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A NOTE ON PRIMARY CANCER OF THE VAGINA WITH
THE REPORT OF A CASE.¹

BY

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Carcinoma of the female genitals is by no means a rare disease, that of the uterus alone causing one-third of the number of deaths of women who have fatal cancerous disease. It occurs most often in those whose surroundings are unhygienic and who have to make a hard fight to earn their daily bread, the disease thus differing from myoma uteri, which is frequently observed in affluent well fed people. While this general statement is true, the seat of the primary origin of the growth varies very much in frequency, the cervix being by far the most common starting point. From here, it may spread in all directions, sending its treacherous and often undiscovered tentacles far out into the cellular tissue of the broad ligament, condemning its victim to certain, painful and speedy death, or else up into the corpus uteri, down into the vagina or into the bladder. In addition to the above origin of cancer of the vagina, this organ is frequently invaded by growths from the bladder, rectum or vulva. It is, however, one of the rarest of circumstances to find carcinoma having its primary origin in the vagina, and, when this does occur, the growth is usually of the papillomatous variety. Only one or two cases are reported annually in the whole of medical literature. Skene, in his most excellent work, "Diseases of women," utterly ignores the subject and it is but touched upon in any text-book which the writer has been able to examine. The rarity of the disease may be judged of from the

¹ Read before the Montreal Clinical Society, Nov. 27th, 1896.

fact that Martin, of Berlin, has seen but one case in over five thousand patients. The writer of the article upon "Malignant Disease of the Female Genitals," in the American text-book of gynecology says:—"Primary cancer of the vagina is extremely rare. In a large experience, but three cases of it have been seen by the author." During the years between 1886 and 1894, only eighteen cases of this were seen at the Berlin Frauenclinic. Labusquière, of Paris, attributes the rarity of the condition to the fact that few cases come under observation until the cervix is affected. This suggestion, however, should not be given too much weight, as many writers would report their cases to be those of primary cancer of the vagina if the cervix was but slightly affected, while the vagina showed extensive disease. In support of this objection to Labusquière's theory it should be noted that in Steele's case (4) post-mortem examination (no operation had been performed) revealed one nodule on the anterior lip of the cervix and another in the fundus, the former having been discovered when the patient was first seen. While the above is true, Labusquière is quite right in throwing doubt on many of the reports published. For example, Oliver, in the report of one of his cases, says that the patient's age was 62 years, that she had been married for thirty-seven years, and had given birth to one child. The menopause came on when she was 47 years old. Her complaint was swelling of her left inguinal glands. For the last three years, she had had occasional hæmorrhages from the genital canal and that, nine months previous to his seeing her, swellings appeared in the left inguinal region, this being followed in three months by a similar swelling on the right side, these enlargements being but slightly painful. The skin over both was puckered. Local examination revealed (quoting the report verbatim) "the anterior wall of the vagina is so extensively invaded by a firm epithelial growth, that digital examination is impossible." There was no pain in the vagina or trouble with the bladder, urethra or rectum. Now here is a patient, reported to have suffered from an extremely rare affection without a careful examination having been made either before or after death to endeavour to ascertain the true seat of origin of the growth. The patient had had hæmorrhages from the genital passage for three years, and implication of the inguinal glands and vagina, but no extension of the disease to the bladder or urethra, all of the conditions pointing much more strongly to the uterus being the primary seat of the disease than that it began in the vagina. If it had started in the anterior wall of the latter, it is extremely unlikely that it would have become sufficiently extensive to entirely block up the vagina without affecting the bladder or at

least the urethra. In July, 1892, Fenger, of Chicago, read a most complete and interesting paper upon the subject (5) before the Chicago Gynæcological Society, in which he stated that his case made the fifty-seventh which had been reported; since his paper was written, reports of eight other cases have been published, viz.: one case each by Coley (1) patient's age 21 years; Leprevost (2) patient's age 32 years; Barber (3); Haven (3); Steele (4) patient's age 46 years; and Fenger (5) patient's age 60 years; and two (?) by Oliver (6) ages, 53 and 62 years. Thus it will be seen that the case reported below will make the sixty-sixth.

The seat of the disease is usually on the upper third of the posterior vaginal wall, out of the eighteen cases observed in the Berlin Frauenclinic, thirteen occupied this situation. This circumstance rather favours the theory of cancer being caused by irritation as it is the part which would be chiefly irritated by a pessary or any acrid discharges which might come from the uterus, the cervix and upper third of the posterior vaginal wall being continually in contact with each other in the normal situation of the uterus.

The age, at which it is said usually to occur, is from forty to fifty, but in the last six cases reported, in which the age of the patient is mentioned, only once did the above hold good. This number is, however, too small upon which to found an opinion.

As regards treatment, of course the only thing to be done, if the case is seen sufficiently early, is to remove the growth just as one would do elsewhere, but nowhere will the courage, ingenuity and skill of the operator be brought more into play than here, as each case requires an operation of its own, keeping in mind the necessity of cutting as clear of the diseased tissues as possible.

The following case occurred in the practice of the writer, the pathological report (without which no case report is complete) being kindly furnished by Dr. Wyatt Johnston, Pathologist to the Montreal General Hospital.

Mrs. C., aged 42 years, came to the gynæcological out-patient department of the Montreal General Hospital on February 20th, 1896. She complained of an extremely offensive watery discharge from the vagina, which had been going on for the last two months, and had been tinged with blood for the four weeks previous to her seeking advice. There was no pain, but she had lost considerable flesh, saying, in fact, that she had "grown ten years older in the last six months." She had been married for twenty years, and given birth to four full time children, the youngest being seven years old. In addition to these, she had had one miscarriage. Her menses had

been irregular for some months. Leucorrhœa was profuse. The patient's history was entirely negative as regards the source of any local irritation, unless we can look upon the irritating leucorrhœa as a possible factor. She had never worn a pessary, her husband had always been healthy and there was no history of cancer ever having occurred in her family.

Upon making a vaginal examination, a growth the size and shape of a large walnut was to be felt protruding from the post vaginal wall at the level of the junction of the upper and middle thirds. The free surface was convex, uneven and spongy. This mass was attached to the vagina by a broad flat pedicle, which could not be felt at first owing to the manner in which the cauliflower-like growth overlapped it. The finger could be passed with ease between the cervix and tumour and no connection between the two could be felt, although this was very carefully sought for. The growth was fairly movable as though it had not implicated the peritoneum but felt as if it slid over this structure.

The cervix and uterus were practically normal, the former being quite soft and not imparting to the finger the sensation which would be produced by a carcinoma.

On inspecting the parts through the speculum, the above mentioned mass was seen to have greyish gangrenous looking patches here and there on the surface, which, in other places was red and angry-looking and bled on drawing the vaginal forceps over it.

The cervix was not torn but was red and inflamed around the os, owing probably to the action of the discharge produced by the growth, but it did not look at all like a cervix which is the seat of malignant disease. The inguinal glands were not involved.

On February 22nd, the patient was anæsthetised and placed in the lithotomy position and the parts very carefully sterilized. After thoroughly exposing the growth an incision was made into the vaginal wall about a quarter of an inch below it. By working carefully with the finger and scissors, the peritoneum of the pouch of Douglas was exposed and the finger was passed up so as to completely separate it from the base of the tumour. The ease with which this was effected convinced me that the growth had not implicated the peritoneum, so it was decided not to perforate it if possible. By exerting traction upon the tumour and using the thermocautery knife, the whole mass was removed, the line of incision being in healthy tissue. The cavity thus made was packed with iodoform gauze and left to granulate. The patient made an uneventful recovery and left hospital on the 10th day after operation. At that time, the wound was contracting nicely but there were some granulations which bled upon pressure.

Pathologist's Report.—The tumour is the size of a walnut with a broad pedicle and over-hanging edges. The surface is fungating and presents numerous ragged, granulating areas. It projects above the level of the adjacent vaginal mucosa and, on section, is seen to be of a pinkish-grey colour and highly vascular. On scraping the cut surface of a vertical section no juice can be obtained except from the fungating area near the surface which yields an opaque greyish pulp, composed of epithelioid cells which are small and oval or pear-shaped, very few being flattened. There are no ribbed or prickle-cells.

Microscopic examination shows a fibrous pedicle, containing large blood vessels. Near the surface, the growth is distinctly alveolar, the alveoli being large and filled with solid masses of epithelial cells, the cells near the alveoli being pear-shaped while those toward the centre are rounder. There are no cell-nests nor do the cells show the character of squamous epithelium.

The growth is evidently a carcinoma and has apparently originated in the vaginal mucosa. The type of cell suggests an origin in the glands rather than from the surface epithelium. The base of the tumour does not appear to be distinctly infiltrated or show any certain evidence of new growth, although some of the lymphatics appear to contain epithelial cells. It may be called a "glandular carcinoma."

Cancer of the vagina is most often described as being secondary to a growth in some other organ such as the bladder or rectum, "but in the present case the appearance of the pedicle seems to negative that origin. The line of operation appears to have passed well clear of the edges of the growth."

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THE TECHNIQUE OF VAGINAL HYSTERECTOMY.¹

BY

L. COYTEUX PRÉVOST, M.D.

The paper which I am about to read before you is entirely devoid of the least pretension, the only merit that may recommend it to your indulgence being its brevity. I am aware of the fact that it contains nothing which is not already known to several amongst you; however I thought that it might not be altogether without usefulness. I read¹ so many things! about vaginal hysterectomy, I heard so much of it, I saw it being performed so many times and by the best gynaecologists, that I believed it advisable to add all this variety of information to my personal experience and conceived the desire of describing what I think to be the most practical mode of operating.

I want, at the outset, to draw your attention to the fact that I do not intend to discuss the superiority of vaginal as compared with abdominal hysterectomy; this question is still "*sub-judice*." Therefore, I do not declare any sympathy with either the laparotomists or those who prefer the vaginal way; experience will tell wherein lies the truth. Still, we may, I suppose, even now admit that there are many cases in which the surgeon must operate through the vagina. The removal of the uterus per vaginam being considered by many as an operation far more difficult than coeliotomy, thus greater technical difficulty has been cited amongst the arguments offered by the laparotomists in favour of their mode of operating. I believe this to be an entirely delusive idea and I deem vaginal hysterectomy just as easy an operation and far less dangerous in its results than the surgical procedure which consists in removing the uterus through the abdomen, provided, it goes without saying, that one knows how to do that operation properly.

Without any further preamble, I come to the fact.

For the convenience of the description, I will suppose that we have to deal with a typical case, without any complications. For example, here is a woman, approaching menopause; she complains of lumbo-abdominal pains, has constant leucorrhœa; repeated metrorrhagias have failed to be controlled by several treatments including curretting; the uterus is more or less voluminous, with or without adhesions. We decide to remove that organ with its appendages hoping by that radical operation to obtain a complete and permanent cure of all the symptoms.

¹ Read before the Canadian Medical Association, Montreal, August, 1896.

It is needless to remark, at first, that vaginal hysterectomy is a major operation and that here, as always, aseptic and antiseptic precautions must have been taken, especially with regard to the disinfection of the vagina.

The woman is placed in the dorsal position. Besides the anesthetist, two assistants are sufficient but necessary, one on each side of the operator. The one to the left, intrusted with the holding of the posterior retractor, may be sitting down, his task thus will not be so tiresome and he will, besides, be in a better position to see what is going on. The assistant to the right, besides making himself generally useful, will attend to the irrigation of the operating field. A reliable nurse will look after the gauze, swabs or mounted sponges and hand them to the operator when required.

First steps of the operation: curetting of the uterus, out of cleanliness as it were, if not for other reasons.

A retractor depresses the posterior commissure and is confided to the left assistant. The cervix is seized with two four-toothed strong volsellas, one applied on the anterior and the other in the posterior lips. The operator holds both volsellas in his left hand and the uterus is moved to and fro in order to ascertain its mobility and also the line of insertion of the bladder on the cervix. The uterus is then pulled down as much as possible. The anterior wall of the vagina may be raised by a superior retractor confided to the right assistant. The cervix is pulled to the left of the operator, care being taken to keep correctly in line with the transverse diameter of the vagina. With a sharp knife, an incision one inch long is carried on the side of the cervix to one centimeter of the os tinæ, cutting through the mucous and sub-mucous tissues only. The cervix is then shoved to the right and a similar incision made on the other side. The cervix being brought to the median line, the extremities of the lateral incisions are united by two others, one crossing the anterior part of the cervix near the os externum, and the other on the posterior surface, midway between the extremity of the cervix and the posterior cul-de-sac. Then incisions, called Segoad's incisions, divide the vagino-cervical mucous membrane into two flaps, one anterior and the other posterior; they greatly facilitate the separation of the tissues and especially help immensely to keep the ureters out of the way. They may be boldly made away up on the sides of the cervix, where the danger of hemorrhage is nill, owing to the absence of any large blood-vessels in a triangular space situated laterally an inch and a-half to two inches from the top of the cervix.

Those incisions being made, the superior retractor is removed and

the volsellas raised carrying the cervix upwards, in the antero-posterior diameter. With the nail of the right thumb, the tissues are separated from the posterior surface of the cervix, the scissors being used occasionally should it be necessary, taking care to hug more closely the body of the uterus when reaching the deep parts of the posterior cul-de-sac. The finger or a nip of the scissors will soon allow the Douglas pouch to be burst through and if there should exist a purulent collection in the pelvic cavity, it will generally gush out at this step of the operation; we must not mind it and let it run freely, but the irrigation should then be started in a good stream and kept up during the whole course of the operation.

The volsellas are now brought downwards to allow the separation of the tissues on the anterior surface of the cervix. This part of the operation is most delicate and must be attended to very carefully, owing to the danger of wounding the bladder or the ureters. The finger nail must be used here almost altogether or perhaps an occasional nick of the bistoury if the tissues do not yield readily. Care must be taken not to work too superficially nor too deeply; in the latter case, the denudation will take place through the cervical tissue proper, which is liable to lead us astray; "Shave the uterus, as it were" according to Segoad's expression. The cervix is well pulled down and the separation of the mucous and sub-mucous tissues carried well up, paying special attention to the denudation laterally in order to take the ureters well out of the way. No superior retractor must be used as it has been recommended, or else we may run the risk of bursting through the bladder with that instrument. It is entirely needless to look for the vesico-uterine peritoneal fold in order to cut it open as we used to do formerly, it will later on present itself under the blades of the scissors during the section of the uterus. Experience alone will teach when the denudation has been carried far enough; sometimes the finger will tell when that point is reached: we feel that we are moving easily in the loose cellular tissue, laterally the finger can be inserted between the anterior and posterior folds of the base of the broad ligament and then feel the beatings of the uterine artery. The uterus is free everywhere from its surroundings, the denudation has been carried anteriorly, posteriorly, laterally, let us say a couple of inches, it is time to proceed to the first steps of the hæmostasia. The flow of blood so far has been insignificant, the irrigation sufficing to keep clean the operating field; at all events, all hæmorrhage will cease as soon as the first clamps are applied. Armed with a long handled Pean's clamp, with short, stout bill, the operator pulls the cervix to his left and grasps the broad ligament away up on

the left side of the cervix, about a quarter of an inch outside of the uterus. The instrument must at first be directed from outwards inwards, the tip towards the uterus. When engaged up to the joint, the clamp is straightened, the handles being carried towards the middle line and then pushed high up, the left hand relaxing in the meantime the tension of the cervix which so far has been kept taut; the catch is then closed to the maximum.

This step of the operation is of the utmost importance and I beg your pardon if I particularly insist upon some points of its technique. In fact the two greatest dangers of vaginal hysterectomy are hæmorrhage and the wounding of the ureters. One must never lose sight of the situation of the latter which can always be avoided with a little care. Thus, when the insertion of the vagina upon the cervix has been separated, and the bladder taken out of the way, the ureter is situated outside of the uterine artery, half an inch from the border of the uterus. If Segoad's lateral incision has been made, the distance between the uterus and ureters is increased still by half an inch. It is therefore through a space of an inch that the clamp can be moved without running the risk of catching the ureter. Now, with regard to hæmorrhage, one cannot insist too much upon the necessity of carefully securing the uterine artery. As you know, during hysterectomy two arteries must especially be kept under control: the ovarian and uterine. Supposing that after the section of the superior border of the broad ligament, the ovarian artery escapes our grasp, we can always run after it, because the superior border of the ligament does not separate in two layers like that of the base, it remains as a floating shred carrying the artery which can be caught again. As far as the uterine artery is concerned, it is different. Should it escape, it steals away between the folds of the ligament and the hæmorrhage is as formidable as it is difficult to control. Before applying the clamp or the ligature, it is generally easy to feel the pulsations of that artery in the side of the uterus provided the tension on the cervix has been relieved by the hand holding the volsella. It remains but to guide the hæmostatic forceps with the finger applied on the vessel. And again, since the ureter, owing to Segoad's incision, is situated one full inch from the uterus, we must not fear to bite a pretty broad portion of the ligament containing the artery to prevent the tissues from slipping out of the clamp should they be caught too close to the uterus.

Another remark: At this step of the operation, as well as further on, should there be a free flow of blood, care should be taken not to attempt to check it by applying a new clamp from below upwards outside of the first one at the base of the broad ligament. The ureter

has been shoved out of the operating field, it is true, but it lies there still, hidden under the broad ligament and can always be wounded. I know a surgeon who met with this accident for having forgotten these abdominal relations.

Both uterine arteries have been clamped on either side, the tissues are severed with a pair of strong scissors, between the clamp and the uterus, and we may then immediately proceed to the section of the cervix. One blade of the scissors is introduced in the cervical canal, and the section extended on either side, right up to the clamps, thus leaving two flaps; one on the pubic and one on the rectal side, both perfectly bloodless. The posterior flap is removed across its base. The anterior one is cut away also, taking care here to fix a volsella to the left of the remaining portion of the uterus before the cervical lip is totally removed. This being done, another volsella is applied to the right of the uterine stump; both volsellas are grasped in the left hand and kept somewhat apart as the uterus is pulled down. With the scissors, a section is made on the median line between the volsellas, one blade in the uterine cavity, the anterior wall only is divided. A triangular section will thus be formed with a volsella fixed at either angle, the apex disappearing above. The volsellas are released and applied higher up, one on each side; the uterus again pulled down, fresh tissue appears and divided as before at the apex. It is during this step of the operation that the vesico-uterine fold of the peritoneum is divided along the uterine tissue without it being necessary to pay special attention to it. Three successive tractions and divisions with the scissors will soon cause the fundus to pop out at the superior part. The right assistant introduces a retractor to keep the bladder and the anterior wall of the vagina out of the way. The scissors continuing the section divides the vault of the uterus as far as the posterior wall. The uterine cavity being exposed, should it be thought necessary, the mucous membrane may be touched with pure carbolic acid to prevent any possible infection of the peritoneal cavity. The uterus is again pulled further out, the volsella confided to the assistant, and the left index is introduced into the abdominal cavity, the palmar surface kept in contact with the peritoneal side of the wall of the uterus and used as a guide to a blade of the scissors which entirely divides the posterior wall. Here we are now, with the uterus divided in two halves, right and left. With the left hand introduced in the abdomen, the appendages are fished out and brought down in the vagina, the tips of the fingers grasping the infundibuliform ligament. On the latter, a stout Pean's clamp is applied from above downwards, the tip of which touching that of the first clamp already fixed on the base of the broad ligament. The catch must be

locked to the maximum, then the appendages and the left half of the uterus are cut off and removed. The same manœuvre is easily done on the other side.

