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Original Communications.

A CASE OF TUBERCULAR PERITONITIS WITH ENCYSTED COLLECTION OF FLUID, SIMULATING OVARIAN CYST.

By WILLIAM GARDNER, M.D.,
Professor of Gynæcology, McGill University; Gynæcologist to the Montreal General Hospital.

S. B., æt. 23, unmarried, domestic servant, belonging to a remote country district north of the Ottawa River, who had lived in the city during the previous six months, was sent to me about last midwinter by my friend Dr. George Ross for examination, as the suspicion of pregnancy had arisen in consequence of extensive abdominal enlargement. She admitted a pregnancy terminating at six or seven months a year and a half previous. She could give no definite account of the date at or about which the present abdominal enlargement began, but her mistress noticed it three or four months previous. It had rapidly increased since then. The girl complained of abdominal pain; menses had been absent for three or four months; general strength, health and appetite had declined, and she had become emaciated. The tongue was red.

Examination.—The belly much enlarged; the skin below the navel presenting recent pinkish striæ, as well as old silvery streaks. Well-marked fluctuation over the whole of the anterior and antero-lateral aspects of the abdomen. Dullness on percussion over the same area. In the lumbar region (flanks) and epigastrium the bowel note present. No firm or solid part

to be felt anywhere. The anterior aspect of the abdomen quite uniform. The perineum slightly lacerated and the posterior vaginal wall partially prolapsed. The uterus, measuring two inches, pressed upwards and forwards, lay immediately behind the pubes. The patient was admitted to the Montreal General Hospital and kept under observation for a few days, when it was found that she had fever of septic type, the temperature at times running very high, with profuse sweating and occasional attacks of vomiting. During this interval she was seen by Drs. Fenwick, Ross, Roddick, Shepherd and J. C. Cameron, who concurred in my diagnosis of suppurating ovarian cyst. Another symptom, red blush and œdema of the central anterior part of the abdominal wall, seemed to support the view. Operation was resolved on, but delayed on account of the difficulty in communicating with the girl's relations, so far distant from the city.

Operation.—The ordinary incision for ovariotomy was made, but on reaching the peritoneum no separation of parietal from visceral layer could be made; the knife entered the collection of fluid, passing through what seemed to be a thickened, closely adherent cyst wall. The fluid was amber-colored, contained flakes, and in the last portions an obvious admixture of pus. The cyst wall did not collapse as the fluid escaped, but appeared to be adherent everywhere, even to the bottom of the pelvis. Acting on this view and with the concurrence of my friend Prof. Roddick, who was assisting, I decided to make no attempt at separation of the supposed cyst, but to drain and irrigate, as affording the patient the best chance. A large glass tube was passed through the wound into the Douglas pouch, and irrigation practised every two hours, night and day. At first weak carbolized water, then corrosive sublimate solutions, and finally solutions of iodine, were used for this purpose. The general condition at once improved, and this was maintained for a period of ten days. Fever diminished and appetite improved. After a few days the reflux water during irrigation contained enormous quantities of fibrinous, flaky material. Soon, however, her condition again declined. Temperature ran high; sweats were profuse. The discharge always somewhat fœtid, became

more so. Soon after the operation the patient suddenly developed a cough with expectoration, which soon became purulent, and was at times bloody. Three weeks after the operation a large rubber drainage-tube was passed through the Douglas pouch and out by the vagina, being carried a few inches beyond the vulva. This did no good. She gradually sank, and died exhausted six weeks after the operation. Two days before death she complained of sore throat, and on examination the fauces, tonsils and posterior wall of the pharynx were found to be covered with a diphtheritic membrane. Until the autopsy, I adhered to the original diagnosis of suppurating, universally adherent, ovarian cyst. Dr. R. J. B. Howard, acting pathologist to the Hospital, made the autopsy. I append his report:—"On opening abdomen a large globular mass presents, of the size of a man's head, occupying false pelvis; this and the parietes are everywhere covered by a grey, rough membrane about one-eighth of an inch thick. The transverse colon is firmly adherent to the upper surface, and is also bound tightly down to the liver. A collection of pus is found below and by the side of the spleen, and another, smaller, under left lobe of liver in middle line. The anterior peritoneal cavity is thus converted into a suppurating cyst, extending from liver down into true pelvis, nearly filled by the mass, which is found to consist of all the intestines, except the transverse colon, closely matted together by recent slight adhesions, which are studded with miliary tubercles. The cyst wall is apparently much older than the inter-intestinal adhesions, and looks like an unhealthy granulating membrane. The walls and viscera of true pelvis are covered by the same membrane. The great omentum has quite disappeared; but no doubt had been spread out over the intestines, and formed part of the membrane covering them. All the abdominal viscera adherent to one another and to parietes. Liver fatty; contains a few gray granulations. Kidneys contain a few gray granulations. Lungs universally adherent; abundantly studded with gray granulations. Tonsils and pharynx—surface gray and sloughy-looking. No loss of substance; same appearance involves œsophagus opposite cricoid cartilage, and about four inches lower down."

Remarks.—The principal interest of the case lies in the diagnosis. It well illustrates how difficult it may be to definitely fix the real nature of an abdominal fluctuating tumor. The fact that the abdominal enlargement was uniform, central, and occupying the anterior and antero-lateral parts of the abdomen, to the exclusion of the flanks, where the clear percussion note shewed the presence of bowel, added to the difficulties. A similar case occurred to my colleague, Dr. Fenwick, some years ago. The same error of diagnosis was made by all who saw the case. This patient died some months after operation, probably also of tuberculous disease, as she developed a pleuritic effusion before leaving the hospital. Other similar cases are reported by Spencer Wells, Erich, Ewing Mears and Atlee. The well-known dangers of tapping ovarian tumors, in my opinion, make that procedure for obtaining fluid for microscopical examination unjustifiable, especially as there is no concurrence of opinion of microscopists as to the certainty of that means of diagnosis. Happily, the treatment in my case leaves no room for regret, as under the circumstances it was the very best that could have been applied. It clearly prolonged life, and if the peritonitis had been simple it would almost to a certainty have saved the life of the patient.

QUARTERLY RETROSPECT OF SURGERY.

By FRANCIS J. SHEPHERD, M.D., C.M., M.R.C.S, Eng.,
Surgeon to the Montreal General Hospital; Professor of Anatomy and Lecturer on Operative Surgery, McGill University.

Treatment of Acute Peritonitis by Abdominal Section.—At a meeting of the Royal Medical and Chirurgical Society of London, held March 10th, 1885 (*Lancet*, March 14th, '85), Mr. Fred. Treves read a paper on the above subject. He remarked that the extreme fatality of acute diffused peritonitis, especially that form due to perforation, and the acknowledged futility of the modes of treatment that are at present employed, give some support to the proposal that acute peritoneal inflammation should be treated by the same methods that are successfully applied to other acute inflammations—viz., by free incision and drainage.

He urged the adoption of this principle of treatment in acute peritonitis, and illustrated the success of this treatment by the report of a case in which the abdomen was opened and the cavity washed out with many quarts of carbolic solution and a drain introduced. The case was that of a woman aged 21, who was admitted into hospital suffering from chronic pelvic peritonitis following gonorrhœa. Three months after the commencement of the chronic peritonitis, an acute diffused peritoneal inflammation suddenly developed, due, as was afterwards discovered, to the bursting of an abscess and the extravasation of its contents into the general peritoneal cavity. After the operation, the patient made a good recovery, and was in the garden on the 40th day.

At the same meeting, Mr. Howard Marsh read a paper on a case of "Acute Circumscribed Suppuration of the Peritoneum treated by abdominal section, with recovery." The patient was a medical student, aged 19, suffering from symptoms of sudden and acute peritoneal inflammation. The inflammation was localized, a swelling about eight inches square existing to the left of the umbilical region. An incision was decided upon, and gave vent to about two pints of fœtid pus. The abdomen was washed out thoroughly with a 1 to 60 solution of carbolic acid, and a large drainage-tube, eight inches long, introduced. This was gradually shortened, and the patient slowly recovered, the wound healing completely at the end of three months.

In the discussion which followed the reading of the papers, Mr. Thos. Bryant said he had long felt that the practice advocated by Mr. Treves was one that had not been sufficiently followed. He had, however, for ten years past, performed surgical operations on cases of localized suppuration in the peritoneum about the cæcum and pelvis; the cause of peritonitis, he thought, must determine whether the surgeons should operate or not.

Mr. Knowsley Thornton said there was a form of peritonitis which appeared to be due to the mere presence of the tumour and not to any perforation—an acute dry peritonitis. He had operated in two of these cases; one died and the other recovered after a very severe illness. In cases of perforation, he con-

sidered the proper course was to operate at once. Drainage was most important. He thought that, unless the surgeon could be certain of obtaining absolute asepsis, antiseptic irrigation should not be used. When asepsis was impossible, he should use large quantities of boiled water, with free drainage.

Drs. Douglas Powell and Goodhurst, and Messrs. Barwell and Meredith, agreed in commending the practice advocated by Mr. Treves.

The practice of opening the abdomen in cases of peritonitis due to perforation or wound in stomach and intestines is now advocated by all antiseptic surgeons, and this method of treatment is one which has already saved many lives. The general feeling amongst surgeons is that, considering the great fatality of acute diffused peritonitis, abdominal section should be resorted to, and the effused fluid evacuated, as is done in pleurisy with effusion. No doubt cases of acute suppurative peritonitis, due to perforation or the bursting of abscesses into the peritoneal cavity, are more suited to this treatment, and the results are apt to be more favorable than in those cases of peritonitis called "idiopathic," or due to some unknown cause. Such a case I saw recently in the post-mortem room of the Montreal General Hospital, in a young girl aged 13. In this case no cause could be found for the peritonitis, and the pus was of such a tenacious character that had the abdomen been opened it would not have drained away, and many parts, as, for instance, the lesser sac of the peritoneum, would have been uninfluenced by the most careful drainage.

Milkulicz of Cracow (*Central. für Chirurgie*, No. 45) says laparotomy is urgently indicated in any case of perforation of the stomach or intestine, due either to direct or indirect violence or some pathological process. The main contra-indication to operation is extreme exhaustion. He relates four cases of laparotomy. The first case was one of perityphlitis, when he evacuated two pints of fœtid fluid; this patient died five days after operation. Another of volvulus, where one pint of darkish fluid was found and the obstruction removed. Patient made a good recovery from the operation, but died from pneumonia some

weeks after. The third case is a very remarkable one. A young man was seized with intense pains in the umbilical region and presented symptoms of obstruction. Sixty hours after this he came under Prof. Milkulicz's care, and he diagnosed internal incarceration, and at once performed laparotomy. In the abdominal cavity he found a pint of thin fœtid pus and some undigested pieces of potato. He discovered also a perforation in the ileum on the left side, just above the brim of the pelvis. The mesenteric glands were enlarged, and Prof. Milkulicz came to the conclusion that it was a case of perforating ulcer from typhoid fever. He brought the edges of the perforated gut together, after being freshened, by a dozen silk sutures. The subsequent course of the case was satisfactory. The fourth case was one of ruptured stomach. Death followed the operation in three hours.

Krönlein has also resorted to the operation of laparotomy for peritonitis due to perforation of the appendix vermiformis.

Removal of Foreign Bodies from the Intestines.—At a meeting of the Clinical Society of London, held May 8th, 1885, Mr. Charles Symonds reported a case of removal of a calculus from the vermiform appendix for the relief of recurrent typhlitis. At first the attacks of typhlitis occurred almost once a month, but the last five weeks he had had six attacks. Three days before admission into hospital he had a severe attack. On examination, a small hard lump was felt in the left groin, a little above Poupart's ligament. This lump, which was painful on pressure, gradually increased in size. It was decided to make an exploratory incision under the spray. This was done two inches above and one inch internal to the anterior superior spine of the ilium. The swelling was incised, the appendix opened, and a calculus removed. There was no pus or fæcal odour. The opening in the appendix was then stitched up and the abdominal wound closed. Some time after pus escaped from the wound, and a sinus was left for several months, but when last seen the sinus had closed, and patient was able to do his work.

Dr. G. E. Fenwick of Montreal reported a case in a young girl to the Canada Medical Association in August 18th, '84, in

which he had successfully removed a large concretion from a Meckel's diverticulum. The presence of the concretion had given rise to an abscess, followed by a fæcal fistula. The abdomen was opened, the concretion removed, and the opening in the diverticulum stitched up. The girl made a slow but complete recovery.

Bullet Wound of the Abdomen; Operation.—Mr. Annandale of Edinburgh (*Lancet*, April 25th, 1885) reports a case of a young lad aged 15 years, who was shot by the accidental discharge of a revolver through the abdomen, half an inch below, and to the left of, the umbilicus. The boy gave evidence of but little shock, and walked 100 yards after receiving the wound. He was admitted into the Infirmary and the bullet wound explored. It was found to penetrate the abdominal walls. The wound was enlarged and the intestines examined; five wounds were found in the small intestine, two in the descending colon, and two in the pelvic portion of the rectum. There was also a wound of one of the large mesenteric veins, which gave rise to considerable hemorrhage. The bullet could not be found. There was no extravasation of fæcal matter. The wounds in the intestines were sutured with catgut, and the whole cavity of the abdomen sponged out with bichloride solution (1 to 2000). The patient rallied from the operation, but died within 24 hours of the accident from exhaustion. At the necropsy, the intestines were much distended with gas, and the abdominal cavity contained six ounces of brick-red serum. None of the sutures had given way; in fact, they were all perfectly water-tight. The bullet was found on the right side of the pelvis, immediately in front of the ischial spine. Although this case proved fatal, why, it is not easy to say, Mr. Annandale feels encouraged to follow out the same practice should another case fall to his lot, as the condition of the wounded intestine after the sewing was in every way satisfactory.

Dr. M. E. Deschamps (*Revue de Chirurgie*, Nov. 1884) reports a case of *bullet wound of the stomach*, which did well for a week, when he left the hospital and went on a drinking bout, and died two days afterwards from peritonitis. The autopsy

showed the course of the bullet was through left sixth costal cartilage, then through the diaphragmatic portion of the pericardium, then stomach, diaphragm again, and lower border of lung was traversed. The bullet was found between the 9th and 10th ribs. The wound in the stomach was closed, and at the autopsy showed no perforation. Dr. Deschamps thinks that the patient would have recovered had he not left the hospital and taken to drinking. The treatment consisted of ice to the stomach, opiates and very light diet.

Surgery of the Stomach.—Operations on the stomach are now of so common occurrence as to give rise to but little comment when they occur. Still, the surgery of the stomach is only, as yet, in its infancy, and records of many cases will be required before exact rules can be formulated as to the proper procedure in the various diseases and accidents which call for surgical interference. In the *American Journal of the Medical Sciences* for April 1885, Dr. Winslow of Baltimore has collected nearly all the cases of pylorectomy and its substitutes—gastrectomy, gastrostomy, digital divulsion of pylorus, &c. He tabulates 61 excisions of pylorus, 13 gastro-enterostomies, 1 gastrectomy, 1 gastrostomy, 3 duodenostomies, and 6 cases of digital divulsion. The following is the summary given by Dr. Winslow :—

1. In cancer of the stomach not producing stenosis, give anodynes in quantities sufficient to relieve distress ; do not operate.

