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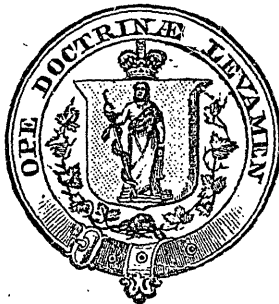
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CANADA

MEDICAL & SURGICAL JOURNAL

AUGUST, 1883.

Original Communications.

VIENNA LETTER.

(From our Special Correspondent.)

VIENNA, June 30, 1883.

THE REMOVAL OF ENLARGED THYROID GLANDS.

There is probably no operation in surgery that is attended with so much difficulty as the removal of an enlarged thyroid gland. No matter what the size and histological characters of the tumor are, its removal is always attended by great difficulty and considerable danger.

The operation, as performed at present, is, however, after all, a fairly successful one. During the last five years Billroth has performed this operation 68 times. The mortality was only $7\frac{1}{2}$ per cent. In the previous five years his mortality was 29 per cent., and 36 per cent. in the five years before that. This great reduction in the death-rate he accounts for thus—1st, The employment of the strictest antiseptic precautions, by which septi-cæmia, which formerly headed the list as the cause of death, is banished; 2nd, Improved method of operating. During the last few weeks Billroth has lost three cases; these cases are not included in the 68 previously mentioned. In one, death took place suddenly on the operating table, immediately after the completion of the operation. The cause of death in this case was supposed to be the entrance of air into the veins. In the second case, the death was directly due to collapse of the trachea five days after the operation. The patient had tetany, and to

this the death was attributed previous to the post-mortem. In the third case, death was directly due to tetany.

In a previous letter reference was made to the remarkable fact of the frequent occurrence of tetany after this operation, especially in women. In the last 73 operations in the General Hospital here, there were twelve cases of tetany, eight of which proved fatal. Even those patients who do not die from tetany, appear seldom to recover completely from it. The writer has seen two cases of very well marked tetany in women following the removal of enlarged thyroids, performed three years previously. There has not been, as yet, any satisfactory explanation given of this complication. Whether it is due to injury of the recurrent laryngeal or sympathetic nerves has not been proved. Billroth considers that, at least in his cases, irritation of the recurrent laryngeal can have no influence in bringing it about, as he is always extremely cautious in his dealings with this nerve. Very recent investigations of Dr. Weiss, which will be published shortly, prove, he thinks, that in tetany there are changes in the anterior horns of grey matter of the cervical spine.

In the surgical cases of tetany, there is no remedy that seems even to mitigate the symptoms. Billroth has long ago given up performing this operation for the simple removal of a deformity. He never performs the operation now unless the life of the patient is directly in danger from pressure on the trachea.

As the method of operating is so very important, and as there is no description of it, as far as I am aware, in any of the numerous English surgical text-books, I will give the different steps of the operation as always practiced by Billroth. It is to him and Kocher that we owe the modern operation.

The incision is made along the internal border of the sternomastoid muscle, its length depending upon the size of the tumor. If it is very large, it is sometimes necessary to carry the incision in a semi-lunar direction to the lower end of the opposite sternomastoid. The fascia and omohyoid are cut through. The dissection is carefully made until the capsule of the gland is fully exposed. Here begins the first difficulty in the operation. The capsule is composed of from three to eight or more layers, and

it is always advisable to cut through each layer until the last one is reached, otherwise there is considerable difficulty in enucleating the tumor. Between the most internal layer of the capsule and the structure of the gland there is a very rich plexus of veins. The internal layer should not on this account be cut through, otherwise serious and uncontrollable hæmorrhage sets in. Should such an accident happen, the only hope of saving the patient's life is to remove the gland as rapidly as possible. After the different layers are cut through until the most internal is reached, the superior thyroid artery is double-ligatured and cut. The next step of the operation is the ligaturing and cutting through of the inferior thyroid artery. This is the most difficult part of the operation—not that this vessel presents any mechanical difficulty in its tying, but that in looking for it, and especially in tying it, there is great danger of wounding the recurrent laryngeal nerve. The artery and the nerve are so intimately connected that it requires the greatest possible care to avoid wounding the latter. The artery, before entering the gland, usually divides into three or four branches. Sometimes the nerve lies in front and sometimes behind the arterial branches. Often, however, it is so intertwined among the arterial twigs that it requires great care to isolate it without injury. If the artery is tied before its division, on removing the gland the nerve will be torn across. The best way to proceed is to find the nerve at the lowest part of the incision, and follow it up until it disappears in the larynx. It can easily be found in the sulcus, between the trachea and œsophagus, and it should be carefully isolated from the sulcus to the thyroid cartilage. The branches, and not the main artery, should be tied. It is necessary, also, to tie the middle thyroid vein. The next step in the operation is the enucleation of the tumor. The operation is completed by removing the tumor from the trachea, and unless this is performed very carefully it is attended by considerable danger. It is necessary to raise the tumor in cutting it away from the trachea, and in doing so the latter becomes bent on itself and the patient is in imminent danger of being suffocated. When there are symptoms of the latter, the tumor should be dropped

back and the trachea allowed to resume its natural position. It is advisable to work for not more than ten seconds at a time. Several deaths are reported from this cause.

At the meeting of German surgeons in April last, Kocher of Berne, who has had a very extensive experience in the removal of enlarged thyroids, said that when the operation was performed on young people, it was apt to be followed five or six years afterwards by a condition resembling cretinism. In these cases the patients complain of a feeling of weakness and coldness. There is slowness of thought, speech and movement, swelling of the hands, feet, abdomen and face, giving the patient the appearance of one affected with Bright's disease. In the discussion which followed the reading of Kocher's paper, none of the surgeons who took part in it had seen any of the symptoms described. This is also Billroth's experience.

ANTISEPTIC PRECAUTIONS TAKEN IN OVARIOTOMY IN BILLROTH'S KLINIK.

In the performing of ovariectomy, or any abdominal section, Prof. Billroth takes the utmost care that in every detail of the operation the strictest antiseptic means are employed. All abdominal operations are performed in a special room. This room is very frequently cleansed in the most thorough manner, and during the operation the temperature is kept at 20°C. The day previous to operating the patient gets a warm bath, and on the morning of the operation the bowels are emptied by injections. The abdomen is thoroughly washed twenty-four hours previous to the operation, and over night it is covered with compresses soaked in a two per cent. carbolic acid solution. Immediately before operating, the bladder is emptied by an assistant, who does not take any part in the operation afterwards. The vagina is washed out with a one per cent. carbolic acid solution, and afterwards filled with strips of iodoform gauze, the object of this being that, should, during the operation, any communication be made between the vagina and abdominal cavity, the danger of septicity will be much diminished. For an hour previous to commencing the operation, a five per cent. spray is kept going

in the room. The spray is, however, not used after the abdominal cavity is opened.

The sponges used in this, and, in fact, in all operations, are cleaned, bleached, and made antiseptic in the following manner :

1. They are cleaned from sand by being pressed between the folds of a towel ; they are then repeatedly washed in lukewarm water which has been previously boiled. The water should not be hot, as it causes a shrinking.

2. In order to bleach them, they are put into a solution of the permanganate of potash (1-1,000) for 24 hours, and afterwards well washed in lukewarm water. They are then put into a solution of subsulphite of sodium (1-100), to which has been added a fifth of the quantity of a solution of hydro-chloric acid (8-100). In this mixture they are kept for a few minutes only. After their removal they are again washed in water, and are finally left for three days in cold water, which is frequently changed.

3. To render the sponges antiseptic, they are first placed in lukewarm water, where they are left from three to five days. The water should be changed daily. They are afterwards placed in a five per cent. solution of carbolic acid, where they are left until required. The solution should be changed every 14 days. Sponges are never used unless they have, at least, lain 14 days in this solution. Fresh or dry sponges are never used.

Care should be taken that a sponge is not left exposed to the air for any length of time during an operation. After operations, where the wound is fresh, the sponges, before being put back in the five per cent. carbolic acid solution, are kept in water for a couple of days to remove the blood coagula, and, for the removal of fat, in a soda solution for a few hours. Sponges that have been used in putrid wounds are burnt. In ovariectomy, the sponges are removed from the 5 per cent. solution, well pressed, and placed in a 1 per cent. warm solution of carbolic acid.

The operator and his assistants wear, during the operation, freshly-washed linen coats, and which, just previous to commencing work, have been exposed for some minutes to the carbolic acid spray. Bleeding vessels are tied with antiseptic silk. The

pedicle is also tied with antiseptic silk. The external dressings consist of a strip of iodoform gauze, which is placed in direct contact with the abdominal wound, several layers of carbolic acid gauze, and antiseptic cotton.

EXCISION OF THE TONGUE.

By G. M. DUNCAN, M.D.

(Read before the New Brunswick Medical Society, July 18, 1883.)

Let me call your attention for a few moments to a case of excision of the tongue. Numerous methods of operating have been proposed, some of which, as, for instance, those of Syme and Regnoli, should be mentioned only to be classed as relics of a past and barbarous surgery. They are accompanied by much hæmorrhage, are very dangerous, and produce horrible mutilation. Simpler and safer methods are those of Paget and Barwell, but simpler and safer still that of Whitehead, who removes the entire organ, from the epiglottis to the os hyoides, through the mouth, by means of a pair of scissors, as reported in the *Lancet*, Oct. 22nd, 1881. In order to successfully remove the tongue without skilled assistance, a very important question to be decided is—What is the best and safest method of excision, taking into consideration the two special dangers of the operation, viz., hæmorrhage and septic complications? No one method will suit all cases. Each must be decided by its peculiarities. Experience has proved that removal of the tongue by the knife, as compared with the wire ecraseur, is not only more liable to be followed by hæmorrhage, but also by septicæmia. The largest percentage of fatality, however, has resulted from the galvanocautery ecraseur. The slough which follows is most offensive, and the period of convalescence prolonged. The different methods and their merits are fully described in works on surgery, or in the journals of the day. That adopted in the following case was a combination of scissors and wire ecraseur:—

Miss M. E., æt. 28. No history of cancer in the family. The trouble in the tongue began about four years ago. The tongue was felt to be sore, especially during deglutition, and

increased salivation was noticed. After a time it was observed that with each menstruation the tongue swelled, and that then it was much irritated by the sharp edge of a decaying 2nd left molar, which finally gave rise to a sore. With the menstrual interval came a period of ease. Ultimately there was constant pain and profuse salivation. The sore increased in size, and felt like a hard lump, painful on pressure. In the autumn of 1881 she consulted a doctor, who broke the tooth in extracting it, and burnt the sore with caustic. The caustic was applied frequently till the end of March, 1882, when, owing to the increasing size of the sore and the almost unendurable pain produced by the caustic, she consulted me. Examination showed a swollen tongue, with an oval, raised, hard, very painful tumor on the middle of the left edge, extending towards the raphe, but not into the right half. Diagnosis, *scirrhus*. A lotion of Potassium Chlorate and fld. Ext. Arbor Vitæ was given, with instructions to report in a fortnight. On her next visit the swelling had subsided, and there was less pain. The lump seemed smaller. The stump of the offending tooth was then extracted, and the lotion continued. No improvement followed. Excision was advised and agreed to, and the day named. Some friends officiously advised her people to send her to Halifax (of all places in the world): Dr. Slayter of that city confirmed the diagnosis, and, assisted by Dr. Turner, excised the *lump*. The *modus operandi* I know nothing of, save that it was accompanied by excessive hæmorrhage. Less than two months after the Halifax operation, there being sharp pains in the cicatrix, darting along to the throat and ear, she consulted me a second time. A firm lump, size of a very large marble, extended from the cicatrix into the right half of the tongue, the point being turned to the left. No enlarged glands were detected. The short lapse of time between removal and reappearance of the disease seems to indicate that a clean sweep had not been made. To remove a part of the tongue and to leave behind a diseased portion is a grave mistake. Partial excisions for cancer of the tongue should *never* be practised.

Of course I advised removal, and she very heroically consented. On the 25th of August last, assisted by two students,

this was done. Chloroform was administered. A Whiteside mouth-gag, with the tongue depressor attachment removed, was applied. A strong ligature was placed through the tongue, about one inch from the tip, by means of which it could be steadied. Firm traction on this ligature upwards and outwards gave a good view of the cavity of the mouth, and served to arrest the hæmorrhage from the smaller vessels. The head was turned well to the left side, towards the light, so that any blood might collect in the pouch of the cheek, from which it was readily sponged by an assistant, and thus the danger from blood in the larynx was avoided. With a pair of angular, blunt-pointed scissors the mucous membrane was divided, from the frenum to the anterior pillar of the fauces on each side, keeping close to the jaw. The attachments of the genio-hyo-glossi to the jaw were snipped and the organ separated from the floor of the mouth, as far as the base of the epiglottis, by short snips of the scissors, aided by the fingers. The hæmorrhage was very slight. Pressure with small sponges was sufficient to stop it. The loop of a Barnes' Improved Wire Ecraseur having been adjusted, and a full turn made every ten seconds, the whole tongue, from immediately behind the foramen cæcum, was removed. The stump fell over the larynx and gave some trouble, till it was secured by a ligature of silk and drawn forwards. Just here let me mention that, to prevent this accident, Mr. Morris (*Lancet*, May 30th, '82,) recommends the passing of a ligature behind the line of operation and previous to using the ecraseur. No ligature or torsion of arteries was needed, and the only styptic used was the 1 to 40 iced carbolic acid lotion in which the sponges were washed. After the loop of silk had been secured over the right ear, the stump was dusted with iodoform, and a double fold of iodoform gauze closely applied to it.

The after treatment was simple. Enemas of beef tea and brandy for four days. The mouth was rinsed out very frequently with iced solution of potassium permanganate till the wound was healed. The loop in the stump and the fold of gauze were removed on the second day. There was considerable nausea resulting from the chloroform, and the recovery from the shock

was not perfect, the catheter being required for three days. On the 28th, a fibrinous membrane like that of diphtheria covered the whole of the roof of the mouth. The stump was free. It was easily detached by means of a swab of absorbent cotton. A red, raw surface was exposed, and she complained of it being very sore. Potassium chlorate was used alternately with the permanganate, some of the former being occasionally swallowed. After the fourth day she drank freely of broths, milk, and brandy and eggs, rinsing the mouth before and after. The membranous deposits were removed twice daily till the 1st September, when no more appeared. On the 12th, the eighteenth day after the operation, the surface was all healed and the mucous membrane of the mouth all equally healthy. The recovery was satisfactory, and there has been, so far, no return of the disease. Microscopic examination of the tumor confirmed the diagnosis.