A careful examination must now be made of the accuracy of the hæmostasia. The two sets of clamps are taken, one in each hand, and kept apart, the Trendelenburg rack is raised a few cranks. Those who have never witnessed the effect of the action of the Trendelenburg position in vaginal hysterectomy will be surprised in observing its results. The bowels recede and one can thoroughly inspect the whole of the pelvic cavity and see almost up to the diaphragm, according to Pryor's expression. The parts are sponged dry, and should a few points give, the oozing spot must be ligatured or seized by a long slender hæmostatic forceps which is left in with the other clamps.

The operation is over. Two strips of iodoform gauze are introduced high up, care being taken to cover the tip of the clamps, a strand of silk being attached to the lower extremities to recognize them the day of the removal. The vagina is packed with sterilized gauze, surrounding the handles of the clamps everywhere to prevent sloughing of the mucous membrane by the direct pressure of the instruments. A catheter is introduced to empty the bladder, a T bandage applied and the patient carefully carried to her bed.

Forty-eight hours after the operation the vaginal packing is removed and also the clamps; the deep strips of iodoform gauze are left in situ five or six days if there be no great elevation of temperature. If it were a pus case, it is advisable to remove the dressing and renew it every day. At any rate, no vaginal injection must be given until at least six hours after the removal of the last piece of gauze; when used sooner, some patients are known to have suffered immense abdominal pains sometimes accompanied with syncope.

The bowels should be moved on the third day by a glycerine enema and the patient allowed to get out of bed two weeks after the operation.

N.B.—Beware of the retractors: the bladder has often been wounded by the awkward manipulation of these instruments.

Operate in the vagina and on the median line. See what you are doing; the knife, scissors and clamps must never be used unless their action be controlled by sight and touch.

Should the tube and ovary be adherent and the application of the clamps of the infundibulo-pelvic ligament difficult, grasp the broad ligament close to the uterine cornu and cut the uterus out of the way. Then try again to detach, clamp and remove the appendages. If the task seems to be too hard, leave them in, no harm will follow: deprived of the uterus they will soon wither and become atrophied.

A CASE OF PERTUSSIS COMPLICATED WITH BRONCHOPNEUMOMIA ; HÆMOPTYSIS, CONVULSIONS AND COMPLETE LEFT HEMIPLEGIA.

BY

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The variety of the complications of this case of whooping cough together with the rarity of those of a paralytic nature, may suffice as reasons why a note of its course and development should be placed on record.

Flora B., aged 5 years, was first seen at the out-patient department of the Royal Victoria Hospital, July 29th, 1896, a subject of whooping cough of a severe type and of four weeks duration, manifestly with pulmonary complications. The temperature was elevated, the respiration accelerated and diminished, resonance was noted in the left infraclavicular region with faint blowing breathing in this area.

The patient's family history showed tuberculosis prominently in both branches while her mother was a subject of pulmonary tuberculosis of an acute type. There was no history of syphilis.

The personal history of the patient is as follows :

At the age of two years she had a convulsive seizure which, from the history, seems to have been due to some digestive disturbance. At three she is said to have had la grippe. At four she had measles and a few months before coming under observation in July she had diphtheria.

On the 29th of July, headache and slight numbness in the lower extremities were complained of. On the following morning the headache was severe and on the afternoon of the 30th, after two very severe fits of coughing she was found unable to walk. The following day, 31st July, on her second visit to the hospital, complete left sided paralysis was observed and the patient was admitted. Her condition may be thus described. She was a fairly well nourished child of average size and development, showing marked pallour of surface, with left hemiplegia, temperature 102°, respiration 62, pulse 158. Her mental state was active.

Convulsive seizures began immediately after admission and recurred at varying intervals for about two and one-half days, during which the cough was troublesome and spasmodic in character. The convulsions were confined almost entirely to the left side and

involved the upper and lower extremity. The head and eyes were turned toward the left and between the convulsive attacks nystagmus was present. The attacks seemed to begin about the left angle of the mouth whence clonic movements, rapidly extending, involved the left side. The right eye was more completely turned toward the left than its fellow, while on one or two occasions the right pupil was larger than the left.

The knee reflexes were absent, the plantar reflexes were present. There was no ankle clonus. During a few days at the beginning there was involuntary passing of urine and stool.

Course of Case. The hemiplegic condition improved during her stay in the hospital while the signs in the lungs extended, dulness passing into the left axilla, and the right base anteriorly presented similar signs. On the third of August slight hæmoptysis began and recurred from time to time during the next few days. The sputum gave no evidence of the presence of tubercle bacilli.

The heart was negative.

The abdomen was also negative.

A trace of albumen was observed shortly after admission into the hospital but no casts were found.

From the 16th of August until her death on 26th September, she was at home, attended occasionally by Dr. J. Asselin, and to him I am much indebted for notes of the progress of the case, as well as for references to other cases recently reported.

In September, she was able to walk about, but always with some dragging of the left foot, and with the forearm flexed and held to her side.

The signs of pneumonia persisted; the cough never left her. From the 10th of September until her death she suffered with much respiratory difficulty, and during the few days preceding the end, delirium supervened and progressive asphyxia soon ended in death.

It is a matter of not a little regret that no autopsy was done on this rare case, and though a diagnosis of pertussis, complicated with pneumonia and hemiplegia is made, yet about the cause and pathological basis of the paralytic condition there may be some question.

Among the possible causes one must include :

1. Embolism or thrombosis.
2. Tuberculous meningitis.
3. Cerebral hæmorrhage.

Since evidence for a source of an embolus is wanting, we may exclude it as a cause. There were no cardiac lesions; no manifest peripheral thrombosis.

The paroxysms of cough may have afforded a cause for thrombosis, but such is less probable than a hæmorrhage.

Tuberculous meningitis may induce alike the formation of thrombi or the condition favouring hæmorrhage, though the occurrence of the latter is doubtful.

Moreover, the hemiplegic attack was not an event in a case characterized by cerebral symptoms, but was an added event, a complication, in pertussis.

It will be agreed, we think, that the type of the complication corresponds pretty closely to hemiplegic conditions due to hæmorrhage.

It was sudden and complete. The leg recovered sooner and to a greater degree than the arm. It was followed by contractures. There was an exciting cause—the severe spasmodic cough. And as external hæmorrhages in whooping cough are not uncommon, a cerebral hæmorrhage need not be an unexpected event.

While hemiplegia is considered among the rarities of nervous complications of pertussis a search over clinical reports and text-books results in evidence sufficiently strong to corroborate the diagnosis of this condition as directly due to the paroxysm.

Among those whose opinions on these points have been reviewed in connection with this case, the following names may be given :

Henoch in his book on Diseases of Children.

Samuel West, London Clinical Society Report, 1887.

Hopkinson, *British Medical Journal*, Vol. II, 1894.

Craig, *British Medical Journal*, June, 1896.

McKerron, *British Medical Journal*, September, 1896.

Recently, additional cases have been reported by Neurath, of Vienna, and Cassirer, of Berlin. While Bernhard's case, lately discussed in the Society for Internal Medicine in Berlin, presented the rare features of paraplegia occurring during whooping cough.

A CASE OF APPENDICITIS WITH THREE RELAPSES— VENTRAL HERNIA.

BY

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For the early history of the case I am indebted to Dr. C. A. Hurd, of Northwood, under whose care the patient was for about a year.

Jas. McQ., a strong healthy farmer of Scotch descent, aged about 30 years, was taken during the night of July 1st, 1894, with severe colic, accompanied with vomiting, severe localized pain in the right iliac region and obstinate constipation. Dr. Hurd advised operation, which was declined. So he put him on half teacupful doses of castor oil and morphia, with poultices to the iliac region. His sickness lasted till the middle of September, 1894. Jan. 19th, 1895, Dr. Hurd was called again, and found a large tumour with great tenderness in the right iliac region, fœcal vomiting, and obstinate constipation. This time Dr. Hurd insisted on operating as the only way of saving the man's life. The patient consented, and Dr. Hurd, with the assistance of Dr. Blackmer, of Albert Lea, Minnesota, opened the abdomen over the tumour, and at once found pus. It welled right out like a spring. The intestines were found all matted together, but the appendix could not be found. A drainage tube was inserted, and the wound stitched up. Fæces and gas escaped from the incision for some time. The soft parts were so undermined and necrosed that the stitches did not hold; but all sloughed out, and the wound had to be strapped together with plaster. This attack lasted till Feb. 20th, 1895. Shortly after he got up, he developed a ventral hernia. On the 20th of May, 1895, he developed a localized peritonitis in the site of the operation which was caused by his wife having a nightmare and accidentally striking him with her knee in the right iliac region. This attack lasted about ten days. In the spring of 1896, he went down to a Homeopathic Institute in Chicago, run by a Dr. Pratt, to be operated on for the ventral hernia, from which he made a good recovery. On the 13th of July, 1896, he came under my care for violent cramps in the stomach, obstinate constipation and vomiting. I ordered turpentine stupes, gave him some heavy doses of salts, and morphia hypodermically. After four visits I left him much relieved, with his bowels freely opened and no pain. My last visit was made on July 15th. On the 19th of July, I was sent for hurriedly to see McQ., and was

told that something had gathered and broken in his belly. On examination I found that an abscess had formed in the site of the operation scar of the hernia and had burst externally in one spot, and that another spot was necrotic. The worst pain he complained of during my first four visits was not over the site of the operation, but on the left side of the abdomen, close to the linea alba. I cleansed the abscess cavity with carbolic acid solution and packed it with iodoform gauze. Next day the necrosed spot had completely sloughed away and there were two large ragged openings into the abscess cavity. I kept syringing out the cavity for several days and packing with iodoform gauze. I was somewhat afraid of an opening into the bowel from the character of the discharge, which had no fæcal odor however, but the abscess healed up kindly. I passed a probe about 4 inches directly downwards into the abdominal cavity. I thereupon armed a probe with Nitrate of Silver and passed it to set up adhesive inflammation if there were any such opening into the bowel. My last visit was made Aug. 6th, 1896, when he was practically well, with the abscess completely healed, and only a little granulating surface left at the level of the skin about the size of a nickel. Curiously enough the patient's wife told me subsequently, that on the very day of my last visit, but after my departure, when she took off the dressing from the granulating surface at night, she found two raspberry seeds on the cloth. He had partaken quite freely of raspberries, which his mother had sent him the day before. She was quite alarmed at this, but wisely said nothing to the patient and awaited developments, which by the way never developed. She showed me the little piece of cloth with two raspberry seeds on it, which she declared were just as she removed them from the wound. He has made a good recovery since and is now strong and well, though not able to do work of any account. I omitted to say that his last attack was brought on by his running against a projecting board in a hay-mow and striking himself directly over the site of the original injury. I think it is very evident, that if he had submitted to operation at the time of his first attack, he would have escaped all his subsequent trouble. As I write McQ., has just come into my office and says he is well and strong, and feels as good as ever.

RETROSPECT OF CURRENT LITERATURE.

Medicine.

On the Differential Diagnosis of Systolic Heart Murmurs.

LEUBE. "Zur Diagnose der Systolischen Herzgeräusche."—*Deutsche Archiv für Klinische Medicin*, Band 57, 3 und 4 Heft, 1896.

Whoever has carefully examined the chests of a very large number of patients, will have been impressed with the astonishing frequency of systolic cardiac murmurs where no other evidence whatever of heart disease is present. Under certain circumstances a diagnosis of the actual condition is well nigh impossible, and one must of necessity be non-committal when consulted. This question as to the presence of a true endocarditis or merely of a hæmic murmur or one due to myocardial disease of the papillary muscles, &c., may be readily differentiated in typical cases, but for a very large proportion of cases one can make no positive diagnosis, inasmuch as the condition present often seems one midway between organic and functional disease. Time and again one hears systolic cardiac murmurs which are induced by no discernible pathological lesion as examined at the autopsy. The importance of this is obviously great to all practitioners, both for diagnosis and prognosis; to none more so than to the examiner for life insurance. Realizing himself the frequent doubts which have arisen in the differential determination of a certain proportion of systolic cardiac murmurs, Prof. Leube, of Würzburg, discusses the subject in a short article, dealing with the main features to be observed and the means whereby a diagnosis may be most easily reached.

Systolic murmurs of this doubtful nature are usually due to one of three conditions, viz.: 1. An ordinary anæmia; 2. A mitral endocarditis with insufficiency; and 3. A myocarditis associated with anæmia or intoxication, and inducing a relative mitral insufficiency.

Firstly. An ordinary anæmia will induce a systolic murmur because of changes in the region of the pulmonary artery—either that the

vessel wall possesses less tonus than normal, and therefore the blood pressed into it causes abnormal stretching, and hence altered central currents in that portion of the circulation—or, as Geigel suggests, anæmia induces a lowered blood pressure in the larger vessels and the ventricular blood may be regarded as passing through an orifice which, under the circumstances, is abnormally small—a physiological stenosis. If the first of these apply, as seems probable in a certain proportion of these cases, the mitral valves would play no part in the causation of the murmur and their closure would be definitely heard, so that Leube regards this as a point of distinct importance in differential diagnosis, viz., that the hæmic murmurs should be always immediately preceded by the closure sound of the mitral valves. Other points of importance in the diagnosis are a normal area of præcordial dulness, a normal unaccentuated pulmonary second sound, and, as already stated, a systolic murmur loudest at the pulmonary area, heard too, perhaps, elsewhere, but with less intensity. The intensity and constancy of this murmur are of minor importance, being variable in different cases, and at different times in the same case, though, as a rule, they are soft and blowing.

Secondly. There is the systolic murmur arising from a mitral insufficiency through endocarditis. In most cases the diagnosis is clear. The shock in the 5th interspace, which obviously cannot be very forcible, the enlarged præcordial dulness to right and left, the accentuated pulmonary second sound varying in intensity according to the amount of blood pressure in the circulation of the lungs, all render it evident that the systolic murmur heard at the apex is of inflammatory origin. Leube insists, however, that a pure mitral insufficiency is much more uncommon than is generally supposed, and that a concurrent stenosis is not only quite frequent, but almost essential as a result of the morbid lesions present. These signs, however, apply in reality to those cases of endocarditis which have been in existence for some weeks—cases therefore of a subacute or chronic nature. For the acute endocarditides the conditions are in many respects different, while the systolic murmur may be unchanged. It is in these cases especially where the differential diagnosis is at times unusually difficult. There is no cardiac hypertrophy at first, and when the enlargement does appear, the left side is invariably first involved. The pulmonary second sound is, moreover, constantly accentuated, a condition absent in the cardiac signs associated with anæmia. This too, however, may, under certain conditions, be changed, and we are then bound to rely on the etiology for an explanation. The presence of an infectious disease or one of the specific fevers does

not give rise, according to Leube, to "accidental" murmurs—but much rather to murmurs which originate, through diseased conditions of the myocardium or valves themselves. To decide, however, as to which of these is present, offers several difficulties, though where moderate enlargement, and a relatively strong pulse are present we may with fair safety diagnose an acute endocarditis. Add to this the supervention of other murmurs, especially diastolic, and the decision may be absolute.

It is this *third* form however, viz. : decrease of the myocardium, which is especially complicated to the clinician. The murmurs associated with myocarditis of the papillary muscles or auricular wall are the result of a relative insufficiency of the mitral orifice, and so far as the valves are concerned, they are functional, not organic, in nature. The mitral valves though intact, do not become sufficiently apposed to obviate regurgitation, since the muscles to which they are attached have become diseased, and the chief factors which induce myocardial changes or muscular weakness such as to produce relative insufficiency at the valvular orifice and signs of regurgitation are various intoxications and anæmias.

The hæmic murmurs occurring at the base are of course readily differentiated from those due to a relative mitral insufficiency associated with anæmia, but the distinction between these last and an acute endocarditis involves greater difficulties, indeed is often impossible.

A murmur of relative insufficiency occurs usually at the apex or at all events is best heard in that situation. It is necessarily weak inasmuch as the myocardium in general is impaired and the stream regurgitating through the mitral orifice is slow. It is moreover most inconstant, often quite absent for a time, inasmuch as the muscle is rarely so degenerated that it cannot under sufficient stimulus be excited to temporary powerful contractions resulting in complete closure of the mitral valves. The systolic shock is weak and so also the radial pulse, while a definite enlargement of the præcordial area is always manifest, from dilatation of the weakened muscle walls. Add to this an accentuation of the pulmonary 2nd sound and the presence of ætiological factors (anæmia) and the diagnosis is in most cases made with moderate ease.

It is further to be remembered that many infectious fevers may induce a combination of endocarditis and myocarditis, in which case a differential diagnosis is difficult or impossible, particularly so when in the course of a chronic endocarditis the signs of lost compensation are superadded.

The Treatment of Anæmias.

DIEBALLA. "Beitrag zur Therapie der Progressiven Perniciösen Anämie.—*Zeitschr. für Klin. Med.*, 31 Band., 1896.

TOWNSEND. "Chlorosis, with special reference to its treatment by intestinal antiseptics."—*Boston Medical and Surgical Journal*, May, 1896.

There are few things less satisfactory to the scientific general practitioner than the estimation of the true value of many drugs and their effects in the treatment of disease. The impossibility of proving the therapeutic values of drugs is in many cases obvious, inasmuch as the individual predisposition, and the gravity of the affection materially determine the efficacy of drugs given. Hence the impossibility of judging from a limited series of cases as to the uses of any medicament and the absurdity of making a general rule for treatment based on observations in one case alone. Nothing is more pernicious and a greater self deception than to conclude from the beneficial effects of drugs in one instance, that to all others the remedy may be applied with equal effect, and it is just this which has recently been done in the present instance.