2. Pylorectomy for carcinoma is followed by 76 per cent. of mortality, hence it should only be exceptionally performed in those cases where, with marked stenosis, the pylorus is not adherent to the neighboring organs, and the patient is young and fairly strong.

3. In other cases of carcinomatous stenosis, as only very temporary benefit can be obtained, perform gastro-enterostomy.

4. In cicatricial stenosis, peform digital divulsion ; but if this is impossible, owing to great thickening of the walls, resection in those who are well-nourished and gastro-enterostomy in the debilitated will both be followed by good results.

5. In the opinion of the writer, hemorrhage or perforation

from ulcer or other causes than stenosis does not present indications for pylorectomy.

6. Duodenostomy, gastrostomy for the passage of a tube, and complete gastrectomy should be replaced by gastro-enterostomy.

According to an editorial in the *Medical News* of April 11th, 1885, of the 56 operations performed on the pylorus up to the present time for carcinomatous stenosis, 75 per cent. were immediately fatal—that is, perished as the result of the operation; in 72.72 per cent of the survivors, there was a return of the disease; and in 27.27 per cent., there was freedom of recurrence for less than one year. Not a single patient was permanently cured. In consequence of these results, the feeling that the operation is not justifiable is rapidly gaining ground.

Gastro-enterostomy has been performed 11 times, with three recoveries. One of the survivors died four weeks after, and the other two were alive after two and four months respectively. Gastrostomy and duodenostomy are not likely to be more successful. Hahn kept his patient alive two weeks by feeding through a tube passed into the duodenum. But the great mortality in all the above operations inclines the author of the editorial above quoted to believe that "such cases should be left to their fate, suffering being palliated by anodynes, and nourishment being afforded per rectum."

In Fibrous Obstruction of the Pylorus, several operations have been performed. Excision of the pylorus has been practiced in nine cases, of which five have recovered. Gastro-enterostomy has been done three times, with one death. (This operation consists in opening the stomach and also the upper part of the small intestine, and uniting these two artificial openings by sutures. It is performed when the pyloric tumor could not be removed.)

Duodenostomy and jejunostomy have also been performed. The first once and the second twice, but with a fatal issue in each case.

Loreta's Operation, or Digital Divulsion of the Stomach.—In the *Brit. Med. Journal* for Feb. 21st, 1885, Mr. T. Holmes gives an interesting summary of two papers by Prof. Loreta of

Bologna on the operative dilatation of the orifices of the stomach. This operation, which is performed for simple and fibrous stricture of the pylorus and cardia, and for cicatricial contraction of the cardiac end of the œsophagus, is a substitute for pylorectomy or gastrostomy. The operation is performed by making an incision two inches long on the anterior surface of the stomach near its pyloric end; the two index fingers are then introduced into the pylorus, which is then forcibly dilated. The chief difficulty of the operation is the great resistance offered by the pyloric sphincter. The first patient operated on in September, 1882, had suffered from dyspeptic symptoms for twenty years, and had been treated for ulcer of the stomach for three or four years. When the operation was undertaken he was in the last stage of emaciation and exhaustion. Digital divulsion of the pylorus was entirely successful, and "five months after the operation the man was in perfect health and doing his ordinary work." The operation has now been performed eight times, with two deaths.

Dr. Russell (*Brit. Med. Jour.*, Feb. 21st, '82) reports a case of non-malignant constriction of the pylorus, with great dilatation of the stomach, where the use of a syphon-tube for washing out the stomach had succeeded in restoring his digestive powers, and for five years he had lived in comparative comfort, and was well when last seen. Before employing Loreta's operation, it would perhaps be as well to put in practice this treatment of washing out the stomach, as no danger is incurred, and the operation of divulsion could be performed later if needed. This treatment by irrigation is not a new one, but the patient's life in this case has been remarkably prolonged.

Dr. D. G. Zesas, in the last number of *Langenbeck's Archiv für Klinisch Chirurgie*, gives an exhaustive article on "*Gastrostomy and its Results*," in which he analyzes 162 recorded cases, and also gives an extended history of the operation. Of these 162 cases, 107 were in men and 33 women, the sex of the remaining 22 cases is not recorded. It was performed 129 times for carcinoma, 31 times for cicatricial contraction, and in 2 cases for syphilitic disease of the œsophagus. The results of the opera-

tions were as follows :—Of the 129 cases with carcinoma, 111 died and 18 recovered ; of the 31 cases of cicatricial contraction, 20 died and 11 recovered ; both the syphilitic cases died. The causes of death in order were : Exhaustion, pneumonia, peritonitis, and collapse. The great majority of fatal cases died within thirty hours of the operation. After discussing the line of incision, and speaking favorably of Fenger's incision (a finger's-breadth below and parallel to the edge of ribs on left side, crossing the rectus muscle), and the question of immediate or delayed opening of the stomach, he goes on to describe the various methods of suture used, and discusses the propriety of feeding as soon as the stomach is opened or waiting for several days, and feeding per rectum. He advocates a small incision into the stomach sufficient to allow a soft catheter to pass, as then the part can be kept closed and remain clean, and there is little danger of infection. When a large incision is made, it is difficult to retain the contents of the stomach, the wound becomes unhealthy, and there is continual irritation in the neighborhood of the stricture.

The vomiting which follows the anæsthetic often gives a great deal of trouble after this operation, and continues sometimes for a couple of days, tearing through stitches and allowing contents of the stomach to escape. Dr. Zesas advocates the performance of gastrostomy by means of a local anæsthetic, as the pain of the operation is by no means great.

Since the introduction of antiseptic surgery the operation is much less fatal. Of 31 operations performed in the pre-antiseptic days, only one recovered ; of 131 operations performed since the introduction of antiseptics, 38 recovered ; and in time it is hoped the percentage of recoveries will be much increased.

The operation is indicated in all cases where there is great difficulty in swallowing, and where the œsophagus is becoming closed. This may occur (1) from congenital defect, (2) from cicatrices following wounds, the swallowing of caustic materials, and constitutional disease, (3) from new growth in the œsophagus itself or its neighborhood, and (4) from a firmly lodged foreign body. With regard to the advisability of performing

the operation in cancerous disease, the author says: Gastrostomy is indicated in cancerous stricture of the œsophagus, and should be performed early, and when the patient has still sufficient strength to bear the operation. The establishment of a fistulous opening into the stomach is preferable to death by hunger, and certainly prolongs life. In cases of cicatricial contraction of the œsophagus, the operation is a most suitable one, and is much more successful than when performed for cancerous disease.

Prof. Billroth (*Allgemeine Wiener Med. Zeitung*, Feb. 24th, 1885) reports two cases in which œsophagostomy and gastrostomy were severally performed for the removal of a foreign body. In each case a set of artificial teeth were swallowed, and necessitated operation. Both cases recovered without a bad symptom.

Toxic Enteritis caused by Corrosive Sublimate as a Surgical Dressing.—Dr. G. L. Peabody (*New York Med. Jour.*, March 14th, 1885) gives an account of eleven cases taken from the records of the New York Hospital, in which the use of perchloride as an antiseptic dressing or application was followed by obstinate diarrhœa, which did not yield to the usual remedies, and which sometimes ceased on the use of the drug being discontinued. In seven of the cases, the application was followed by frequent bloody discharges, griping, tenesmus, prostration, and death. His attention was drawn to the subject by an article by Dr. Fraenkel in the February number of *Virchow's Archiv*. Dr. Fraenkel had been directed to the subject by a short article in the *Centralblatt f. Gynäkologie*, by Stadfelt of Copenbagen, in which a fatal case of poisoning was reported from washing out the uterus with a solution of 1 to 1500 of corrosive sublimate after retained placenta. In this case the autopsy showed numerous ulcers of an irregular or circular shape in the large intestine. The mucous membrane generally was much congested. Several of the autopsies made by Dr. Peabody occurred in surgical cases where the bichloride had been used for irrigating abscess cavities, irrigating wounds after amputation of the breast, &c., wiping the peritoneum after laparotomy with sponges wet in bichloride solution 1–2000. Fraenkel (quoted in *Lancet*,

April 4th, 1885) says he has made autopsies of 14 cases treated by Schede with bichloride during the last two year and a half, in which toxic enteritis was produced by it. Of these 14 cases, two, he thinks, were killed by the poison directly. In the others, the drug did not seem wholly responsible for the fatal result. Salivation is exceptional in these cases. Inflammation is always present in the large intestine, but only exceptionally in the small. Schede (*Volkmann's Sammlung Klin. Vortrage*, No. 251) admits the dangers of bichloride in certain conditions, but thinks it doubtful whether the intestinal lesions may not be due to pyæmia; but both Fraenkel and Peabody say, in these cases of supposed poisoning, the usual lesions of pyæmia were absent. W. Thorn, assistant to the Female Clinic at Halle, in the same number of *Volkmann's Sammlung*, makes an urgent plea for its total abolition from midwifery and gynæcology, alleging its inferiority to carbolic acid, and the dangers attending its use. From these papers it would seem that the immediate use of intra-uterine injections of bichloride is dangerous and perhaps unwarranted. Dr. Peabody says that as far as he can learn death has not resulted from its use in surgical dressings, but has occurred only after irrigation of abscess cavities, uteri, vaginæ, large wounded surfaces, and peritoneum. He thinks it not unlikely that many deaths have resulted from its use that have been ascribed to other causes.

I have, for the last eighteen months, used bichloride dressings and douches in my surgical practice in the Montreal General Hospital, and have never yet met with any untoward results from its employment. I very rarely wash out abscesses with any antiseptic unless they are fœtid, and do not make use of the continued douche in operations, but during the operations, only occasionally irrigate the wound and again at the termination of the operation. The evil consequences in general surgery, I fancy, are due to an excessive and unnecessary use of the bichloride. Still, it is well to be on one's guard, and the notes of warning sounded in the papers quoted above will prove of the utmost value in rendering surgeons more cautious and gynæcologists less prodigal in the use of corrosive sublimate as an antiseptic.

Excision of Cerebral Tumors.—At a meeting of the Royal Medical and Chirurgical Society of London, held on 12th May last, Dr. Hughes-Bennett read a paper on a case of cerebral tumor, the surgical treatment of which was managed by Mr. Rickman Godlee (*Lancet*, May 16th, 1885). The chief features of interest in the case were that during life the existence of a tumor in the brain was diagnosed, its situation localized, and its size and shape approximated entirely by signs and symptoms exhibited, without any manifestations of the growth on the external surface. This growth was removed by a surgical operation, without any immediate injurious results on the intelligence or general condition of the patient, who lived, relieved of his former symptoms, for four weeks, and who, at the expiration of that time, died, not from any special failure of the nerve-centres, but from the effects of a secondary surgical complication. Dr. Bennett said the case, however, taught important physiological lessons, and suggested practical reflections which might prove useful to future medicine and surgery. The history and condition of the patient on examination were detailed, and the reasons given for the diagnosis. The subsequent surgical operation, the progress of the case, and the post-mortem examination were also described.

In the discussion which followed the reading of the paper, Dr. Hughlings-Jackson, after congratulating Dr. Bennett and Mr. Godlee, said there was a kind of monoplegia, often passing into hemiplegia, which was almost certain evidence of cerebral tumor. A paralysis beginning very locally, for instance, in the thumb and finger, and spreading slowly week by week. In such a case he should not advise trephining, since there would be a great probability of a large tumor of the centrum ovale. The convulsive seizures of localizing value were not cases of epilepsy proper, but epileptiform seizures, convulsions beginning one-sidedly, and only locally in hand, cheek or foot. These seizures did not always to a certainty point to tumor, for in some cases there was local softening. When, however, there was also double optic neuritis, such gross disease as a tumor might be confidently predicted. We also require some local persisting paralysis of

the part convulsed. So far then, Dr. Jackson remarked, three things were required for the diagnosis of cerebral tumor—local persisting paralysis, epileptiform convulsion, and double optic neuritis. He strongly advocated operation where the tumor could be localized, but said that we should not overlook three difficulties connected with operative interference—that the tumor might be very large, that there might be softening about it, and that, besides the tumor localized, there might be others. Cases were narrated illustrating these difficulties.

Dr. Ferrier had watched the case with the greatest interest, and was present at the operation. The patient bore the operation without any great shock to the nervous system, and, he might say, without danger to life, for there could be no doubt that death was due to an inflammatory complication. The operation, if performed strictly antiseptically, need not be attended with any risk of encephalitis.

Dr. Macewen, of Glasgow, then enumerated some cases, of which I give an abstract below.

After Dr. Bennett's reply, and some remarks by Mr. Horsley, in which he said from his experience of experiments on animals he believed that a permanent closing of the wound at the end of the operation was the proper course, Mr. Godlee said, in regard to the operation, that he had employed the actual cautery partly to arrest hæmorrhage and also to destroy the tumor, the deeper parts of which were indefinite. In his opinion, the inflammatory action was the cause of the hernia cerebri; inflammation would probably not occur without some putrefaction having been set up. In removing the deep part of the tumour he had used a Volkmann's spoon, but some instrument larger and blunter would probably have answered better. Large wounds in man had not, in his experience, been well treated when the wound was completely closed, and he considered wounds in lower animals were not completely analagous to wounds in man, so that he agreed with Dr. Macewen that a drainage-tube should be used; otherwise there would be no opportunity for an extensive effusion of serum and blood to make its way out. As to the cause of the disaster in his case, he had no doubt that it was due to putrefaction,

which was probably the result of imperfect purification of the scalp. At another time he should have the head shaved all over, and thoroughly washed first with soap and then with corrosive sublimate, and finally soaked in a strong solution of carbolic acid.

The interest in this case is rather medical than surgical. It was a triumph of medical diagnosis. Still there are many points in the case which are instructive surgically, and on which more light is needed. First, as to whether the wound should be closed permanently, as has been so successful in monkeys, or treated by drainage; and secondly, as to the mode of dealing with the hæmorrhage from the parenchyma. Gummata are frequently very vascular, and their removal would necessarily cause hæmorrhage. In Mr. Godlee's operation the hæmorrhage was great, and was controlled by the actual cautery. In monkeys Mr. Horsley has successfully employed morphia, injected hypodermically, to lessen the hæmorrhage, and it is worth trying in man.

