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THE  
**CANADIAN PRACTITIONER**

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**Original Communications.**

**HERNIA.**

BY HON. M. SULLIVAN, M.D., KINGSTON.

Read before the Ontario Medical Association.

GENTLEMEN,—The founders of this Association could not, in their collective wisdom, have devised any scheme more practically useful, more solidifying and beneficial to their society, than that which gives to its chief executive officer the privilege of naming a member to prepare a paper on some subject which shall be discussed in each section, and associating with him a few others who will give the subject more than passing attention. In obedience to that call, I have the honor to appear before you this evening. After recovering from the surprise incident to such a nomination, which I could only attribute to the President's tenderness of heart, I felt it my duty to bow without hesitation to his will and pleasure; not so much for the honor done me, but mainly because I realized the many great advantages of this mode of discussion to the rank and file of the profession. I felt that to that hard-worked and often ill-requited individual, termed the "General Practitioner," with but little time to read and less time to experiment, it was a great boon—enabling him to record and utilize a vast amount of experience; to analyse and test various theories; stimulating him to careful and accurate observation; finally, enabling him to rise from the dull level of routine and monot-

ony to the higher plane of active progress and philosophic thought.

The selection of as subject next gave me no small amount of perplexity. On reflection, the absence of any written record of my work was painfully impressed on my mind, and caused me to select some general practical subject. Thirty-five years had elapsed since I first entered, with, I hope, due respect, the Temple of Hygeia, and, taking a retrospective glance over so long a period spent in the varied field of general practice, I found many subjects which had left more or less impression on my mind, affording, it is true, very little scope for the imagination, yet which could not fail to interest those so numerous represented here to-day, who are going, or will go, over much the same territory as I have.

Now, gentlemen, hernia appeared to me one of those subjects on which I might venture to address you; one which did not need so much original work to commend it, which is of general interest, and which, by its frequency, and sometimes sudden emergency, demands correct, concise, and clear information, followed by prompt, decided action.

To go over the whole subject would be a fruitless and unnecessary task. I will only, therefore, select such points as experience has impressed most deeply on my memory, and the depth of which impressions are, I feel, the best tests of their utility and importance. Previous to doing so, I may remark that no subject can claim higher antiquity than that of hernia. Its

origin is coeval with the enforcement of the edict dooming man to labor; and to no time, nor to any race, was exemption granted from the natural defects or weakness of structure incident to the development and growth of certain parts of the body. The frequency of it among us is well known. The nature of the occupations of the great mass of our people render them singularly liable to it, and there is not one of my hearers who has not had some experience and can contribute some information to the general discussion. I regret that, owing to the meagre nature of our vital statistics, I cannot give any exact figures. I searched the latest volume published by the Legislature of the Province containing the record of deaths and their causes, but did not even find the name mentioned. The American census of 1880 shows that of the total deaths, one in every 600 was due to it; and of 1236 deaths from it, 141 occurred in children under one year. Kingdon gives some statistics of its frequency in England; one in eight of all the inhabitants were affected with it; and in some districts, as high as one in five. He adds, 41 per cent. were under 31 years of age and 59 per cent. over it. These figures show how very frequent it is. I think all will admit that Canada could, in this respect, compete successfully with these countries.

The first point I shall notice is that of its anatomy. What could the examiners on surgical anatomy do without "the course and coverings of hernia,"—its canals, orifices, fasciæ, ligaments, triangles, vessels, relations, etc. It seems heretical to say a word against it, and if practically learned, my remarks would not apply; but when committed to memory from books, it acts as a powerful deterrent to operation; when that time arrives the details become jumbled together, engender doubt and indecision, instead of confidence and resource; delay results, and delay in many cases means death.

It ought to be impressed on the student that he will not see these, in order that he need not look for them; that skin, superficial fascia, and another membrane, being divided, will bring him to the sac. How astonished one is, after seeing his first operation of cutting down on the sac of, say, an inguinal hernia, at the difference between the ideal and the reality!

No one has done more in this Province to encourage the study of anatomy than I; but not from books. Experience tells me it cannot be too strongly impressed on the mind of the newly ordained, that they will never see these tissues in the order named; that no importance need be attached to them. The different varieties, with perhaps one exception, excite no recollection of special merit; one, however, demands a passing notice. I saw it first described in Birkett's very valuable article on hernia, in Holmes' surgery; and when I was examiner to the Ontario Medical Council, I gave a question on it more than once, without receiving, on any occasion, an intelligent answer. I allude to that form of inguinal hernia which occurs sometimes in young adults, and which is due to the non or partial closure of the tunica vaginalis. Sometimes it drops into what is called the funicular portion, and sometimes into the scrotal. Anyone who examines many cadavers will, if he look, be struck with the frequency of this incomplete closure. The differential diagnosis is given in few terms, namely: It occurs in young adults; its form is globular, compared with the pyriform shape of the acquired variety. Sometimes it has an hour-glass constriction. The testis may be felt or it may not. Practically, its recognition, as I have had reason to verify, is of great consequence. The reasons being, 1st, because the constitutional symptoms ensuing are more severe; 2nd, it is more easily strangulated; and 3rd, it requires prompt liberation, else a fatal termination may be dreaded. It is capable of radical cure much more certainly, and eludes the taxis more readily than any other form. Another reason which makes me bring it so prominently before you, and which I have not seen noticed anywhere, is its recognition in medico-legal cases. To illustrate: A man in Kingston a few years ago, while walking along the street one night, fell into an open drain; he fell on the edge of a plank, the whole force of the fall coming on the perinæum and inflicting a severe contused wound in that region. The wound healed well, leaving no evidence of permanent damage. Fortunately for the man, he discovered an inguinal hernia, and "was positive it was not there before, and was caused by the fall." He brought suit

against the corporation, and his surgical attendant swore that it was caused by the fall. (His chances for fees depended on the plaintiff gaining the suit; only a coincidence, however). I was called for the defence and testified that I did not believe it was due to the blow received on the perinæum; but because I could not assert that it was impossible that it could be so caused, the man gained his suit and recovered large damages. Now, had I been fully aware of this form of hernia into the vaginal process, and its sometimes sudden appearance in young men, I would have had no difficulty in explaining the nature of it, and asserting the impossibility of the plaintiff's having been caused by the fall; thus exposing what I believed then and now to be a gross fraud and injustice. In actions for damages, it is well to be aware of this form of hernia; and I submit to the meeting the question of the possibility of the sudden appearance of a hernia, the result of injury unattended by wound. Is it possible? Can hernia occur in this way? Another point, which occurs to me as appropriate, is the subject of trusses. A friend of mine, the subject of a hernia, wished to obtain a perfect one when on a visit to Paris. When the maker learned where he had come from, he told him his best trusses were American, that he would do much better at home. Notwithstanding, anyone who has had any experience in this matter cannot fail to lament the difficulty of obtaining a proper truss. For the wealthy, it is not so bad; they can have proper measurements made; and after fitting by an instrument maker, have the endorsement of the surgeon. Unfortunately, the victims of rupture are more often ruptured financially; they are sent or must go to the nearest druggist, who has a small stock of cheap ones on hand. He is sure to make a fit, whether it will or not. Now, so great a grievance do I feel this truss matter to be, that I venture to ask thus publicly the members of this learned body, if they realize the evil as I do, to bring the influence of this society to bear on the Government of this wealthy Province to secure a grant of a small amount to the public hospitals, whereby, on the certificate of a surgeon of good standing, a well-fitting truss might either be sold at a cheap rate, or given free, to those unfortunate sufferers. If this paper only

aids in removing so great a grievance, I will be richly rewarded, and I solicit your opinion in the discussion which will follow.

It will, I think, be readily conceded that the truss, when it does cure, does not do so by any special power, nor by exciting inflammation of an adhesive character; but by keeping the parts free from causes that will prevent the natural tendency to close going on uninterruptedly. Mr. Bryant, of New York, recommends for the ruptured three trusses, one to be worn during the day, another at night, and one for the bath. It is all important to the young that nature should not be thwarted by badly-made and badly-fitting trusses. It is still the safest, surest and most permanent radical cure we possess. The occupation of the patient must influence the surgeon largely. When applied he should inspect it closely, to see that it fulfils the indications required; that it supports the whole canal, particularly the point of emergence and some distance beyond it; the pad should be firm, flat or slightly convex; the spring, elastic, firm—all bosses or protuberances are very justly condemned. Finally, let me direct your attention to the indifference shown by the general practitioner in this matter. After diagnosing the hernia, he says, "Oh, you must get a truss forthwith," sending him to a druggist or some instrument maker. Now this is very unfair to our patients and ourselves; the surgeon should treat it with the respect and concern due to so serious an affliction. He ought to procure the necessary appliances; see that they fit properly, and have them adjusted from time to time, and obtain a fee worthy of so much trouble and anxiety; and his patients will remember his efforts with gratitude. I speak of this for the section wherein I reside; I may not refer to others:

Next in order and deeply impressed on "the tablets of my memory" is the condition of strangulation, the operation for the relief of which, partly from the old bug-bear of the peritoneum and partly from a vivid recollection of the awful amount of anatomy, was held *in terrorem*; its difficulties magnified to an extraordinary extent; a danger to be dreaded and put off as long as possible; instead of a salutary resource in which safety only required prompt action in seeking it. The symptoms are well

marked. The patient is watched closely ; vomited matter carefully scrutinised ; any justification, no matter how slight, for delay seized on ; taxis tried again and again ; at last when the patient is dissatisfied or the attendant alarmed, a consultation is called. Again a trial is made and the operation is had recourse to, with results such as might easily have been avoided : bruised, inflamed, and gangrenous contents, and death from shock and peritonites soon follows. I have had over fifty cases of strangulated hernia on which I operated ; the mortality amounting to not less than twelve, and all (with one exception of death from hemorrhage) from delay again and again. I have been called in to assume or share responsibility which I should not, and really, I submit, there ought to be some relief from this, and I would like to have your opinion. What rule has the consultant for guidance in such cases ? A practitioner of large practice and good reputation, after keeping a patient, the subject of strangulation, suffering for several days, or even one day, trying from time to time taxis, at the urgent solicitation of friends, and finding the symptoms alarming, calls in a surgeon ; the latter, after examining, finds the case in a dangerous state, and at once recommends the only possible chance, viz., the long delayed operation ; he is requested to operate, does so skillfully, but the patient dies ; his death has been caused by delay and the misapplied taxis, and the blame is at once promptly transferred to the operator. Surgery is injured, and the attendant goes scot-free. This has happened to me on more than three occasions. It is not fair, and the ethics of surgery should admit of some reparation to the unfortunate operator, who, in the goodness of his heart, is made to shield the real transgressor. Is there any remedy ?

