenting part appears, I apply to the vulva a piece of lint dipped in the solution, except, of course, in precipitate labor. After the birth of the child and the removal of the after-birth I wash the patient with the solution; apply a binder; cover the genitals and anus with a piece of lint, wrung out of the solution, eight inches long, and folded so as to form four layers three inches wide, which is exactly the width of the space between the genito-femoral sulci in most women; place outside of the lint a piece of oiled silk which is an inch longer and broader; put a large pad of carbolized cotton on top of the oiled silk, and fasten the whole tightly to the binder. For the binder and this piece between the legs I prefer Canton flannel, but any clean muslin or linen will do. The principle in this bandage is to have an absorbent wrung out of the solution of bichloride of mercury in immediate contact with the genitals, a waterproof substance outside, in order to prevent the bichloride from being absorbed by the external parts of the dressing, and a dry and soft absorbent outside the waterproof material, in order to take up the

discharge which exceptionally escapes from the inner compress, to form a first filter for the air, and to keep the inner compress in contact with the skin. Where strict economy is necessary, the lint may be replaced by muslin or cotton batting, the oiled-silk by gutta-percha tissue, and the carbolized cotton by common cotton or any clean rags. If the perinæum has been torn, it is stitched up before applying the bandage, but all other wounds are left entirely to themselves under the protection of the dressing. Three times a day the outside of the genitals and surrounding parts are washed with the solution, and the dressing is renewed. For this purpose the person in charge of the patient dissolves one of the $7\frac{1}{2}$ -grain powders in a quart of warm water. No trained nurse is required, the procedure being so simple that the husband or any female friend can perform it.

The simplicity of this treatment is apparent; its safety for patients, nurses, and doctors is demonstrated by the total absence of any kind of untoward accidents during the five months it has been in use; and its efficacy is proved by the radical change in the condition of the patients in an hospital that abounds in unfavorable hygienic features, and in which disease used to be permanent and death frequent.—*New York Medical Journal*, March 1, 1884.

The Contagiousness of Phthisis.—One of the evil results of the recent discoveries concerning the nature of tuberculosis has been the strengthening of previously only vaguely entertained suspicions of the contagiousness of phthisis. Since it has been conclusively shown that, with tuberculosis, there is found associated a micro-organism, many have rushed to the rash conclusion that it must of necessity be contagious. Others have even gone so far as to insist upon the strict isolation of all consumptives. But while it is true that the disease may, under certain circumstances, be communicated from the sick to those about them, every day experience teaches us that such occurrences are exceptional, and certainly far too rare to justify the cruelty of excluding such poor sufferers from grateful companionship with their fellow-creatures.

It is quite pertinent to refer here to the work done by the Collective Investigation Committee. Concerning it the *British Medical Journal* says; "A large amount of impressive evidence is forthcoming, that persons who are free from hereditary predisposition may acquire phthisis by being brought into very close personal contact, and especially from sleeping with phthisical patients; but the precise conditions under which the disease is communicated have yet to be studied. While this is perfectly true, it must also be remembered that communication is rather the exception than the rule, and that, while it suggests the precautions of good ventilation, disinfection of air and sputa, and separate beds, sufferers from this disease may be tended with comparatively little risk."

It may also be of interest in this connection to allude briefly to the results of some experiments recently undertaken by Drs. Celli and Guarneiri, and published in the *Gazetta degli Ospitali*, No. 56, 1883. These investigators were unable, after the most careful search, to find tubercle bacilli in the air of an unventilated room in which phthisical patients had been sleeping. The expired breath of these patients was likewise found to be entirely free from bacterial contamination. Nor could the specific micro-organisms be discovered in air which had been passed through the sputa of tuberculous patients, although in every case the expectorations were found to contain them in large numbers. They were also unsuccessful in attempts at inoculation with fluids impregnated with this presumably vitiated atmosphere. It would thus appear that the fears of those who lay too much stress on *a priori* reasoning, and too little on the facts of common experience, are to be treated as an exaggeration of morbid apprehensiveness.—*N. Y. Med. Record*.