Two points to be noted are the monthly enlargement and the appearance of the diphtheritic membrane. The former I have seen no notice of in any work or journal that has come to hand. The latter I have frequently met with lately, dating from a virulent outbreak of diphtheria in the neighborhood two years ago. Wounds so affected were attacked while treated antiseptically, and the membrane had to be destroyed by caustic and removed. The healing process was always delayed.

SUBMAXILLARY GLAND REMOVED AS A SEQUEL.

For some time previous to the last operation she complained of much pain, similar to what was felt in the tongue, at a point under the middle of the right lower maxilla. Nothing could be detected to account for it, and I attributed it to neuralgia, caused by a decayed tooth, which was removed. The pain continuing, after Christmas '82 a thorough examination was made, and what seemed a lymphatic of the submaxillary region was found enlarged the size of a pea, and painful. The pain shot along the jaw to the ear and throat. In April it was larger, attached to the margin of the jaw-bone, and the submaxillary gland was swollen and tender. In the end of May, after painting with Tinct. Iodini co. in the meantime, there was no improvement,

except that it was less painful. As in the case of the tongue at each menstruation, there was an increase in size and pain, both gradually subsiding afterwards. Under the constant dread of its being cancer, her health began to suffer, and on June 25th it was removed.

After chloroformization, an incision, similar to that made in ligature of the lingual artery, was made from about one inch below and to the outside of the symphysis menti to a point directly over the os hyoides and thence to the angle of the lower maxilla. This formed the lower boundary of the tumor. From the centre of this, and at right angles to it, a second incision was made to the edge of the bone. The fascia, platysma and fat being divided and the flaps dissected up, a very firm lump, hard as cartilage, and nodular, was exposed. This was seized by a tenaculum and separated from below, exposing the hyoid bone and the mylohyoid, hyoglossus and digastricus muscles, and the submaxillary gland. The gland was indurated and knotty. It was therefore cleaned away from the facial artery, the submaxillary branches being cut and twisted. The tumor and gland were then separated from the edge of the jaw, to which the former was closely attached. The mylo-hyoid was drawn aside by a blunt hook and the deep portion of the gland dissected out, and the whole removed. There was no hæmorrhage of any moment, and no ligatures were required. The wound was well sponged out with a 1 to 40 carbolic lotion, which was used throughout to cleanse the sponges. After all oozing had ceased, the edges were brought together by seven sutures and a dressing of Chloral Hydrate ʒi to water Oj applied. There was considerable vomiting from about the middle of the operation till next morning. A hypodermic of Morphine Sulph. gr. $\frac{1}{2}$ gave some sleep, and the nausea and vomiting gradually disappeared towards morning. The catheter was required three times. Iced milk, cocoa, and brandy and water were freely used at first, and subsequently beef-tea. The sutures were removed on the sixth day. The wound healed kindly and uninterruptedly, and on the eleventh day she was sent home.

Examination under the microscope showed the tumor to be scirrhus.

THE VALUE OF POST-LARYNGEAL PAPILOMATA AS A MEANS OF DIAGNOSIS IN TUBER- CULAR DISEASE.

By GEO. W. MAJOR, B.A., M.D.,

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(Abstract of a paper read at the Fifth Annual Congress of the American Laryngological Association, at New York, May 23rd, 1883.)

After carefully and systematically observing, during the past five years, the laryngeal appearances of a large number of tuberculous cases, I have arrived at a few conclusions concerning some important indications heretofore practically unrecognized. For the sake of convenience and accuracy alike, I have divided the neoplasms about to be considered into two forms.

I.—The *Velvety*.

II.—The *Filamentous*, or *Feathery*; the latter an advanced stage of the former.

These papillomata, to be of any diagnostic value, must occupy the laryngeal surface of the meso-arytenoid fold. They are of a greyish-white color, and abundantly supplied with moisture.

The *velvety* growth (so called from its resemblance to the pile of velvet), best seen when the arytenoids are widely separated on full inspiration, is not necessarily an indication of active pulmonary tuberculosis, but it is evidence of a decided tuberculous tendency. This form of excrescence varies much in degree from a mere line to an almost shelf-like prominence, running transversely across the space, and its advance in development may fairly be taken as a standard of the patient's state. In a stout and robust man, I have more than once, on inquiry, found a family history of phthisis, where the only suspicion lay in the presence of a very rudimentary ridge. The extensive opportunities afforded by my clinique at the Montreal General Hospital, as well as by a numerous class of such cases in private practice, have led me to place the greatest possible value on these *velvety* developments (when present), not only as a means

of diagnosis and prognosis, but more particularly as a *means of anticipating* a pulmonary tuberculosis, of the onset of which we should be otherwise ignorant. In such cases a climatic change will actually prevent what it could later but feebly hold in abeyance. Of this form, in various stages of development, I have recorded some seventy cases.

The *Filamentous* or *Feathery* form varies in size and extent, sometimes reaching 3 millimetres in length, floating in the column of air, interfering with proper voice production, causing an aggravating cough, holding secretions and debris in its fibres, and giving rise, in breathing, to a fine crepitant, crackling sound resembling the bursting of minute bubbles. This advanced state occurs only in reduced health; though we may not detect tubercle by any physical signs, *it is sure to be present*. It may not have advanced to softening, or even to extensive deposits, but it is there. My experience of this class (filamentous) is based on 17 cases, all of which were particularly rapid in their course, and all fatal; so that, as to prognosis, an advanced filamentous growth is markedly unfavorable.

In so far as my knowledge goes, this last description occurs in about 9 per cent. of all cases; it probably does much oftener, as but a few of all cases are submitted to laryngoscopic investigation until ulceration has taken place, and then no trace of these neoplasms are found. These filamentous bodies ulcerate usually as lung softening sets in, and present themselves in cases where other laryngeal signs are absent.

I do not remember a single instance of pyriform swelling of the arytenoids being associated with either form of papilloma; on the very contrary, the larynx presents an excessively attenuated, sharply defined appearance. These growths are only present *in some cases*, are as often present as any single laryngeal sign,—if we except, perhaps, pallor of the mucous surface,—and are, when present, of all known indications, *the most trustworthy*.

Why the region indicated should be the one selected by these developments, I do not attempt to explain. Does its incessant movement in respiration, a motion from birth to death all but

perpetual, decide the location? That they should occur on the mucous membrane covering the arytenoideus muscle—the muscle most early infiltrated with tubercle in laryngeal tuberculosis—seems more than a coincidence.

These few facts I offer with confidence, as a valuable supplement to the already recognized laryngeal signs of tuberculosis.

RADICAL CURE OF HYDROCELE BY THE INJECTION INTO THE SAC OF CARBOLIC ACID.

BY J. M. JONAH, M.D., OF EASTPORT, MAINE, U.S.

Abstract of a paper read before the New Brunswick Medical Society, July 18, '83.

The reader of the paper first gives an interesting history of the treatment of hydrocele, describing the various methods which have been in vogue during the past century. He refers to the employment of iodine, but thinks that it is uncertain, and, in his experience has been followed by unfavorable results. In 1882 he began to use carbolic acid, as recommended some years ago by Dr. Levis of Philadelphia.

Dr. Jonah's first case is that of a young man whose hydrocele had been tapped no less than 38 times, and once injected with iodine. He removed on the last occasion eight ounces of straw-colored fluid, and threw into the sac 70 grains of the crystallized carbolic acid, held in solution by less than 10 per cent. of water. A sensation of warmth more than pain was experienced. The patient resumed work on the sixth day, and has had no return of the hydrocele.

The second case was that of a man of 54 years, who had been relieved of his "scrotal burden" about twenty times. No untoward event followed, and the patient was attending to business on the fourth day.

After reporting briefly a third case, Dr. Jonah brings his paper nearly to a close by describing the operation in Dr. Levis' own words, and we give the quotation in full:—

"For the purpose, crystallized carbolic acid is maintained in a liquid state by a five or ten per cent. addition of either water or glycerine. After the tapping of the sac, I inject the liquified

crystals of carbolic acid with a syringe having a nozzle sufficiently long and slender to reach entirely through the canula. The object of this special form of instrument is to place the injection entirely within the sac, without any reflow, which would irritate the skin of the scrotum, the fingers of the operator, and without the possibility of injecting it into the connective tissue between the skin and tunica vaginalis. Ninety grains is the maximum and thirty the minimum I have used. As soon as the scrotum is injected, it is freely manipulated by the fingers of the operator so as to diffuse the acid over the lining walls of the hydrocele. A sense of warmth is produced, which is quickly followed by a decided numbness, and the patient is at once able to walk about. I do not enforce rest until 24 hours, when intra-scrotal inflammation renders quietude agreeable or imperative. I have never been able to detect any toxic effects from the absorption of the acid, no general depression, no discoloration of the urine. I believe that the action of strong carbolic acid on surfaces secreting albuminous fluids is to seal them, and, as it were, to so shut them off from the system that absorption cannot readily take place. In a case of hydrocele complicated with a sarcomatous testicle, I had moderate suppuration."

QUARTERLY RETROSPECT OF OBSTETRICS AND GYNÆCOLOGY.

PREPARED BY WM. GARDNER, M.D.,

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NOTE.—*The translations are made expressly for this Journal.*

The Present Aspect of the Cæsarean Operation.—As our readers are doubtless all aware, the old Cæsarean operation has for the last five or six years, at least in continental Europe, been cast quite in the shade by the Porro operation, which three months ago had been performed about 110 times with a mortality of about 56 per cent. For a hundred years or more Cæsarean section, according to the old method, had been almost uniformly fatal in the lying-in hospitals of the Continent. Obstetricians

welcomed with great enthusiasm a procedure which immediately gave results so much superior to the old operation. But at the time alluded to antiseptic surgery was becoming popular, and its greatest triumphs were claimed to be in abdominal surgery.

A reaction is now taking place, especially in Germany, against an operation which, while it may save the life of mother and child, unsexes and mutilates the former by removing the ovaries and amputating the uterus at the cervix. It is an undoubted fact that recovery after the old operation was rendered almost a matter of luck by the gaping of the unsutured uterine wound, with escape of blood and lochial discharges into the abdominal cavity. Dr. H. J. Garrigues, Obstetric Surgeon to the New York Maternity Hospital, in a most admirable paper in the April, May and June (1883) numbers of the *American Jour. of Obstetrics*, eloquently and with great power advocates the reinstatement of the old operation to favor. Dr. Garrigues claims that if the Cæsarean section be done with all antiseptic precautions, if the uterine wound be closely and carefully sutured, and if certain other precautions be taken, it will be attended with as good results as the Porro operation, while it does not, like the latter, take away capacity for further procreation. The advocates of the Porro operation claim this latter result to be a strong point in favor of the operation, and say that it is desirable that a woman with the pelvic deformity or other condition which rendered the operation necessary, shall not again become pregnant. In answer to this latter argument, which I cannot here fully discuss, Dr. Garrigues makes the following remark: "How often do we find, even among poor people, the natural desire of offspring strongly developed? How often is a marriage unhappy because it is childless? How often is the married woman despised because she has no children? Who can tell of what he deprives humanity by producing artificial sterility?" In addition, it may be remarked, experience has demonstrated that when a woman has once passed safely through the Cæsarean operation, her chances are thereby proved to be comparatively good for recovery from a subsequent operation.

I append almost in full Dr. Garrigues' description of the opera-

tion. It is, I have no doubt, the best description of the best and most modern method, with all its details, to be found in the English or any other language. The best time for operating is as soon as labor pains have become strong and frequent.

“The first part of the operation is identical with that of ovariectomy. The bowels and the bladder having been emptied, and the pubes shaved off above the symphysis, the abdomen is washed with soap, ether, and a five per cent. solution of carbolic acid, and the vagina disinfected with the same solution. The operator, his assistants, as well as the instruments, sponges, ligatures and sutures, ought to be disinfected according to the principles of antiseptic surgery. The temperature of the room ought to be about 80°F. The patient is placed on her back on a long, narrow table covered with a mattress, quilts, or blankets, over which is spread a sheet. She ought to be warmly dressed. She is anaesthetized, which may be begun while she is yet in bed. If possible, one or two steam-spray producers, filled with a solution of chloride of zinc, salicylic acid, or diluted chlorine water, are directed over the field of operation. The operator stands to the right of the patient. Besides the one who attends to the anaesthesia, four assistants are desirable. The chief assistant is placed in front of the operator. One to the left has special care of the uterus. One to the right hands the instruments. One to the left of the chief assistant has particularly to attend to sponging. By percussion, the operator ascertains that no intestines are present between the uterus and the abdominal wall, or pushes them aside. The chief assistant presses the abdominal wall against the uterus. An incision is made in the median line through the skin and the *linca alba* from the umbilicus to three or four centimetres (an inch or an inch and a half) from the symphysis pubis. Bleeding is, if necessary, controlled by means of compression forceps. Next, the peritoneum is lifted up with a tenaculum, and a small opening made in it, through which a director is passed, and the membrane incised to the same length as the other tissues. The incision is extended as much upward to the left of the umbilicus as may be deemed necessary for the easy extraction of the child. If possible, a strong elastic tube

or solid rubber cord is passed by means of a uterine sound round the cervix, tied in a half knot, which is grasped with a compression forceps. Behind the compressed piece, thick silk ligatures are passed round both ends and tied. If it is not possible to pass the tube while the uterus is *in situ*, the incision is extended far enough up to allow of its being turned out, as in Müller's operation, and then the tube is passed and, if possible, tied. The uterus may be helped out by pressure from the vagina, besides lifting its fundus through the abdominal wound. If the child is too low down, the tube is merely put loosely round the cervix, and tightened after the removal of the child. The chief assistant prevents the protrusion of intestines by holding the lips of the wound together, pressing them against the uterus, or by applying a flat sponge or a cloth dipped in a warm disinfectant.