No, gentlemen, surgery has not, as yet, freed itself from the opprobrium of the great mortality in strangulated hernia, and nowhere can this fact be enunciated with more force and hope of benefit than from this hall. The cases I have found requiring prompt operation, beyond any other, are those where a reducible omental hernia becomes suddenly strangulated ; you may be sure a knuckle of intestine has descended by the side of it into the sac, and perhaps hides it effectually from observation. I have seen four cases of

this kind ; a remarkable one with fatal results occurred near me a short time ago. The other serious cases are where the bowel drops into an unobliterated vaginal process. Another fact I have noticed : that although the symptoms generally occur in regular order, and are well marked, yet it will prove a fatal mistake to always wait for them. I have a vivid recollection of four cases, one a late medical friend of Belleville, where death occurred after operation, the bowel being almost gangrenous. There was no distress, little pain, slight tenderness on pressure, and no vomiting. We cannot, whether young or old, have too indelibly impressed on our memory the necessity for prompt action, when summoned to relieve an incarcerated hernia. Our line of conduct, as laid down by the unanimous and positive assertion of the most experienced masters in surgery, is simple, clear, and free from any risk ; nowhere should our duty be more strictly defined or more fully rewarded. Moreover, being one of those affections that may challenge one suddenly without any notice, it behooves us to be ready ; only be satisfied that the hernia is strangulated, even if the symptoms are not well marked ; they are a hypodermic injection of morphia, ; inversion of the body ; sometimes an enema ; taxis for 10 or 15 minutes ; if choloform be used with the taxis, the operation should follow. The 10 or 15 minutes trial should satisfy anyone. I would allow no man to try the taxis unless previous to operating. If the patient insists on delay, we are freed from responsibility. Acting thus, mortality would be greatly diminished and surgery vindicated. Always, says the great Desault, "think well of a strangulated hernia where taxis has not been employed." A medical friend said to me a few days ago, "I never saw an operation for strangulated hernia succeed," a significant remark. It will be unnecessary to say anything about the details of so well known an operation ; I may only remark that in making the first incision it is better to make a free one ; it should be so made as to fully expose the point of emergence from the abdomen, so that subsequently we have no trouble, seeing all the steps of the operation, and particularly the deeper ones. The presence of the sac is readily made apparent. The condition of its contents suggests to me a point for your opinion ; of course,

careful examination is always made of the contents of the sac; occasionally, with every precaution, doubt will arise. Now, some assert that when in doubt the abdominal cavity is the best place for restoration of the bowel, and most authorities say it ought to be replaced there. I venture to dissent from this view, for the reason that I complied with it on two occasions, yielding to the majority of those present at the operations, and both cases terminated fatally. I could not help feeling that had I freed all constrictions and left it within the ring, accessible, I could, after some hours, have acted with certainty.

A warm antiseptic, sponge or napkin, would compensate for the restoration benefit; and if vitality were impaired too much, we will be able to form an artificial anus, which might admit of future repair. Should the contents be gangrenous, omentum can be dealt with promptly and effectively, viz., by transfixion, ligature and section. If bowel, excision and intestinal anastomoses are before us. To the ordinary practitioner, this will be found too difficult and should be consigned to the experienced hospital surgeon. The family physician does his duty, and does it well, when he forms an artificial opening; this he can readily do, leaving to subsequent operation the excision. Another point for your adoption or reverse is this: should we go further, and on all occasions of operation for strangulated hernia attempt a radical cure? Leading surgeons in this country cordially recommend a trial; it is, they say, the most favorable time and should not be allowed to pass, as it adds little or nothing to the risk of operating, and is a favorable opportunity not to be lost sight of. Much will depend of course on the nature of the hernia, and other circumstances carefully considered.

An important and so far undecided question is, the part the peritoneal supports of the intestines take in the causation of hernia. From the time of Scarpa, many writers on surgery and authorities such as Cloquet, Cooper, Malquigne, Birkett, and others, refer to it as an important factor. I have failed to find anything positive and definite; no evidence that a long mesentery predisposes more than a short one.

A friend has drawn my attention to a review of three very elaborate lectures recently deliver-

ed by Mr. Lockwood, before the Royal College of Surgeons, England. He investigated with great care 100 subjects, from 5 weeks to 89 years of age, and made a series of examinations in each case, to ascertain the length, the height and range of motion of the mesentery. He gives some singular and not generally known facts. He recalls the existence of the muscle, first discovered by Freitz in 1853, viz., the suspensory muscle of the duodenum, best seen in the child, attached not only to the duodenum, but also conducted by the superior mesenteric artery to the support of the small intestine.

From his examinations, the mesentery at 2 years is  $\frac{1}{3}$  length of the body; at 10 years,  $\frac{1}{2}$ ; at 40,  $\frac{1}{3}$ , and remains so until the end of life. Not one of the hundred had a mesentery so short as to absolutely prevent rupture. Its average length was  $7\frac{1}{2}$  inches. Some had as long as 8 or 10 inches. The mesentery in age glides down to left side. The right segment is always longer after 50 years than the left, and at this period of life, left, right, and double hernia, are equal in number. He does not think the mesentery plays an important part in causation. The congenital are best adapted for operation, precisely those best adapted for cure by support.

The age of 45 marks a turning point in medical cure cases, after that being unfavorable. In describing the operation he lays great stress on transfixion previous to ligature and section as an essential proceeding.

And now, gentlemen, my intention was to conclude here, and I would certainly do so had I not been told that you would experience some disappointment, and my review be very incomplete, if I failed to make some reference to the various methods of permanent cure, now being advised by so many surgeons at home and here. Watson says, "that where you find a great many remedies for any disease, you may be sure that it is very difficult to cure, and no one of them will do so." If the parallel holds good in surgery, then the radical cure of hernia is a most difficult and uncertain one.

In no department of surgery have so many operations been devised, ancient, mediæval, and modern surgery; each has its record, and a list alone would fill a volume, and show that more labor, skill, dexterity and ingenuity have been

spent to overcome this than any other difficulty, and I look with confidence to that combination of qualities possessed by the Canadian surgeon to evolve a simple method, which will secure the long looked-for prize, viz., an effectual radical cure. Not long after I began practice, invagination was in vogue; Gerdy, Wutzer, Rothmund and Wood, of London, I recollect as operators, and were sanguine enough to believe they succeeded. My experience of invagination is confined to one case. The late Dr. Dickson had another previously. We failed, and thus ended my experience of radical cure. Many tried it, and, as now with the open method, asserted their success; but Mr. Kingdon, of the London Truss Society, demolished their pretensions one after another by the stern logic of facts, and men who were reported as successful examples of the radical cure were fitted by him with trusses. Time has proved the truth of its failure, and I fear invagination is soon to be relegated to the capacious storehouse of obsolete operations.

Antiseptics came; it stimulated to an unparalleled degree all surgery, operative and otherwise, chiefly abdominal; the sanctity of the peritoneum was invaded, and became obedient to the general law. It need not be wondered that radical cure again revived.

Mr. Birkett says that the objects to be effected are, closure of the abdominal opening; obliteration of the sac; strengthening the abdominal wall on the track through which it passes; improved tone of the peritoneal ligaments of the viscera; and unless "it completely and perfectly effects these ends, it must certainly fail sooner or later." Hence, one after another, operations have failed, and now all closed methods, as I said, are condemned. But this in no wise dampened the ardor of the progressive surgeon, and at no time has there been so many workers, with clearer notions, strong in their determination to secure success.

Before noting the operations in detail, and reviewing the position and prospects of the operation down to date, I should mention the injection plan attributed to a Mr. Heaton, of Boston. It consists in causing union and solidification by injecting subcutaneously into and around the whole length of the sac a solution, of which oak bark decoction is the main ingredient. Those

who have seen the effects of hypodermic injections of morphia can readily understand it; how it hardens, condenses and unites the tissues. It promised well for a time, having been kept secret for some years. It has the merit of easy performance, and, it appears to me, ought to act well in children; but it is invisible, has not found favor with surgeons of repute, and is not likely to grow in favor and become a standard operation.

All recognised modes of operation now in vogue, and worthy of notice, have many points in common; the essential feature of all is the ligation and obliteration of the sac, and it is worthy of remark, they have been more successful in the practice of the designers of the operation than in that of those who repeated them.

The principal operations in Great Britain and Ireland are those of Banks, Ball, and McEwen; for details of these and many others, you can consult a very valuable retrospect of surgery, published by a leading surgeon of Montreal, Dr. Shepherd. I will only take a very rapid review of them. Banks ligates the sac as high up as possible after cleanly dissecting it out, ties and cuts off omentum, sutures the pillars with silver wire, and caves them in. He recommends a light truss. He followed 66 cases, 44 were successful, 7 only partially so. McEwen, who obtains the remarkable score of one failure, and not one death in 65 cases, dissects off the sac, sometimes cuts it off, and sometimes leaves it; when left, puckers it up to form a boss or bulwark to support the opening; frees the opening around the margin of the inner ring with the finger, then close the canal by stitching conj. tendon and Poupart's ligament; drains the wound; keeps patient in bed six weeks. The first dressing is done at the end of the second week. It would undoubtedly require an experienced surgeon with every appliance at his command. His American imitators assert that nothing like his success can be obtained by them.

Ball, of Dublin, isolates the sac, empties it, carefully applies torsion four or five times; ligates high up, then sutures skin twisted part and pillars. Torsion is the great feature he relies on.

As might be expected, American surgeons have exercised their extraordinary skill, fertility of resources, and inventive genius, on many occasions to achieve success in this operation.

Bryant, of Bellevue, with admirable dexterity, dissects off the sac, and weaves it in plaits with the pillars of the ring.