New Views on Bright's Disease.—At a recent meeting of the Académie de Médecine of Paris, Prof. Semmola, of Naples, communicated to the Society the result of his latest experiments on Bright's disease, under which term he understands chronic parenchymatous nephritis only. The primary cause of albuminuria in that disease is, according to

some, a lesion of the kidneys themselves, while others explain it either by a pathological condition of the albumen in the blood, or by a combination of these two causes. Semmola's experiments go far to show that the lesion in the kidneys is a secondary process. He injected daily under the skin of dogs ten to seventy grammes of white of egg; after four to five days, there were signs of a congestion of the kidneys, which led to hæmorrhage when the dose of albumen was large. After seven to ten days, leucocytes were found in the urine, and the renal epithelium, began to show signs of fatty degeneration. This, after a fortnight, was well marked; and about the twenty-fourth day, there was evidence also of an interstitial lesion of the kidneys. The introduction of albumen into the blood produces a peculiar dyscrasia, and the quantity of albumen eliminated by the urine is larger than that which has been injected; in the animals experimented upon, the bile contained albumen, which is also the case in patients suffering from Bright's disease. As for the cause of the peculiar dyscrasia alluded to, Semmola thinks that it is an alteration of the nutritive functions of the skin. He tried also the subcutaneous injection of blood-serum, yolk of egg, and milk, the first caused a slight albuminuria, but the last two had no effect.

Cider and its Anti-Calculous Properties.—A writer in the *Gaz. Med. de l'Algerie* calls attention to a recent publication by a pupil of Dr. Denis-Dumont, surgeon-in-chief of the Hotel-Dieu, of Caen, which professes to demonstrate that cider is the enemy of stone in all the varieties of calculi which, from one cause or another, affect the bladder. During a long experience in the hospitals of Caen, Dr. Denis-Dumont was struck with the almost complete absence of patients affected with stone—almost complete, because there were a few cases whose habitual beverage was wine. On treating these cases with cider, they were either considerably benefited, or entirely relieved of their malady. Struck with these facts, Dr. Denis-Dumont entered into correspondence with a large number of the medical practitioners of Normandy, principally those who

practiced in localities where cider was the common and almost sole beverage. Of these practitioners, some of whom were of forty years' experience and longer, none had treated a case of stone. If they had treated any affection allied to stone, it was in cases where cider was not the ordinary drink, or it was due to some foreign cause. As a consequence, he has collected a mass of valuable observations which confirm his conjectures, and support him in formulating the proposition that cider is not only a prophylactic against the formation of stone and other affections of the bladder, but also that it is an energetic curative agent, when in the condition to be absorbed, like any ordinary drink, and brewed in the best manner. Cider, even in Normandy, is frequently improperly made—but it would seem that bad cider is not worse than bad wine. The writer, using the precaution to declare that he is not of Normandy, goes on to say, with the effusion of a Frenchman, that, if the results of Dr. Denis-Dumont are admitted, they will furnish cause enough for the encouragement of plantations of apple-trees, and for the fabrication of a beverage which laughs at the phylloxera, which has been served on the table of a Queen of France, to Saint Radegonde, which Charlemagne did not despise; which was celebrated after the epic mode in a Latin poem dedicated to the glory of Phillippe-Augustus by Guillaume le Breton, and which Francois the First appreciated on his visit to Normandy.—*Ex.*

General Anæsthesia by Insufflation of Carbolic Acid in the Larynx.—Brown-Sequard states (*Societe de Biologie*) that the insufflation of carbonic acid into the superior part of the larynx will cause anæsthesia not only of the organ, but a general anæsthesia, in five minutes. This is not the consequence of a local effect, but of absorption of carbonic acid in the lungs. It is an act of inhibition, resulting from the irritation of the laryngeal nerves, which manifests itself through the intermediation of the nerve-centres; in fact, a previous division of the laryngeal nerves prevents the production of anæsthesia. When only one of the laryngeal nerves is cut, anæsthesia is manifested in the side

corresponding to the divided nerve. When general anæsthesia is tardy in production, it suffices to bring it about by a more energetic insufflation. Sensibility returns rapidly in some parts, slower in other parts, and latest in the parts nearest the larynx. Brown Sequard has long since found out that epileptic seizures can be promptly suppressed by the injection of an energetic current of carbonic acid into the larynx.—*St. Louis Med. and Surg. Journ.*; *Maryland Med. Journ.*