An incision is then made in the median line of the uterus so as to avoid the fundus and the cervix, but long enough to allow the child to be withdrawn with ease, say 12 to 14 centimetres ($4\frac{1}{2}$ to $5\frac{1}{2}$ inches). This incision is best begun with a convex-pointed bistoury, and continued with a probe-pointed. If the placenta is in the line of incision, it is cut, together with the uterine wall (Spiegelberg). If the operation is performed with the uterus *in situ*, the chief assistant hooks both his index fingers into the angles of the uterine wound, holding it pressed against the corresponding points of the abdominal incision. If it is performed outside of the body, the assistant to the left of the operator covers the uterus with a warm cloth and steadies it, and the abdomen behind the uterus is covered with disinfected gutta-percha tissue.

If the waters have not broken, the operator tears the bag in such a way as to prevent the escape of the waters, especially if they are decomposed, into the peritoneal cavity. The best way of doing this is by turning the patient on her side, as is done for ovariectomy in this city. The operator tears the bag in a place where he can seize the head, the breech, or the feet of the child. It is an advantage to get the head out first, because the contraction of the

uterus round the neck after the delivery of the body may be so great as to render its removal difficult, and necessitate an extension of the incision. As soon as the child is delivered, the cord is tied and cut, and the child given to a nurse or, preferably, a sixth assistant, who, if it be asphyxiated, uses proper remedies for its revival.

If there is no hemorrhage beyond the evacuation of the blood pressed out of the uterine tissue by retraction and contraction, and if the placenta is not expelled spontaneously, it is good to wait about five minutes before detaching the secundines. This is done deliberately and with great care, so as not to leave any part behind, which is best accomplished by removing the after-birth in one piece. Thereafter clots are turned out from the womb and its interior mopped all over with sponges, and a drachm of the fluid extract of ergot is injected hypodermically. If there is hemorrhage, the tube surrounding the cervix is made to contract by kneading, hot cloths, or faradization. If the hemorrhage persists, and is seen to come from the internal surface, the bleeding parts are swabbed with vinegar, diluted alcohol, tincture of iodine, or liq. ferri perchloridi.

If the hemorrhage is prevented by the constriction of the cervix and broad ligaments, but the uterus does not contract, the same procedures are used.

If the cut surfaces have such a shape as to be easily adapted to one another, sutures may now be passed without further preparation. If, on the contrary, they bulge out so as to oppose resistance to a thorough adaptation, the peritoneum ought to be dissected off to a distance of one centimetre (three-eighths of an inch), a slice of the muscular tissue with the adherent portion of the decidua cut off from either side, and the peritoneal flaps turned down over the cut surface. Beginning at the upper end, a row of uninterrupted sutures of strong carbolized silk are passed one centimetre from the edge through the peritoneum and muscular substance, but not including the decidua. The distance between two and two sutures ought to be from 1 to $1\frac{1}{2}$ centimetres. The ends belonging to a suture are tied together as soon as it is passed, in order to

find those which belong together when they are to be tied. When all these deep sutures have been passed, the provisional knot is cut off from one, and that tied firmly, the chief assistant approaching the edges with two tenacula, and taking particular care to bring as much as possible of the serous surface of the peritoneum of both edges into contact. The same is repeated for every suture from one end of the incision to the other. Then superficial sutures of finer silk are passed midway between the two and two of the deep ones, at a distance of five millimetres (one-fifth of an inch) from the edge. They go only through the peritoneum and the nearest muscular tissue, and in tying them, particular care is taken to bring as large surfaces of peritoneum in contact as feasible. All sutures are cut short.

When all the sutures have been tied, the constrictor is cautiously removed from the cervix. If any hemorrhage should occur, the above-named hemostatics are to be repeated, to which now may be added intra-uterine injection of water so hot that the hand can just be held in it (110° to 115° F). When the hemorrhage is arrested, a finger-thick soft rubber tube with side holes, to which is sewed a thinner tube without such opening, is introduced into the uterus by sliding it over a uterine sound or metallic intra-uterine catheter. The abdominal cavity is cleansed, and the abdominal wound closed with deep silver and superficial silk sutures passed at about twice as large intervals as on the uterus. The deep ones comprise a narrow strip of the peritoneum; the superficial ones go only through the skin.

If, on account of entrance of decomposed amniotic fluid into the peritoneal cavity, or protracted labor, or other attempts at delivery, before Cæsarean section was resorted to, peritoneal complications are to be anticipated, it is better to insert between two sutures a finger-thick glass tube with side openings reaching down into the recto-vaginal pouch. In this is inserted a wire wound with carbolized cotton.

Dressing.—The patient having been carefully cleansed, a full Lister dressing is applied to the abdomen, cutting a hole for the drainage tube, if one has been introduced. The latter is covered with carbolized cotton, and protective tied around it. The geni-

tals and anus are covered with crumpled gauze dipped in a 1 to 40 solution of carbolic acid, and covered with a thick layer of antiseptic cotton (carbolized, salicylated, or impregnated with boracic acid) which extends up to the abdominal dressing, and is fastened to it with a binder.

After-Treatment.—The first indication is to stimulate the patient with external heat and alcoholic drinks. Iced champagne is the best of these, but sometimes small doses of coffee are better retained than anything else (Howitz). Pain is subdued by opiates, which also serve to keep the bowels quiet. After the patient has recovered from shock, she may have light liquid food. If the temperature rises, it is kept down by quinine, carbolic acid, and external dry cold administered by ice-water running through coils of rubber tubing, to be applied to the head and abdomen. Vomiting is combated by opiates, by hydrocyanic acid, bismuth, strychnia, creasote, tincture of iodine, carbonic acid, ice, counter-irritation in the cardia, etc. Peritonitis is treated with large doses of morphia; septicæmia with carbolic acid or salicylic acid, and quinine. A weak and frequent pulse due to anæmia and weakness of the heart calls for hypodermic injection of digitalis, camphor dissolved in ether, or transfusion.

In favorable cases, the abdominal dressing may remain undisturbed for a week. Then the superficial sutures are removed. The deep ones are left in a few days longer, and then replaced by strips of adhesive plaster, or tape dipped in collodium. The genital part of the dressing must be changed morning and evening, or more frequently if a desire for micturition be present. This ought to be done under spray of carbolic acid solution. The water is drawn. The vagina syringed with 2½ per cent. carbolized water. If the lochia should be fetid, or the temperature rise, the uterus is washed out with the same solution."

The Treatment of Abortion.—Three important papers bearing on this subject have recently appeared. The first of these is by Dr. T. J. Alloway, of Montreal, on "The Immediate use of the Uterine Scoop or Curette in the treatment of Abortions, versus Waiting, or the Expectant Plan." Dr. Alloway states that the reasons which have induced him to write this paper

are : The insufficient stress laid upon the importance of immediate removal of the secundines in abortion by the writers of even the most recent of obstetric text books, and his " wish to place before the profession the success which has attended the use of the dull curette, or uterine scoop in his hands in such cases." The author alludes to the mass of evidence to show the danger of hemorrhage and septicæmia in justification of the plea for immediate action when nature is incompetent.

He also alludes to " the occurrence of some discouraging experience I sustained during the first few years of practice " when he followed the teachings of the text books. Dr. Alloway advocates the use of the curette in preference to the finger, believing that the dull or blunt curette may be used to detach the placenta with less pain and greater safety to the patient than the finger, which, from its greater size, requires an amount of counteracting downward pressure or traction, which may be dangerous to the patient. In support of this he quotes from Savage as follows : " The uterus, when pulled down by a vulsellum until it seems to threaten some physical damage to the opposing structures, descends but about one and a half inches." Dr. Alloway reports a number of cases in support of his views.

Dr. Mundé's paper is entitled " The Immediate Removal of the Secundines after Abortion." The doctrines inculcated are in the main the same as those in Dr. Alloway's paper. He says : " I wish to add my testimony to that of Dr. Alloway, in favor of the forcible, (that is manual or instrumental) removal of the secundines immediately after the expulsion of the foetus, in every case where the cervical canal is sufficiently patulous to permit the introduction of the finger or of the large dull curette or the placental forceps. Further if there is hemorrhage, or an offensive vaginal discharge, or if the temperature rises, or there is a chill, and the secundines are still retained, no matter how soon or how late after the expulsion of the foetus, they should be at once removed, and, if necessary, the cervix dilated to facilitate the operation." As regards the methods of removal Dr. Mundé advocates the use of the finger, if the cervix is dilated sufficiently ; anæsthesia being employed if necessary. In

cases where the cervix is somewhat dilated, but from tense or fat abdominal walls, the uterus cannot be forced down, then he uses a curette devised by himself. It is a modification or rather exaggeration of the Thomas' dull curette, and like it is flexible. This instrument and Mundé's placental forceps are figured in illustration of the paper. To dilate the cervix when this is necessary, Dr. Mundé prefers tupelo to anything else, claiming that it is easier, safer, and speedier than anything else, and states that by it he has in some cases been able to effect enough dilatation in an hour. After clearing out the uterus it is washed out with hot or ice cold carbolized water. In answer to questions frequently put concerning this method of treatment, the author asserts most positively that it is so free from danger that every physician can employ it, that the risk from forcible removal of the secundines is not greater than that from letting them alone. Dr. Mundé appends a table based on 57 cases occurring in his experience. Of these 8 had exhaustive hemorrhage and 5 septicæmia. Rapid recovery resulted in nearly all. In one only did death result. Septicæmia was the cause, and it was present before the operation. In another case there was mild cellulitis, with recovery. Drs. Alloway's and Mundé's papers appear in the February (1883) number of the *American Journal of Obstetrics*.

The third paper referred to is that of Professor Spöndly of Zurich, and appears in the last number (Bd. IX, Hft 1, 1883) of the *Zeitschrift für Geburtshülfe und Gynäkologie*. It is entitled "Ueber das Active Einschreiten bei Abortus." (Active Interference in Abortion.) The paper is based on fifty-three cases of abortion treated by immediate removal of the placenta and membranes. The finger was used in all cases. Chloroform as anæsthetic when necessary, and after the operation washing out the uterus with carbolized water were employed. The results were entirely favourable to the method of treatment. A large proportion of the fifty-three cases were in multiparous women, and women advanced in years. A brief report of each of the fifty-three cases is embodied in the paper. There can be no doubt that the teachings

of the three authors just quoted indicate the tendency of the advanced men in the profession with reference to this important question. While it is quite true that many cases of abortion untreated or treated by the expectant method get well, it is equally true that many deaths from hemorrhage or septicæmia, and many cases of chronic invalidism from uterine disease, result from a policy of inaction. The inference ought to be obvious.

Solid Ovarian Tumours.—Mr. Knowsley Thornton, of the Samaritan Hospital for Women, London, has recently been giving his ovariectomy experiences. In April last he had done 338 ovariectomies; of these 10 were solid tumours. These cases were thus not numerous, but they had characters in common. In all menstruation was irregular—entirely suppressed; very irregular; now scanty and again very profuse; very painful, etc. On the other hand in ovarian cysts, as a rule, the menses are regular. The patients do not emaciate more rapidly, nor does Mr. Thornton think they suffer any more pain than the subjects of ovarian cysts. The diagnosis to be made is from uterine fibroids, and then irregular menstruation may mislead, but the facies is different. In fibroids of the uterus the face is often fat, even if blanched; in solid ovarian tumours on the other hand there is usually extreme wasting of face, neck, breast and arms. His experience is that there is much greater danger from the operation than from ordinary ovariectomy. Three of his ten cases died from the operation; of the subsequent condition and results the report is very interesting and important. Of the seven, three were very ill and recovered with great difficulty; four recovered easily; of the three, one only remains in good health, and had a child two years after the operation, but is now suffering from recurrence in the abdomen. The third is suffering from pelvic recurrence. Of the four who made good recoveries, one died within the year from peritoneal recurrence. The other three all died during the year from a diffuse sarcoma in various external and internal situations, and in the glands. This rapid and general diffusion of sarcoma after operations for its removal from the ovary makes Mr.

Thornton think it very doubtful if it be proper to operate at all for their removal; seeing that though life may be prolonged a little, the period of actual health is very short. At the time of writing the article, only two of the ten cases were alive, one only in perfect health; the other suffering from recurrence after, however, eighteen months of good health since the operation, of better health than she had enjoyed for years. The case of the patient who has borne a child was at the time of operation one of the most unpromising. The tumour being of such a nature as to make recurrence exceedingly probable. In view of all the facts of his experience, and that the patients are doomed to death more or less speedy if not operated upon, Mr. Thornton is still inclined to give the patient the chance of operation, unless there is distinct evidence of spread of the disease to the broad ligament or neighboring parts.—*Medical Times and Gazette.*

The Iodoform Treatment of Puerperal Lacerations of Perineum and Vagina, by Dr. C. Behm, Assistant at the University Obstetrico-Gynæcological Clinic of the Charité Hospital, Berlin. This is the title of a paper in the last number (Bd. IX, Hft. 1, *Zeitschrift f. Geb. und Gyn.*, 1883). The iodoform treatment of wounds and raw surfaces has been most extensively under trial in Germany for the last year or two. The author believes that there is no part of the body so well suited to the iodoform-dressing as the perineal region, which, on account of the constant necessity for passing of urine and feces, cannot be treated by Listerian or any dressing which covers the parts from contact with air for a few days. Iodoform has the quality so valuable in a dressing for wounds of this region, of adhering and even incorporating itself (*verfiltzen*) with the tissues of the part, so that when applied to a fresh raw surface it adheres for several days in spite of constant bathing and washing, or even syringing of the parts. It may be applied without any complicated method or apparatus to any part of the body. Salicylic acid powder recommended for the same purpose by Schmidt and Küster is not at all so well adapted. It does not adhere so well to the wound surface, is easily washed away, and

it is irritant, preventing union and causing burning pain. Von Langenbeck and Kuster have advised against the application of iodoform to wound surfaces in which we desire primary union, fearing that it may constitute a foreign body and so interfere with union. Behm, however, thinks that if we refrain from its use in this way we shall be deprived of an agent possessing a most valuable quality, that of limiting the quantity of wound secretions; and that when a small quantity is applied as an impalpable powder dusted over the wound, or, as Unna recommends in the form of iodoform-ether spray, it has, in his experience, caused no irritation, but, on the contrary, by lessening discharge, has assured the union by primary intention. In order to secure as complete asepticism as possible, the author proceeds as follows: The wound, operator's hands, and sutures are disinfected with carbolic acid five per cent. solution, or corrosive sublimate 1 to 1000. The latter, while a more energetic parasiticide than carbolic acid, has the disadvantage that it corrodes instruments and so renders it difficult to pass the needles. The wound surface had better be glazed. All bleeding is to be arrested. Ligatures being used if necessary. For moderate oozing, pressure with dry wadding is useful. Iodoform ether spray has a styptic effect. The dryer the surface the better does the iodoform adhere. It is applied as an impalpable powder sprinkled from a spatula, or dusted from a dredging box, or in the form of the iodoform ether spray. The sutures are then put in. After this is done, more iodoform is applied as powder or spray, and after drying of the surface iodoform collodion is pencilled over the surface. This usually separates about the 3rd or 4th day. The surface may be again sprinkled with iodoform, or dressed with carbolized or borated vaseline. Dr. Behm reports twenty-eight cases of incomplete and two of complete rupture extending through the sphincter and up the rectum. Of the twenty-eight incomplete cases, twenty-three united by primary intention. The two complete cases also united by primary intention, although in one case the sutures were not put in till thirty-six hours after labor, the surface having been soiled with both urine and fœces.