Another operation by McBurney, of St. Luke's, New York, is worth mentioning. He submitted an account of it last February, with 38 cases, nearly all successful. He cuts down, raises the sac, separates adhesions, if existing, carefully removes contents, opens it, pushes his finger in the ring; ligates with catgut even with abdominal peritoneum, letting the ligature slip off his finger, ensuring absence of contents; cuts off to allow secure stump to hold ligatures; then with 4 to 6 sutures binds skin, fascia, external oblique, conj. tendon, same on the other side; packs the wound with iodoform gauze; puts in tension sutures with pledgets of iodoform gauze; stitches, and if need, drains scrotal wound; puts on package of gauze and cotton, secures tightly with bandage, leaves it two weeks, and after six weeks expects a solid scar support. Plaster of Paris is used with children, coated with shellac, and draws off the urine for the first few days.

In the discussion which followed, Stimson, Gerster, Abbe, Hartley, Syms, Kein, and others, strongly commended the operation, and gave it marked preference over McEwen's or Ball's. No truss is employed; he thinks it might interfere with development of scar. It is easy of performance. Dr. Gibney stated he had seen fewer patients with returns come to his hospital after Mr. McBurney's than any other operation. In addition to those I have given, we have the operations of Stokes, who opens the sac, stitches canal and pillars, leaving the sac in position; Alexander, of Liverpool, who ligates sac, flush with peritoneum; divides the neck, leaves sac in and does not suture the pillars. Annandale ties the sac, cuts it away, and stitches the opening. McCormac endorses Alexander's method. Many others might be mentioned with slight differences; they are all on the same principle. Since writing the above, I had the good fortune to meet in the *New York Record*, of last week, a paper on the subject of radical cure, read before the Surgical Association, at Washington, on the 15th of May last, by the eminent surgeon, Dr. W. T. Bull, of New York. Nothing could better illustrate the merits and standing of the operation than this does. It epitomizes a large

amount of labor, and gives what, in considering this subject, one would wish to have, to enable him to form an honest opinion, viz., a large number of different cases, operated on by an experienced surgeon, with every facility and aids to success at his command; not done by one particular mode, but by different ones, and tested by the important test of time. Therefore a summary of it will be a fitting conclusion to this subject. Dr. Bull's cases number 134 operations, extended over a period of seven years; they consisted of 77 reducible, 42 irreducible, strangulated 15. He arranged them in four series: first, 40, in which he ligated the sac at its highest point possible (this was an essential feature in all his cases); the portion below he cut out when small; when large, or containing the testis, he drained it for four days.

The second series, 39 cases, ligated sac as before, with catgut, also sutured the pillars of the ring, and the divided aponeurosis.

Third series: The main feature of this was that the anterior ball only was divided when impossible to reach the neck in any other way. This consisted of 19 cases.

Fourth series, 16 operations, all on children from 4 to 14 years, and all had been done during the past six months. Here he employed a variety of methods. Nineteen of his subjects were over 50 years. He had three deaths, and on four occasions, opened the intestine while separating adhesions, which however did well after being carefully sutured. Primary union was obtained in half of the first three series and in all of the fourth. As to results, in first series he traced 22, and of these, in the first year, there were 7 cases and 6 relapses; 1 to 5 years, 12 cases and 2 relapses. The second series showed, under one year, 5 cases and 4 relapses; from 1 to 4 years, 15 cases and 6 relapses. Third series, 20 cases in first year and 11 relapses; of the fourth series, 16 children and 5 relapses. In percentages, the first method gives 62.63 per cent. recoveries; the second, 60 per cent. Some used a truss after operation, some did not. He recommends a light one for some time after the operation.

His opinion, given with the remarkable candor and fairness, is "that the operation is justifiable; it gives relief for a time, and is not



attended with risk, except in the weak and the aged," but says that "all methods of radical cure will be found unsatisfactory." Thus you will see that, to the majority of us in general practice, there are not many inducements to undertake the operation; unless when after operating on strangulated hernia, we may as well give it a trial and have the best authority advising us thereto; also in some rare cases when the truss will not effect its purpose. But there can be no doubt that still, as of yore, a properly adjusted truss, particularly in the young, maintains its position as the best means of effecting a radical cure, and the remarks of Lawrence, in summing up the criticism of the radical cures in his day, *mutatis mutandis*, apply with some degree of force at present. He says, "the subject of an incarcerated rupture submits to an operation in order to save his life; but he, whose hernia is reducible, endangers his life to get rid of an inconvenience, and the operation affords no greater prospect of recovery than he had without it; for after he has undergone an operation at the hazard of life, the complaint may return, and the only protection against relapse is to wear a truss.

And now, gentlemen, allow me in concluding to express the hope that my thirty-five years, experience of the subject, as it occurs in general practice, may prove advantageous, if not by intrinsic merit, yet by the practical, useful discussion it will evoke; of one fact you may be sure, that I sketched from Nature, whether the draft be true or not. I intended a summary of our present knowledge of the affection, but it is long since anything original has been said on the subject. It has assumed much larger proportions than I intended; yet all the points presented are worthy your attentive consideration.

I need not remind you that the surgery of the present day is bold, active and progressive; never in its history has it occupied so lofty and so brilliant a position. The field of its operations is ever widening, until the imagination scarcely realizes the limit to which it may attain, so the busy general practitioner finds it difficult to keep pace with its progress. Yet the keen competition he has to fight with continually spurs him on. Great, therefore, must be his gratification to have a tribunal such as this to appeal to, where the criticism of different prac-

tical minds sifts and analyses for him; so much diversity of opinion separating what is conservative and judicious from that which is rash and reckless; so enabling him to carry away knowledge complete and condensed to be utilized when the emergency arises. Nor need he tire of waiting recollecting that the great test of truth is time, nowhere more fully realized than by this subject.

When coming here I asked a very good friend of mine to come with me offering as an inducement that I was to read a paper. He replied, "I think not; all you fellows who read papers fly too high." I will fly low; perhaps I have too well fulfilled the promise.

My anticipations have been made agreeable by the fact that there has been associated with me men of well-known surgical skill and experience of acknowledged reputation.

I must express my gratitude to the President, by whose courteous consideration I have been honored with the position of initiating this discussion, more particularly when he might readily have had men much better qualified to perform the duty.

Finally, I thank the members for their forbearance, which I feel I have over-taxed. Their well-known good natured kindness justifies me in expecting that to all the defects of this review they will extend a palliative, if not a medical, cure.

#### NOTE REGARDING OPERATIONS FOR LACERATED PERINÆUM.

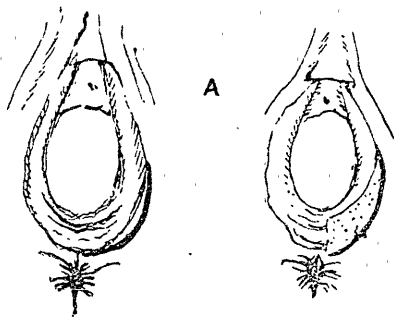
BY JAS. F. W. ROSS, M.D., C.M., L.R.C.P.,  
LONDON.

Surgeon to the Woman's Hospital and General Hospital,  
Toronto.

It is amusing to look over the text-books and read the mystical accounts given of a supposed mystical operation. I would like to enumerate the operations for the repair of a simple injury. Their name is legion. Take, to begin with, Emmet's book. The preliminary directions given are so complicated that the ordinary practitioner would require great courage before he dare attempt to repair a ruptured perinæum. The patient is to have purgatives for a whole week before the operation; an enema is to be given in the knee chest position; then follows

a dose of castor oil, and she is ready to be stitched up. Then follows a description of an operation that is difficult to understand, and difficult for a novice to perform. It is ingenious, but has the one fault of most of these operations, namely, that too much stress is laid upon points that are of slight importance.

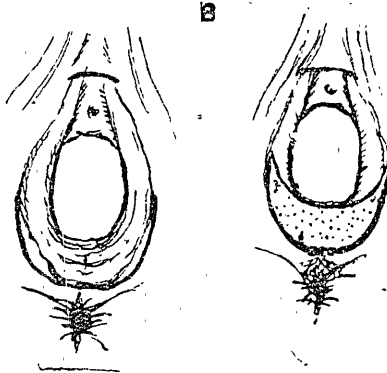
Then let us turn to Fritsch's work. Here we have diagrams more terrible still. The old time operations are given in goodly number. Hegar's double-winged denudation; Hildebrandt's figure for denudation; Freund's complicated figure. Then the author, as does every author, gives a long description of "my method," to still further mystify the hard-working student and hard-worked practitioner. Why all these writers will stray off for another method when the operations already known fully fill the requirements, I fail to see. In this way medical literature is increasing enormously in quantity, but of an in-



ferior quality. Useful time is thus wasted by both writer and reader. To invent a new perinæum operation, or a pessary, seems to be the desire of many. The change of a suture or peculiar curve of an incision at once, in the present era, necessitates a change in the name of the operation. We hear men continually saying: "I did a Jones' operation yesterday"; or, "I will tie a Smith-Hopkin's knot"; or, "I will make a Jones-Smith incision." Certainly this nomenclature is to some extent necessary; but it has been, of late years, carried to such an extent that the student of medicine will have so much name to remember that he will forget the principle involved in the operation itself.

We now turn to Doran's work. He believes with Dr. T. G. Thomas that one week of purgation is not sufficient, and that two weeks could be consumed for this purpose. It may take two

weeks to clear out twenty-five feet of intestine, but any one who has taken a large dose of castor oil feels sure that the alimentary tract of an ordinary healthy man is about empty by the time that the bowels have ceased moving. Perhaps it is different with a woman. "Discharges from the uterus are to be carefully attended to," he says, "and hemorrhoids also require attention. For my part, I snip off any hemorrhoids at the time of the repair of the perinæum, and the cases do very well. A good vaginal douche before the operation, and twice a day subsequently, is sufficient to keep the parts clean, even in the presence of a uterine discharge." He then relates Bantock's operation, the flap of which is identical with that of Hegar's, without the small vaginal prolongation above. Then we have a purse-string operation described—



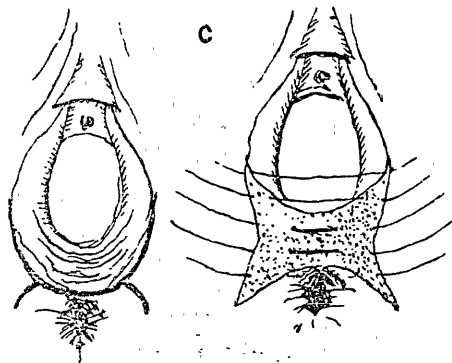
new application of an old principle—ingenious, but unnecessary, with all the good methods already at our hand.