Dieballa has found in one case of pernicious anæmia that where persistent use of ferratin, bone marrow, arsenic, etc., failed to produce beneficial results, that salol was followed by marked benefit and what seemed to be a complete cure. The question of intestinal antiseptics is, however, not a new one, and because one case has been followed by favourable issue (post hoc, but not necessarily propter) the isolated observation is in itself valueless. He has further made the suggestive observation that a careful estimate of the leucocytes, by differential counts will prove of value in the prognosis of all anæmias in the following way: Pernicious anæmia may be considered in all probability as a disease of an infective nature in many instances—the exciting agent being found in the intestine, whence either directly or indirectly it exerts an injurious effect on the blood. If the blood be duly regenerated there will be but little change, but should the blood forming organs from any cause be incapacitated, the anæmia will be protracted and accordingly graver. By examining the leucocytes, Dieballa claims we can estimate the regenerative power of these organs, and particularly so by the eosinophiles. They are usually diminished in pernicious anæmia, so that should they be increased, we may conclude that the bone marrow, whence they probably arise, has good regenerative power and the prognosis is thus rendered favourable.

This observation, however, applies to one case merely, and hence is far from satisfactory, and at the same time there can as yet be no dogmatism as to the origin of the various leucocytes till our information as to the source of the different types is more accurate.

In marked contrast to this investigation is one by Townsend, who has examined a large number of chlorotics, systematically watching their condition from week to week and testing them where possible along identical lines. He has in this way afforded us valuable evidence of his method of treatment, the summary of which is as follows: Basing his inquiries on an examination of Forstheimer's theory of chlorosis, he employed Betanaphthol as an intestinal antiseptic for a number of weeks, finding that the condition improved to a moderate extent, and the average gain in hæmoglobin per week among 30 patients, was 1.05 per cent. ; if at the end of 3 weeks no marked improvement occurred, the patients were given Bland's pills. Thirty-one cases were treated with the iron alone, with an average gain of 5 per cent., *i.e.*, more than two and a half times as much as by the use of Betanaphthol. But a still more marked improvement was observed when Bland's pills were preceded by a preliminary treatment of some weeks with Betanaphthol, for in 28 cases observed, it was found that by this means the average percentage of hæmoglobin was raised in 4.3 weeks from 48 per cent. to 82 per cent. Cascara was tried alone in seven cases without satisfactory results.

C. F. Martin.

Surgery.

The Diagnosis of Carcinoma of the Breast in its Early Stages.

A. MARMADUKE SHEILD. "Clinical Lectures on the Diagnosis of Carcinoma of the Breast in its early stages."—*British Medical Journal*, May 30th, June 6th, and 20th, 1896.

The importance of an early diagnosis of carcinoma of the breast, and the difficulties which are frequently encountered in deciding whether or not a mammary tumour be malignant, have led Mr. Sheild to consider seriatim in the above lectures those points which may aid one in arriving at a correct conclusion. He points out that it is the exception rather than the rule to find a case of scirrhus presenting all the cardinal symptoms of the disease. It occurs most frequently in women between the ages of 40 and 55, but it may be found in patients of 20 or again of 80 years. Its onset is not infrequently very insidious so that the first symptom of the disease is the detection of secondary growths; such as an insidious pleurisy in an elderly woman, the occurrence of spontaneous fracture, the detection of nodules in the skin or a paraplegia. Severe pain is rare in early cancer. The disease does not appear to attack one breast more than the other, and but rarely are both attacked simultaneously. A marked family history of malignant disease is of importance.

Retraction of the nipple, a sign upon which great value is laid, is present only in those cases in which the growth involves the milk ducts and the processes of fibrous tissue. As cancer may occur in any part of the breast, this sign is not necessarily present, but when associated with a hard lump near the nipple, one would be led very strongly to suspect malignant disease. Retraction is frequently simulated by a congenitally imperfect nipple, by chronic inflammatory contraction or by the shrivelling of a cyst which has discharged its contents, and again it is absent in those cases of rapidly growing carcinoma with a sparse development of fibrous tissue.

Women who have had sore and troublesome nipples with or without an eczema, or who suffer from a chronic inflammation of the breast substance in the region of the nipple, are more liable to cancer than others. Chronic disease of the breast however, does not necessarily lead to the development of cancer. A raw kind of redness of the areola accompanied by a viscid and watery discharge with itching and

burning pains, the condition termed "malignant dermatitis" found in elderly women and which resists medication, is considered by the author as being an important predisposing cause.

The puckering of the skin resembling the dimpling seen upon a pig-skin saddle is mentioned as of great value in the diagnosis of carcinoma, and if associated with a hard tumour, the disease is almost certain to be malignant.

This puckering of the skin is to be distinguished from the dimpling which may result from the contraction following upon the presence of an old abscess or of a shrivelled cyst.

The condition of the lymphatic glands varies greatly in early cases. They may be enlarged or again normal in size. Even though they be enlarged, their increase in size may be due to tuberculous disease, chancre of the breast or even to mastitis.

Cancer is most likely to be confounded with acute or chronic mastitis, abscess, cysts, other tumours, phantom tumours or such rare conditions as keloid or syphilitic affections of the breast.

In chronic mastitis, the lumps in the breast, if palpated with the "flat" of the fingers, do not afford the sensation of a definite tumour. If a tumour is found by this method of palpation it is due either to scirrhus or to a small thick walled cyst. Again chronic mastitis is seldom strictly localized, whereas in carcinoma the growth is usually single and isolated. In infiltrating carcinoma, however, the similarity to chronic mastitis is great. If after careful palpation, a definite tumour is found, an exploratory incision is called for.

Chronic induration of the breast will frequently yield to application of Ung. Hydrarg. Co., combined with even pressure by means of a bandage. This method should be tried in young women for a few weeks, but in advanced women, it is better practice to remove the breast immediately.

Acute mastitis is occasionally simulated by a rapidly growing and infiltrating cancer. In chronic abscess, the detection of a spot of elasticity in addition to throbbing pain, sores or cracks about the nipple with a history of abscess of the breast, would naturally lead one to infer that suppuration is present, and as a rule, suppuration is a proof that the disease is not cancerous. It must be remembered, however, that carcinoma has been known to originate in the floor of an abscess cavity.

It is frequently with great difficulty that cysts can be distinguished from carcinoma, and this is particularly the case when they are small and thick-walled. Where more than one definite swelling can be

made out, the probability is that they are cystic. In many cases, exploratory incision alone will determine the nature of the case.

Fibro-adenomata are found usually in young women, are frequently multiple, have not the stony hardness of scirrhus and are *encapsuled* so that they slip about beneath the fingers. Sarcomata are usually associated with cysts and are devoid of the stony hardness of scirrhus.

"Phantom tumours" are frequently due to a slight mastitis, a natural prominence as a costal cartilage or occasionally to a curious contraction of the pectoral muscle. The neuralgic symptoms, the hysterical condition of the patient, and a careful examination, under anaesthesia if necessary, will reveal the true nature of the case. In these cases, the fear of cancer is often very great.

When scirrhus attacks the skin of the thorax, it will be found covered with a large number of hard tubercles and examination of the mamma will usually give evidence of carcinoma. Tertiary syphilis of the skin about the areola usually shows distinct serpiginous outlines with dusky margins.

Keloid is apt to lead one into error in diagnosis. The shiny whitish or pinkish surface, the claw-like processes inclined to be pink in colour, stretching around into the healthy skin, and the burning pain are all characteristics of this condition.

Mr. Sheild lays stress upon the importance of exploratory incision in cases in which there exists any doubt as to the true nature of the disease, particularly in young patients. By incising the tumour before proceeding to the removal of the breast, there would be fewer cases of excision performed for conditions which prove to be non-malignant.

E. J. Semple.

Obstetric Note.

Vicarious Labour Pains.

Mrs. T., *æt.* 37, VI-para, was confined 26th October, 1896. At the beginning of labour the ordinary uterine pains were felt, but after a short time they suddenly ceased, and the patient complained of a severe agonizing pain in the left side of her head, the left shoulder and left arm. The pains in the head were continuous, but became more intense whenever a uterine contraction began, increased in severity until they were almost unbearable, at its acme and then decreased as it passed off. She always knew the approach of a uterine contraction by the increasing severity of the pain in her head, shoulder and arm; at the same time the hand grasping the uterus felt it harden and relax coincidentally with the increasing or decreasing lamentations of the patient. No pain was felt in uterus or abdomen. This condition of things persisted throughout labour, otherwise the case was normal. Four years ago she had a miscarriage with convulsions prior to, during and for six weeks after labour. The same peculiarity in the site of her pains was observed then. Previous labours were normal. This case, which occurred in the practice of Dr. M. W. Lang, of Marine City, Michigan, presents some points of considerable interest. The peculiar train of nerve symptoms observed in the recent confinement, appeared first during a miscarriage four years ago complicated with convulsions. Were these convulsive attacks true eclamptic fits, or were they due to hysteria? If eclamptic, the peculiar nerve symptoms were probably caused by uræmic intoxication. If pregnancy occurs again, a careful examination of the urine would throw some light upon the case.

J. C. Cameron.

Pharmacology and Therapeutics.

Treatment of Tic Douloureux.

EWART, WILLIAM. "On the treatment of Tic Douloureux in connection with the question as to operation."—*British Medical Journal*, November 21st, 1896.

GILLES DE LA TOURETTE. "Diagnostic et traitement du tic douloureux de la face et de la migraine."—*La Semaine Medicale*. 24 Juin 1896.

DANA, D. L. "The treatment of Tic Douloureux."—*Chicago Medical Recorder*, August, 1896.

The medical treatment of this very troublesome affection so frequently proves a failure, that there appears to be a growing tendency on the part of physicians to refer cases that appear to be intractable to a surgeon for removal of the Gasserian ganglion, an operation which has now had a fair trial, and which, according to Keen, of Philadelphia, has had, notwithstanding the severity of the operation, a mortality of only 10.5 per cent. The alternative surgical treatment, consisting in section of the various peripheral nerves and removal of Meckel's ganglion is found to give only temporary relief, and, therefore, cannot be recommended.

The fact, however, that pathology has so far failed to reveal the constant presence of any one definite lesion in the affection, such as might be presupposed to exist, from the prevailing uniformity of the clinical symptoms, and that in some cases absolutely no definite structural changes have been found, should make us, as physicians, hesitate to refer our cases to the surgeon until we have with much consideration exhausted all our resources.

Surgery, writes Dr. Ewart, has thrown light upon two important points. It has shown us that the pain is bound up with the peripheral sensory function, at least as much as with the central function. A temporary interruption in the peripheral conduction by division or resection of nerves, causes cessation of the pain only until a return of the sensory function of the part, whilst a permanent interruption of one branch of the nerve does not protect against its subsequent extension, likewise peripheral, along another branch, whether vicariously or by overflow. Surgery has also shown that the Gasserian ganglion is a bridge, the cutting of which permanently arrests the pain.

Dr. Ewart then calls attention to the many clinical considerations which suggest that in all cases there is a constitutional or functional factor, and that in some this is paramount. A strong argument in point is the existence of a group of cases in which the gouty factor is easily manifest, but there are many others in which the gouty connection is more or less obscure and liable to be overlooked, and these he thinks make up a large proportion of the cases.

The frequency, he says, of a gouty association has probably been under-estimated, because it is often not an immediate one. It is the exception for sufferers from this neuralgia to be attacked by articular gout, and it might be said of them among others, that it is their misfortune that they never experienced gout in their joints. The same immunity is sometimes witnessed in the cutaneous manifestations of goutiness, which may alternate in the hereditary cycle with neuralgia.

Several instances are related in which this gouty tendency had been overlooked by many previous physicians for a long period, but in which relief followed as soon as this factor was recognized. Dr Ewart thinks that it is the easily overlooked gouty tendency, rather than declared gout, which is commonly the basis of this affection, and that many alleged failures of medical treatment have been instances of failure to recognize this underlying factor. The following facts in the personal history of many sufferers, he thinks, may be regarded as pointing probably to gouty underlying conditions: 1. A healthy and often ruddy complexion. 2. The presence of Heberden's nodules, or of tophi in the ears. 3. A previous history of gravel or of stone. 4. A long history, often beginning in childhood, of gastric, intestinal, and hepatic disturbances of a nervous type. 5. The abiding strength of the pulse which strikes us as no less remarkable than the resistance of the patient to the effects of long continued pain and insomnia. 6. The adverse influence of alcohol, and of certain forms of diet. 7. The presence of uric acid sand in the urine noted in several of the cases related.

In his treatment of his cases he lays special importance on diet and hygiene. Whilst ordinary neuralgia is benefited by alcohol, iron, by strong tonics, and by a generous diet, these are precisely the agents which often aggravate *tic douloureux*. Our object should be to raise nutrition without overloading the blood with nitrogenous waste. A modified vegetarianism, *i.e.*, a liberal supply of the vegetable foods and a more or less limited supply of the nitrogenous foods is generally indicated. Alcohol is generally to be avoided except in enfeebled and underfed subjects, when it may be allowed as a temporary help to nutrition. Sleep should be secured by carefully selected drugs. Rest

in bed is indicated in all severe cases at the outset, until remedies have taken effect. For alteratives, he prefers, as yielding the best results, the salts of iodine and mercury, particularly their combination in the proportion of 20 to 30 minims of the solution of the perchloride of mercury to 6 or 10 grains of the iodide of potassium. Later on tonic measures are called for, which should be principally hygienic. Ordinary massage may be applied after one refreshing sleep is obtained, and it may gradually be replaced by "resistance movements." With this may be combined salt baths, and, later on, climatic treatment.

Under this treatment all the cases he relates, which had been sent to the surgeon for the express purpose of operation because medical treatment had failed, were improved and lost their pain more or less completely. In some under the influence of former surroundings, associated with fatigue and worry, the pain returned. How far operation in such cases may be postponed, or ultimately avoided, is a question which can only be answered after true and careful investigation.

Gilles de la Tourette regards some cases of this affection as closely allied in character to epilepsy, and recommends a gradually increasing daily dose of the bromides to be given until some amelioration of the attacks occurs. This dose should then be maintained for some months, and gradually diminished. A complete cure he says may under this treatment be obtained in some instances.

Dr. Dana's treatment, consists in the hypodermic injection of massive daily doses of strychnine. He begins with the use of $\frac{1}{10}$, and gradually increases until by the fifteenth or twentieth day from $\frac{1}{8}$ to $\frac{1}{4}$ is given. These massive doses are continued for a week and then gradually reduced. The patient is then placed on gradually increasing doses of potassium iodide. Rest in bed at the outset is insisted upon.

New Drugs.

MURRELL, WILLIAM. "Senecio Jacobœa in functional amenorrhœa."—*British Medical Journal*, Vol I., p. 679.

FOTHERGILL, W. E. "On the use of senecio in disorders of menstruation."—*The Medical Chronicle*, November, 1896.

The common ragwort, *Senecio Jacobœa*, and some other members of the same genus have long enjoyed, in popular medicine, some reputation as emmenagogues. In old English herbals the ragwort is described as the "French Regulator," and in America *Senecio Aureus*, under the name of life root has long been used as an emmenagogue on the French sea coast, and several other species have been mentioned by various authors.

Within the last few years reports on this drug have been issued by Murrell, Dalché and Hein, and Bardet and Bolognesi.

The plant contains two alkaloids—senecine and senecionine in small quantities. A poisonous fatty acid has been found in two species growing in the tropics. Wiet found by experiments on frogs and guinea pigs that chlorohydrate of senecionine destroys the excitability of motor nerves, but leaves intact the irritability of muscle itself. In sufficiently large doses it is a curariform poison. It slows the heart's action, and in fatal doses stops the organ in systole.

With regard to the action of these drugs, Murrell writes : I found that it succeeded admirably in those cases in which the menstrual function, having been established and performed regularly for some months or years, was delayed or suspended as the result of exposure to cold or some similar cause. In cases in which the amenorrhœa was associated with or dependent on anæmia, senecio uniformly failed to do any good until the anæmic condition had been removed by iron. In cases in which the menstrual flow had never been established, senecio was frequently most useful, and in four cases of vicarious menstruation, nothing could have been more satisfactory. I am satisfied that senecio not only anticipates the period, but that it also increases the quantity. In many cases of dysmenorrhœa it promptly relieves the pain, and not unfrequently the headache from which many women suffer at these times. Senecio is apparently not an ecbolic.

Dalché and Hein conclude that the drug relieves painful menstruation if the reproduction organs are healthy, but not otherwise.

Bardet and Bolognesi conclude that senecio has the property of provoking menstruation, though administered in small and harmless doses. They hold that it always tends to regularise menstruation. They suggest that it produces congestion of the reproduction organs.

M. Blondel, in a discussion on the properties of this drug at the Société de Therapeutique, said that he considered the reports on the physiological action of senecio to be both vague and contradictory, and that until the action of a drug is definitely known its indications and contraindications can not be established. Amenorrhœa, he said, is not a disease but a symptom, and its causes must be discovered before they can be attacked. In half the cases seen it was due to pregnancy, the diagnosis of which during the early months was beset with difficulties. Therefore he thought the treatment of amenorrhœa should always be indirect, both from the risk of causing abortion, and in order to preserve a true clinical spirit. The drugs which act directly in provoking menstruation, he thought, were unreliable, dangerous, and of merely temporary effect.

These remarks of M. Blondel, writes Dr. Fothergill, though likely to catch the sympathy of the superficial reader, are not really calculated to deter any one from giving respectful study to the work of these authors. For, to go over his objections in reversed order, granting that the so-called emmenagogues in use are satisfactory, there is no reason *a priori* why it should not be discovered that one or other of the active principles of the senecios is a true emmenagogue, reliable, safe, and perhaps even permanent in its action. Next, in certain cases, amenorrhœa is not a symptom of any pre-existent disease, but is due to the action on the nervous system of various external and temporary causes. Secondary bad effects, both mental and physical, follow the amenorrhœa, which in such cases is a primary disorder, and is certainly one suitable for direct treatment. Again, the difficulties in diagnosticating early pregnancy, if great, are not insuperable to all; and there is no necessity for any one to administer a possible ecbolic while still in doubt as to the diagnosis. Lastly, if no drug may be used until its action is definitely known and its indications are clearly defined, there is an end to the introduction of new therapeutic agents. All that the most exacting can demand is that the introducer of a new drug shall give a working hypothesis according to which the drug may reasonably be supposed to act.

Menstruation expresses an anabolic surplus produced by the healthy human female from puberty to the menopause, except during pregnancy and lactation, the time of its occurrence probably being determined by the activity of a special centre in the lumbar part of the cord.

Now, says Mr. Fothergill, in the light of this view of menstruation, substances like iron, which affect the quality or quantity of the blood, are only indirectly emmenagogues. Similarly, substances which, by causing renal or gastro-intestinal irritation, promote pelvic congestion and uterine hæmorrhage, are also indirect in their emmenagogue action. To be a direct emmenagogue, a substance must act upon the nervous mechanism which initiates the discharge, namely, the hypothetical centre for menstruation. Thus an emmenagogue is quite distinct from an ecbolic, which is supposed to cause contraction of the uterine muscle by acting either on the fibres themselves or on their motor nerves. It is possible, he thinks, that senecio may be found to contain an active principle which is a direct emmenagogue in the proper sense of the word, and it does not follow that this principle must be an ecbolic.