Beiträge zur Lehre der Castration der Frauen, von Wilhelm

Tauffer, Prof. in Buda-Pesth. (Contributions to the Subject of the Castration of Women. (*Zeitschrift f. Geb. und Gyn.*, Bd. IX, Hft. 1, 1883.) The author reports twelve cases of the operation for small ovarian tumours; cystic follicular degeneration of the ovaries; diseases of the uterus which render menstruation difficult or impossible, the ovaries performing their function in a normal manner; myo-fibromata; displacements of the uterus and ovaries; periuterine and periovarian inflammation; pelvic cellulitis and salpingitis; insanity connected with the sexual function. All the cases recovered. The following are the author's conclusion from his experience:

1. Castration with proper precautions is not a very dangerous operation. The mortality is under ten per cent.

2. The operation should be done under antiseptic precautions and carbolic spray. The abdomen is to be closed, and drainage is only occasionally necessary.

3. Objection to the operation on the ground that the patient is near to the climacteric, is only conditionally valid, inasmuch as this change occurs at varying ages and cannot be definitely predicted.

4. Both ovaries ought, as a rule, to be removed, even when one only seems to be diseased. This conclusion is justified by the fact that the remaining ovary is predisposed to the same disease.

5. The removal of the fallopian tubes ought to be effected at the same time.

6. Hystero epilepsy is curable by castration.

7. The group of symptoms designated by the term hysteria, may often be traced to disease of the ovaries.

8. The question of what influence may be expected on the nutrition of uterine fibro-myoma, by the ligature of certain large nutrient arteries without castration, is well worthy of consideration and experiment.

9. In forming a prognosis, it is important to remember that immediate menopause results only in those cases in which adjacent organs show no sign of disease. Any inflammatory condition delays the menopause.

10. The ultimate result of castration cannot be determined with certainty till several months after the operation.

11. The question as to how far the development of psychoses is influenced by diseases of the female sexual organs is worthy of consideration.

12. And so also whether such psychoses are curable by castration.

Lacerations-du Col Uterin, par le Dr. Agathonoff.—This is the title of a paper read before the Academy of Medicine of St. Petersburg, and published in the August (1883) number of the *Annales de Gynecologie*. The paper is based on 14 Emmet's operations, of which 13 were performed by Professor Slaviansky and 1 by the author. The first trachelorrhaphy in Russia was done by Slaviansky in 1880. In the majority of the cases the operation was done without the preparatory treatment advised by Emmet, and yet the results were, in the large majority of cases, entirely satisfactory. No anæsthetic was employed. The lithotomy position was that in which the patients were placed for operation. Irrigation of the field of operation with 1 to 100 carbolyzed water was used. The sutures were introduced before denudation of the lacerated surfaces, the object being to check instantly any unexpected bleeding. Emmet's needles and needle holder were not used, but, instead, a tubular needle used for perineorrhaphy and fistula operations. The denudation was effected partly by a double-edged lancet-shaped bistoury and partly with scissors, the limits of the intended denudation being first marked off on the edges. The author believes the following conclusions justified by Professor Slaviansky's and his own experience :—

1. The cure of the symptoms produced by lacerations of the cervix is obtained principally by union of the edges.

2. Long preparatory treatment is only necessary when there is intense metritis and cystic degeneration of the endometrium. Apart from other reasons, in such cases, without this preparatory treatment, union of the denuded edges cannot with certainty be obtained.

3. Finally, it must be admitted that Emmet's operation is the

only suitable remedy for laceration of the cervix. No other remedy as successful can be substituted.

It will be admitted by nearly all observers who have experience of the operation that the conclusions here formulated are just.

A Note on Uterine Myoma: its Treatment and Pathology.—This is the title of a paper read by Mr. Lawson Tait at the last meeting (July 4, 1883) of the Obstetrical Society of London. The author took occasion to reiterate his now rather well-known views with reference to menstruation and ovulation. He thought they were independent functions, having, perhaps, a community of purpose. Removal of the ovaries often did not arrest menstruation, but removal of the fallopian tubes nearly always did so. But in one case in which he removed ovaries, tubes, and part of the fundus uteri, menstruation continued more than a year. He thought the term "myoma" should entirely supersede the incorrect term "uterine fibroid." The growth of these tumors is limited to the period of sexual activity, it is influenced by the menstrual functions, and he thought probably its ultimate cause would be found in some disturbance of the nervous body which governed that function. The presence of a myoma indefinitely delays the menopause. He deprecates the triple classification of myomas into submucous, intramural and subperitoneal. For pathological and surgical purposes, he proposed a new subdivision into the nodular and concentric. The latter consists of a uniform hypertrophy of the muscular tissue of the uterus, in the midst of which the canal lies centrally; the tissue of this form is loose and often very œdematous. Of the nodular myoma he proposed two varieties—the simple and multinodular. He believed that each nodule was seated on a central arterial twig; that its growth was endogenous, the older tissue being on the outside. The dependence of such growth on menstruation was proved by the fact that arrest of menstruation stopped the growth, or even caused the complete disappearance of such tumors. This in several cases had been brought about by the removal of the tubes only. He had treated 54 cases of uterine myoma by removal of the uterine appendages, with 3 deaths, a mortality of

5.5 per cent—a mortality in striking contrast to the results of hysterectomy. Of the 51 who survived, in 38 the results had been carefully followed, and were everything that could be desired. In three, the tumors were or became malignant. In three others they continued to grow, although menstruation had been arrested.

During the discussion which followed, Dr. Herman stated that he had published a case in which the symptoms of fibroid polypus first appeared 16 years after menopause. The history of patients after operations like those of Mr. Tait was of great importance, for patients not benefited often did not return to the operator, and he, therefore, was apt to get a too favorable impression of the results.—(*Lancet.*)

Correspondence.

DIGITALIN, NOT DIGITALISIN.

To the Editor of THE CANADA MEDICAL & SURGICAL JOURNAL.

DEAR EDITOR,—In your last issue, you report a member of the Medico-Chirurgical Society as saying that he had administered digitalin in $\frac{1}{4}$ grain doses hypodermically, without very much effect. At the meeting I expressed doubt of the genuineness of the drug. I have now reason to believe that the article used was a nostrum, put on the market by a manufacturing firm under the name of Digitalisin, and not the Pharmacopœia article. In my humble opinion, the profession should not encourage the production of articles having names similar, or nearly similar, to those in the Pharmacopœia, as leading to dangerous confusion.

When Digitalin, Morphine, Atropine, &c., are prescribed, only the articles recognized as such in the Phar. Br. would be dispensed by a competent pharmacist.

The compilers of the Pharmacopœia give the dose of digitalin as $\frac{1}{60}$ to $\frac{1}{30}$ grain by the mouth.

T. D. R.

Reviews and Notices of Books.

Manual of Gynecology.—By D. BERRY HART, M.D.,
F.R.C.P.E., and A. H. BARBOUR, M.A., B.Sc., M.B.
New York: William Wood & Co.

This work, in two volumes, is reproduced from the original Edinburgh edition as the January and February numbers of the Library. The authors are a former (Hart) and the present (Barbour) assistant to the Professor of Midwifery and Diseases of Women in the University of Edinburgh.

Dr. Hart is well known from his most valuable studies of the anatomy of the female pelvic floor. These researches are of course embodied in the work before us, and constitute perhaps its most valuable part. It is certainly this part which characterizes the book when comparing it with other materials. Too much reliance has perhaps been placed on frozen sections to indicate the relations of the various parts. As in an article on the "Topographical Anatomy of the Female Sexual Organs," in the *American Journal of Obstetrics*, the freezing process frequently alters the relations and relative proportions of parts. The other parts of the work are admirable. It is a marvel to find how much has been compressed into the book. In their anxiety to do this, the authors have sometimes sacrificed literary style to the necessity for being brief. The *Lancet* reviewer in speaking of the author's article on "Vaginal Specula," says: "It might be not unreasonably inferred from the chapter on this subject that their chief use was to discover or conceal lacerations of the cervix." This is just the kind of criticism we should have expected from the typical conservative English gynecologist; we are glad to know that even he will soon be a curiosity. Led by Playfair in London, and Simpson, Angus McDonald, and our authors in Edinburgh, the importance of laceration of the cervix, and Emmet's operation for its cure, are being recognized. As might have been expected, from other standpoints, the methods of the Edinburgh school have undue prominence in the book. As an instance of this, the volsella are almost everywhere recommended in preference to

Sims' tenaculum. Now, while there are instances where the volsella cannot be dispensed with, we contend that whenever the tenaculum with its single fine puncture will answer our purpose, it ought to be preferred to the other instrument with its four (to some extent) irritative punctures. We heartily recommend this book to our readers. It is one of the text books recommended to the class in gynecology of McGill University.

The Diseases of Women: A Manual for Physicians and Students.—By HEINRICH FRITSCH, M.D., Professor of Gynæcology and Obstetrics at the University of Halle. Translated by ISIDOR FURST. With 150 wood engravings. New York: William Wood & Co.

This volume is the March number of Wood's Library. The author is well known to readers of the gynæcological literature of Germany as the editor-in-chief of the weekly *Centralblatt für Gynakologie*, and the author of Section III, "On Displacements of the Uterus," of Billroth's celebrated handbook on Diseases of Women. We have examined this book somewhat carefully, and are assured that this translation will be a valuable addition to the library of men who are not familiar with the original language, and who desire to become familiar with German methods. We always feel inclined to test a new author on diseases of women by his appreciation of Sims' methods of examination. In this respect Germans, the author included, are fairly up to the mark.

The translator is not very familiar with English idioms, as appears in many parts of the work.

Manuel des Injections Sous-Cutanees.—Par M. BOURNEVILLE, Medecin de Bicêtre, et Bricon docteur en medecine. Paris: Delahaze & Lecrosnier.

This little handbook is one which may prove very useful to many practitioners. The hypodermic method is one now so universally followed that it is very necessary to be acquainted with the best mode of using each of a great many drugs. The facts concerning these are often not found in the ordinary text-books,

but exist only in the pages of periodical literature. To collect and present these in an easily accessible form has been the aim of these writers. Each drug has a short description of its physiological effects, especially those following its hypodermic employment, together with the formulæ for those solutions which have been found from experience to be the most suitable. In any doubtful case, the name of the authority is almost always given. The whole is prefaced by a brief account of the history of the method, the seats of selection, mode of preparing the solutions, the various forms of instrument which have come into general use, and the local accidents which are liable to occur.

Illustrated Medicine and Surgery.—Edited by GEORGE HENRY FOX and FREDERIC R. STURGIS. Vol. II., No. 2. New York: E. B. Treat.

This number contains a beautiful lithograph of an enormous enchondroma of the humerus. An illustration of the physiognomy of a case of intellectual monomania, with mental depression, by Wm. A. Hammond. Colored plates of cases of trichophytosis barbæ, and of rupture of the choroid, and reports, with woodcuts of interesting examples of syphilitic stenosis of the larynx, multiple sarcoma of the skin, and severe deformity of the lower eyelid.

Therapeutic Handbook of the United States Pharmacopœia: Being a condensed statement of the Physiological and Toxic action, Medicinal value, Methods of Administration and Doses of the Drugs and Preparations in the Latest Edition of the United States Pharmacopœia, with some remarks on Unofficial Preparations.—By ROBT. T. EDES, B.A., M.D., Professor of Materia Medica in Harvard University, President of the American Neurological Association, Visiting Physician at the Boston City Hospital, &c. New York: Wm. Wood & Co.

This is one of a number of very useful hand books that will necessarily crop up from time to time, as an adjunct to the new Pharmacopœia. The work, as admitted by the author in his

preface, is evidently written for the practitioner rather than the pharmacist or student. Each article of the Pharmacopœia is taken in its turn—the French, German and common names being given with concise, and in the case of some of the more important drugs, voluminous therapeutic notes with the doses; these latter, although not coming with the authority of the compilers, can be accepted as fair ordinary doses. After exhausting the pharmacopœial list, the author then gives some remarks upon a few non-official drugs, not admitted in the Pharmacopœia, but largely used in general practice, and these will be read with interest. The work ends with a classified index of drugs, and a very useful table of poisons and their antidotes; but we cannot see the necessity of giving *Oleum Gossypium* the first place as the antidote to Carbolic Acid over *Oleum Olivæ*—an oil more known and much more likely to be found upon the shelf of the housekeeper.

The Transactions of the American Medical Association.—Instituted 1847. Vol. XXXIII. Philadelphia, 1882.