In the *Lancet* for May 16th and 23rd, Dr. Macewen, of Glasgow, has a paper on *Cases Illustrative of Cerebral Surgery*. The first case, that of a man aged 36, was admitted with impairment of power of the left arm, accompanied by muscular twitchings of right side of face and pricking sensations from the shoulder down to the fingers of left arm. He, some months before, had fallen down stairs and was unconscious for twelve hours. When he recovered consciousness, the only thing he complained of was giddiness. Gradually the symptoms for which he was admitted came on. There was no external mark of injury on his head. From the history, as well as from his condition at time of examination, a lesion of the motor cortex in upper half of right ascending frontal convolution was diagnosed, and, as the patient was very desirous that something might be done to alleviate his condition, operation was determined on. Under chloroform a portion of the right parietal bone was removed one inch behind the auriculo-bregmatic line, and one inch above a line drawn from the external angular process of the frontal to the upper angle of

the lambdoidal suture, thus exposing the middle of the ascending frontal and parietal convolutions. A crucial incision was made into the dura mater, and a considerable quantity of clear fluid along with clots of blood about the size of a bean escaped; other clots adhering to the under-surface of the membrane were removed. No brain pulsation was seen, but a membrane-like patch involving the arachnoid and pia mater along with the external surface of grey matter was exposed. This was removed, and now the pulsations of the brain became distinct. The dura mater was replaced, and the disc of bone which had been removed, and which had its periosteum entirely stripped off, was divided into several portions and reimplanted into the aperture in the skull, a small opening being left at the side for drainage. The scalp was brought together with chromic gut, and a decalcified chicken bone tube placed between the scalp and the skull for drainage. The operation was done under the spray and eucalyptus dressings applied. The first dressing was done after 48 hours, and the second three weeks later, when the wound was found healed. The man never had a bad symptom. At the end of six weeks he had improved greatly, there were no twitchings, and he felt his left arm as strong as ever; eight months after he reported himself as regularly at work, and with the power in his left arm perfectly restored.

The second case was a woman aged 26, who was admitted into hospital suffering from left-sided hemiplegia. She had a clear history of syphilis of four years' standing. Among the manifestations of the tertiary period was an ulcer over the occipital line, principally of the left side. There was a history of injury over the same part, to which patient attributed the ulcer. Eight months after the ulcer healed, she began to experience a tingling sensation in the muscles of the left arm, and subsequently in those of the left leg, accompanied by muscular twitchings. Soon she lost power in left arm, and later in left leg. On admission three months later, patient was found to have absolute motor paralysis of left arm and leg, accompanied by slight rigidity. The sensation in the affected limbs was unimpaired. Her intelligence was dull and her memory

affected. Tapping the head gave rise to disagreeable feelings. The absence of anæsthesia from the beginning pointed to the lesion being cortical rather than central; and cortical lesion in right motor area, superior half of ascending frontal and parietal convolutions with probable involvement of paracentral lobule, was diagnosed. As treatment by counter-irritation and prolonged administration of anti-syphilitic remedies had failed to effect the slightest improvement, operative measures were advised. The operation was performed June, 1883. The hair having been partly shaven and the scalp thoroughly cleansed, first with soap and water, then with turpentine, and finally with antiseptic solution, a disc of bone over an inch in diameter was elevated from the right side of the skull, its anterior border touching a point half an inch between the auriculo-bregmatic line, whilst its upper margin reached a point about an inch from the centre of the longitudinal sinus. The internal table of the osseous disc removed showed osteophytic deposits (some projecting 1-16th of an inch), the dura mater was thickened, and a plastic, membrane-like effusion was found over the anterior and posterior ascending convolution and bridging fissure of Rolando. The brain towards the paracentral lobe was resisting, and so was incised, which caused the escape of a gummous fluid with pultaceous particles. Previous to the removal of this matter there were no brain pulsations, but when it was removed they were seen to a slight degree. The interior of the skull was now explored with a probe, and osteophytic projections discovered in the occipital bone, to remove which a second trepanning was performed. As in the previous case, the osseous fragments were reimplanted and the case dressed with gauze, and drainage used. The patient did well, and when last seen, a year and ten months after the operation, the power of the left leg and arm was restored and she was able to walk about to perform household work.

Dr. Macewen has had seventeen cases under his care in which operations have been performed upon the skull and its contents for the relief of cerebral pressure or other brain lesion. In fourteen trephining was performed, and in three elevation of

the bones. There were three deaths, but it was believed that trephining in no way hastened it. In eleven the bones which had been elevated were divided and reimplanted. Hernia cerebri has not followed as the result of any of these operations.

Dr. Macewen remarks that if inflammation in the brain exists at the time of the operation, hernia cerebri may form, notwithstanding the use of antiseptics.

Cerebral surgery is still in its infancy, and the cases of Dr. Macewen will help to give confidence as to the result of operative interference in cases which were formerly considered hopeless.

Treatment of Cold Abscess.—Prof. Verneuil (*Rev. de Thérapeutique*, Aug. 1884) obtains a rapid cure in almost all his cases of cold abscess, abscess from diseased bone or from congestion, &c., by ethereal injections of iodoform of the strength of one in twenty. The abscess is first aspirated by means of Potain's aspirator, and then receives from 100 to 300 grammes (3 ozs. to 9 ozs.) of the iodoform solution. By not exceeding this quantity (℥i to ℥iii of iodoform), no fear of accidents need be felt. The liquid penetrates into all the anfractuosities and diverticulæ of the abscess, the ether becoming absorbed or evaporated, and the antiseptic agent being deposited uniformly on the pyogenic membrane, the action of which it modifies. This simple means, so exempt from danger, and so easy of application, has proved highly successful, very large abscesses having yielded to three or four injections.—(*Quoted in London Practitioner for March.*)

Management of Abscess in Hip Disease.—Dr. A. B. Judson (*New York Med. Jour.*, Jan. 1885) says a comparison of these cases of osteitis of the hip which are free from purulent discharges and those in which such discharges occur, brings to light several circumstances which take away the dread of abscesses. Their occurrence, according to Dr. Judson, shortens the duration of the disease. The degree of deformity depends in no way on the presence or absence of purulent discharges. There is no evidence that the discharges, as such, exhaust the strength of the patient. The precept that pus should be released by an early and free incision is a rule which is not always to be fol-

lowed in the management of hip disease. If the collection of pus were the starting point or the main feature of the disease, an early and free incision would be admissible; but in hip disease, the trouble is primarily and chiefly a disease of the bony tissue composing a joint, which is generally best treated by the administration of tonics and the regulation of the hygiene, and, locally, by fixation and protection from violence. If abscesses occur, it is shown by experience that the retention of pus, even in large quantities, or the presence of a purulent discharge, does not prevent the process of repair. The author has seen no case in which an incision for the release of pus has had a controlling influence for good, generally or locally. Except when tension or pain form decided indications for relief by incision, an expectant treatment is preferable.—(*Quoted in Annals of Surgery*, May 1885.)

Exsection of Fascia in Dupuytren's Contraction.—Dr. R. Gersung (*Wiener Med. Woch.*, Aug. 1884) makes a longitudinal incision of the integument over the prominent aponeurotic bands, and then, through the opening caused by the retraction of the skin, excises this part of the palmar fascia. The wound is closed by sutures and dressed antiseptically. The advantages of this method, he claims, are that there are no thickened and knotty cords left in the aponeurosis, and, further, that owing to the direction of the line of incision in the skin there is but little retraction of the tissues, and the wound heals readily.—(*Quoted in Practitioner*, March, 1885.)

Mr. Reeves (*Brit. Med. Jour.*, March 7th, 1885) also advocates this method of treatment, and reports a successful case in a woman aged 45, with contraction of ring finger of right hand.

Treatment of Ringworm of the Scalp.—Dr. James Forbes of Edinburgh (*Brit. Med. Jour.*, March 14th, 1885) advises the following treatment for ringworm of the scalp:—After having cut the hair around the spots, spirits of turpentine is freely poured over one or more spots at a time, the fingers being used to rub in the turpentine; this gets rid of the dirt and grease, and the short stubbly hairs appear. As soon as the child feels the turpentine "nipping," it is washed off with carbolic soap and

warm water to make a lather, then the lather is washed off, and the head, which is now beautifully clean, dried. Two or three coats of common tincture of iodine are now painted well over the affected parts and allowed to dry, and carbolic oil is rubbed through the hair. This treatment applied night and morning generally cures the worst cases in the course of a week.

Cocaine in Surgery.—Dr. Morse of San Francisco (*Pacific Med. & Surg. Jour.*, May, 1885) reports a case of ligature of the common carotid artery prior to removal of a growth from the pharynx. Fearing the use of anæsthetics, he injected over the site of ligature three-quarters of a grain of cocaine and a quarter grain of morphia. The artery was ligated, then, beneath the omohyoid, without the patient feeling any pain.

New Operation for Naso-Pharyngeal or Fibrous Polypus.—Mr. Furneaux Jordan (*Brit. Med. Jour.*, May 2nd, 1885) advises that a triangular flap should be taken out of the upper lip and side of the nose. A curved bistoury is carried under the lip into the affected nostril, and made to cut its way out. Then the soft part of the nose is divided on one side of the middle line, in a line with the cut in the lip. A few touches of the knife permit the flap to be turned well outwards. The nasal cavity is found, expanded, well defined, and open to any sort of manipulation. To-and-fro traction by one or two fingers in the pharynx and one or two at the front, aided by snips from the scissors or knife, readily detach the tumor, which falls into the hand in the mouth. Delicate adjustment and stitches leave scars so fine that only careful search can find them.

Correspondence.

BERLIN, May 1, 1885.

To the Editor of the CANADA MEDICAL & SURGICAL JOURNAL.

DEAR SIR,—In presuming to write you a letter from here, your correspondent is painfully conscious that the medical soil of Berlin has been so often tilled, and has yielded such bountiful harvests already to the JOURNAL, that there is nothing new under the sun to write about.

The summer semester is now in full swing. The number of students attending in the medical course amounts in round numbers to nearly 1,000, while of these a great number are taking Virchow's classes at the Pathological Institute, the consequence being that a glance into his lecture-room would give a stranger the impression that it was a dime museum, for long before the lecture begins every available seat is filled and there is "standing room only"; indeed, a late-comer is very lucky if he can get a chance to lean against the wall.

Besides the teaching done by his assistants, Professor Virchow lectures himself one hour daily, and holds three demonstrations on morbid anatomy weekly, each lasting from two to three hours. The news of a daily lecture at 7 a.m. is rather startling to a Canadian, but soon the comforting assurance that the professor is *immer spät* tends to console him a little, and when he finds out that a lecture seldom begins till at least 45 minutes after "schedule time," he even begins to feel comparatively cheerful.

A visit to one of the *vie-hofs*, as the abattoir is called, proved full of interest. At the principal establishment on a busy day they slaughter about 2,500 pigs and other animals in proportion. At this vie-hof a staff of 80 trained inspectors is employed to detect diseased meat, and there is a well-equipped microscopical laboratory in connection with it. After watching the systematic way in which the inspection is performed, one almost feels inclined, in spite of deeply-rooted prejudices, to screw up one's courage and venture on a small piece of ham or even a sausage.

The medical men upon the staff are most obliging to visitors, and, on learning that the writer was interested in pathological

[*Our correspondent appears to have made a good start, but the facetious element evidently got the better of him before concluding.—ED.]

specimens, offered to send a regular weekly supply to his boarding-house. Unfortunately, the prophetic vision of an irate landlady and two weeks' notice compelled him hastily to decline. The most common diseases are, of course, trichina, cysticercus, and tuberculosis. Actinomycosis is almost daily met with, and in Berlin it is found more frequently in swine than in cattle.

To return to medical news proper. Quite a number of cases of epidemic cerebro-spinal meningitis have occurred here recently. This disease has a peculiar interest just now, owing to the fact that it, together with fracture of the patella, being the only two remaining diseases in which some German pathologist has not, as yet, succeeded in isolating to his own entire satisfaction some distinctive micro-organism. The prevalent opinion that Koch has recently discovered the bacillus of fractured patellæ would therefore seem to be erroneous, for it appears that (1) the bacillus in question had no connection with the human patella, but merely with the tibiæ of sundry dogs and rabbits, (2) that as the bones were fractured first and inoculated afterwards the bacillus could scarcely be said, strictly speaking, to stand to the fracture in the relation of cause to effect, and, lastly, Koch has lately solemnly affirmed (and there is no valid reason why he should not be implicitly believed) that it was not he, but some other man, who discovered the organism in question.

In spite of this, bacteriology has made vast strides in other directions. Prof. Donner and Dr. H. F. von Blitzen report (see *Krankheit's Archiv*, Bd. II., 1885) their investigations in reference to the *bacillus mal-de-meris*. They find it can readily be isolated by a very simple process which usually procures a temporary relief to the patient. Its favorite habitat would appear to be the lee scuppers, though it has been found in the gangways and even, especially in the more severe cases, in the cabins, while the brilliant pathway noticed at night in the wake of the ship, hitherto thought to be caused by surface infusoria, is undoubtedly due to the spores of this bacillus. Its incubation period in the human subject varies from three or four hours to as many days. The earliest symptoms are, singularly enough, exactly the reverse of those in *agoraphobia*. It flourishes at all

temperatures and seasons, thrives remarkably on sterilized Bouillon (readily obtained on all transatlantic steamers), less vigorously on tea and toast, while its growth can be temporarily arrested by the use of alcohol in a more or less concentrated form.

In a later number of the *Archives*, Dr. Blitzen has communicated some further details respecting this most interesting parasite. He states that he and his colleague, Prof. Donner, carefully controlled, by means of low powers, the lee scuppers of all the large steamers arriving in England during the past winter. This organism, which is usually accompanied by filaments of *leptothrix buccalis* and occasionally by colonies of *sarcinæ ventriculi*, was found in every case, and on one occasion was associated with very large numbers of the micrococcus of malignant endocarditis. Dr. Blitzen states that at first he was somewhat puzzled to explain this occurrence.

A learned physician has been for some time anxious to perform the experiment upon some extensive cultivating establishments unpleasantly near to the Charité, but has so far been unable to secure the necessary favorable conditions owing to an acute eruption of policemen in the vicinity.

A larger organism which has lately been investigated is the *Macrococcus Bolognæ*. This is seen either in rods or clumps hanging on nails in most butchers' stalls. Its color is brown, and occasionally mottled. This is a larger organism than those previously described, as it measures from two to ten feet in length and weighs from three to five pounds. The best way to isolate it is to buy a few for three pfennigs apiece. If treated with a smaller sum, it invariably breaks up into smaller pieces called spores, and then proceeds to spread rapidly. It is good to eat.

The micrococcus Limbergeri has recently been the subject of numerous investigations. In fact every stranger, soon after his arrival in Germany, attempts to investigate it, and with very various results. Unlike those mentioned above, it is very difficult to isolate. One plan lately suggested by Prof. O'D. Rossa (*United Ireland*, 1885) seems to be feasible. It consists in isolating the micrococcus, together with its pabulum and a large

portion of the adjoining sidewalk, by the judicious application of a few pounds of dynamite. This species is *not* good to eat.