The following is his classification of amenorrhœa according to treatment:

No Treatment.—Physiological amenorrhœa—*i.e.*, before puberty,

during pregnancy, during lactation, and after menopause. Amenorrhœa due to congenital or acquired deficiency or to absence of essential reproductive organs.

Surgical and other Local Treatment.—Amenorrhœa due to local defects, such as atresia vagina, atresia cervicis uteri, congenital or acquired neoplasms, etc.

Indirect Treatment.—Amenorrhœa due to general disease which so disturbs metabolism that there is no anabolic surplus—*e.g.*, anæmia and phthisis—where menstruation would be an unnecessary drain on the patient.

Direct Treatment by Emmenagogues—Amenorrhœa due to want of activity of the nervous mechanism initiating menstruation, caused by nervous disease, shock (mental or physical), fear or hope of pregnancy, etc., including those cases in which the function has never been established, but where there is no local defect or general disease sufficient to account for its absence.

SHENNAN, THEODORE. "The action of *Viburnum Prunifolium*."—*Edinburgh Medical Journal*, November, 1896.

This drug was first introduced to the profession by Dr. Phares, of Mississippi, who in a paper published in 1866 recommended it as an astringent, diuretic, tonic and anti-spasmodic, but chiefly as a remedy for dysmenorrhœa and as a preventive of abortion. In 1879 Dr. Rockwell recommended it in dysmenorrhœa in delicate nervous women, in whom the pain was due to slight anteflexion, slight endotrachelitis or partial stenosis. He regarded it as anodyne, anti-spasmodic and toxic. Payne, in a paper read before the Medical Society of North Carolina in 1888, described experiments carried out on the lower animals with an extract of the drug. He concluded that there was no effect on sensibility. The chief action was on the motor track. Loss of reflex action, and of voluntary motion were produced by large doses, but nerve conduction was lost before muscular contractibility. Dr. Payne recommended its use in diseases with increased excitability of the motor centres, and in ovarian or spasmodic dysmenorrhœa, but considered it harmful in menorrhagia due to congestion or metritis. Joseph, of Landick, recommended *viburnum* very strongly in virginal dysmenorrhœa, especially in that form due to mechanical obstruction.

Dr. Shennan draws the following conclusions from the results obtained in some of his own experiments. In moderate doses there appears to be a diminution of reflex irritability, with a quieting effect on involuntary muscular fibre, and possibly some lowering of blood

pressure. The indications for its use are as follows : 1. In habitual abortion, when this is not caused by syphilitic infection or by fatty placenta. 2. In threatening abortion, however caused, and at any period of gestation. 3. In dysmenorrhæa, if functional, spasmodic, or ovarian, it often cures ; if due to flexion or stenosis it may afford much relief. 4. In the menorrhagias of the menopause, and in the nervous disorders of that time it is very beneficial. 5. It is of use in the diagnosis of false pains as it speedily relieves them.

A. D. Blackader.

Pathology.

"La Doctrine des Cirrhoses du Foie."

LEGRY, T. "Historique resumé de la doctrine des cirrhoses du foie."
—*Arch. Gén. de Médecine*, I., 1894, p. 80.

ROLLESTON, H.D. "A clinical lecture on cirrhosis of the liver in children."—*The Clinical Journal*, Sept. 9th, 1896.

SENATOR, H. "Ueber atrophische und hypertrophische Lebercirrhosis."—*Berliner Klin. Wochenschr.*, 1893, p. 1232.

PALTAUF, R. "Cirrhosis hepatica *Lubarsch and Ostertag's*."—*Ergebnisse der Allgem. Pathologie*, Pt. III., 1896, p. 316.

The "doctrine des cirrhoses du foie" held by the individual depended for long years upon the nationality of the individual—whether he has been born a Frenchman or a German—or if the individual had not happened to be born in France or Germany, upon the course of his education—whether he had founded himself upon the medical literature of one or other country. A fervour almost theological has been introduced into the discussion, and just as the old French surgeon declared concerning the circulation *malo errare cum Galeno quam cum Harveio veritatem amplectare*, so the latter day members of the Paris faculty for close on twenty years have preferred to err, if necessary, with Charcot, rather than embrace the gospel of Brieger and Litten, and German professors have not been behindhand in manifesting a like spirit.

Is hypertrophic cirrhosis a distinct entity? According to the French school it was; according to the Germans it was only a stage in the development of one morbid condition.

Happily with Senator's excellent discourse, national feeling has been greatly reduced. The French school now generally admits with Dieulafoy that there exists many cases of "cirrhose mixte," which in itself is a concession to German views; while many Germans, following Senator, agree that Hanot's hypertrophic cirrhosis with jaundice is a distinct though rare disease. When thus the matter is being argued without *parti pris* a favourable opportunity is afforded to review the whole matter dispassionately.

Beginning at the beginning, therefore, it will be remembered that "cirrhosis" dates only from Laennec. In 1819, in his clinical studies:

upon auscultation, he differentiated the contracted hobnailed liver from other hepatic conditions and gave it this name on account of its pale yellow colour. He, it is true, had wild notions as to the pathology of the condition, and it was left to another great physician of the century, Richard Bright, in another equally classical series of pathological and clinical researches, to explain incidentally in his studies upon the relationship of kidney disease to ascites, that the ascites of cirrhosis is due to obstruction of the portal system in consequence of the shrinking of the liver tissue. A few years later the exact histological nature of the process in the organ, received its explanation as being associated with deposit of new fibrous tissue throughout the liver.

Bright had noted that sometimes the liver remained enlarged, but it was not until 1857 that another well-known English physician, Todd¹, drew attention to the fact that two different forms of chronic hepatitis may be recognised, and showed that besides the typical contracted liver of Laennec with associated ascites, there occurred cases of enlarged cirrhotic liver without ascites, but with jaundice. As has so frequently happened with works published in our language, no notice was taken of Todd's work outside England, and not until 1874 and the immediately succeeding years, did Leudet, Hanot, and a series of French observers arrive at the same conclusion.

In 1876 Charcot and Gombault, from experimental and histological studies, showed that ligature of the common bile duct led to a form of cirrhosis characterised by the development of fibrous tissue around the bile ducts, and this they compared with the hypertrophic form recognised by Leudet and Hanot. They further called attention to the peculiar form of generalised cirrhosis, associated with congenital syphilis, and, as a consequence, they declared that there were three forms of cirrhosis:

1. Portal, or Laennec's cirrhosis, the ordinary atrophic form.
2. Biliary or hypertrophic cirrhosis.
3. Congenital syphilitic cirrhosis.

This classification it was that roused so strong an opposition among German writers. Brieger, Litten, Ackermann, and many others pointed out that both clinically and histologically it was impossible to make Charcot's distinction between the hypertrophic and atrophic form. There could be hypertrophied livers presenting all the clinical and histological characters of portal cirrhosis; the contracted liver might be accompanied by jaundice; there could be cases presenting clinically all the features of portal cirrhosis and showing like Charcot's

¹ *Medical Times and Gazette*, December, 1857, p. 571.

biliary form, abundant new development of apparent bile ducts. In short, German writers denied that hypertrophic cirrhosis existed as a condition distinct from that which tends to end in the familiar hobnailed liver. And at this point the matter remained stationary for many years.

Senator's object in his address before the Hufelandsche Gesellschaft was to attempt to reconcile the opposing schools. He pointed out that much of the difficulty that had arisen was due to the fact that the terms employed had not been used with adequate precision. There is, he admitted, a characteristic form of hypertrophic cirrhosis wholly distinct from the ordinary portal cirrhosis, that, namely, first fully described by Hanot (and first recognised by Todd), but Charcot and Gombault had wrongly concluded that this and the cirrhosis succeeding biliary obstruction were one and the same disease, while again the term "hypertrophic cirrhosis" had been loosely and mistakenly employed for all conditions in which (to put it briefly) there exists cirrhosis with hypertrophy, and as a consequence what may merely be a stage in one disease had been compared with what is the constant characteristic of another.

In connection with cirrhosis of the liver, Senator urges that for a clinical diagnosis there are four features that have to be taken into account; the size of the liver; the presence or absence of jaundice; the presence or absence of signs of portal obstruction (ascites, &c.), and the presence or absence of splenic enlargement. Taking this into consideration he concludes that there are three main forms of cirrhosis with secondary forms:

I. *Portal cirrhosis*, the ordinary "hobnailed" atrophic liver.

I. (a.) *Portal cirrhosis with Hypertrophy*—The hypertrophy may in the course of time give place to atrophy.¹

I. (b.) *Portal cirrhosis with Icterus*—Such jaundice is a complication brought about either by gastro-duodenal catarrh or by pressure of the newly formed fibrous tissue upon the lymphatics and bile ducts. It is superadded to the symptoms of portal cirrhosis.

II. *Biliary cirrhosis with subsequent atrophy*—This is the well established form following upon obstruction of the bile ducts (by calculi, &c.) with associated jaundice but without ascites and other signs of portal obstruction and without enlargement of the spleen.

II. (a.) *Biliary cirrhosis with enlarged spleen*—This modification,

¹ Several authors including Rosenstein, have of late denied the existence of this form. While some cases showing hepatic enlargement followed by contraction may well in their early stages be enlarged fatty alcoholic livers, our knowledge of the stages of new connective tissue development fits in with the position taken by Senator, and with Paltauf I think we must acknowledge the existence of this group.

like biliary cirrhosis in general, is most frequent in females. Senator is unable to explain the enlargement of the spleen and is doubtful whether this is a transitional form to—

III. *Hypertrophic cirrhosis proper (Hanot's) with Icterus.*—In this form both liver and spleen are definitely enlarged: there is jaundice, but no evidence of portal obstruction. Cases are rare, affect males rather than females in middle age, and there is generally a history of either alcohol or syphilis or malaria.

It will be seen that Senator thus acknowledges the existence of biliary cirrhosis as one condition, of hypertrophic cirrhosis as a distinct condition. His classification is clear and rational and places the matter in a much more satisfactory position than any that preceded it, and assimilates much of the best in the French teaching up to that date.

Legry, in France, in the following year took nearly the same view, but advanced further in his classification of hypertrophic cirrhosis. In France there have of late been very numerous studies of fibrotic changes in the liver. Thus Kelsch and Kiener pointed out the occasional existence of malarial cirrhosis. Hanot and Chauffard have noted a cirrhosis accompanied by pigmentation occurring in connection with diabetes mellitus. Hanot and Gilbert have especially called attention to the generalised interstitial fibrous overgrowth which may accompany tuberculosis, comparable in many respects with that seen in congenital syphilis. So too sundry French observers hold that the intralobular fibrosis seen in severe cases of chronic obstructive cardiac disease may, in itself, lead to enlargement of the liver, and, as already stated, the enlarged fatty cirrhotic liver of many alcoholics has to be taken into account. So also there may be fibroid changes advancing inwards from the periphery in chronic perihepatitis, and lastly fibroid changes have been discovered following upon cholera, typhoid, small-pox and measles.

It has to be acknowledged, therefore, that while Senator's clinical classification is precise and takes into account the main forms of cirrhosis, it is very far from embracing all conditions, in fact that the "doctrine of cirrhosis" is a larger matter.

Is it possible to classify all these forms of cirrhosis?

In the first place we have to determine what to understand by "cirrhosis." We may include every condition of hepatic fibrosis under the term, or may only use it when the fibroid change is extensive and generalised and recognizable by the naked eye on section of the organ, or again when the condition is so advanced as to lead to the production of a clear train of symptoms. Opinions will differ as

to the course to pursue: the physician will prefer the latter, the pathologist the first, for it alone will aid him in investigating the whole matter. A third course, that of employing the word cirrhosis strictly as a clinical term, and referring to this condition pathologically as fibrosis would be excellent were it possible to maintain the separation.

Approaching this matter from the point of view of the pathologist, two main considerations must guide us: (1) the regions in which the fibroid change has its origin, and (2) the causes at work leading to the development of fibrosis.

Taking first the region of primary development, we have evidence that new connective tissue may show itself in the following portions of the organ:

1. In the portal sheaths around the branches of the portal vein.
2. In the portal sheaths around the bile ducts.
3. In the portal sheaths around the branches of the hepatic artery.
4. In the portal sheaths by extension inwards of external inflammation (primarily along the lymph vessels).
5. In the centre of the lobules around the intralobular branches of the hepatic veins.
6. In the lobules themselves, as a replacement fibrosis, following upon atrophy of the liver cells.

Or in other words, it is possible that in its origin a cirrhosis may be:

1. Portal.
2. Biliary.
3. Arterial.
4. Secondary (to perihepatitis).
5. Intralobular or centrilobular.
6. Replacement, or "pericellular."

J. G. Adami.

(To be continued.)

Reviews and Notices of Books.

Affections Chirurgicales du Tronc. (Rachis, Thorax, Abdomen, Bassin.) Statistique et Observations par le Dr. Polaillon, Chirurgien de l'Hotel Dieu. Professor agrégé à la Faculté de Médecine de Paris. Chargé de cours de clinique annexe. Membre de l'Académie de Médecine, Paris. Librairie, Octave Doin, Éditeur; 8 Place de L'Odéon. 1896.

In 1894, Dr. Polaillon published the first of three volumes, containing a resumé of his hospital experience, which began in 1879. The statistics and observations of the inferior extremities were dealt with in the first volume. The second volume issued a year later, gave the statistics and observations of the extremities, both upper and lower being included.

The present volume deals with the surgical affections of the trunk, and is a resumé of sixteen and one-half years' work in a large French hospital. The injuries are classified and full statistics given of results in each group. For example: "Contusions without wound," include 299 cases; 248 men, 51 women. None of the women were operated upon. Of the 248 men 245 were treated without operation, 3 were operated upon and 5 died.

The contusions of different regions of the trunk are dealt with, and many very interesting and instructive histories are given. An immense amount of clinical experience is put before the reader in these volumes. They are not very liberally illustrated, but what illustrations appear are clear and useful.

G. E. A.

Deformities: a Treatise on Orthopædic Surgery. Intended for practitioners and advanced students. By A. H. TUBBY, M.S., Lond., F.R.C.S., Eng., Assistant-Surgeon to, and in charge of the Orthopædic Department, Westminster Hospital; Surgeon to the National Orthopædic Hospital, &c., &c., pp. 598. London and New York, Macmillan & Co. Ltd; Toronto, The Copp Clark Co. Ltd.

In this book Mr. Tubby gives his experience, gathered from his work in several of the London hospitals where deformities are treated.

He first takes up deformities of the spine and devotes most of his space to Potts' disease. In the treatment of this he strongly urges the advantages of recumbency, especially in children. He considers the plaster of Paris jacket is the best of all fixation and supporting appliances as being less complicated, less expensive and more easily applied, while at the same time it acts as an efficient support.

In speaking of the causes of scoliosis he says "the exceedingly faulty

arrangement of music-stools and school-desks are responsible for many cases of scoliosis," an oft-repeated fact, the repetition of which does not seem to have much effect as yet in the building of school-houses. He also draws attention to the influence of occupation. Regarding the prognosis in this complaint he says "the amount of flexibility (of the spine) is the gauge of the improvement that may be expected under treatment."

In the second section he treats of deformities of the neck, chest and upper extremities. He takes up torticollis, deformities of the thorax, and deformities of the hand and fingers, both congenital and acquired.

Rachitis and the resulting deformities is the heading of a short chapter in which the various deformities resulting from this condition are grouped together, although most of the deformities are treated of under other headings. This section is useful for reference as showing what a prominent part rickets plays in the production of deformities.

The fourth section is devoted to the lower extremity. In the first chapter is described incurvation of the neck of the femur, a condition which has been recognized only during the past few years. It is looked upon by the author as a local development of rickets. Bow-legs and knock-knee come in for their share of notice. In speaking of the former the author says "Of all the deformities arising from rickets, bow-legs are the most common and the least serious." By this he means the curving of the tibia and fibula so frequently seen in children and so rarely in adults. He shows by diagrams, how the improvement is brought about as the bone grows. Under club-foot some interesting observations on the union of tendons are given. These go to show that perfect regeneration of a tendon is not possible but the uniting band remains scar-tissue and also that primary union of a tendon cannot be obtained.

Following the English practice, tubercular diseases of the knee and hip are not taken up, although, as the author himself says, "It is difficult to understand why these should not be included in orthopædic surgery." Certainly on this side of the Atlantic they form a large part of the work in this department.

With these exceptions, the ground is well covered. The illustrations are from drawings and consequently are of more use than if they were half tone plates from photographs, because, where necessary, they can be made sufficiently diagrammatic to illustrate the various important points.

Altogether we have been given a most useful and acceptable book.

R. C. K.

Ophthalmic Operations as practiced on Animal's Eyes. By

CLARENCE A. VEASEY, A.M., M.D. With fifty-six illustrations. Philadelphia, The Edwards & Decker Co., 1896.

It seems very doubtful if Dr. Veasey's little book has a very useful purpose to fulfil and even in attempting to fulfil this purpose it is decidedly faulty.

It is a guide pure and simple for the performance of the usual eye operations on the eyes of dead animals.

The details are frequently very scrappy and the diagrams misleading. As an example of the latter, one need only refer to figure 29, page 44; where in the discission operation, the fingers of the operator are seen grasping the "Needles" not the handles of the needles.

As to lack of detail, it is most painfully evident in the description of the operation for advancement of a muscle, where goodness knows at what particular spot the final insertion of needles is to be made, or again in Mules operation all mention of douching out the globe is omitted.

Typographical errors are not wanting, for example "Staphâlomata" (sic).

The absolute exactness of detail necessary in all eye operations, is sufficient reason for a severe criticism of this work.

J. W. S.

A Manual of Clinical Diagnosis. By means of Microscopic and Chemical Methods, for Students, Hospital Physicians and Practitioners. By CHAS. E. SIMON, M.D., Late Assistant Resident Physician Johns Hopkins Hospital, Baltimore. With 132 engravings and 10 full-page coloured plates. Octavo, p. 504. Messrs. Lea Brothers & Co., Philadelphia and New York, 1896.

This volume is an effort to supply students and practitioners with all the facts in clinical chemistry and microscopy which can be of practical value to them. Chemical and microscopic methods are described in detail, so that the student who has not had special training in such manipulations may be enabled to obtain satisfactory results. The subject matter covers the examination of the blood, the secretions of the mouth, the gastric juice, the fæces, the nasal secretion, the sputum, and the urine. There are also chapters on transudates and exudates, cystic contents, semen, vaginal discharges and milk. In every case a description of the normal material precedes the pathological considerations, and these latter are followed by a clear statement of the methods employed in the examination. While many of these methods are original Dr. Simon has evidently been careful to consult all the more recent work on this subject both in England and on this continent. The illustrations are excellent. We have much pleasure in cordially recommending the work to our students and to those practitioners who desire to keep themselves in touch with the more advanced methods of examinations.