Rheumatism and its Allies in Childhood.—Dr. Thomas Barlow thinks that it is impossible to define systematically what is meant by rheumatism, and at present it is best to agree on what we consider to be a typical case of rheumatic fever, and to study the subsequent relapses, sequelæ, and recurrences of that affection. Attention is drawn to an affection about which there is much difference of opinion—viz.: scarlatinal rheumatism. Rheumatism is often spoken of as a sequela of scarlet fever, but it is more often a complication than a sequela. Often in scarlet fever swellings in the sheaths of the tendons are noticed, and joint-structures become implicated; these symptoms subside very rapidly under the influence of salicylate of soda. In rare cases the effusion in one joint at least becomes purulent. There is also in scarlet fever sometimes an affection of serous membranes parallel to what is found in rheumatic fever, but in scarlet fever these effusions often become purulent. Speaking of skin-lesions in relation with rheumatism, the author does not consider that erythema nodosum is closely related to rheumatism, much less convertible into it; but with regard to erythema marginatum and erythema papulatum, there seems more satisfactory evidence to prove that they are related to rheumatism. Urticaria and purpura are in rare instances also related to rheumatism. Dr. Barlow thus sums up his remarks on the relation between chorea and rheumatism: 1. Chorea should be looked upon as a symptom rather than a disease. 2. We are no more justified in saying that chorea is always rheumatic, than in saying that delirium and hyperpyrexia are always rheumatic. 3. Chorea occurs so

frequently in connection with rheumatic symptoms, both in combination and in alternation, that we are justified in provisionally regarding it as itself often a rheumatic symptom. Salicin compounds are not often of much use in the rheumatism of infants, as these compounds are most useful in cases of joint-effusions with pain and fever; whereas a great deal of the rheumatism met with in children is insidious, being attended with ill-defined joint-affection, slight pain, and fever.—*London Medical Record*, December 15, 1883.

A Ready Means for Removing Foreign Bodies from the Throat.—Dr. M. A. Veeder, of Lyons, N.Y., says: “A loop of ordinary suture wire, which may be readily bent in any shape desired, forms an available means of hooking such as pins and needles out of the throat, and has the merit of succeeding sometimes where more elaborate contrivances have failed.”

To Check the Secretion of Milk.—Dr. Ver-rall (*Brit. Med. Journal*) recommends iodide of potassium, 8 grains, and quinine sulphate, 23 grains, three times a day.

MEDICAL WOMEN IN THE OLDEN TIME.—It is not only at the present time that the Hippocratic art numbers its disciples among the female sex; for the *ancien regime* was quite familiar with the professional equality which the press of our day chronicles as a novelty. For example, we have only to consult the *Calendrier Historique de la ville de Lyon* for 1735, to find at the end of a list of the 43 *maîtres chirurgiens*, and preceding that of the apothecaries, a list of 13 widows of surgeons. It would appear that at that period it was admitted that professional knowledge could be transmitted by cohabitation, inasmuch as these widows had the right to practice after the death of their husbands.—*Lyon Medical*, Jan. 13.

CANADA

Medical and Surgical Journal.

MONTREAL, MARCH, 1884.

THE STUDY OF ANATOMY.

The session of 1883-84 has now come to a close, and as it is the first since the introduction of our New Provincial Anatomy Act, we may be permitted to enquire what has been accomplished by it. The first noticeable fact is that, from last October until the present moment, not one single paragraph has been found in the daily papers having reference to the desecration of graves. It will be remembered that, in former years, complaints were numerous and the excitement of the public on the subject intense. We have, moreover, been informed by the teachers of anatomy that it is their belief that, for the first time in the history of the country, grave-robbing has been entirely unknown. The main object, therefore, for which the Act was passed—viz., the suppression of the resurrectionists—has been completely fulfilled. At the same time, the requirements of the Medical Schools have been amply met, so that, instead of restricting students in their practical studies, much larger classes than usual have been supplied with as much dissecting material as there was demand for. It would therefore seem evident that the Act has proved itself a good and efficient one. All public scandal has been avoided, and no real case in which the provisions of the Act have borne harshly upon members of the community has come to light. To all reasonable people these facts should be sufficient, and any fears concerning the possible ill effects of such legislation ought to be dispelled. Instead of being thankful, however, for this measure, which has been the means of doing away with a source of perpetual irritation, disgrace and disquietude, certain people