Your readers will now be relieved to learn that for the present they will be spared any further remarks upon bacteriology, as the *spiro-gyra barrel-organi* is breeding so freely upon some pieces of Lohengrin just outside the window, that all other matters must be suspended till the disease has been isolated with a bootjack and destroyed by a moist heat of 212°F.

I remain, yours antiseptically,

TERMO.

Hospital Reports

MEDICAL AND SURGICAL CASES OCCURRING IN THE PRACTICE OF THE MONTREAL GENERAL HOSPITAL.

CASES OF HYDRO- AND PYO-PNEUMOTHORAX RESULTING FROM TUBERCULAR DISEASE OF THE LUNG.

UNDER THE CARE OF DR. GEO. ROSS.

CASE NO. I.—*Early stage of Tubercular affection—Pneumothorax—Rapid accumulation of fluid—Great relief from aspiration—Long interval of fair health—Thoracentesis—Death from Hæmoptysis.*

J. K., aged 20, laborer, single, was admitted March 6th, 1884, with great shortness of breath, severe pain in left side, and a dry, irritating cough. Family history negative as regards tubercular diathesis. Has always enjoyed good health up to January 1884. Was then treated in this hospital, the diagnosis being tubercular affection of the lung in stage of deposition. Was discharged after a few weeks improved, and remained fairly well while at home. His present attack began March 5th, '84. Had a slight chill, soon felt feverish, and remained in bed; no pain. About 2 a.m. March 6th, was suddenly seized with a sharp, lancinating pain in left mammary region, diffusing itself in all directions, and increased on inspiration, causing the breathing to be very short and shallow; pain lessened in about 12 hours. Says when it first appeared he heard something snap in left side.

On admission.—Patient anæmic and emaciated; tongue clean, bowels regular, and appetite good. Pulse 120; respiration 30;

temperature 103°F. Has a severe cough; expectoration frothy and bronchial; complains of some pain in left side, but it does not seem to interfere with respiration.

Examination.—Expansion deficient, particularly on left side. Left intercostal spaces effaced. Mensuration: left, 18½ inches; right 17½. Vocal fremitus almost absent on left side. Percussion, on left side tympanitic; right hyper-resonant, with exaggerated breathing. Well-marked amphoric respiration over whole of left lung, with moist crackling râles in scapular region. Bell-note and succussion sound very distinctly heard. Heart-apex not seen or felt in proper area, but occupies a position to right of sternum in 5th interspace, with a triangular area of cardiac dulness in this situation; no murmur. Urine normal.

March 23rd.—Pain disappeared; dyspnœa much less; cough not troublesome; pulse ranges between 120 and 100; respirations 36 and 28; temperature 98° to 100°. This condition of affairs gradually developed, as did the change in physical signs. The same amphoric phenomena remain; but fluid increasing. In sitting posture, dull flat note in front to 5th rib; behind, to angle of scapula. This dulness changes on changing position of patient. Heart displaced more to right. Succussion sound very distinct; patient can hear it himself when turning in bed, or otherwise suddenly moving.

April 8th.—Fluid increased to 3rd rib in front in sitting posture. Pulse 100. Respiration 30. Temperature 100° in the morning, 101° at night. Complains more of dyspnœa when sitting up. Otherwise general condition good. *17th.*—Dulness as high as 3rd rib in front, correspondingly as high behind, and in axillary region. Breathing over fluid is weak and distant, but of an amphoric quality. Pulse 110; respiration 24; temperature 97° to 101°. *22nd.*—Pulse 110; respiration 32. Dyspnœa at night. Decubitus always on left side. Dull note reaches as high as 1st rib. Heart on right side, midway between nipple and sternum, in 4th interspace. Aspirated chest, removing 73 ozs. slightly turbid fluid. During operation patient had a paroxysmal fit of coughing and severe pain over the heart. *23rd.*—Pulse 112; respiration 24; tem-

perature 100° to 101½°. No thoracic pain, but coughing considerably; expectoration muco-purulent and streaked with blood. Examination showed slight expansion of left side with tympanitic note. Above 4th rib in front and 8th behind, breathing remains amphoric, and we have the same bell-note and succussion sound. Heart-apex in 4th interspace on right side, close to sternum, having moved about three-quarters of an inch to the left. 30*th.*—No change in the physical signs. All the amphoric phenomena beautifully demonstrated, and the fluid not increasing. General condition good, and improving.

May 31*st.*—No marked change in patient since last note. Dulness to 7th rib behind; fluid gradually increasing.

June 15*th.*—Since last note, patient has remained about the same. Moist râles, with amphoric signs, remain. Pulse 100; respiration 24; temperature normal. Condition good. Discharged, with advice as regards habits, &c.

The patient returned on 30th June to be examined. Dulness at 4th rib in front, 6th behind, this being moveable according to patient's position; other regions of lung hyper-resonant, and breathing amphoric, weak and distant over dull areas; succussion and amphoric tinkling remain as before.

Aug. 25*th.*—Since last note patient remained fairly well; feels stronger, and gained flesh. Dyspnœa on exertion. Cough remains; expectoration of the same character. Pulse 100; respiration 32; temperature normal. Examination revealed dull flat note over whole of left lung, front and back, with the exception of a small area beneath clavicle and supra spinous region; amphoric respiration, with large mucous râles in infra clavicular region; elsewhere, breath sounds feeble and distant; succussion sound absent. Right lung, vesicular, harsh respiration, with small crepitant râles in mammary and upper axillary, not removed by coughing. Did not remain in hospital.

Sept. 26*th.*—Admitted on account of cough and dyspnœa; dulness up to 2nd rib. Breath sounds very feeble and distant. Apex 5th right space one inch to left of nipple.

Oct. 4*th.*—Aspirated in two different places; only about 4 ozs. of serum removed, but was apparently benefited. Dyspnœa

and cough less. 21*st.*—Condition of left lung remains unchanged. The crepitant râles remain as before in right lung, and appeared recently in infra-clavicular. Discharged.

Dec. 26*th.*—Readmitted. Since last examination, cough and dyspnœa severe. Expectoration moderate in amount, muco-purulent, and devoid of elastic tissue. Condition of lungs remain unchanged.

Jan. 7*th.*—Examination showed expansion of right 1 inch; left, ½ inch. Mensuration: right, 18½ inches; left, 18 inches. Fremitus absent over left, with exception of infra-clavicular; upper axillary and supra-scapular resonance modified accordingly. Dulness below 3rd rib in front, and below 6th behind; above, hyper-resonant. Amphoric respiration over resonant areas of the same character, but weak over dull areas. Succussion and tinkling distinctly heard. Pulse 100; respiration 30; temperature normal. 12*th.*—Complains of severe pain in left mammary region; had several attacks of hæmoptysis, checked by astringents. Fluid gives dull note up to 2nd rib; otherwise, same.

Feb. 9*th.*—Aspirated and removed 48 ozs. of a greenish-white opaque fluid, purulent in character. Under the microscope, abundant pus cells. Apex in normal situation. Condition of patient much improved by operation. Amphoric condition as before over all areas. Pulse 110; respiration 30; temperature 100°. 17*th.*—Pain left mammary region; fluid increasing. Physical signs remain as before. Temperature 101°; pulse 110; respiration 32. 20*th.*—Temperature 104°; pulse 120. Other conditions same as last note. 23*rd.*—Slight attack of hæmoptysis. Temperature 103°.

March 17*th.*—Patient's general condition one of septic absorption. Temperature 103° to 104°; pulse 120 to 130. Fluid reaches 2nd rib. 19*th.*—Thoracentesis was performed by Dr. Shepherd. A large quantity of pus was removed, somewhat fœtid. Dressed antiseptically. Temperature 105°; pulse 120. Sweats profusely. 25*th.*—Has been dressed every second day; discharge decreasing. Temperature 101° to 102½°; pulse 120; respiration 24. Sweats profusely; no dyspnœa.

April 1*st.*—Discharge moderate; no fœtor. Patient quite

anæmic, rapidly losing flesh, and sweating profusely. Pulse 110; respiration 24; temperature 102°. 10*th*.—Patient has been gradually losing ground. On removing the dressings this morning some clotted blood on inner side. A few minutes after being dressed patient commenced spitting blood, blood also coming from opening in side and rapidly saturating dressings. The hemorrhage soon became profuse, and in a few minutes patient was dead.

Autopsy.—Heart normal, and in usual place. Pericardium a good deal thickened toward left side. Left pleural cavity lined by a buff colored, laminated, fibrinous membrane, partly obliterated toward apex by strong adhesions. It contains an enormous clot, weighing 503 grammes, and measuring 17 fluid ounces. Left lung collapsed against vertebræ, airless; upper lobe, the size of a woman's fist, occupied by a cavity whose walls are lined by greyish membrane at the extreme apex, but lower down present a gnawed and ragged appearance, and are crossed in places by strands of tissue consisting almost entirely of vessels and bronchioles. The cavity is full of blood. Toward the posterior and lower part of this cavity there is a free opening, the size of a pencil, into the pleural space. Lower lobe studded with small caseous nodules. Right pleura healthy. Right lung: extreme emphysema; many granulations in lower part of upper lobe. Liver and kidneys fatty.

CASE NO. II.—*Latent Phthisis—Pneumothorax—Fluid rapidly become purulent—Thoracentesis—Surgical Scarlatina—Fatal, with nervous symptoms.*

C. S., aged 19, servant, admitted November 5, 1884. Complains of pain in left side, shortness of breath and general weakness. Always a strong, healthy girl up to 18 months ago. While crossing the Atlantic contracted a severe cold, leaving behind a cough that persisted all last summer and up to date. Had slight attacks of rheumatism in December last. Family history good. Present illness began about six weeks ago with a sudden, sharp pain in the left side, accompanied by cough without expectoration. Still continued to do her work for three

weeks; during the fourth week was compelled to lie down for a short time; felt weak and very thirsty, especially at night. These symptoms increased in severity, except the cough, until a week ago, when she was so weak she had to go to bed. During the last two weeks cough has been absent. Since admission it has returned.

On examination left side, expansion nil; fremitus absent; resonance very weak; tympanitic percussion-resonance (supine position) all over anterior regions to anterior fold of axilla; (sitting up) flat note from 3rd in front, 6th behind. Amphoric respiration over resonant areas; weak and distant in dull areas, with a faint amphoric quality; metallic tinkling and succussion beautifully heard. Right lung—Expansion good, hyper-resonant, and loud vesicular respiration. Heart-apex in 3rd interspace, 1¼ inches to right of sternum; no murmurs. Pulse, 120; respiration, 40; temperature, 100°-102°. General condition, one of extreme weakness.

Nov. 8th.—Temperature, 98°-101°; pulse, 120; respiration, 40. Patient very weak; passed a restless night; dulness reaches 3rd rib, and correspondingly high behind. Other physical signs remain unchanged. Decubitus, left side. *17th.*—Patient passed an uncomfortable night. 7 p.m.—Vomited after taking oil; this exertion caused violent dyspnœa. An attack of orthopnœa during night and early morning. *22nd.*—Passed comfortable night. Examination shows dulness top of 2nd rib. Chest aspirated, and 70 ℥ of greenish-yellow pus removed. The heart returned to left side; felt first under right border of sternum. Pulse, 120; respiration, 38; temperature fluctuates between 101°, and normal. *24th.*—Pleural cavity opened (under chloroform); 60 ℥ of thick pus removed. With each inspiration air bubbled through the pus, showing that the opening in lung still remained. Dressed antiseptically, and rubber tube used on account of close apposition of ribs. *25th.*—Wound permitted much oozing during night; dressings saturated, removed, and fresh applied. Pulse, 104; respiration, 32; temperature, 101°. Cough, with muco-purulent expectoration. *29th.*—Vomited much during the night. Tem-

perature, a.m., 102½°. Scarlatinal rash present over the lower abdominal zone, bend of elbows and calves of legs. Patient very drowsy; can be roused, and quite rational. Dressed: discharge profuse, but septic. 30*th.*—Patient very restless. Temperature, 104°-105°; respiration, 30; pulse, 130. Vomited all through the night, and was very delirious. Passed urine and fæces in bed.

Dec. 2*nd.*—Temperature, 102°; pulse, 144, and very weak; respiration, 40. All night wildly delirious. Passed urine and fæces in bed. Rash is bright, and more diffused over body. Dressed: discharge lessening; quite aseptic. 3*rd.*—Temperature, 101°; pulse, 140; respiration, 40. Delirious; tongue red; enlarged papillæ. Rash almost disappeared. Face, semi-icteroid hue. Dressed: wound healthy; discharge profuse; urine, very dark. No reaction to bile pigment; no vomiting since yesterday. 4*th*-5*th.*—Same condition; gradually getting weaker. 6*th.*—Temperature, 103°; pulse, 141; respiration, 44. Very weak; semi-delirious, but takes nourishment. Died this morning.

Autopsy.—Some yellow serum in anterior mediastinum. Parietal pericardium much thickened. Both layers of left pleura very rough and thick; cavity obliterated in front, contains about ʒiss pus behind. Lung completely collapsed, lying against vertebral column. In some places, especially toward apex, strong fibrous bands, some three-fourths of an inch in diameter, pass between two layers of pleura. Lungs—Small caseous nodule, size of a bean, in left apex, with several still smaller near it. In right lung a small spot of softening posteriorly, containing a few drops of pus. Liver much enlarged; fatty. Catarrh of small bowel, especially near ileo-cœcal valve. Mesenteric glands much enlarged.

CASE No. III.—*Advanced Phthisis—Hydro-pneumothorax—Rapidly fatal by apnœa and exhaustion.*

E C., aged 27, stonecutter, single, was admitted August 1st, 1884, suffering from pain in left side, cough, and shortness of breath. Has had cough and night sweats, and has lost flesh for

the past eight months; symptoms having become aggravated of late. Also an indefinite history of syphilis three years ago. Family history: One sister died of phthisis; other members of family healthy. Present attack came on quite suddenly. On Tuesday, July 29th, '84, while lying on the sofa after a heavy meal, without any apparent cause, he experienced severe stabbing pain in left mammary region, increased by inspiratory act. Great dyspnœa and cough rapidly set in, and have continued up to date.

On admission—Patient is anæmic and emaciated, the muscles soft and flabby; finger-nails clubbed; lips cyanotic; conformation of chest scrofulous; pulse 112; respiration 36; temperature 100°. Examination: Left side, expansion nil; right good. Mensuration, right 18¼; left 18. Fremitus absent. On percussion, tympanitic over whole of left lung to angle of scapula; below this, quite flat. Mediastinum and cardiac area tympanitic; this note also extends beyond normal limit of lung. Breathing amphoric, with moist râles. Succussion and metallic tinkling distinctly heard. Right side, dull, high-pitched note in infra-clavicular region, with harsh breathing and moist râles; puerile breathing in other regions. Heart-apex, 4th right interspace, midway between nipple and sternum, no murmur. Urine normal.