A. D. B.

A Practical Treatise on Materia Medica and Therapeutics.

By Roberts Bartholow, M.A., M.D., &c., Professor Emeritus of Materia Medica, General Therapeutics and Hygiene in the Jefferson Medical College of Philadelphia. Ninth edition, revised and enlarged. D. Appleton & Co., New York, 1896.

A treatise that has reached its ninth edition so rapidly as this one has, calls for few remarks from the reviewer. The present edition maintains the same arrangement of its matter as the previous ones, but numerous

alterations and additions have been made, slightly increasing the size of the volume. Much of the additional matter has been necessitated by the new synthetical remedies which organic chemistry is furnishing to us with such a lavish hand. Regarding these the writer remarks that they are for the most part proprietary; those compounds which evolved by the substitution process, appear likely to possess certain powers are placed in the hands of friendly investigators to study their physiological actions, and are then duly exploited by the manufacturers. While it is undeniable that many important contributions have been made in this way to practical medicine, it is equally true that many have not sustained the pretensions of their promoters, and it is not yet possible to make out of the multitude a more than provisional selection. The author has used his best judgment in deciding which are the more promising. This treatise has maintained a high rank among the text-books on this subject for its clear statement of the physiological actions of the several drugs, and the very practical character of its therapeutics. A. D. B.

An American Text-Book of Applied Therapeutics. For the use of Practitioners and Students. Edited by J. C. WILSON, M.D., Professor of the Practice of Medicine and of Clinical Medicine in the Jefferson Medical College, &c, assisted by AUG. A. ESHNER, M.D., Professor of Clinical Medicine in the Philadelphia Polyclinic. W. B. Saunders, Philadelphia, 1896.

This is a handsome volume of over 1300 pages, similar in appearance and arrangement to the other American text-books published by the same firm during the past year or two. The list of contributors is a long one, and comprises the names of many who have acquired merited distinction in their special subjects. The arrangement of the volume has been based as far as possible upon modern pathological views, but the articles have been written from the standpoint of the practitioner. The various articles have been made as practical as possible, and the most valuable and most advanced therapeutic measures are clearly stated.

Among the more important contributions to the volume are the articles on Diphtheria by W. P. Northrup, on Enteric Fever by the Editor, on Leprosy by the late Beaven Rake, on Tuberculosis by J. F. Whittaker, on Syphilis by Orvilla Horwitz, on Malarial Fever by A. Laverau, on Rheumatism and Gout by James Stewart, on Diseases of the Stomach by Chas. G. Stockton, and on Disorders of Sleep by John K. Mitchell. We have consulted this work on many occasions during the past few months, and can cordially recommend it to our readers, as affording a reliable, and thoroughly up-to-date guide to the best therapeutic measures. There are numerous illustrations, the printing and binding are excellent, and a very full index makes reference to any subject an easy matter. A. D. B.

Correspondence.

ASSOCIATED PHYSICIANS AND SURGEONS OF SANTA CLARA VALLEY.

To the Editors of THE MONTREAL MEDICAL JOURNAL.

DEAR SIRS,—We ask you to give publicity to this letter and accompanying resolutions, to the end that in all communities afflicted with the pestiferous practice of lodge doctoring, physicians may be encouraged to assert their independence through organization.

Here, in Santa Clara County, Cal., containing 70,000 population, all the physicians of the County, numbering 124, have entered the compact that has ridden us of a slavish evil, and wrought independence and freedom for the practitioners of medicine. Investigation shows that medical compensation for lodge work averages about 15 cents on the dollar.

Even respectable lodge physicians feel a sense of degradation in giving their services for 15 cents on the dollar, and the ever-increasing spread of these alleged charitable institutions is absolutely destructive to the business of other physicians.

The main incentive of the persons who band themselves together in lodges is to get cheap doctoring; they are willing to take but not to give. They belong to protective unions, and the same right should not be denied physicians. Ninety-nine per cent of these people are able to pay reasonable fees to physicians, but will not do so as long as a few doctors in every community for the sake of immediate gain can be induced to stand as driven guys to the lodge politicians. No preacher or lawyer would give his services to these people for 15 cents on the dollar. No grocery store or merchandise firm would contract to supply these lodges with goods at 15 cents on the dollar of actual worth.

The remedy indicated in the subjoined resolutions is simple, and manifestly efficacious, depending upon the personal honour and free-will of those concerned. Where one doctor temporarily profits by contract work, the business and ethical rights of fifty others are violated; hence an overwhelming *esprit de corps* is created among physicians which will sustain a strict observance of the pledge.

LINCOLN COTHRAN,

Secretary.

San Jose, Cal., November 18th, 1896.

RESOLUTIONS ADOPTED BY THE PHYSICIANS OF SANTA CLARA COUNTY.

Whereas, Rendering professional service at a stipulated fee per capita per annum is derogatory to the medical profession, we, the undersigned physicians and surgeons of Santa Clara County, California, enter into the following agreement :

1st. We mutually, jointly, and individually, pledge our word of honour not to enter into any contract, or agreement, or renew any existing contract or agreement, either written, verbal or implied, to render medical or surgical services to any lodge, society, association or organization.

2nd. We will not render medical or surgical services to the members of the above mentioned bodies for less compensation than we charge the general public for similar services.

3rd. This agreement shall not be construed to affect existing contracts between physicians and surgeons and the above mentioned bodies.

4th. These pledges shall take effect and be in force for a term of three (3) years from and after May 22, 1896.

This agreement shall not apply to hospitals and purely public charitable institutions.

The duty of the Standing Committee shall be to interview new coming physicians, etc., and, in general, to carry out the purposes of the agreement. Communications may be addressed to the Chairman or Secretary.

Society Proceedings.

MONTREAL MEDICO-CHIRURGICAL SOCIETY.

Stated Meeting, Oct. 16th, 1896.

GEORGE WILKINS, M.D., PRESIDENT IN THE CHAIR.

Malformation of the Hands and Feet.

Dr. A. E. GARROW exhibited a child with malformation of the hands and feet, and showed an excellent skiagraph of the hands taken by Professor Callendar, of McGill University, a full report of which, together with the skiagraphs, will be published next month.

Dr. JAS. BELL pointed out the fact that here the usual history of heredity was wanting. No other members of the family or of former generations had been similarly affected. He contrasted this with a case exhibited by himself on a previous occasion in which several members of one family had a similar malformation.

Mouth Concretion.

Dr. JAS. BELL exhibited a large mass of calcareous matter which he had removed from the mouth of a patient under his care, a report of which will be published later.

A Case of Acute Hodgkin's Disease.

Dr. J. T. ARGUE read for Dr. G. D. ROBINS and himself a paper on a case of this disease. (See page 310 October Number.)

Dr. H. A. LAFLEUR thought that we had been attaching too much importance to the microscopic appearances of the blood in such cases; and judging of the disease by the state of the white corpuscles, leukæmia might exist without much increase of the leucocytes, and at times where the patient had been under treatment, as far as the blood examination went, it was no longer leukæmic blood, though the other signs of the disease are present, such as enlargement of the spleen, liver and lymphatic glands.

Syphilitic Nephritis—Fatal.

Dr. N. D. GUNN reported the following case:

J. L., aged 25, traveller, consulted me on July 17th, 1896, for swelling of the face, and fulness of the abdomen which he had noticed four days before, for the first time.

His family history was good, and his personal history revealed nothing bearing on the case save that he had contracted syphilis six months previously, and had been under treatment ever since, taking

large doses of bichloride of mercury with good results so far as secondaries were concerned, as the rash and sore throat were of the mildest type.

On examination I found general anasarca, temperature $99\frac{2}{3}^{\circ}$, pulse 92, slight accentuation of the second sound of the heart. The liver seemed slightly enlarged but was difficult to palpate owing to tension in the abdomen. The urine was acid, in consistence like thin linseed tea, of S. G. 1022, and solid on boiling.

The patient was put to bed on a milk diet with the administration of citrate of potash and digitalis. The urine in 24 hours was in amount 10 ounces of S. G., 1020, and albumin over the line marked 12 on Esbach's albuminometer; it contained no blood but plenty of epithelial casts.

4th day. Urine 20 oz., no change in albumin.

6th day. The œdema was greatly increased. Temperature $102\frac{1}{2}^{\circ}$, pain and tenderness in both groins, slight diarrhœa, urine 10 oz. Hot baths every six hours with hot abdominal compresses in the intervals were ordered.

7th day. Urine increased to 24 oz., temperature 100° , some delirium and twitching of the eyelids present.

8th day. Temperature normal, pulse 88, no pain, great distension of the abdomen, slight tenderness over the liver, bowels active, urine 27 oz., S. G. 1010, no change in the amount of albumin.

It is not necessary to give daily details after this but only the marked changes in the case.

On the 12th day mercury was given and the digitalis stopped; by the 20th day the urine was 40 oz., albumin down to line 4 (Esbach.)

30 day. Urine 80 oz. Albumin again increased even above line 12, S. G. 1006.

32nd day. Urine 18 oz. No chemical or microscopic changes.

The mercury was suspended, and digitalis and strychnine supplied instead, hot packs and hot air baths were continued as before. From this to the death of the patient on the 12th of October there was a gradual decline. Great ascites developed, with liver tenderness pointing to organic disease of liver; the urine varied between 25 and 50 oz., S. G. never above 1008: Casts were numerous.

The damage to the kidneys was evidently irreparable. No uræmic symptoms developed until 3 days before death, when a semi-coma, which gradually deepened, came on; there were no convulsions. Death resulted from heart failure.

The interesting points about this case are :

1st. Could this nephritis have been induced by the large doses of

bichloride of mercury which this man was taking at the time it developed?

2nd. The treatment hinged on whether this complication was a medicinal irritation or a manifestation of the original disease. Should I have increased the dose of mercury above $\frac{1}{2}$ grain a day, which he was taking when the disease developed? I stopped it for two weeks, then began again with small doses which seemed to do some good for a few days, then a change for the worse came and I stopped it again. I believe I should have continued with mercury from the beginning in doses sufficient to produce the ordinary constitutional symptoms.

Poisoning by a Belladonna Ointment.

Dr. F. W. CAMPBELL related the following case in practice: An acute rash is sometimes difficult to decide as to its character, especially in a defective or artificial light.

The other night he was called to a woman who had been confined three or four days previously. On examination he found a slight rash, universal all over the body, which had the appearance of measles, and somewhat crescentic in its character. Her temperature was a little over 101° . He forgot the exact figure, and the pulse was somewhat quickened. The patient was being treated with a view of getting rid of her milk. On enquiry he learned that an ointment containing Extract of Belladonna was being used on the breasts. All was then clear to him. He had a Belladonna rash to deal with. Dr. Campbell also mentioned several cases of Belladonna poisoning from the local application of Belladonna liniment in small quantity.

Stated Meeting, Oct, 30th, 1896.

GEORGE WILKINS, M.D., PRESIDENT, IN THE CHAIR.

Gangrene of the Foot.

Dr. G. E. ARMSTRONG showed a young woman 24 years of age with spots of gangrene on the dorsum and inner and outer border of the left foot. These spots were seven in number and varied from the size of a 5 cent piece to an area $2\frac{1}{2}$ inches in diameter.

He said; the patient was admitted to the Montreal General Hospital ten days before.

Four years ago she suffered from typhoid fever and during convalescence her left leg became painful and swollen and remained so for several weeks, ultimately returning to its normal shape and size. This is the fourth time that spots of gangrene have appeared on the left foot and leg during the past two years. One patch occurred just behind and a little below the left knee joint.

About six months ago the patient had been under Dr. Kirkpatrick's care in the Montreal General Hospital for a similar condition.

Her father, mother, and several brothers and sisters are living and well.

The onset occurred suddenly without any recognizable symptoms and, so far as I can ascertain, without any probable exciting cause. She denies having worn tight shoes, or having received any injury to the foot, and says she has not been taking medicine of any kind.

Her heart and lungs are normal. Urine high coloured, sp. gr. 1030, acid, and contains no albumin or sugar. Microscope shows amorphous urate, and crystals of uric acid.

It is as yet impossible to say how deep these sloughs will prove to be. At any rate it is quite evident that they involve the whole of the true skin.

I am inclined to think that quite possibly the phlebitis or end-arteritis following the typhoid may have had an etiological influence. It may also be of the nature of Raynaud's disease. It has been suggested that the condition is self inflicted. I don't know how she could have produced this condition if she had tried. I am quite sure that I could not do it. I don't know what I could use to gain this result. This is the fourth time that she has suffered from a similar condition, and always on the same foot and leg. There is not, so far as I know, any other evidence of hysteria about her.

These patches do not all lie within the area supplied by any one artery or any one nerve.

Dr. R. C. KIRKPATRICK said that the patient had been under his care some months before, and the leg was then in a much less marked but somewhat similar condition. There were two or three spots of gangrene on the foot which were quite superficial, and his impression had been that they were self-inflicted.

As bearing on this case he had brought another patient somewhat similarly affected, the condition in this case being undoubtedly due to a burn from a hot water can. He thought that the lesion was more likely to have been produced by the patient than due to an arrest of the arterial circulation.

Dr. F. J. SHEPHERD had come to the same conclusion after seeing the case, and referred to several other cases that he had met with, notably, one in which a series of rings of gangrene appeared, following each other at short intervals. As soon as a watch was set upon this patient and her hands kept tied the eruption ceased appearing.

Dr. D. F. GURD referred to a case which had come under his notice. A slough appeared on the skin of the leg in a child during convales-

ence from scarlet fever, although no hot applications could have been the cause.

Dr. JAS. STEWART asked if the patient showed any evidence of hysterical stigmata. He did not know of any means either from heart or irritants that could induce such a condition. He considered it neurotic in origin.

Dr. ARMSTRONG replied, that so far as known the patient showed no evidence of hysteria, and he agreed with Dr. Stewart that no artificial means, that he knew of, could produce deep sloughs of such a character.

Aneurysm of the Ascending Portion of the Aortic Arch, Leading to External Rupture.

Dr. JAS. STEWART and Dr. J. G. ADAMI reported this case. (See page 386 November Number.)

Limitations of the Visual Field of Intracranial Origin.

Dr. J. W. STIRLING read a paper on this subject. (See page 392 November Number.)

Dr. JAS. STEWART referred to one of the cases mentioned by Dr. Stirling as showing the great value of a thorough examination of the eyes and ocular muscles in determining the nature of intracranial disease.

Hæmorrhage of the Bowels in a very Young Typhoid Patient.

Dr. D. F. GURD read the following case report: Typhoid fever is seen in persons of all ages, but is much less frequent at the extremes of life. Authentic cases have been reported at the ages of 70, 80 and even 90, and Dr. Murchison exhibited the specific lesion in the intestines of an infant of six months. Previous to 1840 it was thought that young children were exempt from this disease but Ribbot and Tampin demonstrated conclusively that they were not, and that most of the cases previously known as infantile remittent were typhoid fever.

Hæmorrhage of the bowels is a rare complaint in young children. This fact is my apology for calling your attention to a case which occurred in my practice.

On Nov. 8, 1895, I was called to see Lizzie H., aged 27 months, who was suffering with fever and slight tickling cough. From the history of the case as obtained from her mother, an intelligent lady, I judged she was then in her sixth day of fever. The case ran a mild course till the evening of the twelfth day, when she had a bloody stool; this made me anxious and I got a trained nurse in attendance. At 8 a.m. the next day she had another, which the nurse said contained about 2 oz. of blood. At 2.30 the following morning, i.e., the 14th day of fever, she had a small stool, having about an ounce of blood

in it. From this time on the temperature rapidly declined, so that it reached normal on the 21st day and never again went above it. The blood in the stools was bright.

A Case of Cephalhæmatoma Causing Bony Deformity ; Gradual Absorption.

On Sept. 16, 1895, G. H., was born with the aid of forceps after a fairly tedious labour. No excessive force was needed. The child had what looked like an ordinary caput succedaneum the size of a large orange.

Next day the nurse called my attention to baby's head, which I examined, and found over the left parieto-occipital region the commonest form of hæmatoma, that is, a blood tumour between the periosteum and the bone. I assured the anxious mother that it might take some weeks, but that it would entirely disappear.

After about three weeks flakes or plates of bone could be felt over the tumour, and those slowly grew larger. When pressure was made over them they would bend inwards, giving a peculiar crackling sound and feel. These plates, perhaps four or five in number, gradually united and finally completely covered the tumour, which by this time had lessened by absorption to about three-quarters of its original size. The child's head at three months was very unsightly, having this large, firm, bony prominence. I saw the child this week and found the deformity much lessened, owing to the greatly increased size of the head during the past ten months, and this, with a fair growth of hair, has masked almost all appearance of anything wrong in the shape of the little fellow's head. I might have removed the contents of the tumour when I found that it was being absorbed so slowly, either by aspiration or excision, but I think the already greatly diminished deformity has justified my leaving the case severely alone.

This condition is said to occur once in 250 new born infants. I have seen several, but never one before which had a firm, bony covering form over it.

Resection of the Bowel.

Dr. R. C. KIRKPATRICK read the following report, to which is appended the pathological report of Dr. W. H. JAMIESON, who exhibited the specimen.

J. C., aged 63, was admitted to the Montreal General Hospital on Sept. 18, 1896. He said that for three weeks he had not had a motion of the bowels, and that for a week before that he had been much constipated. Previous to this time (four weeks before the date of his

admission) he had been well. He had been treated by all sorts of purgatives and injections before he came to the hospital.

The abdomen was evenly distended (37 inches in circumference at umbilicus), and tympanitic throughout. Liver dulness present (1½ inches on mammary line). No tenderness. Digital examination of the rectum revealed nothing abnormal. The case being urgent, the abdomen was opened in the middle line. The small intestines presented and were distended.

On drawing over the sigmoid flexure it was found to be distended until the lower part was reached, where a constriction was found. This was resected, and the ends of the bowel united by a double row of silk sutures. As soon as the rubber tubing (which had been tied round the bowel above and below the field of operation to prevent the escape of feces) was removed, the bowels commenced to act. A large rubber tube was inserted into the rectum and a copious motion was passed, I should think a couple of quarts of fluid feces. This line of union being apparently tight, the abdominal wound was closed. The patient died forty-nine hours after the operation, the highest temperature being 100° and the pulse 100. The abdomen remained soft and flaccid throughout. He had a slight bronchitis before the operation and the ether made this worse, so that I was inclined to look on the pulmonary condition as the cause of death. However, the pathologist has another story to tell, namely, leakage from the line of the re-section and septic peritonitis.

How should such cases be treated? Looking back on this case I feel strongly that the best treatment would be a temporary inguinal colotomy. Then, when the enormous collection in the bowels had been got rid of, a resection could be done with much greater prospect of success. The bowel could be opened at once, or if the patient's condition would permit of it, after twenty-four or forty-eight hours, when there would be no danger of infecting the peritoneum by the discharges.

