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TREATMENT OF HIP DISEASE.

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Children, Toronto.

The importance of correct principles of treatment of this disease may be inferred from two sources: (1) its frequency; (2) the unsatisfactory results that come so often to our notice. Mr. Bryant thinks that 33 per cent. of the total number of joint diseases are cases of *morbus coxæ*. The Clinical Society of London, in 1881, reported 45 cases treated by excision, of which 35.5 per cent. died from causes connected with the disease, and 15.5 per cent. died from the results of operation; 260 cases with suppuration treated without excision, of which 30.4 per cent. died from causes connected with the disease; and 124 cases without suppuration treated without excision, of which 10.5 per cent. died. Of 954 general cases (medical and surgical) admitted to the Hospital for Sick Children, Toronto, 154, or more than 16 per cent. of all the cases, were hip disease.

This disease is pre-eminently one of childhood. Of 1344 cases collected by Dr. G. A. Wright, of the Manchester Royal Infirmary, more than 1,000, or 75 per cent. of the cases, were under fifteen years of age. Of 979 cases reported, 55 per cent. were under ten years of age.

Without entering into the question of pathology, or of diagnosis, it may be stated that the disease referred to in this paper is that which attacks one or both of the bones which enter into the formation of the joint, and tends to go on to its destruction.

ILLUSTRATIVE CASES PRESENTED.

Case 1. July 9th, 1889. W. S., male, æt. 4 years. First noticed lame in August, 1887. Was kept in bed for several months. First abscess formed in March, 1888. The child is pale, but appears fairly nourished. Cannot walk, but shuffles along the floor in a squatting position. Leg is flexed on the abdomen at an angle of 90°, and in marked adduction. The leg is kept in this position, the child not permitting motion of any kind at the joint. Joint tenderness was very great. There are several sinuses about the outer and anterior aspects of the thigh discharging pus, and there is a collection of pus not yet opened at the junction of the thigh with the perineum. Family history, negative; no history of injury.

July 20. A Thomas posterior hip splint applied, the leg being secured at an angle of 140° with the axis of the body. Ordered cod liver oil.

July 27. Splint readjusted and leg placed at an angle of 160°, without as much objection on the boy's part as was made to its first application. The boy creeps about on left knee, without hurting the diseased joint. Sleeps at night without waking and crying as formerly.

Oct. 14. Splint has been readjusted several times, and leg is now retained at an angle of about 175° . General condition of the child has much improved, and suppuration is less in amount.

The leg being rotated outward to an angle of about 60° , I made an addition to the stem of the splint, having a foot-piece attached, by which I was able to correct the rotation, and if necessary secure extension also.

Case 2. M. A., female, *æt.* 8 years: referred to me by Dr. Barton. Family and personal histories good. First noticed lame in March, 1888, and complained of pain in knee and extending up thigh. No pain in hip at that time. Had local applications to the knee. Was soon better; was active during the summer, and thought by her parents to be quite well. In October the symptoms which were manifested in March re-appeared with greater severity. First seen by me Nov. 26th, 1888. She was then pale and poorly nourished, confined to bed, having much pain at outside of knee, much joint tenderness, great thickening of the bone about the great trochanter, flattening of the gluteal region, and lessening of the fold. Sleeps badly. Night startings severe. Passive motion at the joint limited. Angle of greatest flexion 90° , of greatest extension 180° . Slight shortening when measurement was made from the umbilicus. Left thigh one inch smaller than the right.

Dec. 5. American extension-splint applied. Apparent shortening* now is two inches.

Dec. 20. Splint has been worn in bed. Sleeps well, without jerking the limb. Appetite much improved. Takes a mixture of cod liver oil and iron.

April 11, 1889. Splint is worn with comfort. General condition of patient is much better; walks fairly well without crutch. Appetite good; sleeps well. Encouraged to go outdoors. Swelling about the joint increased, pus probably present. No shortening.

July 30. Walked one mile to my office today. General condition good. Large quantity of pus collected behind and below the great

trochanter. Does not complain of tenderness. Slight apparent lengthening. Walks well.

Nov. 26. General health good. Abscess opened spontaneously yesterday. Has lived outdoors much during the summer.

Feb. 10th, 1890. The family being very poor, but not consenting to allow the child to go into hospital, she has been kept in the house nearly all the time, not being supplied with clothing for going out. Walks about the house, but is pale. Has lost flesh, and suppuration is abundant. This splint (shown in fig. 4) is worn with comfort.

Case 3. March 21st, 1889. W. D., male, *æt.* 13 years; referred by Dr. Dawson. History of



lameness extending back three or four years. Is pale and poorly nourished. Thigh flexed on body at an acute angle, and adducted about 30° . Large abscess below region of great trochanter, and an opening near crest of ilium discharging pus. Passive movement at the joint very slight. Had been treated in hospital for several months by extension with weight and pulley. The head and neck of the femur have entirely disappeared through long suppuration, and the shaft is drawn up, so that the left leg is three inches shorter than the right. (Fig 1.)