Skene, in his work on diseases of women, gives the most common-sense directions. He says the denudation depends on the peculiarities of the case—tracing the extent of the original tear by the outline of the scar. He does not fill his book with plates of a great many methods, but gives some useful plates for the student, even if he is wedded to any special operation. He gives some valuable advice regarding secondary hemorrhage. This troublesome complication is completely overlooked by most writers on the subject. Many authors say that union by first intention is necessary, or the operation will fail. If the flap-splitting operation is done with silk-worm gut sutures, the operation will be successful, even if union takes place by second

DIAGRAM EXPLANATIONS.—*A* and *B* incomplete laceration; *A*, dark line, shows line of incision, which must be deep, and shows effect; tissues to be well stripped back with fingers. *B*, same, with addition of other side, incision completed, and separation complete. *C*, *D*, *E*, through sphincter ani. *C* shows angular incisions, to make flaps to complete torn anal orifice. *D*, method of peeling down flaps and of holding in position. *E*, same, with sutures tied, forceps still attached; raw surface left to be closed by two or three interrupted skin sutures.

intention. I have had one such case where the laceration was through the sphincter ani. The cure was complete. She had been operated on before she came into my hands, and the wound did not unite on that occasion, as the operation was done by the paring method, and as silk sutures were used, they required removal about the ninth day. The silk-worm gut sutures employed at the second operation were left in until the wound had closed by second intention at the third week, and were with difficulty removed. One stitch is still *in situ*, and gives rise to an unpleasant pricking when the patient sits down. In any case these sutures will completely disappear by the healing of the tissues over them, but are liable to give rise to subsequent discomfort, and even to abscess formation, on account of the stiff bristly ends irritating the tissues.

In Hart & Barbour's Manual, the operation is described in a manner to be readily understood

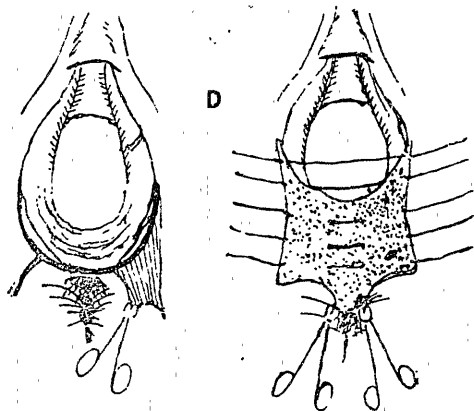


by the student, but they still retain one of the formidable plates of the exact line of denudation as used by Hildebrandt. Simpson's incisions, as described by them, are identical with the incisions made with the scissors to split up the flaps, instead of dissecting them up with the scalpel. Then we have the very elaborate and painstaking record of Kelly, in the American system of gynæcology. He gives diagrams or descriptions of operations of many already mentioned above, and of Bischoff, Voos, Stande, Goodell, Martin. Unfortunately, he does not include plates of the flap-splitting operation.

Munde, in the *American Journal of Obstetrics*, July, 1889, describes the flap-splitting operation and gives drawings to illustrate it.

I believe that all other operations for lacerated perinæum can be laid aside and not missed, and

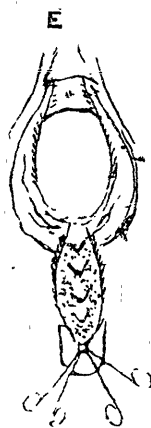
that the flap-splitting operation can be adapted to every case. I have now done the operation many times, have seen it done many times by Mr. Lawson Tait, having seen all the operations performed by him during a period of six months, and my own results have equalled, if not surpassed, my expectations. In two cases of complete laceration that I operated on some three or four months ago, the operation has put the patients in as good a condition as they were in before the laceration occurred. Both have complete control of the sphincter. One case healed by second intention. In neither case did the operation last over ten minutes. The period required for the administration of the anæsthetic is thus shortened. The operation can be performed in any bedroom, with the patient drawn to the edge of the bed. Only one assistant is required, the one to give the



anæsthetic. The instruments are few in number, a pair of angularly-curved scissors, two pair of compression forceps, a curved perinæum needle with a handle, a sponge, and a few silk-worm gut sutures. The tighter the ligatures are drawn the more the mucous edges are forced into the vagina (and rectum in complete laceration), and the skin edges are forced outwards, and the deeper is the resulting perinæum. This is owing to the manner in which the sutures are introduced inside the raw surface, or, in other words, inside the skin and outside of the mucous membrane. The sutures should be introduced beginning with the one nearest to the pubes, and working downwards, so that the upper sutures will not be in the way of the ones next introduced. They should all be placed before any are tried. The mucous skin edges must be

pushed out of the way as the two raw surfaces are brought together, that they may not interfere with the success of the operation. The incision should be made on each side at the outer margin of the old cicatrix, and should be carried up from the middle line towards the labia on either side. The diagrams show roughly the first stroke of the scissors, then the second stroke on the other side, making the complete split. This is all that is necessary in cases of incomplete rupture. To this, for complete rupture, is added a stroke of the scissors downwards and outwards, from this to form flaps to complete the closure of the anal orifice. As soon as the parts are split they gape and present a raw surface of good size. The size of this raw surface, and the extent to which it can readily be enlarged by peeling up the parts with the finger, is rather a revelation to any one doing the operation for the first time. It really resolves itself into A. R. Simpson's flap operation, but the flaps are prepared by splitting with scissors, and by peeling the parts up with the finger, instead of incisions with the scalpel and dissection with the same instrument. The application of the sutures is, however, totally different, and on the correct application of the sutures the success of the operation is largely dependent. A pair of forceps is hung on each of the little flaps left on each side of the anal margin. These are given a half-turn inwards, so as to twist the skin downwards and inwards towards the anus, where they are destined to remain and form a new anal orifice. They are kept in place by the tendency of the sutures, when in place, to force the skin and mucous edges of the raw surfaces, when brought in contact, further away from one another. The vagina is washed out before the operation; the german scrubbing of the parts with soap and water, and the use of the razor may be done away with in this country. The patients will survive and do well without this unnecessary trouble. The patient's bowels must be thoroughly moved before the operation. This movement must be so timed that nothing more is likely to come away during the operation. In my case of union by second intention, the bowels unfortunately moved as I was applying the sutures, and the irritating bilious matter flooded the whole wound surface. This accident was directly blamable to the nurse who, having

forgotten to give the five grains of calomel when ordered, twenty-four hours before the time set for operation, gave it within nine hours of the appointed time. No iodoform need be dusted, as per usual routine, on the wound; but a vaginal douche of warm water should be given very carefully twice a day. For six or seven days the bladder should be emptied by catheter. I move the bowels every day, after the first twenty-four hours, by small enema, and give very light nourishment for a few days. If the patient is restless a bandage is put round the knees, to keep them from any wide separation. The external wound is washed with water, if it is deemed necessary. In those cases in which I have, at



the time of the operation, also snipped off piles, and controlled the hemorrhage from them by suturing the edges, it has been necessary to apply frequently a four per cent. solution of oleate of cocaine, to control the pain for the first twenty-four or thirty-six hours. These cases have all healed up without any difficulty.

The sutures, though coming out on the raw surface near the skin and mucous membrane, must be passed deep into the tissues, so that they may have a firm hold of the deeper strictures. Superficial skin sutures may be applied, if thought desirable, but I prefer leaving the skin edges gaping as they are, so that the sutures may be more easily removed. Sutures that bury themselves are sure to give rise to trouble. The ends should be left long.

The flap-splitting operation may be combined with anterior or posterior colporrhaphy. I have combined it with both, and have recently reported one case of rectocele cured by this combination. The flap, if anterior, is simply dissected off in the usual manner, and then the perinæum is repaired. If posterior, it is cut off at its base, and the perinæum is then split and repaired. I have recently used the combination in a case of cystocele, with a perfect result. If in any case the hemorrhage still continues after the sutures are tied, the best plan is to re-open at once, and find the vessel. If this is not done,

the re-opening may become necessary after the patient has come out of the anæsthetic, and when no assistance is at hand. I have controlled very severe secondary hemorrhage by packing the vagina, but suffered many night calls and much anxiety. The hemorrhage stopped and set in again half a dozen times, and blanched the patient, but I could not see any urgent necessity for undoing all my work. The result was ultimately perfectly successful. The hemorrhage was due to sudden bursting of a stitch, uniting the edges of the vaginal pared surface, occurring during a fit of uncontrollable laughter.

As to silk-worm gut sutures, I may say that they will produce suppuration just as any other sutures will. The wound surface itself may suppurate, but because the sutures can be left in, and because the sutures hold well, union will take place by granulation, and will be satisfactory. In such cases, sutures should be left until healing is complete.

Having seen the operation done, there is no practitioner of ordinary intelligence who cannot sew up a lacerated perinæum, and cure his patient. Careless after-treatment of a case done by any of the many methods devised will surely result in failure. It is not so much the method of operating, as the care of minor details taken before and after operation, that leads to a successful issue.

### THE PARIS MORGUE

The morgue was founded (1) to shelter and preserve bodies, where crime had been committed, till the machinery of the law could be set in motion; (2) to expose the dead bodies of unknown persons to the public gaze, until their identity should, if possible, be established. For this purpose two principal apartments were obtained, about which were grouped smaller rooms for various accessory purposes.

#### PRESERVING ROOM.

The room destined solely for the preservation of the dead is very large, with high ceiling, and paved with stone. In one wall are a number of compartments, arranged in three superimposed tiers, of the length of the human body. Each compartment, resembling a baker's oven, is hermetically closed by bolted wooden doors. The

walls of these cells are lined by pipes, placed side by side in the lowest tier, separated by small intervals, and consequently diminishing in number as we approach the upper tiers. Through these pipes there is a continual circulation of cooling fluid (chloride of calcium solution), which lowers the temperature to 20° below 0°C. in the lowest tier, and from 10°, 8° below in the upper tiers.

At 20° the bodies are frozen in their entire thickness, including the viscera. They now form solid blocks as hard as marble, which can be broken only by the aid of the axe or hammer. In that state they can be preserved for an indefinite period, and it is often curious to witness the stupefaction experienced by some criminals, arrested a year or more after the murder, when they are brought face to face with their victims, and see the wounds they had inflicted, in the identical state in which they had left them.