The strain put upon the line of union by the contents of the bowel is very apt to be too much for the sutures or whatever device is used to approximate the cut ends, especially as there is a chronic inflammation going on, and consequently leakage takes place. Again, such patients have very little resisting power, the absorption from the bowel having already depressed the vital powers.

Pathologist's report—On opening the abdomen there was evidence of fibrino-purulent peritonitis. The abdominal cavity contained about 3viii of greyish-yellow purulent fluid with fecal odor. In the region of the sigmoid flexure of the colon a line of sutures extends

around the circumference, a portion evidently having been removed. The omentum is stitched to this at one point. The contents of the bowel escape here. On opening the bowel the edges are found in apposition. No leakage taking place anywhere except from a small spot corresponding to where the omentum is attached; the edges of the wound here are un-united and gangrenous. A perforation, through which a good sized probe can be passed, leads through a mass of omental tissue between the sutured edges and allows the escape of the contents of the bowel.

Anatomical diagnosis—Resection of bowel for adeno-carcinoma. Incomplete union of edges with escape of bowel contents into peritoneal cavity. General septic peritonitis. Broncho-pneumonia. Brown atrophy of the heart and some fatty change. Chronic interstitial nephritis. Fatty degeneration of the liver. Infection by streptococcus and colon bacillus.

MONTREAL BRANCH OF THE BRITISH MEDICAL ASSOCIATION.

The annual meeting of this Branch was held on the 2nd December, at 9 o'clock, in the rooms of the Association, Dr. Roddick in the chair. There were present Drs. J. A. Hutchison, Wm. Gardner, James Perrigo, G. G. Campbell, K. Cameron, Morrow, E. P. Blackader, J. G. Adami, Kirkpatrick, Proudfoot, G. T. Ross, Birkett.

The President reviewed the work of the past year as follows :

The year about to terminate has been an eventful one in the history of this Branch. Your Council has been called to meet many times during the year. Quarterly meetings have been regularly held and we are indebted to Drs. Adami, Johnston, Macphail and Martin for pathological specimens shown at each meeting. We are also indebted to the following gentlemen for contributions towards the programme of each meeting : Drs. Armstrong, Kirkpatrick, Evans, Alloway, James Stewart and others, for many interesting specimens shown.

During the past year, By-law No. 4 was amended so that five instead of three ordinary members are in future to be elected to Council.

The following new members were elected during the year : Drs. Edward Semple, G. A. Berwick, H. B. W. Carmichael, F. J. Hackett, R. C. Kirkpatrick, George Fisk, S. F. Wilson and J. A. Henderson making 85 present members.

On January the 18th, the British Medical Association was invited unanimously by the Branch to hold its annual Meeting for 1896 here, provided Carlisle would forego her claim. The invitation was cabled to England, but it was found to be impossible, as arrangements had already been made in that city. However, at the next meeting on April the 15th, a further invitation was tendered the Council in London to meet here in 1897, and a meeting on June 26th following, Drs. Armstrong and Adami were elected delegates to the annual meeting at Carlisle, to further press the matter, the result being that the invitation was accepted, and Dr. T. G. Roddick, President of this Branch, was elected to the distinguished position of President-elect. As a consequence of this, your Council immediately set to work to organize for the coming event, and at a meeting on September 14th, presented a representative list of names that might constitute desirable committees to carry on the various branches of such an organization.

The following have applied for membership : Drs. R. F. Rorke, South Woodsee, Ont. ; Charles F. Martin, Montreal ; George A. Dickinson, Port Hope, Ont. ; William McDermid, Vankleek Hill, Que. ; Robert B. Martin, Cleveland, Ohio ; W. B. Nesbitt, Toronto, Ont. ; John A. Hutchinson, Westmount ; George E. Josephs, Pembroke, Ont. ; J. V. Clemesha, Port Hope, Ont. ; Joachim Guimane, Toronto, Ont. ; James Ross, Dundas, Ont. ; T. P. Shaw, Montreal ; Henry Lunan, Campbelton, N.B. : A. L. DeMartigny, Montreal ; William Burnett, Montreal ; A. G. Morphy, Lachine ; H. J. Harrison, Cornwall, Ont. ; Grosvenor Hayes, Barre, Vermont ; William Mason, Montreal ; George Villeneuve, Montreal ; Ridley Mackenzie, Montreal ; H. D. Hamilton, Montreal : Ahern, Quebec : David A. Hart, St. Lambert's, Que ; W. H. Jamieson, Montreal ; J. C. Webster, Montreal ; Jas. Warburton, Charlottetown, P.E.I. ; A. F. Garrow, Montreal ; Henry Beaumonte Small, Ottawa. These 29 new members were elected.

Dr. Hutchison, the Treasurer, then read his report, which was duly adopted and showed a balance of \$37.03 on hand. Drs. E. P. Blackader and K. Cameron were nominated auditors by the chairman.

The question then came up as to what should be the annual fee to this Branch, including the subscription to the *Journal*, and after much discussion it was moved by Dr. Hutchison, and seconded by Dr. Kirkpatrick, that the sum of \$5.25 be the fee for 1897 for new members living outside the city and its suburbs. Carried.

The election of officers for the ensuing year was then proceeded with. It having been suggested by the meeting, that in view of the fact that the present officers having already in hand the preparations for the coming meeting here next August, it would be advisable that the same officers be elected again for the ensuing year, this was adopted by the meeting. President, Dr. T. G. Roddick ; Vice-President, Dr. E. P. Lachapelle ; Treasurer, Dr. J. Alex. Hutchison : Secretary, Dr. J. A. Springle. Council—Drs. F. J. Shepherd, James Perrigo, Sir William Hingston, George E. Armstrong and J. George Adami.

In view of the fact that a large number of members would be elected for the ensuing year, and it would be impossible to call together the Branch for such elections. it was moved by Dr. Gardner, seconded by Dr. G. G. Campbell, that the Council be empowered to elect such members for the present year and 1897. Carried.

SECOND PAN-AMERICAN MEDICAL CONGRESS, HELD IN THE CITY OF MEXICO, NOV. 16TH TO 19TH, 1896.

INTRODUCTORY ADDRESS BY DR. M. CARMONA Y VALLE, PRESIDENT
OF THE CONGRESS.

At the end of the fourth century after the discovery of America by that great man called Christopher Columbus, the idea was suggested to our neighbour, the great Anglo-American Republic, of celebrating that anniversary, among other ways, by the meeting of a Medical Congress in which all the nations existing on this continent and on the adjacent islands would take their part.

This happy thought was realized, and on September 5, 6, 7 and 8, 1893, we met in the city of Washington. The meeting was a perfect success, whether we consider the number of physicians attending, the importance of the papers that were read, or the magnificence with which we were all received and treated by that great nation and by its prominent men, who to their great talents add an extreme courtesy and a perfectly refined taste. We, who had the good fortune to take part in that first Pan-American Congress, can never forget either the affectionate reception that was given us, the great courtesy with which those gentlemen treated us, or the sumptuous entertainments with which they diversified our stay in that beautiful country. In remembrance of such an agreeable time, I can not do less than assume to myself the representation of the other American nations, and repeat to our northern neighbours, "Thanks, friends; a thousand thanks." We will know how to reciprocate, if not with such opulence, certainly with the same entire sincerity in our own affections.

At the time of closing that great scientific meeting it was arranged that another Pan-American Congress should meet three years after. It was decided that the meeting place should be the capital of my beloved country.

This, gentlemen, is the reason of this meeting. Do you wish to know why I have been selected to occupy this place and to have the honour of addressing you to-day? I would inform you that I owe this honour purely and simply to my age; because there are numberless persons who have a better right than myself to such a position, and who would have filled it with great success. But let this be how it will, it now becomes my duty to extend the most cordial welcome to all our illustrious guests; to express my hopes that they will have

an agreeable visit to our beautiful country, and that on their return to their homes they may not find anything but reasons to congratulate themselves for having come. I very well know that on leaving their *lares* and *penates* they must always feel something of an indefinite melancholy, but I also know, because I myself have experienced it, that this melancholy feeling disappears as soon as they find that instead of meeting foreigners and strangers, as was to be expected, they find themselves in the midst of brethren who receive them with open arms and treat them with the effusion of a sincere friendship. You are welcome therefore, my esteemed friends, and you can be certain that in each one of us you will find a brother ready to help you in everything you may desire.

But I must go a little further, gentlemen, and under pretext of making a presentation, I must give you a little knowledge of our scientific antecedents, and lay before you our medical education. But to be able to do so, I have to bring to your remembrance certain data of our history, and rectify certain reproaches, that are often passionately thrown out to Spain, our mother country.

It is often said that the Spaniards attempted to keep us submerged in ignorance with the object of facilitating their domination. Gentlemen, such imputations are really calumnious, and unworthy of the always grateful and well constituted heart of a good Mexican. During the war of independence, we were loyal enemies; but in times of peace we are her grateful sons.

Let us remember, gentlemen, that on the 13th of August, 1521, the imperial city of Mexico fell into the hands of the conquerors under the leadership of Hernan Cortés. Eight years after that event the College of San Juan de Letrau was founded in Mexico, dedicated to the preparation for the clerical and legal professions, which were those in vogue at the time.

Let us detain ourselves for a moment and ask: what other conquering Nation, but the noble and chivalrous Spain, would have thought of founding colleges in such an extensive and newly conquered country? Would it not have been more natural at that time to have thought of sending forward troops, of increasing the means of defence, and of taking advantage of the abundant wealth of the magnificent soil? And after all, for whom was this college intended? It is not probable that it should have been for the Spaniards, because we can not conceive that any great number of Spanish families could have come to the New World, before the lapse of eight years after the conquest. It is more natural to suppose that the immigrants of that nation would be well grown men capable of defending themselves, and

would not find much use for any college. On the other hand, the mixed race could not in the course of eight years have become very numerous, and would be too young to require the foundation of any school of secondary education. We must therefore come to the conclusion that this college was founded with the object of educating and developing the intelligence of the aboriginal Indian races.

But there is more yet; the first Viceroy of New Spain, Don Antonio de Mendoza, in the years 1534 and 1535, that is to say, 13 or 14 years after the conquest, petitioned the King to allow the founding of a University in Mexico, and feeling certain that this petition would be granted sooner or later, he ordered certain classes to be given which would later on be opened with the sanction of law in that institution. Unfortunately these negotiations were at that time subject to long and wearisome steps, and the distance between ourselves and the mother country was so long and the means of communication so difficult that Don Antonio de Mendoza could not realize his plan; but the second Viceroy, Don Luis de Velasco, when he came in 1551, brought with him, amongst other things, the commission to found the university, and that institution was legally established in 1553.

Subsequently, in the year 1573, the colleges of San Gregorio and San Ildefonso were founded. In 1587 that of Santiago Tlailolco was founded, and later on the College of Saints and the Clerical Seminary. Well now, seeing that during this short space of time seven colleges were founded in the City of Mexico, for superior education, can we still say that the mother country attempted to keep us submerged in ignorance. Far from this: the education in Mexico during the sixteenth and seventeenth centuries was of such a character that it merited the name of the Athens of the New World; and by way of results it produced such men as Ruiz de Alarcon and such women as Sor Juana Inez de la Cruz.

Gentlemen: Every age has its own ideas and its manners of appreciating them. During the sixteenth century, not only in Spain, but in the whole of Europe, the careers open to nobles were those of arms, the church and the forum. The career of medicine was at that time considered very low, and surgery was thought to have something ignoble about it. For this reason perhaps the University of Mexico established with a certain pomp its theological, canonical and forensic classes, without taking the medical science into account, up to the year 1578. In that year the chair of medicine was founded, called the "*prima*," or morning class, this being the first chair of that science which was founded in the new world. There was only one sole professor, and he taught the complete course of medicine in four years

whilst the practice was acquired by the side of some well reputed practitioner. The candidates to this career were required to study Latin, the course of Arts and Astrology, or Mathematics, so that from the moment when the medical career was established in Mexico, the candidates were required to undergo a more or less complete course of preparatory study, and to obtain the degree of Bachelor of Arts.

In spite of the slight importance that was in those times accorded to the study of medicine, it was very soon seen that one professor was not enough for the teaching of this science, and in the year 1599 a second chair of medicine was founded in the university, which was called "*vesperas*," this being the second class of medicine given in New Spain. In the year 1661, the chairs of *Metodus medendi* and of anatomy and surgery were created, to which, later on, the class of dissection was added.

The professor of *prima* studied the healthy man, physiology, and probably hygiene. The professor of *vesperas*, or afternoon class, studied the sick man, pathology, medical by preference. The professor of *Metodus medendi* taught the treatment of the sick; therapeutics, materia medica and pharmacy; and lastly, the professor of anatomy taught dissection and surgery, described the elements that constituted the human body, taught the practice of operations, and probably also entered somewhat on surgical pathology.

The first professors were appointed by the viceroys, but they were subsequently appointed by competitive examinations. There were two classes of lecturers; incumbents and provisional lecturers. The former gave the lectures as long as they lived and were able to do so, and when they died their places were filled by competitive examinations. The temporary lecturer served four years, after which time an examination was called for. Should an incumbent professor become superannuated, an examination was called for, but the professor who obtained the position entered with a provisional character and was changed every four years. The new incumbent was never appointed until the former one died.

Medicine was studied in a four-year course, besides those that might be employed in the preparatory studies. Once the course was terminated, the student could obtain the degree of Bachelor of Medicine, and when he perfected his practice and increased his knowledge, he could, after passing a fresh university examination, obtain the degree of licentiate and subsequently that of Doctor in Medicine.

The ecclesiastical and forensic studies could be completed in the university or in any other of the colleges I have already spoken of: that of San Juan de Letran, San Gregorio, San Ildefonso and the

seminary, although all the degrees were given in the university, but the medical studies could only be followed in the last institution. Nevertheless, a decree was issued in 1768 for the creation of a Royal College of Surgeons, in imitation of a similar organization that then existed in Cadiz and of another in Barcelona. The institution was opened to study in the year 1769, but the official opening was only held in the following year.

There were four chairs founded in this college: first, anatomy and dissection; second, physiology; third, operations; and fourth, clinical surgery with elements of medical jurisprudence. In this college the Romancist surgeons studied; so called to distinguish them from the Latin surgeons who studied in the university. From thence also came the phlebotomists, the dentists, the bone-setters, the midwives, etc.

The surgeons who studied in this school were called Romancists, because when the institution was founded no preparatory studies were demanded for matriculation, from whence arose a certain contempt, due as much to the title of surgeon which was there obtained as to their want of solid instruction, in view of the absence of preparatory education. Nevertheless, in the year 1793 orders were given that the matriculation in this school should require the previous study of Latin, an order which was not carried into effect until the year 1803.

This was the condition of things when in 1821 we obtained our independence from the Mother Country. The university continued under the same conditions and the Royal College of Surgeons changed its name to that of National Surgery. In the year 1830 a great step in advance was taken, when orders were given that nobody should be admitted to the School of Surgery who did not previously prove his degree of Bachelor of Philosophy. At that time even the Latin surgeons of the university were obliged to follow the courses of the School of Surgery, the by-laws of which had been amended. In the year 1831 another step was taken. Before this time physicians' diplomas were issued, as well as of Latin and Romancist surgeons, and from that time the faculty was ordered to only issue the diploma of physician and surgeon, thus putting an end to the division in the profession and obliging the candidates to undergo an examination in medicine and surgery.

The year 1833 arrived and with it came great events in connection with public education. Orders were given for the closing of the university and a general board of education was organized, creating several new educational establishments of a superior class, amongst which was a school of medical science, which is the one that interests

us for the moment, as we may call it the germ of our present School of Medicine. In this institution the following classes were established: Anatomy, Physiology and Hygiene, Medical Pathology, Surgical Pathology, Materia Medica, Medical Clinics, Surgical Clinics, Operations and Obstetrics, Medical Jurisprudence, and lastly Pharmacy. The government appointed the ten professors, and from amongst them one who should be the director. On the 5th of December of that year this institution was inaugurated in the building in the Betlemitas Alley and at once entered on its labours.

The institution had not been opened a month when at the end of 1834 an entire political change came over our country, and consequently the university was ordered to be opened afresh and things went back to the state they were in before the 23d of October, 1833. Fortunately for the new-born school, orders were given to the university to make an inspection of this institution and present a detailed report of its present condition. For the sake of truth, we must confess that the university acted with the greatest impartiality, and its report was so favourable to the Institution of Medical Science that it was decided to keep up that school.

It would be too long to enumerate all the vicissitudes and difficulties that were suffered by this corporation, but we can easily imagine them when we bear in mind the frequent changes of our governments; the total want of pecuniary resources; the want of a proper locality for the classes and the necessary cabinets; the many enemies, some of them powerful, against whom it had to struggle in order to establish a system of teaching that abandoned the old style, etc.

When we consider all this, we can no longer wonder that in the midst of such squalls, this frail vessel should have been on the point of sinking on two or three occasions, and that its classes should have been temporarily closed at such times. The heroic founders of our school found themselves more than once obliged to resign their positions, seeing that although they gave their lectures gratuitously, and that they shared between them the necessary expenses of the institution—in spite of that, I say, they suffered rude treatment from the government, or they were deprived of the building they had occupied and were turned into the street. The self-denial of these men was such that every one of them deserves the erection of a statue and the engraving of his name in letters of gold in our school.

Although very slowly, nevertheless the improvements were continued. In August, 1835, the director proposed certain improvements of which the principal were as follows: (1) That a professor of obstetrics should be appointed and this class separated from that of opera-

tions; (2) that eleven substitute professors should be appointed, one for each incumbent; (3) that thereafter all appointments of substitutes should be made by competitive examination; (4) that pharmacists should be obliged to take the course in the institute, of botany, chemistry and pharmacy; (5) that no student should be allowed to matriculate without having the title of Bachelor of Philosophy; (6) that after the lapse of five years, no student should be allowed to matriculate in the school, unless he had taken the courses in Latin and logic, first and second course of mathematics, physics and experimental chemistry; (7) that the physicians should be required to go through a four-year course, and pharmacists a two and a half year course.

All the above amendments were accepted and the greater part of them went into effect little by little, but the difficulties that the institution encountered were so many and serious that the results could in no way correspond to the ambition of the founders.

With the year 1836 the school commenced a period of comparative calm, because, although it continued its struggle with the scant pecuniary resources and the want of a proper locality, the persecutions at least decreased and the governments now began to try and assist the institution. At the end of that year certain reforms were established, of which the principal was that of assigning a course of five years for the medical career, and the others were amendments to the regulations. As a general rule we can say that every fresh administration introduced more or less change into the regulations of public education, but they all left untouched the fundamental part of the studies which were carried on in the school of medical science. Amongst the reforms which were decreed in the year 1842, there was one that merits attention, because with that the name of the school was changed, and instead of being the "Institution of Medical Science" it has since been called "The National School of Medicine."