Aug. 8th.—Fluid increasing; otherwise the same. Pulse 100; respiration 30; temperature 101°. Great distress from the cough and dyspnœa. General condition not improved. *14th.*—Patient getting weaker; decubitus left side; complains very much of cough and dyspnœa. Pulse 110; respiration 36; temperature 101°. *30th.*—Remains about the same. Physical signs unchanged. Feeling of suffocation when lying down.

Sept. 17th.—Patient has been gradually getting weaker. Fluid increasing. Pulse 120; respiration 38; temperature 101°. Died of exhaustion at 9 p.m.

Autopsy.—Diaphragm bulged down on left side to lower end of costal margin; displacing the liver downwards, lower border at umbilicus. Spleen displaced downwards, being on a level with crest of ilium. On removing sternum, a quantity of compressed air escaped. Left pleura contains a quantity of sero-

purulent matter, 50 ℥ in all, in which a large flake of lymph was floating. Left lung greatly compressed and covered with a dense coat of lymph extending to the costal pleura, and most marked at the lower part of pleural cavity. A number of dense bands bound down the lung at apex and also pulmonary pleura to the pleura over the pericardium. Right pleura contained a little fluid. Apex of lung was firmly adherent to costal pleura. Heart's apex on a level with fourth interspace, under sternum. No excess of pericardial fluid. After removal of left lung, on further examination of apex, a small hole about one-eighth of an inch in diameter was seen to communicate with a small cavity. On section of right lung, a small cavity was found on the apex. Upper lobe of lung was well filled with tubercles, and lower lobe had a moderate amount. Liver was enlarged, and showed signs of fatty degeneration. Kidneys normal. Mesenteric glands were slightly enlarged.

CASE No. IV.—*Advanced Phthisis—Hydro-pneumothorax—Rapidly fatal.*

W. S., aged 22, clerk, single, was admitted Feb. 35th, '85, suffering from shortness of breath, cough, severe and very troublesome pain in left side, and general weakness. Has always been healthy until about a year ago; since then failing in health and strength, losing flesh. No cough until six months ago, and has continued up to date, expectoration all the time being muco-purulent. Has had night sweats; no hæmoptysis. Family history: one sister died of phthisis; other members healthy. Present attack: On the night of Feb. 21st, while in bed, was seized with severe cramp-like pains in left mammary region, rapidly developing, and diffusing itself to all the other areas of chest; no fit of coughing previous. Felt as if something had given way. Breath very short directly after pain, and remained so ever since.

On admission—Patient very anæmic, emaciated, and muscles soft and flabby. Pulse 120; respiration 36, short and shallow; temperature 102°; coated tongue. On examination, left side expansion nil, bulging; intercostal spaces obliterated; tympan-

itic note, with obliteration of cardiac dulness; area of percussion extends beyond normal limits; breathing feeble, with amphoric and metallic phenomena; succussion sound marked. Right side, dull at apex, front and back; harsh blowing breathing, with numerous moist rales over anterior region and to angle of scapula behind. Heart: apex at right nipple, no murmur.

March 4th.—Gradually getting weaker; breathing very difficult; respiration 48; pulse 130; temperature 100° to 104°. Unable to take nourishment. Died at 2 a.m. to-day. No autopsy.

Reviews and Notices of Books.

The Principles and Practice of Gynæcology.—By Dr. Thomas Addis Emmet, Surgeon to the New York Women's Hospital, &c. Third edition. Philadelphia: Henry C. Lea's Son & Co. 1884.

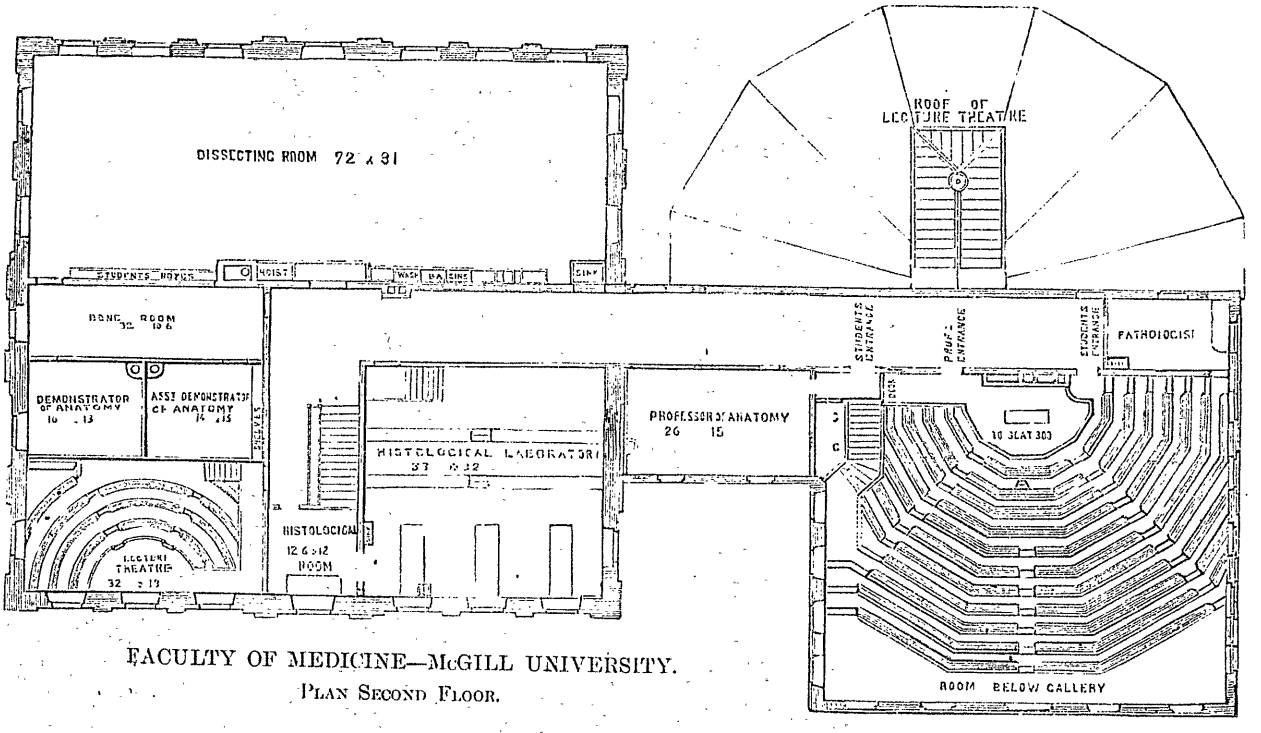
The first edition of this well-known work appeared in March 1879; the appearance of a third in six years indicates the great influence wielded by the distinguished author in his specialty. There can be no doubt that not a man living, or any dead these last ten years, has done so much for the advancement of gynæcology. The author claims in his preface to have added to, revised and rewritten a large part of his work, and an examination of the book fully justifies his claim. Like every good, honest progressive man, profiting by his vast experience, he has modified, and in some cases changed his views. He has advanced. These changes have been foreshadowed by papers contributed to the American Gynæcological and other societies, and published in the current periodical literature of the last three years. The most important new things in the book are the description of a new operation for narrowing the posterior vaginal wall and perineum, and the operations on the bladder and urethra for the diagnosis and treatment of disease of these organs. We naturally turn with, perhaps, most curiosity to the chapters on laceration of the cervix uteri and its treatment. Certain recent utterances of the distinguished author had led us to expect some modification of doctrines promulgated in previous

editions. Dr. Emmet does not operate as often as formerly. He finds that the preparatory treatment sometimes removes the symptoms, which are therefore often due to the cellulitis and endometritis which complicate the laceration. With reference to the proper cases to select for operation, the following sentence will convey the author's opinion: "I should state in a general way that when reflex symptoms exist, with enlargement of the uterus, after the cellulitis has been fairly removed, and when the woman suffers from neuralgia and persistent anæmia, an operation is necessary, notwithstanding the parts may have healed completely, and the thorough removal of the cicatricial tissue from the angles is absolutely necessary for success."

Dr. Emmet is sometimes startling in the opinions he sets forth, but this is probably true of most new opinions. Adverse criticism seems scarcely less than presumptuous on the part of men of less experience. Who, then, may presume to criticise this author? Very few, certainly. Dr. Emmet's attention to details indicates an important source of his success. It is evidenced in every page of his book. We have not space to say anything more than that every practitioner who practices gynæcology should carefully study its every page.

Elements of Surgical Diagnosis.—By A. PEARCE GOULD, M.S., M.B., Lond., F.R.C.S., Eng., &c. Philadelphia: Henry C. Lea's Son & Co.

This is one of those manuals for medical students which are now being published simultaneously in London and Philadelphia. It fully sustains the reputation acquired by its predecessors in the series, and will be much sought after by senior medical students engaged in hospital work. The diagnosis of injuries is separated from that of diseases for the sake of simplicity. The book opens with a valuable introductory chapter on the art of diagnosis, which it would repay many practitioners, as well as students, to "read, mark, learn and inwardly digest." After describing the diagnosis of the injuries of the various parts of the body, there are several chapters on the diagnosis of tumors and swellings, ulcers, sinus and fistula, and gangrene; then come the



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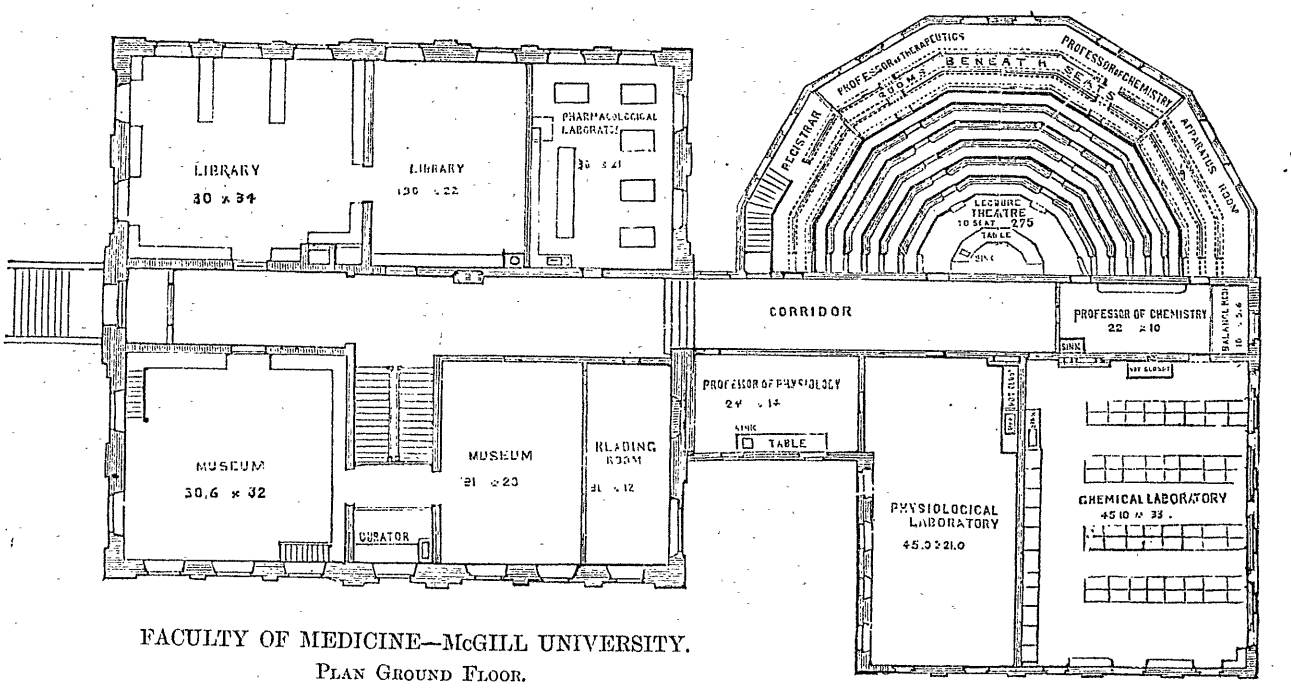

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chapters on diseases to which different parts of the body are liable. The work is remarkably concise, and for its size contains an immense amount of information which is admirably and systematically arranged. We can unhesitating recommend this work not only to students, but also to practitioners, old and young.

A Manual for the Practice of Surgery.—By THOMAS BRYANT, F.R.C.S., Eng. Fourth edition; with 747 illustrations. Philadelphia: Henry C. Lea's Son & Co.

The fourth edition of a manual of surgery needs but little praise. Like the good knight of old, it has won its spurs, and cares little for what men may say of it. We need only mention that every chapter has been carefully revised, and, where necessary, new material added. Many sections have been entirely rewritten, those especially, where, owing to the ever onward march of knowledge, matter, even only a couple of years old, seems out of date and ancient. Under such a category come operations on the kidney, removal of tumors from the bladder, hysterectomy, osteotomy, Charcot's disease, &c. Embodied in the chapter on colotomy is a synopsis of the paper read by the author at the Copenhagen Medical Congress in 1884, which contains the analysis of 82 cases performed by himself. This is a most valuable addition to the literature of the operation. The author's operation of colectomy is also described. Some chromo-lithographs of diseases of the tongue, breast, &c., are included in this addition, but, in our opinion, in no way enhance its value. Mr. Bryant is to be congratulated on the popularity of his book, which is well deserved, and shows that the reading medical public is appreciative of honest work.

A Manual of the Medical Botany of North America. By LAURENCE JOHNSON, A.M., M.D., Lecturer on Medical Botany, Medical Department of the University of the City of New York, &c. New York: Wm. Wood & Co.

There is ample room for a book of this nature to do good service. Knowledge of the numerous plants indigenous to this country which possess more or less active medicinal properties

is not sufficiently general. A good deal of scepticism about them comes thus to be expressed, much of which may possibly be traceable to ignorance of the actual facts. A great many of our common Canadian and American plants furnish useful additions to the physician's armamentarium, and, though, perhaps, not calculated to displace more potent remedies, may yet usefully serve him to meet special indications and special circumstances. We find here a pretty complete exposition of all the North American plants known to be medicinal, and which are either recognized officinally or have been proved by long household usage to have some beneficent properties. It surprises one to see what a long list they make. An examination of the pages makes us think that the views here expressed are generally very moderate—no exaggerated claims being made for the potency of the various drugs, but their merits fairly presented in accordance with such reasonable evidence as is afforded by the writings of observant men, and by the author's own experience. It has been so prepared as to act as a short manual for those not familiar with botanical studies, a long chapter serving as an introduction upon "the general principles of vegetable growth and reproduction," with a glossary of botanical terms. It is embellished with several very handsome colored plates of important plants, and numerous woodcuts.

A Practical Treatise on the Diseases of the Ear, including a sketch of Aural Anatomy and Physiology.—By D. B. St. John Roosa, M.D., LL.D., Professor of Diseases of the Eye and Ear in the New York Post-Graduate Medical School and President of the Faculty, &c. Sixth edition; revised and enlarged. New York: Wm. Wood & Co.