Bodies fished out of the Seine, and already in a state of putrefaction, are exposed to the same temperature (20° C.). They, of course, do not return to their former condition, but all decomposition is completely arrested.

Although this proceeding preserves the body, it renders the autopsy very difficult; for, that it may be strictly accurate, the body should have regained its previous suppleness. The body thus frozen, when exposed to external air, requires several days, even in summer, to return to its natural state, and frozen tissues quickly putrefy when thawing takes place.

To obviate this difficulty, a hot chamber has been erected in a neighboring room, whose temperature can be raised to above 200° C. The bodies are exposed to this temperature for three or four hours, after which the autopsy may be proceeded with.

When it is not necessary to preserve the bodies for a long period, they are placed in the compartments of the upper tiers, where the integument and muscles are frozen, but not the viscera. Such bodies are well preserved for some weeks, and are much more easily thawed out.

#### EXPOSING ROOM.

The exposing room is the one accessible to the public. It is divided by a glass partition into two rooms of equal size. The one is accessible from the street; the other is entirely shut

off, and contains the bodies lying on tables, the feet turned to the public, the head raised by a block, so as to bring the face fully into view. The bodies are fully dressed, and in the same condition as when found, so that they may easily be recognized, if any one who had known them in life should, by chance, pass in front of the window. In this event, all he has to do is to make a statement to the clerk, who is always to be found in an adjoining room.

The temperature of the inner room is constantly maintained from 2° above to 2° below 0°C. At this temperature bodies cannot be kept longer than eight or ten days. At the end of this time it becomes necessary either to transport the bodies to the compartments, or to bury them.

The method employed for obtaining a low temperature in this room is the following:—In the upper part of the room, near the ceiling, is a double-inclined plane, consisting of metallic plates, superimposed in the manner of a tiled roof. The ridge of this extends across the whole breadth of the room. The pipes containing the chloride of calcium solution, open at this point, and distribute the cooling liquid in two large sheets, thus bringing a large surface into contact with the circulating air. At the bottom of each incline, the fluid is collected into a trough, whence it is emptied into a frost-covered pipe, which brings it back to the machine room.

The maintenance of the low temperature is very expensive, on account of the great size of the room. The first contractor received 20,000 francs per annum. The expense has since been reduced one-half, by substituting compressed air for steam as the motive power.

As we have already seen, the lowering of the temperature is due to the dissolving of the anhydrous chloride of calcium, which, in passing from the solid to the liquid state, produces a degree of cold sufficiently intense to freeze mercury (40°C.). Pumps are used to propel this solution through the pipes which we have seen in the interior of the compartments of the preserving room, and over the double-inclined plane in the exposing room. The air brought into contact with this intense cold is soon reduced to the same temperature.

There is a good amphitheatre where autop-

sies are performed. On one side there is a small laboratory, where only elementary researches are carried on, and where specimens, which it is necessary to submit to more minute examination, are collected in special jars. Still further, and near the entrance, is a comfortable room, in which the physicians of the establishment can assemble.

G. A. F.

## NATURE, THE BEST ACCOUCHEUR.

By J. H. GARDINER, M.D.

I am a general practitioner of eleven years standing; and for at least eight years of that time, I have attended from ten to twenty cases of confinement monthly, with the following results: I have had six deaths during the puerperal period; two from embolism, two from puerperal inflammation, one from typhoid fever, and one from shock caused by a large loss of blood at time of birth, and a sudden chilling from open window on a frosty night in October, two days after premature birth of twins. Six of my patients have suffered from pelvic cellulitis; at least four of these belonging to families with a tubercular diathesis. Four or five others have recovered slowly from causes unknown. All others have been well enough to be up and around by the ninth or tenth day. I have seen one case of puerperal convulsions in a very mild form, and in two or three cases I have had a post-partum hemorrhage.

I always wash my hands with soap and water on entering the lying-in room, and if I have been attending any suspicious surgical or medical case, use carbolic acid in the water. I use either sweet oil or lard, or whatever other substance I can get in the house where I am attending, for lubricating purposes, both for hands and instruments. I am careful to see that all clots and portions of the placenta are removed, and that the patient is free from all bloody or wet clothes, and also that the bed is clean and dry, before I leave the house. I know of one case in which the cervix uteri was ruptured, but the patient refused to have it operated on, and she has since borne children, but never complained of any inconvenience from the tear. I have once stitched a ruptured perinæum; in all other cases nature has performed the cure to the

satisfaction of myself, the patient, and the husband. I do not know whether specialists on women's diseases would be pleased or not. I am sure that, from the amount of violence I have had to resort to in some severe forceps' cases, considerable bruising must have resulted to the soft pelvic structure; but nature, in all forceps' cases save one, effected a cure in the usual puerperal period. The exception was one in which cellulitis followed with perfect recovery, after six months in bed. In severe cases I always examine my patient to ascertain if much damage has been done, and if the parts are very much bruised, I order, on the third day, a warm carbolic injection. I also use this in all cases, if the discharges become at all offensive, and generally instruct the nurse to use a little carbolic acid in the water she uses to bathe the patient with.

Now, what are the causes of puerperal inflammation, or puerperal septicæmia? In order to answer this, it is necessary to study the woman before delivery, and the changes that have taken place during the nine months' growth of the fœtus; also, how nature restores the normal condition of affairs, whilst guarding with jealous care the well-being of the patient.

The first period is one of building up—of growth. The second period, one of breaking down—of decay. During the first period, large quantities of adventitious tissues are formed; these being no longer wanted, have to be removed. In the second, nature's disinfecting and excretory apparatus are taxed to their utmost, and all that is asked by her is a fair field and no favor. Give the skin, the lungs, the kidneys, the bowels, and the uterus, a fair show, and in ninety-nine cases out of every hundred, no other treatment will be necessary. But chill your patients, and stop the action of the skin, and the kidneys, bowels, uterus, and even the lungs, will become engorged, and in time paralyzed. The mammary glands will cease to secrete, and your patient will have puerperal fever. Restore the secretions of these parts, and the patient is better. Again, introduce some source of septic poison into the vagina or uterus, and it may become absorbed, and the same result follows. The same may be said of the lungs or bowels. In every case the strictest care is required, always remembering

that nature, as a rule, is the chief agent, and all that the accoucheur can do is simply, where she fails, to aid her in her efforts, never to retard her in her work by injudicious meddlesomeness or criminal carelessness; and do not ascribe to art that which can be done, and is done, in a far more effective, if less expensive, way. A general practitioner attends all classes of cases, and strict care should be observed; but it is only in a very few instances, such as erysipelas, pyæmia, or septicæmia, that any special care is necessary. And I think it safer to refuse to attend cases of confinement, if you have a well-marked case of puerperal fever.

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THE  
Canadian Practitioner

A SEMI-MONTHLY REVIEW OF THE PROGRESS  
OF THE MEDICAL SCIENCES.

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*Contributions of various descriptions are invited. We shall be glad to receive from our friends everywhere current medical news of general interest.*

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TORONTO, AUGUST 16, 1890.

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THE UNIVERSITY OF TORONTO, AS  
COMPARED WITH FOREIGN  
UNIVERSITIES.

We have received a letter from a Professor of the University of Toronto, who has been abroad for some months, which gives some very interesting particulars about certain universities in Europe, and especially in Germany. The University of Zurich stands in the front rank, although its capacities, when compared with those of many other institutions, are somewhat limited. Being about the size of the University of Toronto, it becomes a matter of interest to compare the two. The Canton of Zurich contains altogether 200,000 inhabitants, certainly not a vast population; but it gives to the university, in which it takes great pride, no less than \$50,000 a year. A canton is much like one of our counties. From present indications, this generation will have to pass away before the County of York, with the generous City of Toronto,

will give as much as 50,000 cents to our University. In the matter of money, therefore, it will be seen that Toronto and little Zurich are as far apart as the two poles.

They don't object to medical faculties in connection with universities in any part of the world, excepting this Province of Ontario. Zurich, like most of the important universities, has a medical faculty. Our correspondent, who, by the way, is not connected with the Toronto Biological Department, tells us that the facilities of Toronto University, in the primary subjects, are quite equal to those of Zurich, and that its physiological laboratory is decidedly better. He adds, incidentally, that he has not seen a physiological laboratory in Europe that is superior to the one planned and conducted by Professor Ramsay Wright. In the Pathological Department, Zurich is far in advance of Toronto. This fact has been appreciated for some time by the friends of the latter, and it was hoped that the Government of Ontario would give some assistance in this direction. As the Government, however, has not shown any aggressive spirit in the matter, the friends of the medical faculty are raising a fund by subscription, to aid in the teaching of this important subject.

In the matter of clinical teaching, Zurich, in some respects, stands ahead of Toronto, but the methods of the latter have improved so much lately that she is not far behind her German sister. We understand that efforts will be made during the coming session to make the clinical teaching in Toronto more thorough and practical than it has ever been before. There is no reason why the medical teaching in Canada should not be equal, in all respects, to the best in the world. We are glad to know that professors of the University of Toronto are fully impressed with this fact, and we are pleased to be able to state that six members of the staff are spending a goodly portion of the summer in studying the methods of teaching, both primary and final subjects, in the best British, French, and German medical colleges.

#### THE UNIVERSITY OF TORONTO AND THE CITY OF TORONTO.

The defeat of what was known as the University By-law, by an overwhelming majority, was a great surprise to many, both in and out

of Toronto; and we are frequently asked, What does it mean? We cannot undertake to answer the question; but will try to state briefly the position of matters. Many years ago, the authorities of the University gave to the city certain lands, known as Queen's Park, and the Queen and Yonge Street Avenues. There were certain conditions connected with the gift, which compelled the city to carry out certain provisions in connection with maintenance, etc. The city failed to fulfil its portion of the contract, and finally the courts decided that it had forfeited all rights to said lands, which consequently were to revert to the University.

The position of things at this juncture was deplored by all, and after several conferences between University trustees and members of the City Council, with the Mayor, it was agreed that the city should get possession of the park and avenues without any restrictions, and should give to the University \$6,000 per annum to endow two chairs—such chairs to be chosen by the city. It was thought that the city could easily give such a sum to the University; and on the part of the trustees of the latter, it was considered that, although the sum was small, under the circumstances it was better to accept it, and thus remove all causes of friction between the two. After the disastrous fire, offers of assistance came from all nations, in all climes. It was proposed in the City Council that Toronto should give the University \$50,000. After some considerable discussion, a scheme was proposed which would cost the city little or nothing, while it would be a great benefit to the University; that was, to give the University a lump sum of \$200,000, instead of \$6,000 a year forever. As is well-known, the by-law to grant the \$200,000 was defeated by about four to one. Little wonder is there that the result created surprise.