The results of the St. Paul meeting, as embodied in this volume, afford the best possible warrant for the change in the mode of publication from an annual volume to a monthly journal, which has now taken place. The volume is a small one and contains, exclusive of the reports, addresses and minutes, but twenty-two papers, not one of special merit. The truth is that the various societies now in existence, devoted to special branches, have killed the sections of the American Association. Compare the Proceedings of the Surgical Association with that of the surgical section, and our meaning is clear. In the present volume there is not a single paper on anatomy or surgery. With the more speedy method of publication and the more extended circulation which the journal will have, we predict better contributions to and more active work in the sections of the association.

Books and Pamphlets Received.

A TREATISE ON THE DISEASES OF THE EYE. By J. Soelberg Wells, F.R.C.S. Fourth American from the third English edition, with copious additions. By Charles Stedman Bull, A.M., M.D. Illustrated. Philadelphia: Henry C. Lea's Son & Co. Montreal: Dawson Brothers

THE PRACTITIONER'S READY REFERENCE BOOK—A HANDY GUIDE IN OFFICE AND BEDSIDE PRACTICE. By Richard J. Dunglison, A.M., M.D. Third edition. Philadelphia: H. C. Lea's Son & Co. Montreal: Dawson Bros.

THE UNTOWARD EFFECTS OF DRUGS. By Dr. C. Lewin. Second edition. Translated by J. J. Mulheron, M.D. Detroit, Mich., Geo. S. Davis.

HANDBOOK OF ELECTRO-THERAPEUTICS. By Dr. Wilhelm Erb. Translated by L. Putzel, M.D. With 39 woodcuts. New York: Wm. Wood & Co.

THE MICROSCOPE AND ITS REVELATIONS. By Wm. B. Carpenter, F.R.S., &c. Sixth edition. Illustrated by 26 plates and 500 wood engravings. Vol. II. New York: Wm. Wood & Co.

A NEW SCHOOL PHYSIOLOGY. By Richard J. Dunglison, A.M., M.D. Illustrated. Porter & Coates, Philadelphia.

A HISTORY OF TUBERCULOSIS FROM THE TIME OF SYLVIVS TO THE PRESENT DAY: Being in part a translation, with additions from the German of Dr. Arnold Spina. By Eric Suttler, M.D. Cincinnati: Robert Clark & Co.

TREATMENT OF DISEASES OF INFANCY AND CHILDHOOD. With over four hundred Formulæ and Prescriptions. By Charles H. Goodwin, M.D. New York: C. H. Goodwin, M.D.

Society Proceedings.

MEDICO-CHIRURGICAL SOCIETY OF MONTREAL.

Stated Meeting, May 25th, 1883.

R. A., KENNEDY, M.D., PRESIDENT, IN THE CHAIR.

The following resolution was passed:—

Resolved,—That this Society has heard with deep regret of the death of Dr. W. E. Scott, one of its oldest and most respected members,—a prominent member of the medical profession, a representative governor of the Province for many years, a well-known and successful teacher as well as an energetic surgeon and practitioner, and feels sure that his loss will be widely felt and much deplored.

Resolved,—That this Society extends its deepest sympathy to Mrs. Scott and her family in their affliction, and that a copy of these resolutions be sent to Mrs. Scott and to the press.

DR. OSLER exhibited an *Aneurism of the Anterior Cerebral Artery*. There was meningeal hæmorrhage about longitudinal fissure, and at the base. On separating the median surfaces of the hemispheres, and clearing the blood away, a small nodu-

lar projection was seen on the right side just about the middle of the convolution of the corpus callosum. On further dissection this proved to be a small aneurismal sac, on a branch of the anterior cerebral. It was imbedded in the sulcus between the gyrus fornicatus and precuneus, and the substance about it was lacerated. The rupture was at the edge of the sac, and of considerable size. In the white matter, half an inch beyond the aneurism, there was a round, well-defined spot of hæmorrhage, the size of a cherry. DR. BELL said the above was removed from a boy six years of age, who had been brought to hospital in an unconscious condition; with feeble pulse, pale face, eyes and head turned to right and left hemiplegia,—he remained so till death, six hours later; no wound was found. Some time before he had been run over by a baker's cart, which left him halt in his left leg. Three weeks before his last accident he had fallen from a hay loft. Nothing followed this but drowsiness for a short time.

Uterine Fibroid Polypus.—DR. GARDNER showed this specimen which he had removed from the posterior surface of the uterine wall close to the inner os. Very slight hæmorrhage followed, which was easily stopped by tr. iodine. Dr. G. T. Ross, whose patient the woman was, gave the following particulars: Mrs. L. had been married ten years, no children; had good health till two years ago, when she began to suffer from dysmenorrhœa. Had also more or less pain throughout pelvis, and radiating down right thigh. About six months ago menorrhagia set in, and more recently the flow became continuous, alternating occasionally with a watery discharge from uterus. She became markedly anæmic, and complained of uterine tenesmus. An examination revealed the above tumour projecting from the os.

DR. RODDICK exhibited a photograph and cast of a case of extremely varicose condition of the veins of the leg operated on successfully by Dr. Malloch of Hamilton, by excising portions of the affected veins, and by carbolic injection.

DR. KENNEDY shewed photographs of Barnum's alligator-skinned child, at the birth of which Dr. Kennedy attended the mother. He said it was an ordinary labor, but the baby's skin was

as if varnished, but presented no cracks or creases, and the child could not open its eyes; he ordered it to be rubbed with Cod Liver Oil. Dr. Kennedy lost sight of his patient, as the parents soon after left the city. Dr. Fox, of New York, seeing such a beautiful specimen of Ichthyosis at Barnum's Show, wrote to Dr. Kennedy for information about the history of the case.

Lawson Tail's Operation.—DR. GARDNER exhibited a set of uterine appendages (ovaries and Fallopian tubes) which he had removed a week previously. The ovaries were somewhat enlarged, and contained several cysts, one of them being three-quarters of an inch in diameter. The Fallopian tubes were slightly distended with a catarrhal secretion.

The patient was a charwoman, æt. 36, unmarried, never pregnant. Began to menstruate at 17; flow always copious, with clots, and attended with hypogastric pain. Otherwise she had fair health till a few years ago, when, after reaching over-head to wash a ceiling, she suffered increase of pelvic and lumbar pain, with "painful sitting" and aggravation of the dysmenorrhœa and menorrhagia. When patient first came for advice, menses had continued for a month. Examination revealed a small, circular os uteri, with a bulky, completely retroverted uterus, measuring $3\frac{1}{2}$ inches. The channel was tortuous. Marked tenderness around uterus, with thickening felt in posterior cul de sac. After dilatation with a small laminaria tent, a fibro-cellular polypus of the size of a cherry was discovered hanging through the internal os, attached by a pedicle further up. This was removed, and the curette then passed over the whole endometrium, bringing away a quantity of soft granulation-like tissue. Immediately afterwards the endometrium was swabbed over with Churchill's tinct. of iodine. The uterus was then replaced, and an Albert Smith pessary introduced. Hot vaginal douches were prescribed, and rest in bed enjoined. No relief followed. The next two periods were profuse, with clots and pieces of membrane, found by microscopical examination to be the uterine lining membrane. She was then treated for some weeks by careful tamponing of the vagina with cotton soaked in glycerine, with iodoform. This gave temporary relief, but menstruation

continued to be excessively painful, and attended with vomiting and great general prostration. Oophorectomy was proposed as a *dernier ressort*. The patient eagerly grasped at the idea of any expedient that gave a prospect of relief; so, on the 18th of May, nine days after the cessation of menstruation, the operation was done. No difficulties were encountered. The ovaries and tubes were not adherent. They were easily raised between the edges of the abdominal wound, ligatured, and cut away. A good deal of abdominal pain and incessant vomiting were suffered for a few days. Temperature in the vagina never rose over 102°F. The patient was kept profoundly under the influence of opium (Battley's sed. solution) given hypodermically, and nourished exclusively per rectum for a week. Only small pieces of ice given by the mouth. The menses, or a metrostaxis of blood of dark cherry-red colour, appeared on the second day, lasting four or five days. The abdominal incision united perfectly. After the first week, recovery, though slow, was steady. The patient, who had been a terrible sufferer from indigestion, was much improved in this respect, as in many others. Defecation, which formerly was agonizing, now almost painless. Chloasma (uterine), formerly most marked, now disappearing fast. All the symptoms much mitigated.

June 17th.—A month since operation. Improvement in all symptoms. It is slow as regards pelvic pain. This symptom, depending as it does on pelvic peritonitis, metritis and endometritis, cannot disappear entirely for some time to come.

DR. TRENHOLME said he was the first to perform this operation in Canada. His patient is now enjoying good health, and has not menstruated since. He believed the operation ought to be done oftener than it is.

DR. RODDICK asked if it were not possible to make the operation less serious, by merely ligating the Fallopian tubes between the uterus and ovaries and then cutting them through, which operation could be done with a very small opening in abdomen.

DR. GARDNER said no, for it might produce gangrene or septic peritonitis, and often the ovaries are in a bed of inflammatory exudation.

DR. TRENHOLME said the operation might be performed through the vagina if there were no adhesions.

DR. OSLER was surprised to find that ovaries so slightly diseased required such heroic treatment.

DR. GARDNER said the operation was indicated even if the ovaries were healthy, for you remove the organs which are the cause of all the monthly symptoms. His case was not ovarian, but uterine dysmenorrhœa.

DR. F. J. SHEPHERD read the following paper on *Two Cases of Wound of the Palmar Arch*: Perhaps there are no more troublesome cases to treat or ones that give rise to greater anxiety than wounds of the palmar arch. If treated properly, as a rule, these cases terminate favourably, but even with the most skillful treatment, serious results sometimes follow. It seems extraordinary how often wounds of the palmar arch are badly treated, when every text book in general and minor surgery gives such definite directions as to what should be done. But a case is brought to the surgeon where there is a small wound in the ball of the thumb which has bled freely at first, but now the hæmorrhage is arrested, and he probably merely applies dressing, with perhaps a small compress, and sends the patient away; in a day or two when the clot breaks down, profuse hæmorrhage comes on, (possibly at night) and before a surgeon can be found, the patient has lost a great deal of blood. Now a compress may not arrest the bleeding, and the brachial artery may have to be tied to save life, or the forearm may in worst cases have to be amputated. These serious results would not have happened had the surgeon in the first instance enlarged and thoroughly cleansed the wound, plugged it from the bottom with lint, placed a compress in the palm of the hand, and bandaged the whole firmly and evenly, and then left alone for three or four days. Very often the wound is plugged, and a compress and bandage applied; but the anxiety or officiousness of the surgeon prompts him to examine the wound daily, to see that everything is all right. This disturbs the parts and oozing commences, which cannot be arrested by the most careful pressure, and in consequence the serious operation

of tying the brachial has to be resorted to. The truth of the old axiom that "meddlesome surgery is bad surgery," cannot be too often insisted on. When the wound is once plugged and properly bandaged, it should be left undisturbed for at least three or four days, if the pain or discomfort is great, morphia should be administered to allay it; but on no account should the wound be disturbed. In exceptional instances the plug causes a gangrenous condition of the wound, or a diffuse cellulitis is developed and the surgeon may have to resort to amputation to save life. I shall now relate two cases which came under my observation during the past year, and which fortunately terminated favorably, though at the time they caused me much anxiety.

CASE I.—J. S., aged 15, while washing bottles fell with one in his hand. The bottle broke, and cut him severely in the ball of the left thumb, a little to the ulnar side and parallel to the first metacarpal bone. There was considerable hemorrhage at the time which was controlled by a tight bandage round the arm. In this condition he was brought to one of the hospitals; as there was no hemorrhage from the wound, it was not explored but a couple of stitches were put in and the wound was dressed with dry absorbent cotton, kept in position by a light bandage. The boy was then sent home. This happened on Tuesday, March 7th, 1882. The dry dressing was left on till Saturday the 11th, when, as the wound was suppurating, it was removed and replaced by water dressing. On Saturday night profuse hemorrhage suddenly set in from the wound. The boy was brought to the General Hospital as quickly as possible, and one of the house staff controlled the hemorrhage (temporarily) by means of a cork compress and tight bandage. On Sunday evening there was slight oozing, but very little blood was lost till next morning, Thursday 13th, when the hæmorrhage became again profuse. I saw him now for the first time. The bleeding was controlled by an Esmarch bandage, and the wound was examined. It was found to extend through the ball of the thumb down to the bases of the metacarpal bones of the thumb and forefinger, which could be felt quite bare. On cleansing

the wound and loosening the Esmarch, no bleeding point could be discovered, as the tissues were much infiltrated with effused blood, which also welled up from the bottom of the wound. The Esmarch having been again applied the wound was thoroughly cleansed and plugged from the bottom with a firm cone of absorbent cotton, soaked in carbolic oil (1-16), over which was placed some lint folded square and dry absorbent cotton. The whole was kept in position by a short flat stick, placed across the palm and held firm by a figure eight bandage going round the two ends of the stick, and over the back of the hand. By this means good counter pressure was effected. The hand was now closed on the palmar pad and stick and bandaged firmly; the bandage was continued to near the elbow (which was flexed) and then carried round the forearm and arm, so that the elbow was fixed in a position of extreme flexion. The boy was sent home to bed and a quarter of a grain of morphia was prescribed. The hand was left in this position for four days, during which time the boy's temperature kept at about $100\frac{1}{2}^{\circ}$ F. There was considerable pain of a throbbing character, but a quarter of a grain of morphia at night always procured sleep. The bowels were kept open with calomel; at the end of the fourth day, an Esmarch having been applied to the forearm, the wound was examined, and the plug of cotton wool removed. It came away quite easily and was bathed in a healthy pus; the bottom of the wound was granulating freely. The skin in the neighborhood was perfectly healthy, with the exception of a small spot on the inner edge, from which a slough came away in a day or two. As there was much pus between the first and second metacarpal bones, and the only tissue at that point between bottom of the wound and the back of the hand was a thin skin, an incision was made through it, and a short drainage tube introduced. On loosening the Esmarch no hæmorrhage took place. The large hole into which the wound was now converted was filled with absorbent cotton soaked in carbolic oil, and the hand was placed between two splints, well padded with absorbent cotton (dry), and carefully and firmly bandaged, and slung across the chest.