When the first edition of this work was published, eleven years ago, otology was enriched by a fund of knowledge partly in the form of a clear and concise exposition of a subject which at that period seemed to require a good deal of boiling down of crude materials, and partly by the results of Dr. Roosa's own observations and experience in this progressive branch of science; and

although the first edition may still be looked upon as a standard work, the great advances since made in aural surgery have necessitated some alterations and many additions in all its divisions, but more especially in regard to the pathology and treatment of ear diseases. The work is, therefore, in its sixth edition, considerably larger than formerly, and now appears as a handsome volume of 700 pages, every one of which is worthy of careful perusal. The illustrations are numerous and remarkably well executed. If anyone imagines a treatise on aural surgery must necessarily contain a great deal of dry and difficult reading, he has only to study this work and be thoroughly convinced to the contrary. The first chapter deals with the progress of otology, and is replete with interesting and instructive historical facts. To this is appended an alphabetical list of authorities consulted by the author. Throughout the work, the author's arrangement of facts is such as will commend itself to the reader as being easy and natural. Before dealing with the morbid conditions of the different natural divisions of the organ of hearing, a lucid and sufficiently exhaustive description of the anatomy and physiology pertaining to each is given, a circumstance that cannot fail to meet the approval of intelligent readers. When such works as this are considered an indispensable part of every educated physician's library—and the day has now come when they should be so—the conscientious practitioner will learn that diseases of the ear are just as amenable to treatment as those of any other organ, and by taking the proper measures in time to prevent the ravages of disease which stupid negligence has almost habitually allowed to do its worst amid the most delicate of all structures, one more fruitful source of human misery will be reduced to a minimum. We most cordially commend the work to every student and every practitioner of medicine and surgery.

Aneurisms of the Aorta, with especial reference to their position, direction and effects.—By OSWALD BROWNE, M.A., M.B., Trin. Coll., lately House Physician at St. Bartholomew's Hospital. London: H. K. Lewis.

This pamphlet, which is a reproduction of an exercise for

the degree of M.B. in the University of Cambridge, consists of an elaborate analysis of 88 unpublished cases of aneurism of the aorta, together with an examination of, and remarks upon, all the cases of aneurism of the aorta dying in St. Bartholomew's Hospital during the last 17 years. To all who are interested in the subject, this collection will form a valuable reference for points connected with the portion of the vessel affected, the direction the growth is likely to take, and the effects which are to be expected from it. The tables are very complete, and have been compiled with great care.

Books and Pamphlets Received.

WHAT TO DO IN CASES OF POISONING. By William Murrell, M.D., F.R.C.P. Fourth edition. London: H. K. Lewis.

A PRACTICAL TREATISE ON URINARY AND RENAL DISEASES, including Primary Deposits. Illustrated by numerous cases and engravings. By William Roberts, M.D., F.R.S., assisted by Robert Maguire, M.D., Lond. Fourth edition. Philadelphia: Lea Brothers & Co.

A TREATISE ON THE SCIENCE AND PRACTICE OF MIDWIFERY. By W. S. Playfair, M.D., F.R.C.P. Fourth American from the fifth English edition; with notes and additions by Robert P. Harris, M.D. Philadelphia: Lea Brothers & Co.

THE REGIMEN TO BE ADOPTED IN CASES OF GOUT. By Dr. Wilhelm Ebstein, Translated by John Scott, M.A., M.B. London: J. & A. Churchill.

A SYSTEM OF PRACTICAL MEDICINE BY AMERICAN AUTHORS. Edited by Wm. Pepper, M.D., LL.D., assisted by Louis Starr, M.D. Vol. II. Philadelphia: Lea Brothers & Co.

HAY FEVER AND ITS SUCCESSFUL TREATMENT BY SUPERFICIAL ALTERATION OF THE NASAL MUCOUS MEMBRANE. By Charles E. Sajous, M.D. Philadelphia: F. A. Davis, Atty., Publisher.

ON SOME COMMON INJURIES TO LIMBS: Their Treatment and After-treatment, including bone-setting (so-called). By Edward Cotterell, M.R.C.S. (Eng.), &c. With Illustrations. London: H. K. Lewis.

DIAGNOSIS AND SURGICAL TREATMENT OF ABDOMINAL TUMORS. By Sir Spencer Wells, Bart. London: J. & A. Churchill.

THE CURABILITY AND TREATMENT OF PULMONARY PHTHISIS. By S. Jaccoud. Translated and edited by Montagu Lubbock, M.D. (Lond. & Paris), M.R, C.P. (Eng). New York: D. Appleton & Co.

BERLIN AS A MEDICAL CENTRE. A Guide for American Practitioners and Students. By Horatio R. Bigelow, M.D. Sandy Hook, Ct.: New England Publishing Co.

Society Proceedings.

ONTARIO MEDICAL ASSOCIATION.

The fifth annual meeting of the Ontario Medical Association was opened at the Victoria Hall, London, Ont., on Wednesday the 3rd inst. Dr. Worthington of Clinton, President, in the chair.

After the minutes of last session were read and approved, the report of the Committees on Arrangements and Credentials were presented and discussed. The remaining business of the forenoon session was of a purely routine character.

The first business on the programme for the afternoon session was the reception of guests and delegates. The President cordially invited Dr. Jenks of Detroit and Dr. Stewart of Montreal to take seats on the platform.

Dr. Pope of Bothwell exhibited a boy, aged 15, who, since the first of January last, has been suffering from what he believed to be a form of epidemic cerebro-spinal meningitis. The case is particularly remarkable for its long course, high temperatures, and the paralytic condition of the lower limbs. For a period of two weeks, at the beginning of the trouble, the temperature was constantly in the immediate neighborhood of 105°F., while for 24 hours it remained at 107.5°. The pulse during this period of hyperpyrexia varied from 150 to 160 per minute. The temperature at the present time is frequently found elevated from one to two degrees during some, but no regular, periods of the twenty-four hours. There is a marked loss of power in both lower extremities, but especially of the right. The patellar reflex in both limbs is abolished. There are no urinary or rectal disturbances, however.

The President showed a woman, aged 40 years, who was suffering from what was considered to be neuralgia of the tongue.

Dr Worthington then delivered his presidential address, his subject being "The Cold Water Treatment of Fevers." Before entering upon his subject, he tendered the members of the Association his sincere thanks for the honor they had paid him in electing him as their president. He could say that no honor ever conferred on him had been so highly prized, and he thought

justly prized, as there was no profession in which there was such a vast field for scientific research—in which discoveries of such magnitude have been made for the benefit of the human race, from which they were receiving such marvellous revelations through the untiring labors of specialists—and in which inexhaustible fountains for observation still exist. The learned speaker then went on to contrast the treatment of disease at the present day with what it was about a hundred years ago, dwelling especially on the marked contrast in the treatment of fever then and now. A graphic picture was drawn of the blindness and folly of the physicians of the early decades of the present century in throwing away the thermometer and the cold douche introduced by Currie of Liverpool now over one hundred years ago. The President concluded his excellent address with the hope and the assurance that these means so powerful for diagnosis and treatment would remain forever with us, and that to them would soon be added other measures through which we would be in a position to deal more telling blows against the fevers that yearly carry away such large numbers of our population.

The SECRETARY read a telegram from J. T. Reeves, Secretary of the Wisconsin State Medical Society, in session at Milwaukee, conveying the greetings of this Society to the Association, and wishing it every success. The message was received with applause, and Dr. Oldright instructed to send a suitable reply.

Dr. BRAY of Chatham read an account of a case of labor where it was necessary to resort to Cæsarean section in order to effect delivery. The patient had a distorted pelvis, caused by fracture of the right ilium.

Dr. JENKS of Detroit, who performed the operation, gave in detail the different steps of the procedure he adopted. The woman lived 48 hours after the child had been removed.

Dr. TYE, of Chatham, read an exhaustive paper on the "Etiology and Treatment of Diphtheria." After describing and laying stress on the preventive treatment, he dealt with the subject of the relation between membranous croup and diphtheria. Dr. Tye considers that far too much stress is laid

on the local treatment of this disease by physicians in general. He looks upon the constitutional treatment as the most important. The remedies commonly employed at the present time were then passed in review.

The reading of this able paper was followed by a lively discussion, in which Dr. Graham, of Toronto, and a number of others took part—some contending for the superiority of local, while others looked upon the constitutional treatment as the most important.

The next paper read was one on the "Continued Fevers of Western Ontario," by Dr. Fraser, of Sarnia. Dr. Fraser considers that typho-malarial fever is not a distinct disease, but simply typhoid fever slightly modified by malarial influences, and with which view the majority of the speakers who took part in the discussion agreed.

The first event of the evening session was the introduction, by the President, of Dr. Parks of Buffalo to the members of the Association.

The SECRETARY read a communication from Dr. McLean, of Detroit, wishing the Association every success, and extending to all members a warm invitation to attend the meating of the Michigan State Medical Society, which will be held at Port Huron on the 10th and 11th instant. The Secretary was requested to write to Dr. McLean, thanking him for his letter, and stating that many of the members would be glad to accept his kind invitation.

Dr. POWELL, of Edgar, read a paper on "Plaster Splints." He exhibited a large number of different forms of these appliances. With respect to materials, he advised that only the finest and freshest dental plaster should be used.

Dr. HOWE, of Buffalo, then read a carefully prepared paper on "Blindness occurring during Pregnancy," in which he attempted to prove, 1st, That pregnant women are liable to an impairment to vision, which, though generally temporary, may become permanent; 2nd, That this is due to albuminuric retinitis; 3rd, That the danger to vision alone is sufficient, in certain cases, to warrant the induction of labour. Dr. Howe

illustrated his paper by diagrams thrown on a screen, showing the different stages of the pathological changes going on in the retina. He looks upon amaurosis occurring before the seventh month as permanent, if premature labour is not induced; while those cases happening later on, especially during the last two weeks of pregnancy, are recovered from even when the normal course of events is not interfered with.

A very practical paper on "Urinary Calculi, and the best method of dealing with them and the causes that give rise to them," was read by Dr. Groves of Fergus, who has had a very extensive experience in these cases.

The last paper of the evening session was on "Placenta Prævia," by Dr. Edwards, Sr., of London. He gave the details of seven cases that he has met with in his own practice, and the way in which he dealt with them. The reading of this paper was listened to with keen interest by many members present.

Second Day.

The first paper in the forenoon session of the second day was one on "Intra-Uterine Medication," by Dr. Temple, of Toronto. Dr. Temple dealt with his subject in a very thorough and exhaustive manner. Although strongly impressed with the necessity of active local measures in many uterine troubles, he warned the members not to neglect constitutional means of relieving these disturbances.

The discussion which followed this paper was taken part in by Drs. Holmes of Chatham, Roseburgh of Hamilton, Gunn of Brucefield, Powell of Edgar, and Adam Wright of Toronto.

Dr. Edwards, of London, exhibited two brothers, aged respectively 12 and 14 years, both the subjects of pseudo-hypertrophic paralysis in an advanced stage. In both cases the first marked symptoms of the disease showed themselves when the patients were eight years of age, and they have steadily progressed up to the present. The boy aged 14 is quite unable to stand or perform any movements. The muscles of all the extremities are atrophied. This atrophy is not specially marked in any muscular groups. The calves, which were for-

merly greatly hypertrophied, are now smaller than they normally should be. The patellar reflexes are absent. There is no bladder or rectal paresis. The younger of the two brothers is still able to walk a few steps, but with the greatest difficulty. His calves are much hypertrophied, as are also the muscles of both forearms, while those of the upper arms are in an atrophic state, but not markedly so.

The members of the Association took a great interest in the examination of these remarkable cases.

Dr. Brodie, of Detroit, President-elect of the American Medical Association, who was present, received a cordial reception from the Association, and was invited by the President to take a seat on the platform. In returning thanks, Dr. Brodie expressed the pleasure he felt at meeting so many professional brethren on this side of the river, and regretted that he had been unable to be present on the first day, as he had intended. He invited those members of the Association who could spare the time to be present at the annual meeting of the Michigan State Medical Society, which opened in Port Huron on the 10th instant.

On the afternoon of the second day, the Association, on account of the very large number of papers still unread, decided to divide into medical and surgical sections. Drs. Graham and Aikins of Toronto were named chairmen of these sections.

In the medical section, the first paper read was by Dr. Henderson of Kingston, on "Pulmonary Cavities." Dr. Henderson gave a rapid survey of the modern pathology of tuberculosis, including a description of the character and relations of the tubercle bacilli.

Dr. Owens of Arkona then exhibited a man, aged 21, affected with *Epileptiform Tic* of eight years' duration.

Dr. Arnott of London read a very suggestive paper on "The influence of proper diet in the treatment of disease."

Dr. Graham of Toronto read a paper on "Mitral Stenosis." He specially insisted on the frequency of the occurrence of this form of cardiac lesion, and on the seemingly great ignorance that prevails in the profession with regard to it. He gave an account

of several cases. These all illustrated the usual sudden termination of cases of this kind, death being nearly always due to embolism.

Dr. Duncan of Thamesville read a very thoughtful and well prepared paper on "The use of Warburg Tincture in Canadian Practice."

In the surgical section, the following papers were read :—

"Intestinal Obstruction,,' by Dr. Atherton of Toronto.

"Treatment of Abortion," by Dr. Adam Wright of Toronto.

"Hæmorrhage after Abortion," by Dr. Murray of Thorndale.

"Foreign Bodies in the Larynx," Dr. Harrison of Selkirk.

"Straight Splints in Elbow Fractures of Childhood," by Dr. White of Toronto.

"Uses of Cocaine in Diseases of the Eye," Dr. Reeve of Toronto.

The special committee appointed to answer the questions submitted to the Association by the Ontario Women's Christian Temperance Union presented the following report :

1. Is the beverage use of alcoholic liquors by persons in health beneficial? Answer—No.

2. Is the indiscriminate use of alcoholic liquors by persons not in health beneficial? Answer—No.

3. Is alcoholic liquor, as obtained in common sale, necessary in medical prescriptions; if so, in what cases? Answer—No; except in cases of emergency.

4. What ought to be the attitude of the medical profession towards the sale of intoxicants? Answer—The medical profession is opposed to the indiscriminate sale of alcoholic liquors.

The report was taken up clause by clause, and, after considerable discussion on clause 3, was finally adopted as a whole.

The committee on Necrology reported that since the last annual meeting of the Association several members of the profession had joined the silent majority, and have all left an honorable record of faithfulness, ability and integrity behind them. Of these, mention was made of the late Drs. George Willcox of Toronto, Thomas C. Howe of Dundas, Lorne C. Campbell of Port Arthur, O. T. Heartwell of Dunnville, John Small of Toronto, and C. P. Mulvany of Toronto.

The committee on Nominations recommended that the following be appointed officers for the ensuing year :—

President—Dr. Tye of Chatham.