are even now trying to keep up an agitation on the subject started some time ago. Two of our daily papers have been lending themselves to this unwise opposition. They do not adduce cases of real hardship—cases where the feelings of friends or distant relatives have been wounded by the enforcement of the law. They cannot, for the law has been very carefully administered, and under the supervision of the competent inspector, such possibilities are carefully guarded against. Their arguments are based upon purely hypothetical cases, and upon these they call for agitation for a repeal of the Act. We think this unfair. Take fairly the facts as they exist. Much good has been done; the country relieved of a great incubus of dread and fear of graveyard desecration: the *morale* of all students improved by the removal of a stain upon their name: teachers relieved from a horrid and secret traffic in bodies with midnight marauders. Against this, we know of no substantial case of outraged relatives crying out against a real injustice. Influential papers should think twice before adopting a course so opposed to a real reform. The strangling exploits of Burke and Hare are not yet forgotten: the horror of the events with which these names must always be associated led to the passage of Acts like this for the supplying of the Medical Schools of Great Britain: since when people's minds have been at rest. History repeats itself. In many States of the Union there is no Anatomy Act. The inevitable consequences have followed. Last year we had the scandals in Philadelphia concerning the sale of bodies to the schools by a bribed guardian of the cemetery. This year we have what will long be known as the "Avondale murder." In Cincinnati, the schools had great difficulty in procuring bodies, and the demand was urgent. Two negroes, already versed in the traffic, proceeded to a secluded cottage where dwelt an aged man and two younger people. They attacked and beat to death these three unfortunates, conveyed the corpses to the Ohio Medical College, and sold them to the Demonstrator of Anatomy. "No questions asked." They set fire to the house, which was entirely consumed. Suspicion was aroused by the fact that not a vestige of the three persons was discovered in the ashes; search

was made, and they were at last discovered in the Medical School. The murderers have confessed, and await trial. This awful and truly diabolical triple murder is clearly the outcome of the supineness of the State in not having made proper provision for that which is an admitted necessity in every civilized community, and the responsibility for which the people everywhere recognize as falling upon the governing body. Do we wish to revert to a state of things which would permit of the possibility of the re-enactment of such a horrible tragedy? We sincerely hope not, and we think all medical men should impress upon their lay friends the necessity of giving a fair and reasonable trial to the present Act before condemning it. Let those opposed to it only wait, we are convinced they will find their fears groundless, and that after a time they will fain admit that the law is good and has truly been made in the best interests of the State.

We may mention that Ontario is moving in the direction of enacting an Anatomy Act similar to that of the Province of Quebec. We trust their Legislature will see the wisdom of passing such a measure.

PROPOSED SANITARY BUREAU.

A meeting of medical men took place on the 4th, at Ottawa, in the Railway Committee Room of the House, for the purpose of considering the question of a Dominion Sanitary Bureau. Most of the professional members of the Senate and Commons and fourteen or fifteen of the local physicians.

DR. BERGIN, M.P., took the chair, and DR. PLAYTER acted as secretary. Dr. Playter proposed the following plan;—

It is proposed that in accordance with the present arrangement of the departments, a Sanitary Bureau be associated with the Department of Agriculture. That the Minister of Agriculture be also Minister of Public Health in all such matters relating to the public health as come within the supervision or jurisdiction of the Federal authority, such as vital statistics, quarantine, etc. That there be a Deputy-Minister or Superintendent of the Sanitary Bureau, who shall be a medical man,

appointed by the Government, and who shall be practically chief sanitary officer of the Dominion sanitary system. That there be a permanent Sanitary Committee associated with the Sanitary Bureau, which shall consider and discuss all matters coming within the province of the bureau, and all matters pertaining to the public health of the Dominion, and which shall confer with and advise the Minister and chief sanitary officer in all such matters, and consider what legislation, provincial and federal, will best promote the public health. The Sanitary Committee to consist of a certain number of members, one at least of whom shall be from each of the principal provinces. That the Sanitary Committee have a chairman and secretary, appointed as such by the Government and to be medical men; the Minister and deputy or superintendent of the Sanitary Bureau to be *ex-officio* members of the Sanitary Committee; the Sanitary Committee to meet at certain times in the year in Ottawa for the consideration of such matters relating to the public health of the Dominion as they shall think most desirable; the chief sanitary officer and the secretary of the Sanitary Committee each to receive a salary, but only travelling expenses and per diem honorarium while engaged on the duties of the committee to be paid to the other members of the committee; that there be appointed by the Government in various localities throughout the Dominion a number of local sanitary officers, who shall be medical practitioners, and who with the committee and officers before above named shall constitute the sanitary system of the Dominion; every local sanitary officer is to send to the department at Ottawa, on the first day of every month, a report or statement of the nature or kind, extent and course, so far as could be by him obtained, of any epidemic or epidemics of infectious disease that had prevailed in his locality during the previous month, and such information concerning the general condition of the public health therein as he may be able to obtain, or as may be determined upon by the Sanitary Committee; each local sanitary officer shall be paid for each and every such report or statement the sum of \$2; as the present system for the collection of mortuary statistics is enlarged

from time to time, these local sanitary officers may become statistical officers of their respective localities for making correct returns of deaths to the departments; and on the outbreak of any epidemic of infectious disease in any locality, the local sanitary officer of such locality may, at the request of the chief sanitary officer, make investigation into the source, origin, or cause of such outbreak. The department to issue for free distribution, early in each month, a report containing the synopsis of the reports received from all the local sanitary officers, and any other sanitary information for the public that may be deemed advisable by the Sanitary Committee; and that it shall issue an annual report.