That night the boy slept well without an opiate, and the case thenceforward progressed most favorably, the large cavity taking, of course, some time to fill up, which it did from the sides principally. After the first dressing, cotton wool saturated with iodoform was substituted for the carbolic oil dressing, and had the remarkable effect of almost preventing suppuration. By April 7th the wound was completely healed. When last seen the boy had only a little stiffness of the thumb. The cicatrix was not very noticeable.

CASE II.—E. C., butcher, aged 58, whilst sawing a meat-bone, accidentally cut his left thumb with the saw, on the back of joint, between 1st and 2nd phalanges. He paid little attention to the wound, and merely kept it tied up with a piece of rag, but after seven or eight days the wound began to inflame, and poultices were applied. I saw him for the first time two weeks after the receipt of the injury (Sept. 12th, '82). At that time the whole hand was œdematous, the thumb greatly enlarged, boggy to the feel, and covered with an erysipelatus blush. The wound was discharging a stinking pus. Temperature 102°F.; pulse 104. On examining him further, it was found that the pus had burrowed up in the inner side of the thumb as far as the middle of the metacarpal bone. Two deep incisions were made, the one in the inner side of the first phalanx and the other on the back of the metacarpal bone, and a large quantity of pus was evacuated. The cavity was washed out with a 1 to 20 solution of boroglyceride, and a drainage tube was put through the two incisions from the upper to the lower, and the thumb was dressed with lint soaked in boroglyceride; a well padded splint was placed on the palmar surface of the hand, and the whole evenly and firmly bandaged with a gauze bandage. On re-dressing the hand two days after this (Sept. 14) and withdrawing the tube, a free bleeding took place, the bleeding point not being found on enlarging the wound. It was plugged with cotton soaked in boroglyceride and glycerine equal parts; over this a pad of boracic lint was placed, and the whole firmly bandaged to a pasteboard splint. By this means the hemorrhage was completely controlled. On removing the dressing three days after,

the plug came away easily, and was bathed in healthy, sweet pus. No hemorrhage occurred. The hand looked much better, was reduced in size, and no erysipelatous blush was present. Temperature and pulse normal. Wound dressed as before with boroglyceride solution. The dressing was changed every third day, and all went well for more than a week, when suddenly an alarming hemorrhage occurred whilst he was straining at stool. The loss of blood was so great that he fainted. The friends partially arrested the hemorrhage by tying a silk handkerchief around the wrist. I was immediately sent for, and on arriving at the house I put on an Esmarch bandage and examined the wound. I again enlarged it, and cleaned it of clots, but on loosening the bandage, could not detect the bleeding point. The blood seemed to well up from the bottom of the wound, which extended the whole length of first phalanx. I reapplied the Esmarch, cleaned the wound of clots, and plugged it firmly from the bottom with lint soaked in equal parts of boroglyceride and glycerine, and bound the hand and thumb firmly on a splint, well packed with boracic cotton. I also put a compress over the radial artery, near the wrist, and kept the hand against opposite shoulder. The dressings were left on for four days, at the end of which time the patient had a severe rigor, followed by a temperature of 104°F. I then removed the dressings and let out about an ounce of perfectly sweet pus. The wound was redressed with boroglyceride, and covered with a pad of boracic cotton, the splint reapplied, and the whole kept in place by a firmly and evenly applied gauze bandage. No hemorrhage occurred after removal of the Esmarch, which was applied during the dressing; and from this time forward the case progressed favorably, the wound granulating from the bottom.

No doubt, in this case, the drainage tube ulcerated through either the princeps pollicis artery or a branch from the radial, which so often passes over the web of the thumb to complete the superficial arch, and which is also connected with the deep arch by a short trunk. Fortunately, by the thorough drainage the cellulitis had been controlled before the severe hemorrhage

came on. The second hemorrhage was due no doubt to the displacement of the clot by the straining at stool.

Testis in perinæo.—DR. R. L. MACDONNELL related the case. The patient is 15 years old. The left testicle has rested in the perinæum from the time of his birth. It is situated slightly to the left of the ano-scrotal raphe, rather nearer the anus than the scrotum. The organ is well developed, and freely moveable. It can be put into its proper place, but cannot be retained there. The scrotum is not so well developed on the left side as upon the right. There is left inguinal congenital hernia. The boy has been under observation for the last five years. He is said to have been born prematurely at the sixth month, and up to the present time has been very delicate, but the deformity has, as yet, caused him no inconvenience.

Nitro-Glycerine in Epilepsy.—DR. F. W. CAMPBELL spoke of the good effects of a one per cent. solution of nitro-glycerine in two cases of epilepsy. The first was a young woman who used to have an attack every four or five weeks; occasionally would be free for about two months. Gave her one drop three times a day, since which time (Dec. 16) has not had a single attack. The second case was a man whose attacks varied in frequency from three or four a day to one in two or three weeks. Three months ago put him on one drop doses three times a day. He has not had an attack since.

DR. HENRY HOWARD asked if these were cases of pure epilepsy, because the nitro-glycerine treatment has not proved to be of much use in true epilepsy—that is, where there is loss of memory and micturition during the seizure.

DR. CAMPBELL did not know if his patients micturated, but believed they were true epileptics.

DR. HENRY HOWARD said that according to modern alienists, loss of memory and micturition must be present else it is not true epilepsy, and the treatment of most use in these cases is tying the internal carotid. This is useless in the pseudo cases.

DR. KENNEDY mentioned having had good success in one case of epilepsy with 10-grain doses of borax three times a day.

NEW BRUNSWICK MEDICAL SOCIETY.

The third annual meeting of the above Medical Society was held in the Oddfellows Hall, St. John, on the 17th of July, 1883. The President, Dr. S. Z. Earle, called the meeting to order at 10 a.m. Those present enregistered their names and paid their dues. The following were present: Drs. S. Z. Earle, D. E. Berryman, D. M. Jonah, Jas. Christie, L. C. Allison, F. N. Welling, Chas. H. L. Johnston, Thos. Walker, Frank A. Nevers, W. A. Fairweather, R. Percy Crookshank, H. Geo. Addy, J. T. Steeves, J. W. Daniel, Geo. P. Caldwell, H. P. Reynolds, B. McMonagle, J. G. Atkinson, P. R. Inches, J. G. Nugent, J. N. Smith, J. H. Wilson, Joseph Andrews, John Berryman, Thos. W. Musgrove, W. J. Norfolk, S. G. Woodforde, B. Travers, P. R. Moore, F. MacFarlane, W. F. Coleman, G. A. Hetherington, James H. Gray, W. M. Caldwell, Geo. A. Hamilton, J. Z. Currie, Henry C. Preston, James Hutchison, E. M. Patterson, G. E. Coulthard, T. C. Brown, B. N. McCleery, Geo. McKay, J. E. March, J. D. White, M. C. McDonald, G. M. Duncan, J. C. Mott, Wm. Bayard, Lau. McLaren, E. A. Vail, G. R. J. Crawford, G. B. Noyes, A. B. Atherton, J. J. Lawson, J. E. Church, Jno. J. Gaynor, M. Sheffield, Geo. E. Hetherington, M. H. Macdonald.

The minutes of last annual meeting were read and confirmed.

DR. ALLISON, from the By-Law Committee, read the report, which was adopted after a few trifling amendments.

DR. INCHES, Treasurer, submitthd his report. Income, \$40; expenditure, \$34.70; leaving a balance on hand of \$5.30.

DR. COLEMAN read the report of the committee to arrange the business of the meeting.

DR. COLEMAN moved that the President appoint a committee to arrange a scale of fees for the N. B. Med. Society. Seconded and carried. Drs. Coleman, Brown, Wilson, Jas. Christie and Moore were appointed that committee.

DR. COLEMAN moved that a committee be appointed by the President to consider what means may be taken by the Society to assist the Council to induce physicians to register and to pre-

vent unqualified persons from practising. Seconded by Dr. Travers. Carried. Drs. Coleman, Allison, McFarlane, Duncan, D. E. Berryman, G. P. Caldwell and Daniel were appointed that committee.

DR. WALKER, from the committee in the case of Dr. McKay, asked an extension of time to prepare their report. After a discussion, in which Drs. D. E. Berryman, Patterson and Travers took part, the request was granted.

DR. PATTERSON then read the report of the committee appointed to revise and amend the N. B. Medical Act, 1881.

The report was, on motion of Dr. Inches, received and laid on the table.

The PRESIDENT (Dr. Earle) then delivered the annual address, taking for his subject "General Principles of Diet."

The election of officers was then proceeded with by ballot, and the following members were declared elected:—President, Dr. Vail; 1st Vice-President, Dr. Walker; 2nd Vice-President, Dr. Patterson; Secretary, Dr. G. M. Duncan of Bathurst; Corresponding Secretary, Dr. Coleman, St. John; Treasurer, Dr. Nevers; Trustees, Drs. Daniel, Allison and Berryman.

DR. BAYARD, President of the Council of Physicians and Surgeons of New Brunswick, then read a report, which was, on motion of Dr. Daniel, seconded by Dr. Patterson, received and ordered to be entered on the minutes.

DR. CURRIE read a "Report of Cases in Practice"; 1st. A case of Lupus exedens of about nine years standing, associated with Lupus erythematodes; 2nd. Nævus of the face treated by electrolysis. (This paper will appear in the next number of this Journal.)

At 8 p.m. a conversazione was held. An excellent display of instruments was made by Drs. John and D. E. Berryman and Dr. Coleman, and others. Refreshments were served by a committee of St. John ladies and a pleasant time spent. A vote of thanks to the ladies called forth pithy and witty remarks from Drs. Walker and Moore. Meeting adjourned to meet at 9.30 a.m. of following day.

SECOND DAY—JULY 18TH.

The President (Dr. Earle) in the chair.

DR. J. G. ATKINSON, Oakhill, read a paper on "Sponge and Sea-tangle Tents in Gynecological Practice." The materials, forms, methods of preparing, qualities, and modes of introducing were fully described; length of time tent should be retained, mode of removal and effects and dangers were lucidly explained, as also their use as means of diagnosis and treatment. Cases were given in illustration of these statements.

DR. PRESTON moved order of business be suspended, and the Amendments to the Medical Act proposed by Committee taken up, seconded by Dr. D. E. Berryman.

DR. ATHERTON moved in amendment that order of business be continued, seconded by Dr. Inches and carried.

DR. PATTERSON moved that five minutes be allowed each member for discussion, seconded by Dr. Brown. Carried.

DR. MUSGROVE highly appreciated Dr. Atkinson's paper.

DR. PATTERSON said it was officiousness to use tents in many uterine diseases, *e.g.*, sub-involution, potash salts with ergot were sufficient. It was highly objectionable to give woman an idea she had uterine disease.

DR. BROWN related a case of "Fishbone in Rectum." Twelve years before patient had, while laughing, swallowed a mouthful of chowder without mastication. For a month there was pain in the stomach; removed then entirely after a glass of brandy; no further trouble till day of removal, when there was the most excruciating pain calling for examination, which resulted in its discovery and removal.

DR. GAYNOR, Debec, read a paper on "Chloroform as an Anæsthetic—its physiological action and therapeutic value."

DR. PATTERSON declared this another valuable paper and agreed with Dr. Jonah that they should be published with the transactions of the society.

DR. COLEMAN said that in his experience death came from the heart, and he failed to understand why it was recommended to study the breathing and pay no attention to the pulse. Ether is safer because a cardiac stimulant.

DR. MUSGROVE, in regard to stimulants administered before using chloroform, said it added to the danger and was now condemned.

DR. ATHERTON said that as regards safety *that* depended on purity. Hard to get it pure. He believed death came from stoppage of respiration, which occurred before pulse stopped. Recited a case of his own in which tracheotomy was performed, and patient's breathing was resumed. He deprecated the use of brandy before chloroform inhalation. In regard to food given before, better given three hours before than six.

DR. MACFARLANE believed that the heart and lungs stopped simultaneously.

DR. INCHES pointed out that Dr. Atherton did not watch the pulse in the case related. He thought the pulse sounds the warning. Duncan and Flockhart's Chloroform is pure, and can always be had.

DR. GREY said that in his experience the pulse slows first and runs up when administration stopped. Careless administration had something to do with fatality.

DR. MOORE did not attend to either breathing or pulse particularly, but watched all the conditions, and gave no undue importance to either. Extraction of teeth under either ether or chloroform, is a reprehensible practice. Recited cases showing danger of food a short while before. Had assumed no food taken; vomiting ensued, and danger of suffocation for some time.

DR. CURRIE agreed with Dr. Moore's statements.

DR. BROWN had occasion to take chloroform many times, no difficulty till lately. Glass of brandy taken slowly overcame this. Stomach should be empty or at least no food for five hours before.

DR. NEVERS had misgivings in regard to ether. At his first administration in Philadelphia, death had occurred. Since that had always given chloroform. Case given in which chloroform was used in extracting a tooth. Pulse was all right. Respiration stopped, and there was considerable trouble to resuscitate.

DR. COULTHARD, in re heart, *v.* pulse, said: In confinements there is little danger from chloroform. Why is this? Diaphragm is called into action to aid expulsive efforts of abdominal

muscles, and respiration goes on regularly, and difficulty he therefore thought was from failure of respiration and not of heart.

DR. CALDWELL had experience as dentist in giving both ether and chloroform, as well as gas. Preferred ether or chloroform when a large number of teeth had to be extracted. Effects more lasting than gas which was suited for short operations only. Does age influence? He thought chloroform less safe than ether in the aged, and *vice versa*.

DR. JONAH related a case of Dr. Pancoast, of Philadelphia. Ether was being administered, those doing so were paying no attention to their duty. Dr. Pancoast noticed cyanosed condition, sprang to his patient, and after much vigorous effort danger was averted. May not death from chloroform in some instances be due to some idiosyncrasy? In some other cases drugs disagree, *e.g.*, tobacco. May not ether and chloroform disagree with particular patients irrespective of purity or careful administration?