March 22nd. Under ether, assisted by Drs. Dawson and Harley Smith, the adductors were

* By *apparent shortening* I express the condition shown when measurement is made from umbilicus to internal malleolus; by *real shortening* the condition found when measurement is made from the anterior superior spinous process.

cut subcutaneously, so that adduction could be nearly corrected. Flexors were cut, so that the leg could be brought down to 150° . Fixation in this position was secured by plaster of Paris. Cod liver oil and iron prescribed.

April 12. General health much improved. Large amount of pus being discharged from the opening near the iliac crest, and from one where the flexors were cut. Long splint applied.

Sept. 9. Though he has broken his splint many times, and has been hard to control, yet improvement has been very satisfactory till lately. He engages in rough sports, and changes the splint without my knowledge. Splint is in bad condition to-day, there is movement at the

junction of the stem and pelvic band. Has been walking without any elevation of the foot on the sound side. Adduction is much increased.

Oct. 5th. Owing to my inability to govern the boy, I applied a Thomas' posterior splint to-day.

Nov. 3. Improvement has occurred since the Thomas' splint was applied.

Feb. 10, 1890. Improvement is very satisfactory. The leg is extended to about 170° . The boy has grown well; increased in flesh; sin-

uses have nearly closed, and there is no tenderness about the leg or hip joint. (Fig. 2.)

Case 4. June 1st, 1889. M. Y. (Fig. 3) (referred to me by Dr. A. H. Wright), female, 4 years. Lameness of an indefinite kind, first noticed seven weeks ago. Grandmother died of consumption. Is very pale, poorly nourished, has an anxious look, very poor appetite, lies in bed on the diseased side, with leg drawn up to a varying extent, although extension is applied by means of a pulley and weight of about two pounds. Complains of pain in the knee. Movements at the knee are found normal; no swelling. Muscular spasm very marked at the hip, and all movements at that joint much

limited. No night startings. Slight atrophy of thigh muscles of the diseased limb.

June 11. Long extension splint applied to-day, and flexion to about 150° permitted. McGee's Emulsion of Cod Liver Oil, with ext. mait, ordered.

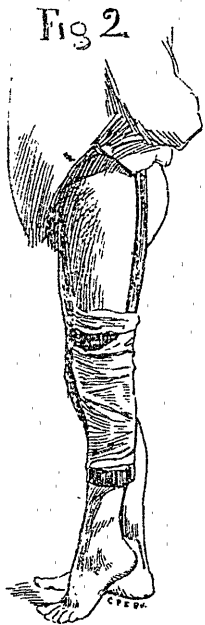
June 14. Splint worn with much comfort; readjusted to-day in line with axis of body. Sleeps better, appetite and spirits improved.

June 27. Last night abscess opened spontaneously, just below the middle of Poupard's ligament. For some time the leg has been held in abduction.

Aug. 20. General condition good. Sleeps and eats well; walks with great freedom. Pus is still discharging from the sinus. Leg can be moved through an arc of 45° without discomfort.

Jan. 31. The progress thus far has been most satisfactory, the utmost attention and care being given by the parents to all directions. The general health is good, patient has grown well, the leg is held in normal position, and free movement permitted through an angle of 90° .

Case 5. July 14th, 1889. J. K., 17 years. Family history good. About Christmas, 1886, had pain in sacro-iliac region. Had also pain in the side on deep breathing, and pain in the epigastric region. In May, 1887, a spinal brace was applied, which gave no effective support. Was able to go skating at Christmas, 1887, but after sitting for a short time, was unable to rise or to remove skates because of pain in region of hip. In January, 1888, a long hip-splint was attached to the spinal brace. Went to bed in March, 1888, and leg soon became flexed to a right angle with the body. Extension by weight was applied, and flexion corrected. In bed five months. Admitted to the General Hospital in September, 1888, and extension applied till



Christmas. An abscess, which formed on outer side of thigh, was aspirated, and subsequently an incision made about three inches below and about two inches anterior to the great trochanter. At home, while in bed, extension kept applied till May, 1889. From that time moved about on crutches. Is pale, but fairly well nourished. As he lies in bed, both legs are equally extended. Leg is swollen from foot to the gluteal region. Very great tenderness, especially about the great trochanter, and below Poupert's ligament. Will not permit anyone but his mother to help him. Cannot turn in the bed, rise from it, nor lie down again, without her assistance. Frequently necessary to apply the extension at night to quiet the jerking of the limb. Cannot endure it constantly. Considerable discharge still from the opening on outside of thigh. No thorough examination made, because of the great suffering in handling the leg.

Aug. 6. Extension hip-splint applied.

Sept. 16. After a little discomfort the splint is being worn with great relief. Can rise from the bed or couch, unaided, and lie down again; walks without a crutch, sleeps well at night, suffers no pain, has fallen twice without injury.