The outside offers of assistance have materialized, and princely gifts, especially for the library, are coming in from all quarters. Toronto, which derives more substantial benefit from the institution than all the world besides, is the only place in the world that has positively refused to raise a finger to assist the University in its time of distress. Fortunately, it will make no difference to the University. It will be restored, and far more than restored. A little



more will be left for its friends to do, but they will assume the burden. The city will some day, we hope, be heartily ashamed of its action. If St. Paul lived now—in Toronto—he would scarcely boast that he was a citizen of no mean city.

### LODGE PRACTICE.

It is well known that what is called "lodge practice,"—that is, the practice of attending lodges, clubs, etc., at a contract price of so much per annum,—is becoming very prevalent in this province. It is rather difficult to realize the extent to which it has grown in Toronto. We have various kinds of lodges, of religious societies, mutual benefit societies, national societies, united workmen societies, and other organizations of all sorts and conditions, composed of employees of factories, mills, etc. Physicians frequently join a number of these societies, simply for the purpose of securing contracts as "lodge doctors."

We have no desire to discuss, now, the question of principle involved. There is something to be said on both sides of the question. The practice originated, we believe, in the old country, and is, at the present time, looked on with considerable favor by a large number of independent and high-minded members of the profession in Great Britain. We do not wish to get on too high a pedestal and cry "unclean" to every one who engages in this contract business; but we must adhere to the opinion which we expressed some months ago, that it is, in several respects, degrading to the profession of which we are members. Usage in this direction in Great Britain will not carry much weight with us, especially in view of the fact that the social status of those who engage largely in such practice is generally low in England.

Our desire is rather to point out the fact, as stated by a correspondent, Galen, in the last issue of *THE PRACTITIONER*, that professional opinion appears to be decidedly against such practice. Galen referred, among other things, to three very pronounced expressions against it in the month of June: one at the meeting of the Ontario Medical Council, and the other at the meeting of the Ontario Medical Association. The President of the latter body, Dr. Temple,

in his annual address, denounced the practice very strongly. Some of the American visitors expressed their surprise on hearing that it was so common in our cities.

It has been proposed by some that all physicians engaged in such practice should be excluded from such societies as the Ontario Medical Association. We would not like to say that such drastic measures are necessary or expedient; but we are inclined to think that professional opinion is going to have an effect, in the near future, in the way of curtailing the practice. Even now many who are engaged in it are thoroughly tired of it. No one now takes much pride in boasting that he has become one of the Grand Knights of the Maccabees, or a member of the Ancient Order of Peanut Vendors, or one of the Brotherhood of the King's Own Cobblers, simply for the purpose of making money out of contracts with these worthy organizations. Many of our young practitioners, who are ambitious to attain good positions, have fully decided to avoid lodge practice in every form. Others who have been engaged in it are giving it up. It is only fair to say, however, that quite a number of physicians of various ages, whose names are above reproach, have been, and still are, engaged in more or less contract work.

### CLEANLINESS IN MIDWIFERY.

We publish in this issue a communication from Dr. Gardiner, of London, on "Nature, the best Accoucheur." We are afraid there are some points connected with antisepticism, or asepticism, which are not sufficiently understood. The important desideratum is perfect and thorough cleanliness, and for this purpose hot water, soap, a nail brush and a pen-knife, are really the essentials. In addition to these, carbolic acid is sometimes used in a way that is perfectly useless, or worse than useless, if any virtue or entire sense of security is associated with it. We frequently see a little carbolic acid, a drachm or thereabouts, added to a quart or two of water for disinfecting purposes. It may do no harm in such proportions, but it certainly does no good. If it be deemed advisable to use a germicide, the bichloride of mercury is the best in ordinary use, and it may be carried very con-

veniently in the obstetric bag, in the shape of the tablets which can be procured from all druggists.

The ordinary routine, in all cases of labor, should consist in perfect cleansing of the hands with warm water and soap, before making an examination. In addition, it is well to have a solution of bichloride, 1-2000, in a separate vessel, for further cleansing of the hands. The accoucheur should have his own lubricant in the shape of borated vaseline, or something of that sort. If he has not this at hand, he should not use every specimen of lard or grease which may be presented to him. We think ordinary soap and water are safer, even though the soap may to some extent neutralize the germicidal effects of the bichloride. A similar warm bichloride solution is one of the best that can be used for washing the external genitals after labor is completed, or warm water alone will answer very well. The "little carbolic acid" that may be added by the nurse for the same purpose, simply makes a certain amount of *smell*, without accomplishing any good.

The directions about cleanliness are exceedingly simple and easy to carry out. They appear to be too simple for some great minds, and are frequently, through that or other reasons, neglected. This neglect of these simple precautions is the common cause of puerperal septicaemia. The poison is generally introduced from without on dirty finger tips. We agree with Dr. Gardiner in thinking that, in the absence of septicaemia, nature is generally able to effect a cure even when there is considerable bruising; and probably we would not be very wide of the mark if we considered that there is always considerable bruising. Laceration of the cervix is very common, if it does not occur in the majority of cases, and our correspondent is correct in supposing that nature is generally able to unite such tears, and probably does her work better when there is no interference. Meddlesome midwifery is a nuisance—dirty midwifery is an abomination.

#### CENTRAL BOARD OF EXAMINERS FOR THE STATE OF NEW YORK.

An important act has been recently passed by the legislature of the State of New York which will materially affect the standing and sta-

tus of the medical profession in that State. The bill was approved June 5, 1890, and will go into effect September 1st, 1891. According to the text of the bill, as published in the Buffalo *Medical and Surgical Journal*, there will be three separate boards of medical examiners: one representing the Medical Society of the State of New York, one representing the Homœopathic Medical Society of the State, and one representing the Eclectic Medical Society of the State. These three boards of medical examiners will be under the supervision of the Board of Regents of the University of the State of New York. The questions for the various examinations will be submitted by the three boards to the Board of Regents, who will choose the questions to be used in such a way that these will be of the same standard for all candidates in all subjects, excepting practice of medicine, therapeutics, and materia medica. Each examination will be under the supervision of the Board of Regents, through an examiner appointed by that board, such examiner not being a member of any of the three boards of examiners.

This arrangement will throw the responsibility of conducting the examinations chiefly on the Board of Regents. This will be, practically, the central board of examiners for the State, and will be very much like our system in Ontario, where the board of examiners for the Medical Council is supreme in the matter of granting license to practice. A degree or diploma from any university, or teaching body, will cease to carry with it a license to practice in the State of New York. The power to grant such license will be entirely in the hands of this Board of Regents. The act also demands a preliminary education, in accordance with the standard and rules of the board. Such preliminary examination may be passed at any time before the completion of the first year's studies. Each candidate for the final examination will be required to have attended lectures during at least three full sessions. Arrangements have been made for the recognition of similar licenses granted by examining boards of other States, providing that they show a standard of requirements equal to that of New York.

This is likely to raise, considerably, the general standard of education in New York, and other States adopting similar regulations. It is not

yet quite what we would like to see. The preliminary examination should be passed before the student commences to study medicine, and a course of four years should be required, as in Ontario.

#### DR. SULLIVAN'S PAPER.

The Hon. Dr. Sullivan's paper on "Hernia," read before the Ontario Medical Association, appears in the present issue of THE CANADIAN PRACTITIONER. We trust that it will be carefully read, not only by the general practitioner, but by the specialist in surgery. The individual who has a rupture, suffers from a condition the gravity of which it is difficult to over-estimate; we are apt to think lightly of it because of its great frequency; it is a class of disease with which we are all familiar; it is a common thing, too, for us to come in contact with afflicted patients who have been absolutely neglectful of their hernia, because they do not realize the serious nature of the complaint. The danger of strangulation, which may prove fatal in a few days, should always be kept in view, and the treatment, therefore, demands our greatest care.

Dr. Sullivan has written a valuable paper; he has had extensive experience, and he has presented to us his views, as the result of that experience, in an able manner. The truss is often spoken of as if it were a palliative form of treatment only, and that a cure is not to be anticipated. We are pleased to see that Dr. Sullivan differs from this view, and states that the truss "is still the safest, surest, and most permanent radical cure we possess"; he rightly condemns all bosses and protuberances, which keeps the canal open, and prevents the possibility of cure.

We heartily endorse his views with regard to the grave dangers of delaying the operation where the bowel has become strangulated, and the exception he takes to the opinion of some authorities, who advocate returning gangrenous or "doubtful" bowel into the abdominal cavity. There are many other valuable suggestions in Dr. Sullivan's paper, which we cannot refer to at length, but which will be appreciated by all, coming, as they do, from a man of exceptional skill and experience.

#### PYOKTANIN, THE NEW ANTISEPTIC.

The antiseptic powers of the aniline dyes have long been known to bacteriologists, who have observed their effects upon gelatine cultures. Stilling and Wortmann, of Strasburg, have been studying their action, with the idea of applying them to practical medicine. Their researches have led them to regard certain anilins as antiseptics even more powerful than corrosive sublimate. Merck has patented them, and introduced them under the name of Pyoktanins, the pus destroyers. Of these there are two, the blue and the yellow.

Pyoktanin, under the name of methyl violet, is well-known to every physician and microscopist as a staining agent. It may be used in the form of a pencil made of the pure drug, or as a powder, two parts of Pyoktanin to 1,000 of talc, or in watery solution, 1 in 1,000 or 2,000.

Pyoktanin is free from any smell or any toxic effect, a great advantage as compared with the antiseptics now in use. Unfortunately, unless very carefully handled, the clothes and the hands are deeply stained by it. These stains may be easily removed by a dilute solution of hydrochloric or of nitric acid.

Pyoktanin has proved itself specially useful in soft or in hard chancres, and in all sorts of syphilitic ulcerations. One reporter claims that by its use soft chancres are soundly healed in from three to ten days. It is said to give satisfactory results in gonorrhœa, when used as an injection of 1 in 1,000.

There would seem to be in these anilins a dangerous rival to the derivative analgesics, such as antipyrine, for it is now proposed to use methyl blue to relieve pain.