Vice-Presidents—Dr. Arnott, London ; Dr. Temple, Toronto ; Dr. Hilliary, Aurora ; and Dr. Henderson, Kingston.

General Secretary—Dr. White, Toronto.

Treasurer—Dr. Graham, Toronto.

Corresponding Secretaries—Dr. Adam Wright, Toronto ; Dr. Campbell, Seaforth ; Dr. Aylesworth, Collingwood ; and Dr. Mitchell, Enniskillen.

The report was adopted.

It was decided to meet next year in Toronto.

MEDICO-CHIRURGICAL SOCIETY OF MONTREAL.

Stated Meeting, April 3rd, 1885.

E. H. TRENHOLME, M.D., 2ND VICE-PRESIDENT, IN THE CHAIR.

Dr. STEWART exhibited the patient, and read the following account of a case of *Tabes Dorsalis* with exaggerated patellar reflex :—

The patient (a man), who is 42 years of age, complains of dimness of vision, flatulency, and of shooting pains in various parts of his body. He dates his troubles to a "cold" which he contracted three years ago. Among the first symptoms he noticed were the darting pains which have troubled him with more or less severity ever since. Two and one-half years ago he suddenly became aware that he saw objects double, and on shutting his right eye he was surprised to find that the vision of his left was markedly diminished. This diminution in the vision of the left eye steadily progressed until a few months ago, since which it has remained stationary. During the past five or six months there has been a steady and progressive diminution in the vision of his right also. He injured his back a few years ago, but neither at the time nor afterwards does it appear that he suffered in any particular way from this injury. In 1875 he had two sores on his penis, but there is no positive evidence whatever that those sores were of an infecting charac-

ter; otherwise, his past history was unimportant. There is nothing of importance to be derived from the family history.

His present condition is as follows:—There is no paralysis or atrophy of any of the voluntary muscles—their mechanical, faradic and galvanic irritability are normal. All the superficial reflexes are more or less exaggerated with the exception of the plantar. The cremasteric reflex is especially exaggerated. The patellar reflexes are exaggerated, as are also the triceps reflexes, but only to a slight extent compared with the patellar. The organic functions of defecation and micturition are considerably interfered with, while the swallowing reflex is normal. Shortly after urinating he is able, by "pressing hard," to pass a number of ounces of urine. That the sphincter of the bladder suffers as well as the detrusor is shown by the fact that when the desire to urinate comes on, unless he is ready, the urine floats away in spite of all his voluntary efforts to retain it. Although not troubled with constipation, he has difficulty in expelling the contents of the rectum. The "shooting pains" which trouble him are, for the most part, situated in the lower extremities. Sometimes, however, they have their seat in the hands, arms, trunk, face, neck, and even the ears. He has no delayed sensations, but he frequently experiences a sensation as if some one was pinching him or pulling from within outwards—a pain through his skin. There is no inco-ordination or disturbance of the muscular sense.

Dr. Buller's report of the condition of the eyes:—"Argyl-Robertson Pupil.—There is a very considerable atrophy of both optic nerves, with great limitation of the visual fields, especially of the left. The nerves are pale and of a blue-gray color. The blood-vessels are very small. There is no evidence of a previous inflammatory condition." The functions of the remaining cranial nerves are normal.

Dr. STEWART remarked that there was no doubt that the man was suffering from tabes dorsalis, despite the fact of the marked exaggeration of the patellar reflexes. There were present two of the three characteristic symptoms of this disease—the lightning pains and the reflex immobility. In addition there was

the optic nerve atrophy, the temporary diplopia, together with the bladder and rectal symptoms, forming a combination of symptoms that, at least up to the present, have only been described under the head of that myriad-sided disease, tabes dorsalis. Absence of the patellar reflex, Dr. Stewart remarked, is looked upon as one of the most important and earlier symptoms of the disease. A few cases have been recorded where it has not been absent, but up to the present time he had not read of any case where it was exaggerated. On theoretical grounds it had been suspected that, preceding the stage of loss of patellar reflex in the tabes, there is a period when it is exaggerated. Even were this supposition true, it would not aid us at all in this case, for it is one of considerable standing, although still in the pre-ataxic stage. The increased reflexes cannot be explained by disease of the lateral column, for there is an entire absence of any increased tonicity, this symptom being, next to the exaggerated reflexes, the most trustworthy evidence of a sclerosing of the pyramidal strands. Dr. Stewart concluded by stating that the honor of having made the diagnosis was Dr. Buller's, and it was owing to Dr. Buller's kindness that he was enabled to present him to the Society.

Dr. HENRY HOWARD said that the expectation of mental symptoms depended on whether the lesion begins high or low in the cerebro-spinal system, for in descending lesion death takes place before any dementia occurs. Hence, the important point is to know what centres are affected, and whether these be above or below the reflex centres usually implicated in tabes. Here it is interesting that the cortical substance having been involved some years, there is yet no impairment of mental powers.

Dr. CAMPBELL said that owing to the better knowledge in general, and especially of ophthalmoscopic signs, cases of this disease were now detected which formerly escaped diagnosis; but he did not believe such cases occurred with greater frequency to-day. He spoke of a case (which had been seen in consultation), by Dr. Trenholme, in which a woman evidenced exaggerated sexual desire, and subsequently became insane.

In answer to Dr. Trenholme, Dr. STEWART said death was often due to exhaustion from the pains.

Dr. H. HOWARD said that pneumonia was sometimes a cause of death, due to implication of pulmonary trophic centres and respiratory tract.

In answer to questions as to treatment, Dr. STEWART said though there was little evidence of syphilis, he had put his patient on anti-syphilitic treatment. Electricity is useful to control the pains. The flatulence was thought part of the disease, due to paresis of intestinal muscles.

Some discussion as to the use of ergot in tabes followed, and Seguin and Althaus were quoted in support of its use. Dr. STEWART said that it was perhaps dangerous, as ergotism caused an apparently genuine tabes.

In reply to questions as to etiology, Dr. STEWART said symptoms, especially eye symptoms, no doubt preceded injury and heat, etc., referred to.

Dr. REED called attention to disturbances in the function of urination as early symptoms in tabes.

Dr. REED spoke of *second attacks of measles* in same patient, and spoke of two such recently observed by him.

Dr. CAMPBELL said he had seen at least six such cases, and, much more extraordinary, had seen scarlet fever recur within a few weeks of first attack. He also spoke of the severity of the complications in the present epidemic of measles, as pneumonia, pleurisy, etc.

Dr. KENNEDY followed to same effect, and cited a case where scarlet fever, measles and whooping-cough were interchanged among the children of one family. Dr. Kennedy also spoke of a case where he diagnosed measles ten days before the development of rash, owing to catarrhal symptoms and a prodromal rash.

Dr. CAMPBELL spoke of whooping-cough frequently following measles in this epidemic. He advised treatment with quinine, with cures *in every case* within five or six weeks. He said the theory was that the spores deposited on fauces kept up irritation, and the quinine by causing profuse secretion led to these germs being washed away. This being the theory, the practical point is that the treatment by quinine is very successful.

Dr. REED said that Henoch found that "the measles usually followed whooping-cough, and that quinine had failed in his hands, he finding morphia most efficient."

Dr. TRENHOLME said that, in his hands, Drosera Rotundifolia (Parke D. Extr.) and Eucalyptus had done good service in whooping-cough.

Extracts from British and Foreign Journals.

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

The Treatment of Ruptured Perineum by Iodoform.—The *London Medical Times* says that a recent number of the *Zeitschrift fur Geburtshulfe und Gynakologie* contains an article by Dr. C. Behm on the above subject. He points out that in the region of the vagina and perineum the efficient application of the ordinary kinds of antiseptic dressing is very difficult if not impracticable, on account of the unavoidable fouling of them by urine and fæces. Iodoform has the property of closely adhering to wound surfaces, over which it forms a felt-like covering, difficult of detachment. It is, therefore, peculiarly suited to the needs of the ano-vulvar region. The method which Dr. Behm recommends, is the painting the surface of the wound with "iodoform-collodion" (iodoform one part, flexible collodion ten parts). He believes that the protective film thus formed does not act as a foreign body, and prevent primary union, but that, on the contrary, by checking secretion, it favors this mode of healing.—*New York Medical Journal.*

The Third stage of Labor: Obstetric Hints.—BY J. SAVAGE DELAVAN, M.D.—As soon as the child is in the world, *I place my hand on the abdomen of the mother*, grasping, gently but firmly, the contracting uterus, only relinquishing my grasp on finding contraction taking place. Then I request the nurse to place her hand where mine has been, directing her how to apply it. I then sever the funis between two ligatures, and again relieving the nurse, continue, gently, the kneading process. If this is properly done, in a short time the uterus will be found firmly contracted. I then

discontinue my manipulation, not following entirely the method of Crédé, by keeping up the kneading until the placenta is expelled from the vulva; but, finding the uterus contracted, I introduce my right hand into the vagina and find the placenta, which I carefully and slowly withdraw, winding and turning it in my hand, so that the membranes are twisted into a rope and come away intact. Before disposing of the mass it should be carefully examined to see that no portion is retained. I then seat myself by the bed, and with the left hand keep up gentle but firm pressure with manipulation for *at least* half an hour, at the end of which time I sweep the vagina with my right fore-finger, to clear it of clots and to see that no portion or shred of membrane remains either in the canal or the uterine mouth. Finding the womb hard and firmly contracted, *I then, and not till then*, apply the binder, folding a napkin saturated with spirits and placing it over the uterus under the bandage. When the binder is applied, I have the soiled clothing removed, place the patient in a comfortable position, the head not too high, and then—what? Go home? No. I wait *religiously* another half hour. Then, if the pulse is normal, as it should be, and the napkin which has been placed at the vulva after the bandage is applied shows that there is no hemorrhage, I leave my patient, instructing the nurse to put the child to the breast as soon as the mother is rested, and order some light nourishment to be administered in an hour.

The hour spent at the bedside *after* the birth of the child will save many a sudden summons, many an anxious moment. There is *always* danger to the parturient woman until the emptied uterus is firmly *permanently* contracted, and the physician who leaves the patient immediately after the delivery of the secundines, and trusts to nature to accomplish the rest, fails in his duty, and will, sooner or later, bitterly repent his negligence. Remember this: "*No one has a right, with our present knowledge, to lose a life from hemorrhage from the uterus, immediately after confinement*," and if the means I have described are taken, post-partum loss of blood will be of rare occurence.—*N. Y. Med. Times.*

CANADA

Medical and Surgical Journal.

MONTREAL, JUNE, 1885.

THE NEW BUILDING OF THE MEDICAL FACULTY OF McGILL UNIVERSITY.

We are quite sure our readers will be pleased to hear that the continually increasing success of the Medical Faculty of McGill University during the past few years has been so great as to render the large building at present occupied by them altogether too small for teaching purposes. In consequence, the Faculty have now in course of construction an annex larger than the present building, which will greatly increase the facilities for all the classes. As it is now, the Faculty building is much larger than any other Medical College in the Dominion. When the annex is completed, and the extensive alterations contemplated in the old building have been made, it will be one of the largest and most complete on this continent. A student of former years will be unable to recognize the inside of the building in which he studied, as the only rooms existing then and now are the library and museum, and these, too, have been added to. Some idea of the size of the whole structure, complete, can be formed from the fact that the main hall on the first floor will be 136 feef long, with a room 28 feet long at the end of it, giving a total length from front to rear of 164 feet; also by the fact that the building covers 13,930 square feet. Accompanying this will be found a plan as taken from the College calendar.

For those interested we give a description of the entire building:—

Ground Floor.—The library, which is a very extensive one, containing over 10,000 volumes, will now consist of two rooms, the additional room being 30×22, and opening off the present

one. On the opposite side of the hall is the museum, which will now be connected with an extensive additional room by a small chamber—in this way almost doubling its present capacity. In the latter, the curator will have facilities for his special work. Continuing along the main hall, the second door we come to on the left will be the entrance to the pharmacological laboratory. This room is to be specially fitted up for demonstrating, experimentally, the actions of drugs, as well as for giving courses on practical pharmacy. On the opposite side of the hall is the students' reading-room, which is to be comfortably fitted up. Next to the reading-room is the private room of the Professor of Physiology. This is chiefly for the purposes of the experimental work of the professor himself. Here, also, will be kept the valuable apparatus of this department, which has been extensively added to, and is now thoroughly efficient. This opens into the physiological laboratory, which is the next room to the right. Here the students will themselves take an active part in the physiological work, just as in the adjoining chemical laboratory they study chemistry practically. The chemical laboratory will have accommodation for seventy-five students, all engaged in the practical work of this subject. Here every convenience is provided for enabling the student to pursue this special work. Opening off the laboratory is the "balance room" and private room for the Professor of Chemistry. On the opposite side of the main hall is the large lecture theatre for the classes on these two branches. This room is hexagonal in shape, and its widest part measures 76 feet. It is lighted by a skylight, and three windows to the rear of the students, which also serve admirably for ventilating purposes. It will seat comfortably 275 students. Beneath the higher seats are four rooms, each 8 feet high and 10 feet wide. The Professor of Therapeutics will occupy the first two rooms, one of which will be for the convenient performance of his duties as Registrar. The Professor of Chemistry will use the other two rooms for physical apparatus and also for private experimental work.

Second Storey.—Opposite the main staircase is the dissecting-room. This will be now 72 feet long; and will be pro-

vided with 20 tables. The room will be splendidly lighted—by daylight from two skylights, as well as windows from three points of the compass; and at night there will be both electric lights and gas. Opening off the dissecting-room is the bone-room. This will have a large table in its centre and seats, will be well supplied with bones, and will be a convenient place for the study of osteology. Opening off the bone-room will be rooms for the Demonstrator and his assistants.

Turning sharp to the left after ascending the main stairway, the first door we come to is the entrance to a small lecture-room or theatre for demonstrating purposes. This will be used for pathological and other demonstrations to at least fifty students at a time. Close to the door of this theatre is one of the entrances to the histological laboratory, the other entrance being to the right of the head of the stairs. This laboratory will have, commencing about its centre, a stage two feet six inches high, reached by three or four steps, on which will be two tables extending across the room. Behind this will be another of a similar heighth, and arranged in the same manner. Each of these tables will have three or four microscopes. There will also be four tables ten feet long, with microscopes, on floor level. This arrangement of stages is to prevent students standing in front of the tables from obstructing the light of those using the microscopes. This laboratory will be furnished with thirty microscopes, also microtomes and other apparatus for practical work.

In the annex on this flat will be a large lecture-room, capable of seating comfortably 300 students. Its measurements are 56 by 46. This theatre will be utilized as the anatomy lecture room, besides other purposes. Separate entrances are provided for the students. The Professor of Anatomy will have his room opening off this theatre. Beneath the higher seats will be rooms eight feet high and twelve feet wide at narrowest part. Their occupants have not yet been decided upon, but will be so arranged that the Pathologist of the College can utilize what he may require. He will also have the room to which his name is attached in the accompanying plans. In the basement of the building will be a cloak room for students.