The probable cost of the whole system per year would be about \$10,000 or \$11,000, a very moderate sum for a Dominion health bureau.

Hon. Senator ALMON said he had examined the plan before the meeting, and thought it all that could be desired to commence with.

DRS. GRANT and ORTON spoke strongly in its favour.

DR. POWELL asked if it would not be well to learn first if the Government would entertain the acceptance of any plan at present.

DRS. SPROULE and ORTON believed from what the Government had stated that if the members of the House and others could decide upon some plan, the Government would endeavour to have it carried out.

Hon. Senator PAQUET thought it would not be well to delay, something had better be done now.

DR. HICKEY suggested that the meeting discuss the plan in detail, but as all present had had each a copy of it, it was thought this would occupy too much time.

It was at length moved by Dr. ORTON, seconded by Dr. CHURCH:—That in the opinion of this meeting it is desirable that a Dominion Health Bureau be established and associated with one of the Departments of State in Ottawa.

Carried without opposition.

Moved by DR. ORTON, seconded by DR. HICKEY.—That the

following be a committee to wait upon the Government with the plan under consideration, and ask the Government to provide means to have it or some similar plan carried out, viz. :—Hon. Senator Dr. Paquet, Drs. Grant, Bergin, Church, La Rocque, and the mover and seconder, Drs. Orton and Hickey.

Carried without opposition.

SOMETHING NOT GENERALLY KNOWN TO SURGEONS.

The following cutting from *Wilford's Microcosm* for February will be another argument in favour of "Resurrecting," and will also show how the science of the 19th century is pervading all ranks of the community! What next?

SENSATION IN AMPUTATED LIMBS.

Ed. Microcosm.—In Louisiana, Pike Co., Mo., lived a few years ago, a celebrated surgeon, Dr. Bartlett. His son related to me the following:—Dr. Bartlett was very suddenly called upon to amputate the fractured or broken arm of Mr. Stark, Sheriff of the County of Pike. The broken arm was nicely amputated, and by the friends buried as is customary in such cases. Mr. Stark complained very much of great pain in the small finger of the buried arm or hand. The Dr. (Bartlett) was called in. He (the Doctor) believed that such suffering might possibly be caused by an improper burial of the amputated part. So he took up the hand (arm), straightened out the little finger and placing cotton nicely between the fingers, he re-buried the arm very carefully, and there was no more trouble or pain suffered by Mr. Stark. These are the facts in the case. Dr. B. is known as a first-class surgeon, and as a man whose statements are not called in question. Yours truly, J. B. BRADLEY.

REMARKS ON THE FOREGOING.

Professor Bradley, of the Christian University of Canton, Mo., is not the man to state such facts as the above unless he had quite reliable evidence as to their correctness. We have in former volumes printed several statements of similar facts from reliable sources, and have called upon scientific thinkers and

investigators for an explanation. If the incorporeal organism in man is a real substantial entity, and the exact counterpart of the physical structure, as Substantialism teaches, this certainly would suggest an explanation. The amputation of the physical arm does not, according to this view, take away entirely the incorporeal arm whose form remains connected with the living body. Yet it does take enough of such incorporeal arm to retain its form also in the severed limb, and thus keep up a sympathy between the two till decomposition in the buried arm takes place. Who can offer a more rational solution?

VERMONT MEDICAL COLLEGE.—The opening exercises of this school took place on the 6th ult., and were of a special nature, inasmuch as the University had been made the recipient of a splendid gift of a new building for the Medical Faculty, which is now ready for occupation. Judge Wales, on behalf of the donor, Mr. John P. Howard, made the formal delivery of the building to President Buckham, who made a suitable reply, and then handed the keys to Dr. Grinnell, Dean of the Medical Faculty. The Hon. Henry Ballard then delivered the dedicatory address. The new building is of brick, 50 x 90, and contains chemical and histological laboratories, a large dissecting room and a spacious theatre capable of seating 368 persons. We congratulate the Faculty on having secured such a suitable building.