#### UNIVERSITY OF TORONTO MEDICAL SOCIETY LECTURES.

A letter from Dr. Ferguson, the President of the University of Toronto Medical Society, appears in this issue, and gives some interesting particulars respecting the regular courses of scientific lectures which are to be delivered annually for this society. As our readers are aware, the first course was delivered a few months ago by Dr. E. C. Seguin, and the lectures were highly appreciated by all who heard

them. Abstracts of the three lectures were published in *THE PRACTITIONER*. They were published in full by the *N. Y. Medical Journal*, and reprints are now in the hands of Dr. Ferguson for distribution to life and ordinary members. All practitioners are urged to become life members. In doing so, they will receive a direct return for themselves, and will, at the same time, assist a very worthy enterprise. The President and members of the society, who are chiefly students, deserve much credit for the work they have done, and should receive every encouragement.

### A LICENSE IN NORTH DAKOTA.

According to the new law regulating the practice of medicine in North Dakota, no one will be allowed to engage in practice until he has passed an examination in all the primary and final branches. No one will be admitted to such examination until he has taken at least three courses of lectures of six months each. The examinations will be conducted by a Central Board, appointed by the Governor of the State. Dr. J. R. Logan (Trinity, '85) is secretary of the board, and examiner in Diseases of the Eye and Ear, and Nervous Diseases. Dr. F. N. Burrows (McGill, '85) is examiner in Practice of Medicine. Dr. C. MacLachlan (Tor., '89) is examiner in Obstetrics and Diseases of Women and Children. Dr. T. O'Brien (McGill, '84) is examiner in Anatomy and Surgery. It will thus be seen that Canadians are well represented on the board.

## Hospital Reports.

### FACIAL PARALYSIS.

UNDER THE CARE OF A. M'PHEDRAN, M.B., IN  
THE TORONTO GENERAL HOSPITAL.

Reported by Mr. Heaslip.

Henry G., æt. 53, engineer; admitted June 20th, 1890. Had gonorrhœa when about twenty-three; no history of syphilis; no other serious illness until January, 1889, when he helped a neighbor for a few hours to shingle the roof of a barn. As he shingled, there beat upon his right side a driving storm of rain, hail, and snow. The next day he found he had taken cold, and on the evening of the third day

after the the exposure pains came on rather suddenly, commencing in right leg and passing up the arm of the same side. The sensation is described as that of the passage of a current of electricity. His features became drawn towards the left, much as they are at present. He thinks that at this time he experienced a very slight loss of power in arm and leg of right side. His hearing, though dull for some years previously, now became still worse on the affected side. Difficulty was experienced in pronouncing certain of the longer words. He resumed work after six weeks, and in two or three months the face became again quite straight; at the same time, hearing and speech improved.

He was quite well until attacked by "La Grippe" in February, 1890. Soon after its commencement he felt pain in the right frontal and temporal regions, where it has since continued.

About May 1st, he noticed paralysis of right side of face coming on again, becoming complete in about two weeks. At the same time the patient became totally deaf in the right ear; muscles in right side of face are paralyzed; in speaking, the mouth is drawn towards the left side. The patient is unable to wink or close the right eye; in attempting to do so the eyeball is drawn upward. The lower eyelid is depressed; owing to this and to paralysis of the orb. palp. there is epiphora. From constant exposure, the conjunctiva has become inflamed; there is also a very small ulcer on the cornea. The eyebrow is lowered and the patient is unable to frown or wrinkle the forehead on the affected side. He is unable to whistle. The right cheek is flaccid and sometimes is bitten during mastication. He has difficulty in preventing the food becoming collected between cheek and gum. The cheek and lips are puffed out on the affected side by the expired air in speaking or blowing, and the air passes out almost entirely at the angle of the mouth on the affected side. There is loss of sense of taste in the right half of the tongue; appetite is good; some nausea and belching up wind after eating; vomits after nearly every meal, occasionally before breakfast. He says he does not vomit his food, but only some mucus. This condition has only existed for a few days previous to admission.

The muscles supplied by seventh nerve react to a strong Faradic current; reaction to galvanic current considerably exaggerated.

The treatment consisted in counter irritation behind the ear, by blistering with liq. epispasticus, the administration of pot. iodide, and the stimulation of the facial muscles daily with the Faradic current, to prevent atrophy of them. Sedatives were also given for the stomach. He left the hospital early in July, very little benefited; but much could not, in any case, be expected in such a short stay.

The prognosis is fair; he will probably make a fair recovery after some weeks. The response to the electrical currents shows the function retained in at least some fibres of the nerve.

The first attack he had was evidently due to cold, but there is no such history in this attack. In nearly half the cases there is no such history. The man has been subject to rheumatic pains, he says, and the neuritis may possibly be rheumatic. The complete deafness indicates the internal auditory meatus as the seat of lesion, a rare location. It is not in the medulla, else the muscles in the upper part of the face would suffer little, if any, and both voluntary and emotional movements would not be equally and completely paralysed, as they are here.

#### A CASE OF TETANUS OF THE UTERUS, TREATED BY ANTIPYRIN.

UNDER CARE OF A. H. WRIGHT, M.D., M.R.C.S. ENG.  
IN BURNSIDE LYING-IN-HOSPITAL, TORONTO.

Reported by L. F. Barker, M.B.

I. A., æt. 22, primipara; has always been well with the exception of leucorrhœal discharges, which have been present for the last two years. Habits have been sedentary. Pelvic outlet slightly narrowed. Pregnancy normal. There was prolongation of first stage of labor owing to rapidity of os extern. cervicis and premature rupture of the membranes. Three 15 grain doses of chloral hydrate were given to assist in relaxation of the os, but 24 hours elapsed before the completion of the first stage. The head descended rapidly until the middle of the vaginal canal was reached, when progress became slow. At the end of 40 hours the head was well down on the perinæum, but as the latter remained very rigid and the vaginal outlet

much contracted, the pains became ineffectual. Up to this time the general condition of the patient had been satisfactory, but symptoms of exhaustion now began to appear. The pains became shorter and more frequent. The pulse rose to 100 and over, and patient complained of nausea and thirst. Before very long it became impossible to make out distinct intervals between the pains, and on examination the uterus was found retracted, and in a state of *tonic* contraction. Dr. A. H. Wright ordered 15 grain doses of antipyrin every fifteen minutes for three doses. Before the second dose had been given, patient felt easier, and the tonic internal contractions could again be made out. After the 45 grains had been taken the pains were about three minutes apart, and the tetanic contractions had disappeared. The head, however, being very large in proportion to the outlet, and no advance being made, chloroform was given, and the house surgeon, Dr. L. F. Barker, applied the forceps and delivered the head by gradual traction. The uterus did not contract down well and some blood was lost. Ergot was administered in one drachm doses and the uterus watched closely for three-quarters of an hour, when it contracted well. The results obtained from the administration of antipyrin in this case would justify its use early in uterine tetanus, before the muscle-fibres and nerve-centres are exhausted by prolonged tonic contractions. It would seem probable that the drug acts directly on the nerve-cells in the parturient centre in the lumbar cord, lessening their irritability.

#### DOUBLE PYOSALPINX—PELVIC PERITONITIS—RECURRENT OPERATION—SECONDARY HEMORRHAGE—RECOVERY.

UNDER THE CARE OF DR. JAMES F. W. ROSS, M.D.,  
L.R.C.P. LONDON, IN THE TORONTO  
GENERAL HOSPITAL.

Mrs. J.; æt. 26; referred to me by my friend, Dr. Parry, of Toronto. Menstruated first at about 14. Was then irregular, at times coming on every other week, and at times going from two to five weeks. Married, and had one child. In the last three years has had four miscarriages, the last one two years ago. Has been unwell about every four weeks until lately,

when it has come on every two weeks ; clots and a profuse discharge of blood ; leucorrhœa. Had "inflammation" after her miscarriage ; ill for three weeks ; pain in the back, down sides, and in front of the lower part of the abdomen. Has been very tender since, and suffers much pain when menstruating. Attacks of pain and tenderness have been coming more frequently of late, accompanied by chills and fever ; confined to her bed most of her time ; losing flesh ; attacks come on whether in or out of bed ; at times cannot straighten her right leg.

When I saw her, the temperature and pulse were both elevated. On examination, I found uterus enlarged and pushed toward left side. A mass connected with the uterus felt on right side, evidently dilated tube or enlarged ovary. A very indefinite feeling. Pelvic organs seemed matted together. Operation advised ; husband consented.

April 4. In hospital. Chill last night ; temperature, 100.4 ; pulse, 107 ; severe pain over lower abdomen.

April 5. Herpes labialis ; temperature and pulse still elevated.

April 10. Operation ; chloroform given ; removed thickened tube filled with pus from left side ; adhesions very dense ; pelvic organs all matted together ; hemorrhage very severe ; right tube could be barely made out, but at last peeled from its bed with the corresponding ovary ; washed out with hot water ; hemorrhage ceased ; drained ; pus found in each tube, and each thickened to about  $\frac{3}{4}$  in. ; ovaries not enlarged ; microscope showed loss of epithelium over villi of the tubes and small cell infiltration of the tube walls.

3 P.M. Tube emptied every  $\frac{1}{4}$  hour ; 5 II each time chiefly serum.

9.30 P.M. Return of hemorrhage ; 5 II of pure blood every 15 minutes until 10.30 ; I was sent for, but on arrival found that the blood had again ceased flowing ; temperature, 100.8 ; pulse, 102 ; pain severe ; hypodermic,  $\frac{1}{10}$  grain morphia sulph.

April 11, 1 P.M. Pulse, 100 ; temperature, 102.2 ; after this, severe distention came on, but was controlled ; patient made an excellent recovery.

July 14. Patient returned, looking hearty, and feeling entirely relieved.

## Personal.

DR. W. G. BIGELOW (Tor. '90) has settled in Chicago, Ill.

## Correspondence.

### LETTER FROM BERLIN.

*Editor of CANADIAN PRACTITIONER :*

BERLIN, July 29th, 1890.

DEAR MR. EDITOR,—According to promise, I send you a few notes of my brief sojourn in Europe, hoping that some of the facts given may not be uninteresting to your readers.