When I entered that school in the year 1849, it occupied a part of the College of San Juan de Letran, after having held its meetings in Betlemitas, in the Espiritu Santo, in the College of S. Ildefonso and sometimes in the professors private houses for want of any public building in which to meet. But at the time I now refer to, I repeat that the school existed in the College of San Juan de Letran, and for the sake of truth we must confess that as guests we were fairly lodged, as we had good high rooms and some of them of sufficient size to contain the magnificent cabinets of physics and chemistry which the institution then possessed.

The requirements for matriculation were either a diploma of

Bachelor of Philosophy, or at the least certificates of having studied French, English, two years of Latin, and the two first years of philosophy, but with this difference, that those who like myself found themselves in the first case, that is to say with a bachelor's diploma, were matriculated to take what was called the sixth's year's course of preparatory studies, botany, physics and experimental chemistry, whilst those who had only taken the second year class of philosophy were matriculated into the fifth year, for the study of botany and physics, and in the following year only took the class of chemistry. Once the six-year preparatory course was concluded, we commenced on the five years of medical study, which were distributed as follows: First year, anatomy and pharmacy; second year, a repetition of anatomy and a course of physiology; with first year of surgical clinics; the third, surgical pathology, operations, bandages and apparatus, together with first year of medical clinics; fourth year, materia medica and therapeutics, medical pathology and second year of surgical clinics; fifth year, obstetrics, medical jurisprudence, second year of medical clinics.

During my student's career, great events happened which are worthy of being related, because they show the misfortunes that frequently overtook the school and the magnanimity and liberality of our professors. In the year 1850 the director was informed that a part of the building of San Hipólite could be purchased which then belonged to the municipality, and that the school of medicine could there be located definitely. The necessary negotiations were entered into, and the professors having agreed to yield \$50,000 out of their overdue salaries with the object of paying for the building, the deed of conveyance was prepared and the school took possession of its house. The necessary arrangements and repairs were made, and in the following year of 1851 we entered into our new home. With the greatest satisfaction we remained there for that year and for the year 1852: but when least we expected it, in the year 1853, a peremptory order came from the government to disoccupy the building, as it was required for a barracks. It was in vain that we protested that the building was the property of the school and that it was beginning to be adapted to its object. Nothing could avert the blow and we were obliged to make up our minds to search for a lodging in some other place, and eventually went to the College of San Ildefonso in the character of guests, where we passed the examination at the end of the year. Having reached the year 1854, which was the last of my studies, we commenced our classes in January; but hardly had a month passed over our heads when the rector of that college, through

his secretary, and without taking any notice of our own director, commenced to subject us to certain measures that we considered offensive to ourselves and to our professors, for which reason we decided to abandon that institution, but offering our own director that we would subscribe amongst ourselves to pay the rent of a house in which we would continue our studies. Fortunately for us, our director just then obtained information that a part of the building of the ex-inquisition, which belonged to the seminary, could be purchased in the same way as the building in San Hipólito had been purchased. Our professors, who were always generous and free-handed, this time ceded \$50,280 of their unpaid salaries, and in that way we acquired the ownership of the building, which has from that date been occupied by our school. I can therefore say that at the conclusion of my student's career the peregrinations of our beloved school also came to an end, and that I was one of the first to receive the diploma of physician and surgeon in that building.

From that date the School of Medicine has progressed more or less rapidly to its high position. It is true that even then the salaries of the professors were paid with great irregularity; but, to say the least, the minor expenses of the institution were covered, and a small fee was required for each matriculation and for the partial examinations. The general examinations used to cost us a little over \$70, and the examiners had some participation in all these revenues, whilst the other part was dedicated to the funds of the establishment. I remember that I myself got the advantage of some of these perquisites when I was a substitute professor, but all these disappeared with the law of the 2nd December, 1857, from which date the salaries of the professors have been properly paid, with very rare exceptions. The scientific instruction continued improving with great rapidity. I have already said that the Institution of Medical Science was created in the year 1833, with ten professors, who divided amongst themselves the whole of the classes; and that a little later on the classes of operations and obstetrics were separated, from which date the professors were eleven in number. In this way things continued until the year 1866, when the obstetrical clinic was established. The law of the 2nd December, 1867, created the classes of topographical anatomy, general pathology and hygiene. The law which is now in force, and which was enacted on the 6th of May, 1869, made no alteration in the number of classes; but a little later on the class of normal histology was opened. So that in less than one decade five new classes were established.

We now come, gentlemen, to the present period—I mean to the

period under the administration of General Diaz. I have had much hesitation as to the manner in which I ought to treat this part of our history, and my pen has hesitated a good deal, because I have found it difficult to see my way in continuing my story. Am I going to wound the modesty for which our chief magistrate is proverbial? Do I expose myself to be taken for a mean adulator? But at the same time, how can I keep silence with respect to public facts? How can I seek to hide that which is perfectly well known to all Mexicans? I shall therefore confine myself to the dictates of my own heart, begging in the first place the permission of our president, and on the other hand, assuring everybody who does not know me that I never say what I do not feel. Experience on the one hand, and history on the other, have taught us how difficult it is to unite in one and the same person the character of a consummate warrior with that of an able statesman and politician. The rare exceptions that are found are considered as phenomenal, and they constitute a real era in the history of nations. But, gentlemen, it is necessary to confess that General Diaz is one of those rare exceptions. He is as brave in the field of battle, when it has been necessary to punish him who has dared to stain the name of Mexico, or him who has dared to disturb the public peace, as he is an able statesman and a courteous gentleman, and always has been, during the long periods of peace that he himself has provided for the country. He has as perfect a knowledge of the sharp and concise language to manage soldiers as of the soft and gallant language that is necessary to deal with ladies in the parlours of the highest society. With the same facility does he treat political personages with reserve and prudence that he displays during moments of good humour that are proper for private friends. We who have had opportunities of dealing with him in matters of more or less importance have always been astonished at the special talent that he has for understanding at first sight the difficult point of any problem, and for coming to the most prudent decision on the subject: and this even when treating of scientific questions, or of matters of which he has no knowledge.

Very seldom has he found any necessity of postponing a resolution in order to give himself time to investigate or meditate on any question.

Endowed with these rare qualities, and with an extraordinarily keen intelligence, nobody will wonder that the School of Medicine should have progressed during his administration as it never could during the first forty-four years of its existence. At the time when it was founded, it may be said to have had eleven classes, and from the year 1833 up to 1877 only five chairs were added, while from

1877 to this date, ten professors have been added to the school without counting a large number of assistants, prosectors and chiefs of clinics; and all of a new creation.

Both the President and his learned Minister of Public Education being convinced that a great number of students can not be attended to by one professor, they duplicated the number of those who teach medical and surgical clinics, as well as those of medical and surgical pathology. They did not consider it desirable that the male and female students of obstetrics should attend the same class, and therefore created a new chair for the exclusive teaching of midwives. In view of the absolute necessity of teaching pathological anatomy, a special professor was appointed to this new chair. And lastly, in view of the constant advancement of science in our days, which renders it difficult for any one man to possess, even to a fair degree, all the knowledge now accumulated by medical science, four chairs were established of special subjects—that is to say, of Bacteriology, Ophthalmology, Gynæcology and Pædiatrics.

In order to give an exact idea of the present condition of medical teaching in Mexico, I would inform you that nobody is admitted to the study of that science who does not prove that he has passed a successful examination in his five year course of preparatory studies, which are composed of the following subjects: First and second year of Mathematics; first and second year of French; first and second year of English; first and second year of Latin, Spanish, Figure and Landscape Drawing, Physics, Kosmography, Chemistry, Greek roots, Universal and National Geography, Botany, Zoology, Logic, Morality, Universal and National History and Literature. The medical courses must be taken in another five years, and consist of the following studies: Descriptive Anatomy and Dissection, Normal Histology, Elements of Pharmacy, Physiology, Surgical Pathology (two years), Medical Pathology (two years), Topographical Anatomy, Operations, Bandages and Apparata, Therapeutics and Materia Medica, General Pathology, Surgical Clinics (two years), Medical Clinics (two years), Medical Jurisprudence, Hygiene and Medical Meteorology, Obstetrics, Anatomy and Pathology, Bacteriology, Ophthalmological Clinics, Gynæcological Clinics and Clinics of Infantile Diseases.

You have now before you a picture of the present condition of our School of Medicine. Study it with some care and you will be convinced that without possessing the resources of some of our neighbours, but having men of the high character of our founders, and governors such as we now have, we have no reason to blush for our school, when compared with the best organized European schools.

Gentlemen, I should be very sorry to abuse your kindness, but I have considered myself in duty bound to present our medical institution to our visitors, as it was and as it now exists. I still have to point out to your consideration certain medical questions of interest in the present day, and that merit a careful study in our Congresses. I shall try to do so in a very concise manner, seeing that men of such practical scientific knowledge as I now have before me do not require me to enter into any great detail.

The whole world will support me in saying that with the recent bacteriological studies, science has taken an enormous step in advance; but these same studies have produced such a commotion in the old nosological knowledge that we now have a condition of real anarchy in the classification of diseases, many of which are considered, as microbial, before science has demonstrated the fact. Besides this, many of them which were formerly considered inflammatory are now excluded from that group, and placed amongst the microbial diseases, and through this fact alone they are classified amongst the general diseases. It is now time for us to undertake a scientific classification of all these complaints, founding our work on certain general principles, which I take the liberty of pointing out.

The first is, that we must either suppress from the nosological classification the idea of phlegmasia or inflammation, or if we admit that symptom, you must agree that this process, that is commonly of a microbial character, can be caused by very varied organisms; thus showing that every disease which shows symptoms of phlegmasia can be considered as inflammatory, whether the generating germ is called *staphylococcus albus*, *micrococcus tenuis*, *staphylococcus pyogenes*, *streptococcus*, *pneumococcus*, *gonococcus*, etc., and whatever might be the organ in which this micro-organism is developed.

The second consideration that we must not lose sight of is the following: there are microbial diseases in which the microbe appears to be a fundamental part of the evil, as in the case of leprosy and tuberculosis, whilst in others the microbe takes a secondary place and its ptomaines take the first, as for instance in tetanus, diphtheria, etc.

And lastly, we must not forget that however numerous may be the diseases of a strictly microbial character, there are many others which only have that appearance and perhaps some analogy, but that as long as science does not fully prove the existence of the germ, they must not be reputed as such; in spite of the fact that the greater part of the pathological writers so consider them. I refer to rabies, syphilis, small-pox, measles, scarlatina, etc. It appears to me better to modify our nosological classifications from time to time, and not

prejudice the question by acting on analogy and popularizing or spreading errors that must always be injurious.

The second question that I would desire to see treated in our Congresses, I will present by means of a simple question. In the present condition of science, can the surgeons have a perfect certainty in their asepsis and antisepsis, so as to authorize them to undertake operations for the sake of satisfying the patients, when these operations may be of such a character that the slightest neglect or accident may endanger the life of the patient operated on ?

And lastly, I would point out an abuse that has gradually introduced itself, and with respect to which I would call the attention of the profession in general, and especially my colleagues who form the section on therapeutics. I refer, gentlemen, to the progressive and fabulous increase of the so-called patent medicines. Little by little, our drug stores are being transformed into simple warehouses for medicines already prepared ; and in some foreign towns, I have seen with the greatest wonder that it is very rare to see any prescription made up of any of the physicians practising in the locality, thus completely setting on one side the pharmacists, who are converted into ordinary merchants, without any responsibility whatever for the goods they furnish. This practice can lend itself to the greatest abuses and lead to the most unfortunate results, that would be very difficult to remedy. A prescription that is made up in a known drug store and by an intelligent pharmacist constitutes a guarantee for both the physician and the patient ; not only because the scientific reputation of the pharmacist requires that the substances employed should be perfectly pure, but also because it affords a certainty that the dosification and manipulation of the medicine has been properly done. The method of procedure leaves us perfectly satisfied, and in case of an accident, it is easy to discover whether the fault lies with the physician or the pharmacist ; but when the patent medicines are employed, many of which come to us from abroad, all guarantee disappears. Indeed, how could we possibly make those manufacturers responsible ? How could we demonstrate to them that the altered or badly prepared medicine had come out of their factories, or that some falsification had been committed ?

But there is more yet : I maintain that the use of prepared patent medicines is a practice entirely contrary to science. Because in fact, just as it is an undeniable truth that disease does not exist but that patients do ; that the morbid types are only found in the books, and that what we see in practice are individuals who modify the clinical symptoms by reason of their age, sex, constitution, idiosyncrasies and

medium in which they live ; in the same manner it must happen that no specific medicine can exist for such diseases as anæmia, tuberculosis, dyspepsia, etc. ; but that the medicines must vary just as the patient varies, and the former must be adapted to the requirements of the latter.

Let the patent medicines be abandoned to the vulgar herd, and to those who will not call in a physician ; but the latter, if he is a man of learning and knows his profession, must first of all form a complete diagnosis, and afterwards, bringing into action all his knowledge in materia medica and therapeutics, he should prescribe the patient a medicine that would be in perfect accordance with the special indications presented by the symptoms. To proceed in any other manner could only be likened to a bad tailor, who insisted on dressing his customers with ready-made clothes.

Gentlemen, I bring my long and ill-arranged discourse to an end, expressing a desire that all my co-professors may have an agreeable stay in Mexico, and that their labours may attain the most complete success, and also that our subsequent meeting may further enrich the science of medicine and increase the high reputation of science in America.

THE

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BRITISH MEDICAL ASSOCIATION.

MONTREAL MEETING.

Not only is the Local Branch in Montreal busy organising the meeting next August, but the leaders of the Association in London are actively at work. The *Journal*, of December 5th, may indeed be called a Canadian number. It contains a very full article on Montreal, its medical institutions, the ways of reaching Canada and the proposed excursions, as well as excellent papers by Dr. G. E. Armstrong (Upon Operative Interference in Typhoid Perforation); Drs. Wyatt Johnston and D. D. McTaggart (Upon the Serum Reaction in Typhoid Fever), and Drs. C. F. Martin and G. H. Mathewson (Upon the Relationships Between Leuchæmia and Pseudo-Leuchæmia); all these are contributions of the highest order. We only wish that the *Journal* had given the opportunity to a larger number of Canadians to contribute. As it is, we learn that these articles were contributed at little more than a moment's notice. The success of this number leads us to suggest that in future the *British Medical Journal* would do well to bring out a series of Colonial numbers each year: Canadian, Australian, Indian, and so on,—and thereby would help to familiarise those at home and throughout the Empire, with the quality of the work done in the colonies, and with the leading workers in various parts of the world.

In addition to this we learn that the authorities in London have addressed circulars and forms of application for membership to the nearest Local Branch, to every practitioner in Canada, inviting membership in that Branch. If there are any who have not received these applications, the Local Branches at Montreal (2204 St. Catherine street); at Toronto (Dr. W. B. Thistle, McCaul street); at Halifax (Dr. G. C. Jones, 136 Hollis street); at Victoria, B.C., (Dr. G. L. Milne),

and at Ottawa (Dr. C. P. Dewar), will be glad to forward all information and forms of application.

During the month two new branches have been formed, one at Toronto, with Dr. I. H. Cameron as President, Dr. W. J. Wilson, Vice-President, Dr. Machell, Hon.-Treasurer, Dr. W. B. Thistle, Hon.-Secretary, and with the following members of Council: Drs. Allan Baines, John Caven, Chas. Sheard, A. McPhedran, R. A. Reeve.

Drs. Wilson, Baines, Caven, are presidents of the Medical, Clinical, and Pathological Societies of Toronto, respectively. With so active and influential a list of officers, it is evident that Toronto is joining most cordially in the attempt to make the meeting a success.

The other branch was established at Ottawa on the 15th inst., and we heartily congratulate our confrères at Ottawa for the enthusiasm they displayed in thus uniting together. Dr. Roddick, President-Elect, was present, and addressed about 40 out of 50 practitioners in the city, and of these over 30 applied for membership. Dr. C. R. Church was elected President, Dr. L. C. Prévost, Vice-President, Dr. W. C. Cousens, Hon.-Treasurer, Dr. C. P. Dewar, Hon.-Secretary and the Council of five, includes the well-known names of Sir James Grant, Dr. H. P. Wright, Dr. W. R. Bell, Dr. A. J. Horsey and P. A. MacDougall.

At the annual meeting of the Montreal branch thirty-one new members were added, and in the ten days that have elapsed since then, close upon forty further applications for membership have been received by the Secretaries in Montreal.

We may again point out that members may be transferred from the Montreal and other local branches to other branches which may be formed in their neighbourhood during the ensuing few months. It is in all respects advisable that members belong to the branch in their immediate neighbourhood. By a resolution passed at the last meeting of the Montreal branch, it was determined that the subscription, including the delivery of the Journal, should be reduced to \$5.25 for all members living outside Montreal and suburbs.

That the Montreal City Council is most anxious to render help, is evidenced by the fact, that \$3,000 to this end, has been inserted among the items of the loan for which the City seeks authorization in the Quebec Legislature. The Mayor and other leading members of the City Council of Montreal, have throughout shown themselves most anxious to forward the interests of the Association and deserve the hearty thanks of the profession for their endeavours on our behalf.

Among the local entertainments to be given to the members of the Association and its guests at the meeting, will be the excursion to Ste. Agathe and Montagne Tremblante in the lovely country 50 miles north of Montreal, an afternoon excursion down the river in one of the finest boats of the Ottawa River Navigation Company, a similar excursion to Ste. Anne and down the Lachine Rapids, and an entertainment upon the Mountain. These will be given by the local branch. It is as yet too early to make any statement with regard to private acts of hospitality.

The Museum, devoted to the exhibition of foods, apparatus, medical preparations, books, and everything of special interest to physicians, promises to be an important feature of the meeting. The Museum Committee are authorized to spend \$1,000 in fitting up and arranging the Victoria Skating Rink, the largest and most convenient building which could be obtained for this purpose, and the exhibition will be made attractive to the general public as well as to the profession.

Already leading manufacturers of medical specialties both in England and in the States, are making active enquiries about the Museum, which promises to assume an international character, the leading firms in England and France desiring to introduce their goods into America; the American firms being anxious to familiarize the visiting members of the Association with the qualities of American products. There will thus be much competition shown and the exhibition promises to be a remarkable one.

ON INTERPROVINCIAL REGISTRATION.

In the *Montreal Gazette*, of December 11th, was printed a leading article written, we are informed upon good authority, by a layman, and headed, "A Great Opportunity." This article so fully expresses our own opinions upon the matter, and withal is written in so vigorous a style, that we venture to reproduce it.