HEALTH AND HOME: A JOURNAL OF SANITARY SCIENCE AND HOME HYGIENE.—We have received the first number of a new periodical with the foregoing title. It is to be edited by Mr. Fred. N. Boxer, of this city, who is well known as an active and advanced sanitarian. Mr. Boxer has already done good service in Montreal by exposing the entire absence of proper system in connection with the Health Department of the city, and by insisting, as a member of the Sanitary Board, upon the necessity for defining in the clearest manner the duties of all its officials. He has also been largely instrumental in the formation of the "Canadian Sanitary Association," of which he

is the Secretary and of which this publication is to be the official organ. It is not to be exclusively scientific, but will contain to a considerable extent reading matter that will render it suitable for general circulation. It is to be hoped that the dissemination of literature of this nature will serve to arouse in the profession and the general public increased interest in the hygiene of themselves, their homes, schools and public buildings. The Journal itself is very neatly gotten up, and the contents are suitable and varied, and the topics well chosen. We wish a long and useful career to "Health and Home."

THE TERM "PLUCKING."—At this season, when feathers are in the air, it may interest some unhappy candidates to know the origin of the term. In the "Notes and Reminiscences of the late Mr. W. H. Harrison," he mentions, in the description of a visit to Oxford, a custom in which it no doubt originated. He says, in describing the conferring of degrees: "I observed that one of the proctors who sat by the Vice-Chancellor when a passed undergraduate was proposed for his degree, left the side of the Vice-Chancellor and walked down the line formed by the 'heads of the houses,' and then, returning, resumed his seat. Dr. Bliss explained this by saying that in former times, if any one of the 'heads of houses' plucked the gown of the proctor it barred the degree. And this he might do without assigning any reason; but if he did so a second time, his reason was challenged. - And this is the origin of the term 'plucking.'"

— We have much pleasure in congratulating our friend Mr. H. R. Gray, pharmacist, upon his election as alderman for St. Lawrence Ward. Mr. Gray conscientiously refrained from taking any personal part in the canvas, and yet has been returned by an overwhelming majority. This speaks volumes for the respect and esteem entertained for the new alderman by his fellow-citizens. We can only say we wish the City Council contained more like him. It is said that Alderman Gray will be put upon the Board of Health. In this capacity he will have full scope for the exercise of the many talents his friends know him to possess, and we trust his presence there will aid in bring-

ing about a new era in the administration of our civic sanitary affairs, for it is notorious how deplorably deficient these are.

Prof. Archibald, of McGill College Law Faculty, has also been elected Alderman for St. Antoine Ward. The upright character, wide learning, and high attainments of this gentleman will no doubt prove of eminent service in the councils of our city.

Medical Items.

AN OLD DEFINITION OF THE MEANING OF "DOCTOR."—A. Cresswell Rich writes to the *British Medical Journal*: The following epigram appears at the end of the preface to "The Practice of Physic," by Lazarus Riverius. From my study at Montpellier, July 1, 1653. It is signed "W. R.":—

"Doctors, or Teachers, they of *Physick* are
 (Whether by Pen they do it, or in Chair,
 With lively *Voyce*), that teach the way to know
Man's Nature, Health and Sickness, and do show
Diseases, Cause, and Cure. But they who spend
 Their Life in *Visits*, and whose Labours end
 In taking *Fees*, and giving *Paper-scrouls*,
 FACTORS of *Physick* are; and none but *Owls*
 Do count such *Doctors*, that no *Latin* know.
 From whence that *Name* did to our Language flow.

W. R., Doctor, and Factor of *Physick*."

—In Manchester, Eng., a druggist dispensed "three pennyworth of quicksilver and three pennyworth of aquafortis" to a man who wished to mix them to make some sort of an ointment. The man had bought these articles before, but they had always been put up separately. On this occasion they were put in the same bottle, which the man placed in his breast pocket, and left the shop. Very soon the bottle exploded, burning his face and eyes so seriously that he died at the Manchester Eye Hospital.

Maltopepsyn.—Since its introduction into the Dominion of Canada, some four years ago, Maltopepsyn has met with a constantly increasing demand. This has no doubt been to a great extent created by the support of the medical profession. It is also said to be gaining ground in Great Britain, and to have been received there with much favor. It continues to sustain its reputation for the alleviation of digestive disorders and the cure of infants' troubles, such as cholera infantum, &c.