DR. WALKER spoke of death in the dentist's chair as due to the chair. Position should be horizontal. In regard to food before using anæsthetics. Two cases of danger from suffocation he related. His practice was to operate early in the morning before food could be taken.

On motion of Dr. Brown, seconded by Dr. Walker, it was agreed to suspend the order of business and decide the place of next annual meeting.

DR. BROWN moved that the Society meet next year in Fredericton. Seconded by Dr. Atherton.

DR. BERRYMAN moved in amendment that the meeting be in Moncton. We ought to meet in different places yearly. Seconded by Dr. McMonagle.

DR. TRAVERS said next meeting would be a very important one, as the members of Council were elected.

DR. NEVERS said that St. John was the proper place to hold meetings, being central, and moved in amendment to the amendment that the meeting be held in St. John. Seconded by Dr. MacLaren.

DR. ALLISON would vote for amendment to amendment, be-

cause St. John was central and meeting important, therefore large attendance was desirable.

The vote being then taken, it was decided in favor of St. John, the vote standing 28 for St. John and 16 against.

AFTERNOON MEETING, THE PRESIDENT IN THE CHAIR.

DR. ALLISON read a paper on "Free-trade in Medicine."

DR. JONAH read a paper on "Hydrocele," advocating the discarding of the painful injection of iodine for the painless and certain one of carbolic acid crystals. (An abstract of this appears in this number of the JOURNAL.)

DR. ALLISON moved that the reading of papers be suspended and new business taken up, as the Fredericton men would leave shortly. Seconded and carried.

DR. ALLISON then moved "that the Council be respectfully requested to furnish each member of the Society annually with a copy of the current register, in any way that may be most convenient." Seconded and carried.

DR. BAYARD, President of the Council, said he had no doubt the Council would do so.

DR. DANIEL read the report of the committee appointed to consider what means may be taken by the Society to assist the Council to induce physicians to register and to prevent unqualified persons practising.

After some discussion, Dr. Addy moved, seconded by Dr. Steeves, that the report be received and laid on the table. Carried.

DR. STEEVES moved that the President be requested to name a committee of three, with permission to add to their number, to consider and report upon, at next annual meeting of the Society, the advisability and practicability of establishing a New Brunswick Quarterly Medical Journal, having the following aims in view: 1st, The establishment of a work that shall be the exponent of the N. B. Medical Society, and also of the views of the individual members. 2nd, The establishment of a channel through which members of the profession may report special medical and surgical cases of unusual interest for the benefit of the whole, it being a well known fact that many highly instruc-

tive, rare cases have occurred among us, and have not been reported mainly because no medical journal was published within a convenient circle. 3rd, The instruction of the public mind on subjects hygienic, through discussion upon questions relating to sanitary laws and regulations. To physicians it is a fact patent enough that few persons have a correct knowledge of sewerage, plumbing or ventilation, and that a still less number know that more than three-fourths of the deaths among children and young persons arise from a want of knowledge upon these subjects. 4th, and finally, It is hoped that there will be diffused through the instrumentality of a spirited journal a greater interest in subjects medical, including medical education.

DR. ATHERTON was afraid funds might not be available.

Motion was then put and carried.

The President appointed Drs. Steeves, Bayard and Atherton that committee.

DR. CURRIE, Registrar of the Council, said that the Council requested those who know of unregistered or illegal practitioners to report them to him, when action would be taken.

DR. MARCH then read a paper on "Plaster of Paris Dressings." (This paper will appear in our next number.)

DR. ALLISON agreed with Dr. March, but thought that in some instances starch or dextrine suited better, *e.g.*, fracture of limbs, where its lightness was preferable.

DR. HAMILTON said that felt was even better than either.

DR. G. P. CALDWELL read a paper on "Fracture of Jaw," with apparatus.

The following papers were then, for lack of time, read by title: "Hip Joint Disease," Dr. M. C. Atkinson, Bristol. "Cases of Puerperal Septicæmia," Dr. J. S. Benson, Chatham. "Diphtheria," Dr. E. Cameron, Grand Manan. "Excision of Tongue," Dr. G. M. Duncan, Bathurst. "Cases," Dr. Jno. Brady, Barnesville. "Tracheotomy," Dr. H. H. Hanson, Andover. "Puerperal Septicæmia," Dr. D. R. Moore, Sackville. "Pneumonia," Dr. J. N. Smith, Hampton. "Treatment Post Partum Hæmorrhage," Dr. G. A. Hetherington, St. John. "Conservative Surgery in Compound Fractures," Dr. MacFarlane,

Fairville. "Meningitis," Dr. T. Walker, St. John. "Surgical Cases," Dr. Atherton, Fredericton. "Vencsection," Dr. T. W. Musgrove, Carleton.

DR. COLEMAN then read the report from the Committee on the 'Tariff' of Fees.

DR. CHRISTIE moved that report be received, and taken up section by section. Seconded and carried.

DR. COLEMAN then read the report section by section, each being adopted as read, except fee for Post Mortem, which was made \$20.

DR. J. CHRISTIE then moved that the tariff as a whole thus amended be adopted. Seconded by Dr. Allison and carried.

DR. ALLISON moved that the Secretary get a number of copies printed for distribution to each member. Seconded by Dr. Johnston and carried.

The meeting then adjourned, to meet in St. John the third Tuesday in July, A.D. 1884.

G. M. DUNCAN, M.D.,
Sec. N.B. Med. Society.

Extracts from British and Foreign Journals.

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

Good Remedies out of Fashion.—In an address on this subject, delivered at the Annual Meeting of the Metropolitan Counties Branch of the British Medical Association, by the President Dr. C. J. Hare, late Physician to University College Hospital, the lecturer made some interesting observations on emetics and bleeding.

"It is not long ago that, in a very urgent case of bronchitis, I advised the administration of an emetic; when the gentleman whom I had been called to meet in consultation, said: "Why, I never gave an emetic to an adult in my life." In former times, it was not unusual, on the contrary, to commence the treatment of many diseases with the administration of a dose to procure vomiting; and although the remedy might then be given sometimes indiscriminately, and according to routine, only those who have seen the effects of emetics, properly and judi-

ciously given, can conceive the beneficial effects they sometimes produce. In the early stage of an attack of croup, it was by no means unusual to give an emetic of tartarised antimony or of ipecacuanha; and it is in accordance with the recorded experience of some of the best authorities and most practical men, and quite consonant with my own experience, too, that symptoms which presented the most certain augury of a severe attack were by these means cut short, the hoarse voice resumed its natural character, and the feverish symptoms were in a few hours relieved. I know quite well that a great fear is entertained by some as to the depressing effects of emetics; but the fear is theoretical, and not practical, and those who have had most experience in the administration of them best know how groundless the fear is. In diphtheria, too, I have seen the false membranes which are out of the reach of local remedies, and which the patients cough and cough in vain, and utterly exhaust themselves to get quit of, readily brought up by the action of vomiting, to the immense relief of the sufferer.

“ In suffocative bronchitis, the effect of emetics is sometimes magical, and by their administration in such cases not only is immense relief given, but I verily believe—I am certain—that lives are saved. You are called to a patient who has been ill a few days, with increasing dyspnoea; she is sitting up in bed (I draw from nature), for to lie down is impossible; she is restless and tossing about; the lips, and indeed the whole face, blue; the eyes watery and staring; the pulse quick and small; the cough constant; the expectoration semi-transparent and tenacious; over every square inch of the chest, front and back, from apex to base, you find abundance of rhonchi; moist, sonorous and sibilant ones in the upper part of the lungs, and muco-crepitant or mucous râles towards the bases. Ammonia and stimulants, right and good in their way perhaps, in such a case are too slow in their action; the patient is, in fact, more or less rapidly suffocating. An emetic of twenty-two grains of ipecacuanha in an ounce of water is given; in ten or fifteen minutes, the patient vomits and brings up a huge quantity of that tenacious mucus, and the whole aspect of the case is

altered ; the distressed countenance is relieved ; the breathing is at once quieter ; and the patient is able for the first time for twenty-four hours to lie moderately low in bed, and to get some sweet refreshing sleep. The patient is, in fact, rescued from the extremest peril, and in this case, and in many similar ones, too, I believe, from otherwise most certain death. Of course, in such cases the emetic is not given for its effect on the stomach, but for its collateral effect in mechanically clearing out the enormous amount of secretion which accumulates in the bronchial tubes, and which the patient is otherwise quite incapable of getting quit of ; and thus the half-choking, almost asphyxiated, condition is changed for one of comparative comfort, and time is gained for the action of other appropriate remedies. No doubt the secretion may, and often will, accumulate again ; and I have not hesitated again in bad cases to repeat the same good remedy ; but it is a fact, and a very positive one too, that, quite contrary to what those who have had no experience in the plan suppose, the system rallies instead of being more depressed under the action of the remedy.

“ There is a class of cases in which the right heart is engorged with blood, and in which the only hope of rescuing the patient from death is by bleeding. A man of middle age (I again draw from nature) has considerable chronic bronchitis, with some congestion of the lungs, and, like many other unwise persons, he goes to a southern watering place instead of remaining in his room and in an uniform temperature. Becoming worse, he determines to return home, and travels on a cold spring day ; his dyspnoea is so much worse on the journey, that his friend and fellow-passengers doubt whether he will arrive home alive ; and when his carriage meets him, it is with the greatest difficulty he is conveyed to his house, and got into his drawing-room. You are at once sent for, the message being that the patient is dying, and when you arrive you find that that is the fact. He is sitting in a chair (to lie down is impossible for him), his face is blue and swollen, his lips purple, the eyes suffused and staring, his heavy gasping breathing you have only too distinctly heard and recognized as you ascended

the stairs, and when you see him you find his chest heaving, and each short gasping inspiration followed by a long wheezing and moaning expiration; his lungs are full of moist sonorous, and mucous and submucous rhonchi, and scarcely a trace of vesicular respiration is to be heard, and he is pulseless. He looks to you beseechingly, and gasps out, in scarcely articulate words, that he is dying. This is but too true. Now, the treatment for such a condition at the present day is "to pour in stimulants" (though the patient can scarcely swallow). Brandy and water are given, and ammonia, and perhaps ether; then, if the patient live long enough to have them made, mustard poultices are applied to the chest, and to the calves and to the feet, and the patient is fanned and the patient dies. Something has been done, but that which true pathology—and, indeed, common sense, unshackled by prejudice, custom and fashion—would dictate, has been left undone. Appearances have been saved, but not the patient's life.

"The fact is, that here the danger lay in the right side of the heart being gorged with blood, so that it was impossible for its stretched and distended walls to contract and to propel forwards the thick and blackened blood. Oh, as you value your patient's life, as you value the blessed consciousness of being a minister who has done everything possible for his welfare, let me beg of you not to be contented with the futile treatment of to-day; relieve that poor oppressed distended heart, and all may be well! Open one of those veins which are, with every systole of the heart, tending to carry more and more blood to this already distended right ventricle, and all may yet be well with your patient. Sometimes this blood-letting, in extreme cases, is no easy matter; it may be necessary, before you can effectually open the vein, to place the patient's arm in warm water, so as sufficiently to distend the vein; and even when the ligature has been efficiently applied, and the vein well opened, you may have to press, and squeeze and rub upwards the arm before a drop of the thick and tarry blood will flow. But, when it *does* flow at length freely, oh, what a marvellous change may you see take place!—the breathing becomes quieter,

deeper, and less noisy, the haggard face resumes the appearance of tranquillity, the blueness of the skin is replaced by a more natural tint, the pulse becomes more and more distinct, and, in a word, the choked up heart is set free. This is no fancy picture. Every word is simple truth, and I appeal for confirmation to the memory of every senior member present who recollects the experience of his earlier days, and who can also probably tell you the after-progress of such cases was sometimes almost miraculously rapid, so that in a few days even the patients might become convalescent.”—*British Medical Journal*.

Note on Disinfectants.—Dr. W. E. Buck writes :
“Most practitioners must have often realized the inefficiency of disinfectants in allaying the fetor of cancerous ulcers, an annoyance which sometimes troubles patients even more than the pain, or the thought of death. I have used the whole round of disinfectants for cancerous ulcers, but all have failed in allaying the fetor, and keeping the ulcer clean. The disinfectants tried were carbolic acid, sanitas, terebene, resorcin, creasote, boroglyceride, chloride of zinc, charcoal, &c. After failure with these, I tried a saturated solution of hyposulphite of soda added to an equal quantity of water, and found it exceedingly efficacious. The ulcerating surface was well syringed and washed with the solution, and was then covered with rags steeped in the solution. The granulations were kept clean, and the fetor was well kept under. Most disinfectants seem to lose their virtue after a few days’ application, but I have used this one for months on the same patient with continuous good effects. It is cleanly, has no smell, does not stain, and is very cheap.—*British Medical Journal*.

CANADA

Medical and Surgical Journal.

MONTREAL, AUG., 1883.

TERRITORIAL REPRESENTATION.

This journal has for several years past on every suitable occasion, directed attention to the anomalous manner in which the elections for the Provincial Medical Board are at present conducted. We have also been surprised to find that this matter was not more earnestly discussed by our contemporaries, although as the sequel shows it was one which strongly interested the entire profession. Our readers will have observed by the report of the proceedings at Quebec published in our last number that a motion by Dr. Osler brought the subject before the meeting. It was in effect to give power to the incoming Board to evolve a scheme for having each representative elected by the physicians in his own district, and by them only—to go to the Legislature for an amendment to the Act to that effect—and to carry it into force at the next Triennial meeting. A long and animated discussion took place, a majority of those who spoke favoring the general proposition, but deprecating haste in bringing it into effect. It was finally agreed that the Board should carefully consider the whole question and report thereon at the next meeting. The defects of the present plan of voting were never more clearly shown than at the recent election. That one man with from 125 to 150 proxies in his hand, should be able to elect a candidate who was voted against by nearly every member of his own locality is absurd, and yet we have good reason to believe that such things did actually occur. Such a member cannot by any stretch of the imagination be looked upon as a *representative* of that district. What is wanted is *representation*, and the object

aimed at is entirely defeated by the existing method of wholesale voting. Some would oppose the new scheme, because it takes away from the power hitherto wielded by the cities. We must admit the fact, but would not look upon it as an unmixed evil. Others think that it would involve too great an expense. On this point we cannot speak, but it will of course have to be considered. On the whole, we feel satisfied that the Board will approve of the change, and that the next Triennial will be the last conducted upon the present faulty system.