"The annual meeting of the British Medical Association in Montreal is for many reasons an important occasion. The mere sending out of the programmes will draw attention all the world over to the attractions of Canada for tourist travel, and the advent of so many visitors is certain to make widely known the material resources and the industrial and social advancement of the Dominion. These are facts which it is to Canada's advantage to have known in the Old Country, and there is no class better fitted to spread that knowledge than the medical profession who are constantly brought into friendly relations with all classes of the population. But there is another

advantage likely to accrue from the meeting of no less moment. It will give an impetus to medical education and research all over the Dominion, and will bring the doctors here into touch with the profession in the Old Country. It will also show the most influential members of the profession in the United Kingdom what a high standard of medical education has been reached here, and that our institutions will not suffer by comparison with those on the other side of the Atlantic. But to take full advantage of this opportunity, it is necessary that an important step should be taken in the interim. The Canadian Medical Association will meet at Montreal on August 28th and 30th, immediately before the British Medical Association meetings, and the scheme of interprovincial registration, which was referred to the provincial council at the last annual meeting, will come up for discussion, and, it is to be hoped, for final adoption. The medical profession in Canada have had this subject under discussion for many years, and it is quite time that it should be finally dealt with. The present condition of affairs is anomalous and vexatious. A doctor on one side of the Ottawa River cannot attend cases on the other, and Montreal specialists are prevented from being called in to consult on cases in Ontario. Even in the matter of legal evidence, opposing counsel may prevent a doctor from being heard because he has not the provincial qualification. All this is very absurd, and a serious injury to the public, which has a right to the best medical attendance procurable in the Dominion, wherever patient or doctor may happen to reside. The present arrangement is also a great disadvantage to medical students, who do not always know where they will find their best opportunity to practice, and are, therefore, compelled, as a matter of precaution, to take two or three provincial qualifications, thereby needlessly increasing the fees and the examinations. Another unfortunate result is that no Canadian qualification is recognized by the Medical Council of Great Britain as giving a right to practice in the Old Country, and Canadian diplomas are not regarded with the esteem they deserve. The McGill and Bishop's courses are accepted as a sufficient guarantee for the preliminary work, but the Canadian graduate has still to do some months' studying in England and take the final examinations before he can obtain an English qualification. In Australia, where the various colonies have a common standard of examination, the graduates have obtained the right of registration in England on merely presenting their diplomas. Medical education in Canada is quite as far advanced; but the General Medical Council of Great Britain say, reasonably enough, "We cannot be expected to enquire into the various qualifications

that obtain in the different Provinces of the Dominion; adopt a common interprovincial standard, and we will gladly admit you to registration." At the meeting of the British Medical Association in Montreal next August there will be an unparalleled opportunity for advancing in this direction, if the scheme of interprovincial registration now before the provincial boards is adopted in the meantime. The British Medical Association takes cognizance of all matters of interest to the profession, and after seeing our system of medical education, the equipment of our institutions, and the men who administer them, it might very properly pass a resolution recommending the Medical Council in England to admit Canadian practitioners to registration in the Old Country on presentation of their diplomas. Such a recommendation could hardly fail of its effect, for the leading members of the Medical Council are also leading members of the Association, which is thoroughly representative of the profession in the United Kingdom. But in order to gain this valuable privilege, it is absolutely necessary that there should be a common standard of examination throughout the Dominion. So long as the various provinces refuse to accept each other's qualifications, one can hardly expect the British Medical Council to accept any of them."

There are in this article one or two points that require possibly some little explanation. We believe for example, that the reason why the authorities in England permit Australian practitioners to register, is not that there is a common standard of medical education throughout the Australian Colonies, but because those Colonies have up to the present time remained separate and are not confederate. If, as is not outside the range of possibility, the Australian Colonies unite, then according to the present British law they will lose their privilege unless they establish some scheme of inter-provincial registration. But as the matter stands at present undoubtedly the Australian graduate can register in Great Britain, and can in consequence practice over a large portion of the empire, and the Canadian cannot, until some common scheme of licensing is agreed upon by the Provinces of the Dominion.

We are glad to learn from the pages of our esteemed contemporary, *L'Union Medicale*, that in the Province of Quebec the report of the inter-provincial reciprocity of the Canadian Medical Association has already been brought before the Provincial Board of Medicine of Quebec; and that a committee composed of Drs. D. Marciel, A. T. Brosseau, J. M. Beausoleil, E. E. Laurent and C. S. Parke have reported to the Board in favour of adopting the scheme put forward. This Committee asks that the officers of the Council be authorized to

sign a preliminary treaty with the other provincial Boards of the Dominion, and with that of Prince Edward Island, so as to be able to give a special license conferring the right to practice throughout British North America.

As the British Medical Journal remarks in another able leading article, it is fitting that the sixtieth anniversary of the Queen's accession be celebrated in the profession by an act which indicates the imperial unity of our profession, namely: this Montreal meeting of the British Medical Association. The members of the profession in Canada can, it seems to us, celebrate the great occasion in no more memorable way than in drawing together and, by accepting inter-provincial registration, gaining great and imperial opportunities.

MEDICAL CLUBS AND FRIENDLY SOCIETIES.

We have received from Dr. Belleau, the Secretary of the College of Physicians and Surgeons of the Province of Quebec, the following timely resolutions on a subject which has from time to time been attracting a good deal of attention from the medical profession, namely, the abuse of the club system.

We have also received from California a set of resolutions which have been passed by a number of physicians there, dealing with the same question. These we publish under another heading.

[TRANSLATION.]

PROVINCIAL BOARD OF MEDICINE.

Extract of the minutes of the Provincial Board of Medicine, held at Quebec, 12th September, 1895, in the new rooms of the School of Medicine of Laval University.

Proposed by Dr. S. Gauthier, seconded by Dr. Beausoleil, and resolved, "That a committee composed of the members of the Legislature, together with the proposer and seconder, be authorized to study the rules and constitution of the several friendly societies doing business in the Province of Quebec, and that it be resolved that this Committee take means to do away with the despotic rules that these associations, calling themselves philanthropical, impose upon the medical profession.

"That the College of Physicians and Surgeons of the Province of Quebec express their disapproval of the conduct of members of this College who make engagements with these societies to attend the members of the lodges for a salary agreed upon in advance.

"That it is derogatory to professional honour and ethics to be bound in all cases to make known the name, the cause and the nature of the sickness of the members of these associations.

“ That this Committee confer with the several managements of these associations of mutual help, so as to cause the withdrawal from their constitutions of the clauses requiring the doctors to certify, even under oath, the causes of the demands for benefits, from their members.

“ These obligations being a cause of crying abuse in a great number of cases, at the same time that they expose the medical profession to popular discredit.

True Copy.

Signed, A. G. BELLEAU,
Secy. C. M. & C. P. Q.

Extract from the minutes of the Semi-Annual Meeting of the College of the Province of Quebec, held in the rooms of Laval University, at Montreal, the 2nd July, 1896.

Dr. S. Gauthier, Secretary of the Committee on Legislation made the following report :

“ REPORT OF THE COMMITTEE ON LEGISLATION.

“ Seeing that the College of Physicians and Surgeons of the Province of Quebec is of right the protector of the interests of the medical profession, it is urgently required to take into its serious consideration the resolutions of its committee on Legislation, held at Montreal, the 10th June, 1896.

“ This Committee resolved that it was of absolute necessity to protect the members of the College of Physicians and Surgeons of the Province of Quebec against the injury done to the medical profession by these friendly societies doing business in the Province of Quebec.

“ The rules of these associations which impose on physicians prices fixed in advance for their services, are supremely ridiculous and should be annulled. The Committee on Legislation demands also from the College of Physicians and Surgeons that it declare that the conduct of physicians who subscribe to the rules of these several friendly societies is derogatory to professional honour, and that by so doing they render themselves amenable to the discipline of the Council.

“ The interests of the medical profession require that the members of these several associations shall remain at liberty in the matter of the choice of a doctor, and that these friendly societies should be satisfied with the certificate of any physician duly qualified by the College of Physicians and Surgeons.

“ It is derogatory to the honour and ethics of the profession that a physician become a member of the board of directors of any of these associations, or permit himself to exercise control (either by visiting

the patients of their confreres or revising their certificates) or to influence the *clientele* of a whole district.

In effect we are aware that certificates of physicians unconnected with these societies, certificates that require the specification of the cause and of the nature of the illness, pass into the hands of physicians who accept a miserable pittance for doing the medical practice of the lodges, and are subject to commentaries more or less malicious.

" This position is no longer tenable, and the respectable portion of the profession of medicine is not disposed to any further put up with such indignities.

" If the friendly societies, which are certainly called upon to do good, are willing to understand their own interests, let them cause the disappearance of the arbitrary clause in their rules, otherwise the medical profession will be forced to protect itself.

" There will be a general rising against these abuses. Physicians in all parts of the world where these associations exist are suffering from these monopolies.

(Signed,) N. P. CARTIER, M.D.,
J. M. BEAUSOLEIL, M.D.,
J. C. S. GAUTHIER, M.D.

This report was adopted without discussion.

True copy,

(Signed) A. G. BELLEAU,
Secy. C. M. & C. P. Q.

SEGUNDO CONGRESO MÉDICO PAN-AMERICANO.

The second Pan-American Medical Congress held in the City of Mexico on the 16th to the 19th of November proved to be in many respects a highly successful meeting. In all some 500 members of the profession registered; this number, considering the season of the year, may be considered large. Next to Mexico, the United States had, as would be expected, the greatest number of representatives.

Considering the great distance and period of the year, the representation from Canada was respectable, seven having put in an appearance, six being from Montreal and one, Dr. Rice, of Woodstock, from the Province of Ontario. The Montreal representatives were Sir William Hingston, Drs. E. P. Lachapelle, Benoit, Blackader, J. Chalmers Cameron and James Stewart.

The delegates from the United States were fairly numerous, but only feebly represented the types which we meet with in the Congress of the special associations at Washington.

Dr. William Pepper, the president of the First Pan-American Medi-

cal Congress, and to whose zeal and ability the foundation of the Congress is due, was present and took an active part in the proceedings.

The formal opening of the Congress took place at the Teatro Nacional on the evening of November 16th. The proceedings were opened and closed by a few remarks from General Perfirio Diaz, the President of the Mexican Republic. He extended a warm welcome to the visiting delegates, and expressed the hope that much good would arise from the meeting together of so many kindred minds all imbued with the lofty aim of conferring benefit on their fellows.

The General Secretary of the Congress, Dr. Eduardo Liceaga, reported that 550 physicians from different parts of the Western Hemisphere had promised to be present at the Congress, and that the papers promised in the various sections amounted to fully three hundred. Dr. Liceaga concluded his able address in the following words, which were loudly cheered by the immense audience: "We have every reason to hope that the results of our meeting will be beneficial to the progress of science and will tend to alleviate the evils that afflict humanity. It is in every way a consolation to see the spectacle that is presented by such meetings as this. They make us appreciate the advances of civilization, the benefits of the association and at the same time give us a practical proof of the universal fraternity that is found in scientific studies.

"The physicians who come from the continent, from the islands, from the northern points, from tropical countries or from the distant republics of the South, all come animated with the same idea. They will separate from their discussions all questions or controversies that could touch politics or religion. Their studies and mutual instruction will not be interfered with in any way by difference of race or of language.

"Those who come from distant countries have not taken into consideration the pain of leaving their families, nor have they measured the distance that separates us from their distant lands; they have not been afraid of the dangers to be met with in their long journeys, nor have they counted up the losses incurred through the abandonment of their business, and still less are they animated by the sordid avarice that the celebrated English poet, Lord Byron, so bitterly censured in those traders who abandoned their comforts, their families and their countries, who defied the dangers of the seas and the ardent sun of the torrid zone in search of wealth without ever being able to satisfy their unlimited avarice.

"No, gentlemen, you have not been brought here by the thirst for gold; you do not sacrifice your peaceful and laborious life, nor do

you abandon your homes and countries for the sake of ignoble passions. You come here to bring your contribution of knowledge and experience to the progress of medical science ; you come to investigate the truth, to study the means of alleviating physical pain and to advance the improvement of human intelligence.

“ Gentlemen, I can only express the hope that the fulfilment of the duties which you have freely imposed upon yourselves, and the realization of these beautiful ideas will compensate you for your sacrifices and contribute to the progress of humanity.

“ Gentlemen, in the name of my country I thank you for your presence at this meeting. Gentlemen, you are welcome.”

Dr. Carmona Y Valle, President of the Congress, then delivered a most interesting address on the history of medicine and medical education in Mexico from the time of Cortes to the present day. We publish this address in this number. It will well repay perusal. It makes clear the great difficulties that the profession laboured under in Mexico until very recent times, but now owing to an enlightened and progressive government, medical education there compares favourably with many of the American States.

Dr. William Pepper, of Philadelphia, followed Dr. Carmona. He delivered a very eloquent address, which was loudly applauded. He began by referring to the marked progress made by the Mexicans in recent times, politically, socially and in science. He dwelt on the more important recent bacteriological discoveries, and referred to the great importance likely to be played in modern medicine by Roentgen's discovery.

The last paper in the first general meeting was read by Senor Don José Gamboa, a prominent legal gentleman in the City of Mexico. He chose for his subject “ International Sanitary Legislation.” He strongly advocated the appointment in each Capital of the Pan-American States of a committee who would have power to deal with all questions affecting, or likely to affect, the general health. In this way he claimed that uniform laws would be enforced.

Senor Gamboa's address, which was delivered in Spanish, was well received.

The next speaker was Dr. E. P. Lachapelle, the able representative of Canada. He dwelt on Bacteriology in its relation to Preventive Medicine. The address, which was delivered in French, reflected great credit on the speaker.

The general closing session of the congress was held in the Chamber of Deputies, when the official delegates of the various representative States made appropriate allusions to the success of the meeting.

In the space at our disposal it is impossible to give even a summary of the more important papers read at the various sections. The section meetings were held in the School of Mines, a building well adapted for such a purpose. In the section on Medicine a paper read by Dr. Wm. Pepper on "The use of the Roentgen Ray in Thoracic Aneurism" attracted considerable attention. Dr. Pepper exhibited a series of skiagraphs well illustrating the dilatation of the vessel. Several noteworthy papers in Spanish were read on Yellow Fever. This subject was more dealt with in the several sections, and in the general meetings than any other. A long address in English at one of the general meetings, dealing mainly with cholera and yellow fever, was listened to with great attention. The speaker, an official representative of the American Navy, appears to think that a little effort on the part of England and Spain would forever banish these two diseases from the face of the earth, a little more drainage in India and a little more cleanliness in Havana, being apparently all that is necessary to accomplish this end.

The section on general surgery was usually well attended. The papers read were considered to be fully above the average of congress meetings. The various other sections were, with the exception of that of obstetrics and hygiene, rather poorly attended. Considering the difficulties of different official languages this is not surprising. The Anglo-Americans who are acquainted with Spanish are extremely few and the Hispano-Americans who know English appear to be about as few.

Considering these difficulties the Mexican meeting must on the whole be considered a success. The great courtesies and hospitality shown to the strangers by all classes in the City of Mexico was unbounded.

The reception tendered to the members of the congress by the Mayor and City Council of the City of Mexico, in the Municipal Palace, was a most successful function. There was a grand serenade and display of fireworks on the Plaza de la Constitución given in honour of the guests.

A bounteous supper in an artificial grotto was an event which any one who had the privilege of seeing will never forget.

The social event of the meeting however was the reception tendered in the Palace of Chapultepec by the President of the Republic and Mrs. Diaz. This took place on Thursday afternoon, and was attended by all members of the congress with their ladies, as well as by a very goodly company of the leading citizens of Mexico.

There is probably no palace or house in the world that commands

a more magnificent panorama than that of Chapultepec. The hill, an isolated rock rising to a height of several hundred feet, was the first abode of the Aztecs before they built Tenochtitlan. At its base there is a magnificent grove of huge moss-draped cypress trees, dating from long before the conquest by Cortes. On the summit the castle is built, surrounded by marble paved terraces, bedecked with flowers.

The valley of Mexico, with its city, the lakes and the magnificent snow-capped volcanos, together make a picture of resplendent beauty.

THE AMERICAN GOVERNMENT AND THE CANADIAN NURSE.

"BUFFALO, N. Y., December 18.—Immigration Inspector De Barry received from Washington, last night, notice of a new ruling by the Secretary of the Treasury on the alien labour law. This ruling is on the question that was raised in this city two years ago as to whether the Canadian trained nurses who come to this country to work in hospitals, do so in violation of the law.

"The Secretary of the Treasury has ruled that these nurses can be deported. As soon as Mr. De Barry received the notice of this new ruling he started out to get lists of the Canadian nurses in the hospitals. Mr. De Barry said last night that all of these nurses would be deported. Inspector Ezell, of Ogdensburg, is now at Dansville, where he went to deport five Canadian nurses, who are employed in a Sanitarium there."

The foregoing extract from the daily papers is pitiful. It reveals a depth of meanness with which we can scarcely credit any government in our own enlightened times. According to the same authority the great de Barry has signified his gracious intention not to interfere with the Canadian nurses already graduated and at work in that land of liberty, the United States; but HE will not allow any more to come in. Evidently the American trained nurse is getting crowded out. It looks as if the Canadians were too popular and that in order to protect home products intruders are warned off. If this view be correct it is a direct compliment to our nurses.

This method of making citizens rather smacks of the way in which Mahomet went to work. He went about with a Koran in one hand and a sword in the other and people took their choice. De Barry does not cut off their heads, that is illegal, but he deports them, threatening imprisonment and fine if they are ever seen again in the enlightened land over which wave the stars and stripes.

The whole matter looks like the child's quarrel so graphically described in the popular song a year or two ago, "You shan't play in my yard."

Obituary.

PROFESSOR NEWALL MARTIN.

Lack of space in our last number, or more truly, the large number of other obituaries, prevented us from referring to the death in mature life of one, who perhaps accomplished more to raise in America an enthusiasm for exact scientific work in the domain of medicine and physiology than any other teacher of his time. Indeed Professor Newall Martin may be regarded as the Pioneer Physiologist of America. It was given to him to be the pioneer in other things. He was the first scholar in Natural Science to be appointed in Cambridge, England, and the first resident at the Hostel, or University Boarding-house, established by one whose death we recorded last month, namely, Sir George Murray Humphry, in order to encourage active minded young fellows to enter the university. That was in the days, when the old English Universities were still regarded more as the abiding-place of the well-to-do than as centres of learning properly so-called. Humphry told many stories of his old pupil. Before he left England, by his well-known little work published in conjunction with Michael Foster, he did much to stimulate the laboratory and practical teaching of physiology. What the Johns Hopkins, and the other universities of this continent owe to him it is difficult to say; and it is sad to think that one with such power of stimulating others should, while in the prime of life, sink rapidly and be cut off from his fellows.