All the work is being most substantially performed, the east and south faces of the annex being built of stone, the rest of brick. It will be well heated, every regard being had for the comfort, as well as the educational requirements of the student. The contractors undertake to have the work completed by the 15th of September, so that the Faculty will commence work on the 1st of October with facilities unequalled in Canada.

THE INTERNATIONAL MEDICAL CONGRESS.

The action of the American Medical Association at New Orleans bids fair to jeopardize the success, if not the existence, of the congress to be held in Washington in 1887.

The facts of the case, so far as we can learn, are as follows: At the Washington meeting of the American Medical Association in 1884, a committee of seven was appointed by the President to "extend, on behalf of the medical profession of the "United States, to the International Medical Congress about to "meet in Copenhagen, a cordial invitation to have the next In- "ternational Medical Congress meet at Washington in 1887," and to this committee was given full power to add to their membership and to perfect the organization. The invitation was tendered and accepted, and, as we understand it, the committee was entrusted by the Executive of the Copenhagen meeting with the care of organizing the next Congress. It became *de facto* a committee not of the American Medical Association but of the profession, deriving its existence from the International Congress and no more responsible to the American Medical Association than to the American Academy of Medicine. In this way only is the organic continuity of these international congresses maintained; each executive appoints its successor, and the committee nominated at Copenhagen is the descendant of the committees which organized the previous meetings. Believing that it had full powers to act, the committee added 18 or 20 members, chosen rather on professional than geographical grounds, and, at a meeting in November, appointed the officers of congress and arranged the sections. A pamphlet giving the details of

organization and a list of the officers of the various sections was issued this spring, and widely distributed in Europe. At the New Orleans meeting, Dr. Billings reported progress on behalf of the committee, but the Association expressed its decided condemnation of the work already done and nominated thirty-eight additional members to take the place of those selected by the original committee of seven.

It is a great pity that Dr. Billings did not then and there assert the independence of the committee, once having been entrusted with power from the Executive of the Copenhagen Congress. The additional thirty-eight men nominated by the Association may be representatives territorially, but certainly not of the profession, as were those nominated by the committee of seven. With the exception of eight or nine, they are unknown men. Among the officers who were appointed by the committee are several prominent New York physicians, who, on the Code question, are not in harmony with the American Medical Association, and this seems to have been a special offence. Nothing illustrates more forcibly the necessity of the Executive of the Congress being absolutely independent of the Association, for, if controlled by it, there will be men of great prominence in the profession excluded from participation on account of this wretched Code quarrel—men who, if the Congress was in any other country, would be cordially welcomed. The new committee has, we learn, decided to meet in Chicago at an early day, and it is to be hoped the members will see the false position in which the Association has placed them and quietly discharge themselves. It is for the original committee now to determine whether the meeting in 1887 shall be under the wing of the American Medical Association, or whether it shall be truly an International gathering, managed and controlled by representatives of the medical profession of the United States. Upon their determination rests the success or failure of the Congress.

There can be no doubt, as the *New York Medical Journal* says, that the Association was forced into taking this action by some notorious wire-pullers who were discontented at not having been placed in office. The presence of some of these men on

the new committee is the most objectionable feature about it, and will assuredly alienate the support and sympathy of the very men of the profession who are most needed to make the Congress a success.

MONTREAL GENERAL HOSPITAL.—On the 21st ultimo the Governors of the Montreal General Hospital held their annual meeting for the appointment of officers for the ensuing year. The proceedings were of more than usual interest—Dr. Osler's resignation as an attending physician having been already accepted, it became necessary to fill the vacancy. The candidates between whom the election lay were Drs. Richard MacDonnell and F. W. Campbell. The result proved highly favorable to the former, Dr. MacDonnell receiving 93 votes against 71 for Dr. Campbell. We congratulate Dr. MacDonnell upon his well-deserved promotion, and the Governors upon having secured to the staff the services of a young, capable, energetic and zealous physician.

By-laws having been recently passed providing for the appointment of a Gynecologist and a Laryngologist to the Hospital, the positions were filled by the election of Drs. W. Gardner and G. W. Major respectively.

Drs. MacDonnell, Gardner and Major having all been on the staff as assistant physicians or surgeons, three vacancies were created. These were filled as follows:—For Assistant Physicians, Drs. A. D. Blackader and F. W. Campbell; for Assistant Surgeon, Dr. James Bell. Dr. W. R. Sutherland, who was also a candidate, was only two votes behind Dr. Campbell.

MEDICAL HEALTH OFFICER.—The Board of Health have received and accepted the resignation of Dr. Larocque, Health officer for the city of Montreal. Steps are therefore being taken to provide his successor. It is a very important appointment, and it is to be sincerely hoped that some medical gentleman will be selected who will do credit to himself and to this great city. A point which should not be lost sight of in making a definitive appointment is, that the person chosen should be one

who, from his general standing and previous record is held in respect by the large body of medical practitioners of the city, will be acceptable to them, and will command their loyal assistance in his endeavors to ameliorate the sanitary condition of our city. The Board have formed an advisory committee from members of the different medical schools in the city, and it is to be hoped that, with the assistance of these gentlemen, a conclusion may soon be reached. The salary now offered ($2,500) ought to be sufficient to bring out a capable man, and we have no doubt that, if he proved himself the right man in the right place, this would be increased.

—It is pleasant to find some of our hard-working physicians occasionally seeking relaxation in the lighter paths of literature. Our friend, Dr. John Campbell, of Seaforth, Ont., has always been noted as possessing a *penchant* for sharing his thoughts with his fellow-man either in written words or in one of his own peculiar and stirring addresses. He now presents us with a little volume which will interest a large circle of readers. It is called " The Land of Burns," and consists of a series of letters addressed by him to his local paper from Scotland, where he was enjoying a well-earned holiday. They all bear the stamp of his own fresh and enthusiastic nature, and are written in a pleasing and racy style. We hope the worthy doctor's modest venture will meet with a large demand.

—The fifth annual meeting of the Ontario Medical Association, which was held in London on the 3rd and 4th inst., was the most successful meeting hitherto held of this young and vigorous body. The attendance, which was upwards of 100, included representatives from all portions of the Province—from the east, from the west, from the north and south. Cities, towns and villages had their representatives. And yet many places were unrepresented. More than one place which delights to call itself a city, within an hour's journey of London, had no medical man to represent them. This state of affairs should not be. This is not the first occasion on which it has happened. It always happens, and it always will happen as long

as the present apathy exists on the part of so many. Dr. Worthington, of Clinton, the President of the Association, filled his high position with credit to himself and his profession. His address was full of sound philosophical teaching. His suggestions for a more rational and scientific treatment of pyrexia are worthy the earnest attention of all practitioners. Dr. Tye of Chatham was elected President for the ensuing year. We congratulate Dr. Tye on this mark of the esteem in which he is held by the profession throughout the Province. The Association is fortunate in its choice, for Dr. Tye has all the qualities, in an eminent degree, which are necessary to fill this important position with success.

ONTARIO MEDICAL COUNCIL.—The first meeting of the recently elected Council was held in Toronto on the 9th inst. The following officers were elected:—President, Dr. D. Bergin, Cornwall. Vice-President, Dr. Douglas, Port Elgin. Treasurer, Dr. W. T. Aikens, Toronto. Registrar, Dr. Pyne. Dr. Burns gave notice of motion that the lowest standard of matriculation examination for the Medical Council of Ontario, hereafter, be the Arts examination of Toronto University.

THE MILITIA MEDICAL SERVICE.—The following letter to the *Canadian Militia Gazette* raises a question which is of interest to many of our readers. When we shall have learnt something from the medical officers now on service in the North-West of the working of the present system, we shall be in a better position to judge of the comparative advantages of the two systems alluded to by Dr. Tobin:—

To the Editor of Canadian Militia Gazette.

DEAR SIR,—I should think it would be of interest, at present, to medical officers serving with the troops at the front, and throughout the Dominion, if you would devote a space in your columns to a discussion of the relative merits of the regimental and departmental medical systems. As an army surgeon of some ten years service, I have had, in my time, experience of both. My experience as a militia surgeon dates only from the beginning of the present campaign. I have no opportunity, therefore, of ascertaining the views of my militia confreres on this subject, but think the present time opportune and the columns of your paper appropriate for the discussion. At all events, I have no doubt, this campaign will have

opened the eyes of most of us to the necessity of reorganization. Should this take the form of the departmental system now prevailing in the British service? It has been found, in war time, that the pure regimental system is a failure. But has it not proved so on the present occasion? Of course our regimental hospitals have not been properly equipped as such; nor have our field hospitals (such as I have seen of them at least) been put upon a proper footing; but would not a well organized departmental service have been more efficient, more movable and cheaper than the present one? With a surgeon-general at Ottawa as head of the department, one deputy-surgeon-general for each province, with a suitable staff of surgeons-major and surgeons under him (transferable on duty as required from one point to another within the province, from one corps to another, and available for home and foreign service), we would have a simple, cheap and readily movable staff, possessing more authority, independence and *esprit de corps* than can ever be obtained under the present system. I only throw out these ideas hoping to obtain a ventilation of the subject, and, having nothing but agreeable reminiscences of both systems whilst in the home service, consider myself as quite unprejudiced in the matter.

Yours sincerely,

W. TOBIN, F.R.C.S.I., Surgeon Halifax Batt.
Late Surgeon A. M. D. and late
Assistant Surgeon H.M. 24th Regt.

Camp, Medicine Hat,
21st May, 1885.

Medical Items.

DISFRANCHISING DISPENSARY PATIENTS.—The English Government has passed a law disfranchising all English voters who have accepted medical relief from the parish. This, throughout England, will bar probably 200,000, or one-tenth of the whole number of voters.

—Some one, imbued with the spirit of the Arabian Nights, has observed that there are men walking about in Germany without viscera, or with but a fractional part of the proper anatomical amount. Metres of their intestine have been resected; their spleens have been removed; one kidney has gone; they have neither pylorus nor gall bladder.

—A lady in a leading town in the Dominion consulted an itinerant professor of medicine regarding her defective vision. She paid her $1 entrance fee to the show for the privilege of speaking to the "Doctor." He informed her she was rapidly losing her sight, but shewed her a little bottle which he said would positively cure her. Price only $10. This staggered her. She immediately resolved to "go it blind."

—The following story is told of the celebrated Oppolzer: Shortly after his arrival in Vienna he was consulted by an invalid, whom he advised, after a somewhat hasty examination, to go to Pistyan, in Hungary, and take the waters. After several months the man, whom the professor had forgotten, again presented himself, with an aggravation of all his symptoms, and said he had just returned from a course of the Pistyan waters. The professor examined him, this time rather more carefully, and then, with some wrath, asked him what confounded ass had advised him to go there, as it was the worst thing he could possibly have done. Moral: Always speak well of your neighbor.

A MEDICAL STUDENT AGED SEVENTY-FOUR.—Our Berlin correspondent writes:—It is not often that one hears of a student of the age of seventy-four taking a degree at a university. The "bernoostes haupt" is sometimes to be seen at German universities, but he is generally a man who has spent his last years in idleness. The Nestor of the Berlin students to whom I now refer has been studying at Berlin since 1881, and has just taken a degree of Doctor of Medicine. The professors addressed him as "worthy colleague," the students as "papakin." In 1833 he was matriculated at Berlin and studied theology till 1837, and spent his time from then till 1881 as a missionary in South Africa. It had been his wish all his life to study medicine, but pecuniary difficulties stood in his way. Now that he has passed his examination, having worked with all the zeal of a young student, he is going to return to Africa, where he will practice medicine.—*Brit. Med. Jour.*, March 7.

SWEATING TO DEATH.—Such an unusual case as that which Dr. Myrtle reports in the *British Medical Journal*, is worthy of comment. The patient, a healthy, active man, after suffering for three weeks from pain of rheumatic character, relieved by sodium-salicylate, was seized with profuse sweats, frequently of most offensive character, and lasting at times for ten hours. Atropine and ergotine both caused sudden symptoms of collapse. He improved for a time on arsenic, and the

perspiration lost its fœtor. He died from exhaustion 121 days after he had first felt the flying pains. No necropsy could be obtained. Dr. Myrtle regarded the case as one of paresis of nerves supplying the sweat-ducts, caused by frequent exposure to cold during his employment. Dr. Braithwaite, Dr. Hutchinson and Mr. Wheelhouse related cases of excessive sweating, which in one instance was relieved by the external application of belladonna-liniment, and in another by taking copper-sulphate. Dr. Jacob thought the intermittency of the attacks precluded a peripheral paresis, and pointed rather to the sweat-centres being affected.

HYPODERMIC INJECTION OF COCAINE.—M. Dujardin Beaumetz has been using with success hypodermic injections of cocaine in such minor surgical operations as the opening of an abscess. He insists upon the maintenance of the lying position on the part of the patient, injections in the standing or sitting position being usually followed by faintness. The dose injected by him has been 1 ccm. of a solution of the strength of 1-50th per cent., and the sedative action from this dose has usually been apparent in from 5 to 10 minutes.—*Progrès Médical*, *March* 21, 1885.

—An English clergyman having vaunted the curative power of shelled snails for eczema, the following recipe is sent to the *Medical Times*:—Take of common or garden clergymen—who must not be confused with the sentimental and inferior hedge parson—as many as require the treatment, tear off or carefully remove all the skin and nails, rub them well over the gravel walk in sight of the living creature which they have proposed to torture in order to provide a quack remedy for skin diseases. This will give relief to the Snails, and will cure the clergymen of their disregard for the feelings of your obedient servant, HELIX NEMORALIS.

—Dr. Furber, writing from Kansas to the *Eastern Medical Journal*, says that the surgical mania of his State is spaying of women and young virgins. He says that in his waking hours he often dreams of a courting scene in which the conversation runs thus: "Miss Doolittle, have you been spayed?" "Sir?" "Have you undergone ovariotomy?" "Please ex-

plain yourself, Mr. Blunt." "I desire to be informed, Miss Doolittle, whether or not you have been oöphorectomised?" "Certainly, I have, Mr. Blunt. A council of regular physicians was called by my parents, when I was a child, to consider the nervousness exhibited by my three elder sisters and myself, and thus oöphorectomy was performed on all four of us, by that eminent surgeon, Prof. Cassius Fitz Greene Browne, A.M., M.D. My older sisters all died because they were not operated upon earlier in life. So the doctors said, and they all agreed that where parents neglect to have their girl babies oöphorectomised, it ought to be done by the city surgeon appointed for that purpose, to prevent the thousand and one diseases that assail girls when they grow up to womanhood as their Creator made them, and they farther say it should no more be neglected than vaccination, and certainly my own case proves the truth of their assertion." "I will thank you for my hat, Miss Doolittle. Good night." "Good night, Mr. Blunt."