It is well to remind the members again of the great importance of keeping themselves clear upon the books, and making their payments in due season. The strict letter of the law was in all cases applied, and some who would certainly have been elected were disqualified from want of payment of dues before the legal date. One member who was pronounced disqualified before the election, was reported afterwards to have been fully qualified. He was a candidate and we think would have been elected. If our information is correct, the case is one of considerable hardship. Mistakes may of course happen, but the entries in the official register are so important that it comes very hard to excuse blunders which cause such serious consequences—consequences which it is impossible subsequently to remedy.

ROMA LOCUTA EST. CAUSA FINITA EST.

The end has come. The fiat has gone forth. The ultimatum has been reached. The Church has spoken, and its firm decree can never be recalled. The Medical Faculty of Victoria University, or the Old School of Medicine and Surgery, of Montreal, is virtually a thing of the past. They were long ago instructed to commit suicide, annihilate themselves and disappear. Having refused to do so, their execution was decided upon, and now the axe has fallen. After many delays, after appeals to bishops and to Rome itself, at last the full power of the Roman church has been called into effect, and the faithful have been notified from every parish pulpit, that the most unquestioning obedience is called for.

For the benefit of those of our readers who may not have followed the course of the controversy between the opposing schools of Laval and Victoria, in this Province, we make the following abstract from the *mandement* of Bishop Fabre, of this diocese, which recapitulates the case from the time when instructions were first issued that Laval should be supported. He regrets that some Catholics have still continued to act contrary to the spirit of this official declaration. He next states that an opportunity was given the professors of Victoria to effect an amalgamation with Laval University and retain their positions. This was declined. The next move was to order the Sisters of the Hotel Dieu to refuse admission to all professors and students except those attached to the one recognized University. The ladies appealed to Rome, the unrecognized teachers to a Committee of Provincial Bishops. The latter have confirmed the pretensions of Laval—the following extract from their report shows how completely: “No Catholic can conscientiously form part of the said school (Victoria) or attend the lectures, and the professors and students cannot be admitted to the Sacraments of the Church.” Rome simply reiterated its commands to the nuns. They have, of course, submitted and shut their doors upon their *quondam* staff. His Lordship is of opinion that by these decisions “eternal welfare is offered to our studying youth.” Parents and guardians are warned that in encouraging any opposition to the decrees on the part of students, they are “inoculating them, and that for life, with the virus of prejudice and bad faith.” The reason why the church *should* be allowed full authority in *all* matters of education, secular and other, is thus given by the Bishop at the conclusion of his address: “It is without doubt our salvation that comes to us from Rome; it is the salvation of our society, because it is the guarantee of a Christian and solid education, and as we all know, education is the basis of society.”

It is a strange sight in this latter half of the 19th century, in a free country, to see an old and well-established, numerous attended, medical school wiped out of existence by a higher power, in spite of its most strenuous efforts to maintain a separ-

ate existence. Notwithstanding all the liberalism which has crept into men's ways of thinking, the terrors of the church in a thoroughly Catholic country like this, are a real power.

Rumor has it that the Old School will re-open as usual. We do not see how this is possible. They have no longer a hospital, and can students withstand the pressure that will be brought to bear upon them to bring them within the fold of Laval?

M. SOUVIELLE CAUGHT IN THE ACT.

The public has been made aware of the return of M. Souvielle, the Proprietor of the Lung and Throat Institute, and his doings in Europe. Almost every newspaper (in which his advertisements appear) has had laudatory puffs about the tin-pot inventor. In none of them, however, do we find any reference to the following interesting transaction which shows to what length this person has gone to get a qualification. In the London *Lancet* of June 30th, appears the following editorial item:—

“An official announcement at the University of Erlangen, states that one Matthew Souvielle, from Montreal, has attempted to obtain the doctorate by palming off as an original dissertation an essay on Diabetes, by Dr. Bürgel, which appeared in *Deutsches Archiv für Klin. Medicin* in 1873. The would be graduate performed his imposture somewhat clumsily, for he neglected throughout the essay to substitute English names for the German ones. He had, however, converted “Professor Liebermeister” into “Professor Spencer.”

NEW BRUNSWICK MEDICAL SOCIETY.

Through the kindness of Dr. Duncan, the Secretary, we are able to present our readers with an interesting report of the annual meeting of the New Brunswick Medical Society. By the provisions of the New Brunswick Medical Act of 1881, all persons who register under the Act constitute the Provincial Medical Society. The Council appointed to carry out the Act consists of nine members, five of whom are elected by the Medical Society and four nominated by the Governor-in-Council, so

that the Society has an important function in addition to the promotion of the general welfare of the profession, and is more closely connected with the State than other Canadian associations.

The suggestion of Dr. Steeves to establish a journal is one which we should like to see carried out. The Maritime Provinces are quite able to support one, and from what we know of the general professional attainments of the practitioners in those parts, a journal devoted to their interests should not suffer from lack of original communications. It is true the "Provincial Medical Journal," started in Halifax in 1868, was not long lived, but in the past fifteen years a great change has come over the profession, and the members are more alive to the necessity of supporting associations and journals. There are nearly six hundred medical men in Nova Scotia, New Brunswick, and Prince Edward Island, and a quarterly or bi-monthly periodical should receive ample support, and with a subscription list of three hundred, and a fair share of advertising pages, would pay expenses.

WHAT NEXT?—We have long been satisfied of the utter inefficiency of our present Health Board, and quite recently some (as Mr. Boxer, a member) have spoken very plainly on the subject. One would naturally suppose that the city authorities themselves, and the Health Officer particularly, would be the parties to be looked to in such matters. Not so, however, we have in this Province only one man who can do anything. Is it necessary to say that we allude to the "great uncrowned," "His Excellency," Chevalier Senecal? He has arrived from Europe, where delighted capitalists vie with each other in pouring money into his lap. He has spared a few moments from his great railway, beet root, land and lumber schemes to look round this city; has found its sanitary state very bad; has delighted our Health Officer by telling him that he is interested in this matter, and will introduce him to some wealthy French capitalists seeking information on the climate and resources of this country. This scheme is an excellent one. It will cause the worthy Dr. Larocque to find himself in excellent company, on which we congratulate him. But how that

is going to help clean our dirty backyards, or promote an efficient sanitary system in our midst, it might be difficult to say. Still, though our Anglican stupidity may prevent our seeing this, a large section of the public will now be perfectly satisfied. Has not Senecal said that he is interested in the muddle of our Health Office? And is it not enough for him to see an unsolved problem to solve it?

CANADA MEDICAL ASSOCIATION.—The sixteenth annual meeting of the Canada Medical Association will be held in Kingston on the 5th, 6th and 7th of September, under the Presidency of Dr. Mullin of Hamilton. The Local Committee has made the necessary arrangements, and a large meeting is anticipated. The usual reductions will be made on railways and steamboats, and the necessary certificates will be forwarded on application to the General Secretary, Dr. Osler, Montreal.

Personal.

Henry O'Keefe, M.D. (McGill, '82), is in Minto, Dakota.

Dr. Orton, M.P., of Fergus, Ont., has removed to Winnipeg.

S. S. C. Phippen, M.D. (McGill, '83), has settled in Owasso, Mich.

J. Simpson Lathern, M.D. (McGill, '83), has passed the L.R.C.P., London.

Charles E. Cameron, M.D. (McGill, '83), has passed the M.R.C.S., Eng.

C. E. Lamirande has been gazetted Inspector of Anatomy for the Montreal district.

F. H. Mewburn, M.D. (McGill, 1881), House Surgeon to the Winnipeg Hospital, was in town this month.

W. A. Shufelt, M.D. (McGill, '81), has given up practice at Brome, Q., and has gone to England to pursue his studies.

Dr. George Ross and Dr. Buller have gone to the Northwest for a holiday trip, and will return about the 7th of September.

Capt. Webb, the celebrated swimmer who lost his life in the Niagara Rapids, was the son of Dr. Thomas Webb, of Cheadle, Staffordshire.

J. B. Lawford, M.D. (McGill, '78), has been appointed Registrar and Chloroformist to the Evelina Hospital for Sick Children, London.

Dr. John Marshall, the Surgeon and Physiologist, succeeds Sir Spencer Wells, Bart., as President of the Royal College of Surgeons.

Dr. Calvin Ellis has resigned the Deanship of the Harvard Medical School, and Dr. H. P. Bowditch has been elected in his place.

W. J. Prendergast, M.D. (Bishop's, 1882), late House Surgeon at the Woman's Hospital, is about to begin practice at the east end of the city.

Dr. Riddell has resigned the coronership of Toronto, a position which he has filled for many years. Dr. J. T. Duncan has been appointed associate coroner.

Dr. Strange, of Toronto, and Dr. F. W. Campbell, of Montreal, have been appointed Surgeons to the Militia Schools of Instruction in the Provinces of Ontario and Quebec.

Dr. Reginald Southey, one of the Assistant Physicians at "Barts" has been appointed a Commissioner in Lunacy. As he is not a specialist in this department we may expect an outcry from the alienists.

The retirement of Dr. John C. Dalton, from the Chair of Physiology in the College of Physicians and Surgeons, will be universally regretted; all the more on account of the reasons, ill health, which have led to it. Dr. J. A. Curtis succeeds him.

Dr. Pitman, Registrar of the Royal College of Physicians, London., Mr. Saunders, Surgeon Dentist to the Queen, and Mr. Porter, of Dublin, one of the Surgeons to the Queen in Ireland, have been knighted. Dr. Banks of Dublin declined with thanks.

Reuben Levi, M.D. (McGill, '77), M.R.C.S., Eng., late of Inverness, P.Q., has returned from Europe, where he has been studying for nearly two years. Dr. Levi intends moving to the larger sphere of New York, where his ability and perseverance will in time command success.

Dr. Thomas Dwight has succeeded Dr. Oliver Wendell Holmes as Parkman Professor of Anatomy in Harvard. The appointment is in every way a suitable one. Dr. Dwight, who is a grandson of Dr. J. C. Warren, whom Dr. Holmes succeeded

in the chair, has been well known for some years as an original worker in Anatomy, and has published some important memoirs and papers.

Medical Items.

—Joseph Bell, a leading Edinburgh surgeon, is dead.

ECONOMY.—The annual grant of \$750 dollars made by the Provincial Government to each of the Medical Schools of the Province has been reduced $33\frac{1}{3}$ per cent.

—Oliver Wendell Holmes says that the great secret of success in every form of quackery is hope kept alive in the patient; while the too fatal gift of science is a prognosis of despair.

—Dr. Liddell, of New York, died suddenly on the 8th July. During the war he was Inspector-General of the Army of the Potomac. His name is well known in connection with nervous diseases.

—Most of the cheap cigarettes now flooding the market contain proportionately more nicotine than an ordinary cigar. One reason for this is, that many of them are made from cigar stumps, which contain the nicotine of the entire cigar.

—One person out of every five in the United States has one or more corns, and the cost of effecting a cure is \$1.30. What is the number of corn victims, and what would be the cost of placing every person on a sound footing?

—Dr. Kingman, in the *Boston Med. and Surg. Journal* of July 14th, calls special attention to the advantages of Prague for the study of Obstetrics. A new departure by several of the assistants is to give clinics in *English*. This will be done in the latter part of the summer, if sufficient English-speaking students shall warrant it.

—Dr. L. J. Lennox, of the International Throat and Lung Institute, Toronto, has brought suits against Dr. McCammon of Kingston and Dr. Bray of Chatham. The writs claim \$10,000 each for damages for slander spoken by the defendants of the plaintiff at the last meeting of the council in that city, in his connection as proprietor of the "spirometer," calling him a quack, a medical prostitute, &c.

—At a meeting of the Board of Trustees of the Women's Medical College, Kingston, the following were appointed professors:—Obstetrics, Dr. M. Lavell; Surgery, Dr. M. Sullivan; Anatomy, Dr. C. Irwin; Materia Medica, Dr. A. S. Oliver; Practice of Medicine, Dr. H. Saunders; Medical Jurisprudence and Sanitary Science, Dr. T. M. Fenwick; Institutes of Medicine and Histology, Dr. W. H. Henderson. The college will be opened in October.

—In the crowded railway carriage. First traveler: "I say, do open that window there, or I'll suffocate!" Second traveler: "Don't you open that window there, or it'll give me an attack of pneumonia." First traveler: "That makes no difference! If you have pneumonia, you won't have it for a week, whereas if I am suffocated, I'll be suffocated now. Open that window there."

THE BLESSING OF QUININE.—The traveller here soon learns to duly appreciate the value of cinchona. Take away its alkaloid extract, quinine, and in less than two generations the low lands of Central America would relapse to barbarism; without this precious safeguard, steamship lines would never have been established here, nor would Northern engineers have been able to penetrate the tangled fastnesses of the dense woods, to survey routes for railroads. Hence medicine, in the discovery of the virtues of Peruvian bark, has contributed the most potent factor towards the advancement of civilization in these regions where nature so stoutly resists its progress. Humboldt, in his "Ansichten der Natur," shows that this discovery is wholly due to our profession; for instead of its being an aboriginal remedy, he found in his travels among the Andes that the Indians, when attacked with fever, could not be persuaded to take this Peruvian bark.—*Dr. L. C. Lane on Guatemala.*

Physicians' Account Books.—We received a short time since from W. Benj. Plow, at John Lovell & Sons, a set of two books specially prepared and ruled for the use of physicians. The one is a day book and the other a *resumé* of the whole, or ledger. We have made trial of them, and can strongly recommend them to others as being very convenient, and saving a wonderful amount of writing and trouble in the posting of their books, and preparing half-yearly accounts. They may be had for a small sum by applying to the above address.