Eight or ten day's time is too short for any one to form even a crude idea of the advantages of London as a place for medical education. When, however, one has previously spent some months as a medical student in that great city, he can more easily appreciate its present state, as well as any changes which may have been made. The London schools are at present, as they have been for years, noted for their eminently practical character. The physicians and surgeons are, if possible, more courteous, and every facility is given for the examining of patients. There still exists the same difficulty in the study of special branches. It is not easy to spend more than two or three hours each day in work at any one subject, and this can only be done by examining the various calendars, and carefully noting the lecture hours in each. The formation of a post-graduate faculty does not seem to have made much improvement in this respect. The lectures are given in different parts of the city, and much time is lost in going from one to the other. If one of the larger hospitals, for instance, St. Bartholomew's, Guy's, or the London, was given up entirely to post-graduate instruction, London would be without a rival as a centre for advanced medical education. The thorough and practical instruction given makes up for many defects. There is no "rule of thumb" diagnosis. The physician endeavors, both in the examination and treatment of patients, to grasp the whole case, so as to be of the greatest service to the patient. He is, at the same time, clear and thorough in his remarks to students, taking up the various bearings of the case, and the reasons for the treatment adopted. This, of course, needs much

time and patience, both of which are freely given. In going from one clinic to another, one is struck by the general sameness of treatment. This is more particularly the case in the department of skin disease.

The prevailing treatment for alopec̄ia areata is the external administration of chrysophanic acid, fifteen grains to the ounce of lanolin. The disease is generally thought to be of parasitic origin; but, in some cases, its nervous character seems established. Mild citrine ointment is the usual external application for impetiginous or pustular eczema.

The usual treatment of tinea tonsurans, of which there is in London an enormous number of cases, may be given as follows: First, wash the patches with ol. terebinthin., and then apply Coster's paste. This is continued for two applications, one each week, when some milder agent is used, such as the mixture of carbolic acid and liq. potassæ. In Dr. Crocker's clinic, a little girl of about ten years of age, suffering from warts upon the hands, was being treated by the internal administration of alkaline purgatives. She had not taken the medicine long enough for one to judge of its efficacy. In a general way, it may be stated that lupus erythematosus is treated by scarifying, and lupus vulgaris by scraping and cauterization. Superficial epitheliomata are treated by scraping and the after application of strong nitric or sulphuric acid. Pyrogallic acid is not used so generally as with us; its place being taken by salicylic acid.

Chronic eczema, with a slight amount of itching and infiltration is treated externally by the following lotion and ointment:

Rx.—Liq. carbonis detergen      ℥ ii.  
Aq.    ℥ viii.

to be mixed with an equal quantity of liq. plumbi subacetat dil. This is applied five or six times during the day, so that the part is constantly moist, and at night the ung. precip. alb. is used. This, together with proper internal medication, appears to be very effectual.

The writer had the pleasure of passing some hours in the museum of the Royal College of Surgeons, accompanied by Dr. Peters. It is only fair to say here that Dr. Peters' success in passing the primary examination for Fellowship of the Royal College of Surgeons, three weeks after his arrival in England, was considered in

London to be an unprecedented feat. The general rule is that after a year's special training the majority are rejected. A noted London physician, with whom I was speaking of Dr. Peters' success, quietly remarked, "You must understand well how to teach anatomy in your school."

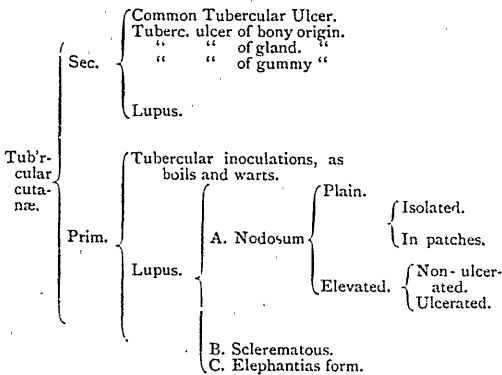
As we examined some of the more interesting specimens in that wonderful and unrivalled collection of the College of Surgeons, we could not but express the hope that a museum on a more extensive scale would soon be established in connection with the Toronto University. There is no reason why a fairly good anatomical museum could not be completed within a few years. It would be of the greatest practical importance to students. The expenditure of a few hundred dollars each year for alcohol and glass jars would be all that would be required; the industry and energy of demonstrators and students would supply the rest. Will the University take it in hand?

A noticeable change has been made in London with regard to practical laboratory instruction in both primary and final branches. The English medical schools, although slow in following the German and Edinburgh universities, are now paying great attention to laboratory instruction, regarding it as absolutely necessary that a student should have abundant and deep foundation upon which to build the superstructure of professional knowledge.

Paris presents features in medical education quite different to those of London. There is but one medical school, with a very large faculty. The latter includes almost all the best known names in the French capital. There are at least six or eight large hospitals in different parts of the city, where the clinical lectures are given by members of the faculty. The lectures in the primary department, as well as those of a didactic character in the final branches, are given in the École de Médecine, two large buildings, one of which is principally made up of immense laboratories, and the other of museum and lecture rooms. The practical laboratory instruction seems to be of a most thorough character, but the clinical teaching is not as good as one might expect. Charcot's clinic, at the Salpêtrière, and Fournier's, at the St. Louis, were excellent, but the lectures which I heard

by Dr. Germain See could scarcely be called clinics. He simply related the history of a case, the patient not being present, and made remarks thereon. His observations were of a deeply philosophical character, very interesting, but not of great practical importance to students.

Two features of the instruction given in the final branches were particularly noticeable, the immense amount and variety of material, and the great number of didactic lectures, as well as the didactic character of the so-called clinics. To give some idea of the great variety of cases presented, I will relate briefly a lecture by Hall-opeau. The subject was, "Tubercular Diseases of the Skin," of which he made the following classification :



After explaining the reasons for making this classification, he exhibited about twenty cases of such varied character that they illustrated almost every form given in the schedule. At the same clinic, bichloride of methylene was used very successfully as a local anæsthetic.

The Paris system, if not the best for the student, certainly tends to the development of the professors ; and on this account, France has always been noted for possessing some of the brightest stars in the medical profession. The great number of old men in actual work is also noticeable, as well as the slow and gradual advancement of the very brilliant younger men.

The subject of hypnotism still engages the attention of neurologists. Charcot does not give so much time to it as formerly, but every Thursday morning an exhibition is given by Dr. Luys, in the "Charité." Its practical uses are not yet well defined, and its possible abuses are so great that one hesitates before adopting it as a therapeutic measure.

The pleasure of attending lectures in Paris

was very much enhanced by the presence of Professors Osler and Ramsay Wright, and Dr. Meyers, all Canadians, who were again experiencing the delight of students, sitting on hard benches and listening to medical discourses hour after hour. I will give in my next letter some thoughts of the German system of medical education, comparing it with the English and French system. Yours truly, J. E. GRAHAM.

UNIVERSITY MEDICAL LECTURES.

Editor of CANADIAN PRACTITIONER:

SIR,—Will you permit me, through the columns of THE CANADIAN PRACTITIONER, to make a few statements regarding the University of Toronto Medical Society Lectures? Many know already that the first course of these lectures, under the auspices of the above society, was delivered by Dr. E. C. Seguin last March. These lectures have now been reprinted in pamphlet form, and are ready for distribution to members of the society.

The advantages of being a life member are very considerable. In the first place, it brings all into close touch with one important department of the Provincial University. In the next place, it enables members to attend the annual course of lectures, and to obtain a copy of them when printed. It can be safely said that any one course of lectures is worth the entire fee for life membership.

The fee for life membership is fixed at \$4, payable only once. Surely there is not a practitioner in the province who will not gladly embrace the opportunity of becoming a life member, and at once pay his four dollars to make up the fund needed to fully establish the work the society has undertaken?

Although this is the first year of the course, the results have been most gratifying. Practitioners from all schools are becoming members and contributing their portion to the good work. To all who send in their names and fees, the recent lectures of Dr. Seguin shall be at once forwarded, and the lectures of the future as they shall appear. When we look around and see the zeal that permeates the alumni of some other universities, surely we may hope for good things from our own.

An early response is urgently requested. Address all communications to

JOHN FERGUSON.

264 College st., Toronto.



## Births, Marriages, and Deaths.

### BIRTHS.

PRIMROSE—On Saturday, July 26th, at 196 Simcoestreet, Toronto, the wife of Alex. Primrose, M.B., C.M., of a daughter.

HASTINGS—On the 5th inst., at 256 Wellesley street, the wife of Dr. C. J. Hastings of a son.

### MARRIAGES.

McLEOD—BRANDON—On August 6th, at the residence of the bride's parents, Cannington, by the Rev. C. W. Watch, Donald McLeod, Esq., M.D., of Duntroon, to Martha, only daughter of Christopher Brandon, Esq., of Cannington.

### DEATHS.

BAXTER—On Wednesday morning, at his father's residence, 194 Spadina Avenue, John Gordon, second son of John Baxter, M.D., in the eleventh year of his age.

## COLLEGE OF

# Physicians and Surgeons

OF ONTARIO.

## Medical Council Fall Examinations

SEPTEMBER, 1890,

IN TORONTO AND KINGSTON.

The written Primary and Final Examinations commence on Tuesday, the 23rd September, 1890.

By Order

R. A. PYNE, Registrar,

*College Physicians and Surgeons  
of Ontario, Toronto.*

N.B.—Candidates' application forms may be had on application to the Registrar. The application is to be properly filled out and declaration executed, and delivered into the hands of the Registrar, accompanied by the tickets and certificates, and the Treasurer's receipt not later than the 17th of September, 1890. All candidates for Final Examination are required to present their primary tickets and certificates at the same time. Candidates for Primary who have attended a prior examination will require to pay a fee of \$10. Candidates for Final who have attended a prior examination will require to pay a fee of \$10.

The Treasurer's address is Dr. W. T. Aikins, 282 Jarvis St., Toronto.

# University of Buffalo, Medical Department

## BUFFALO, N. Y.

### FACULTY.

EDWARD M. MOORE, M.D., Emeritus Professor of Surgery.

WILLIAM H. MASON, A.M., M.D., Emeritus Professor of Physiology and Microscopy.

E. V. STODDARD, A.M., M.D., Emeritus Professor of Materia Medica and Therapeutics.

CHARLES CARY, M. D., SECRETARY, Professor of Materia Medica, Therapeutics and Clinical Medicine. Residence—340 Delaware Avenue.

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