Oct. 11. Experiences great comfort night and day in wearing the splint. Leg may now be handled freely. Movements at both hip and knee very limited. General health good. Lay in bed for a few days while splint was being repaired. During this time the extension by weight and pulley had to be several times employed, as the old jerking returned.

Feb. 1. Improvement in this case has been rapid and continuous. He goes about town, comes two miles to my office, and I have given consent for him to return to his business as book-keeper—still wearing the splint. (Fig. 4.)

Case 6. Dec. 14, 1889. H. B., a pale, strumous-looking boy of 12 years; referred by

Dr. Carson. In August, 1887, there were evidences of hip disease, and the boy was kept in bed with a Liston splint. In a few weeks he seemed quite recovered, and remained apparently well for several months. Showed symptoms again in February, 1888, and was put to bed with extension by weight and pulley, and was kept there till August, 1889. At some time, during this period, an abscess opened at outer side of the thigh, but only a small quantity of pus was discharged. The leg is held flexed, at an angle of about 140° , and abducted about 30° . There is shortening to the extent of $2\frac{1}{2}$ inches, and the left thigh is two inches smaller than the right. Fibrous ankylosis at the joint



seems so complete that no movement could be obtained.

Dec. 28. Thomas' hip-splint applied, and the deformity slightly corrected.

Jan. 16, 1890. General condition improved. Is taking cod liver oil. Splint readjusted, increasing the angle of extension about 15° , without discomfort. Sleeps well; appetite good. Slight excoriation in gluteal region, under the splint.

Feb. 1. Splint is being worn with comfort; leg is extended to about 165° , and abduction is reduced to about 15° .

Case 7. B. F., 8 years, came under treatment Aug. 28th, 1888. (In Hospital for Ruptured and

Crippled, N.Y.) Family history, negative. Had some trouble in hip at 17 months. Was treated at Bellevue Hospital by a Taylor splint. Wore splint 3 years, after which for 3 years nothing was done. Is fairly well nourished. Deformity at left hip (Fig. 5.) Great trochanter $\frac{3}{4}$ inch above Nelaton's line. Leg flexed on thigh, and thigh on abdomen. Adduction about 20° . Adductors quite tense. Angle of greatest extension 135° . Angle of greatest flexion 100° . All movements limited. No grating felt in the joint. No joint tenderness. No peri-articular tenderness. Stands with marked lordosis, and some scoliosis to the right. Walks with marked hip



point of first importance in treatment at all stages is to secure for the patient good food and good air. To these, no doubt, is attributable much of the improvement resulting so speedily in many cases removed from the houses of the poor to the hospital wards. In all forms of wasting disease more trust, to-day, is placed in the good effects of fresh air, sunlight, proper climatic influences, change, and good food—in a word, in hygienic management in its widest sense—than in any list of drugs. As an aid in supplying the needed nourishment, cod liver oil requires a first place. Fortunately, children take it more readily than adults, and generally become very fond of it in a short time. In cases where difficulty is found in inducing a child to take the pure cod liver oil, a beginning may be made with some of the emulsions, after using which for a length of time, the pure oil is often taken without difficulty. Iron makes a good second in importance.

In favor of securing rest for the diseased joint, there is a general consensus of opinion. Greatly varied are the means employed for its attainment. In Britain perhaps more than elsewhere, this indication has been thought of sufficient importance to justify keeping the patient in bed for many months together, thus losing the advantages universally admitted as of great importance in the treatment of all other wasting diseases—the advantages of sunlight, fresh air, and exercise. While thus kept recumbent, extension is applied by means of a weight and pulley, adjusted at the foot of the bed, while the head of the bed is lowered so that the weight of the body acts in counter extension. My observation goes to show that the cases most in need of rest for the joint, fail in obtaining it satisfactorily in this manner. For its successful employment the patient must be constantly upon the back in one position. Movement to one side or the other disturbs the line of traction and interferes with the rest which the joint should have. Every movement causes the amount of traction to vary, thus making the effect of the apparatus a changing quantity, and therefore preventing rest. The muscles, thus irritated into frequent efforts, make necessary the use of a much greater weight than would be required if the traction were constant. When the means employed for procuring extension are such that all the attachments are

limp, heel being four inches from the ground. Deformity reduced by tenotomy and moderate extending force, and leg retained in position by plaster of Paris spica. Cod liver oil given.

Oct. 13. In excellent health. Hip splint applied. Caries of the spine found, and plaster of Paris jacket applied.

In a few months this patient was discharged, and continued as an out-patient.

Fig. 6 shows this patient to be wearing a plaster of Paris jacket for spinal caries. (This case is published by consent of Dr. Gibney.)

Hip disease, with few or any exceptions, being a chronic articular osteitis of tubercular origin, a

made to the patient and none to the bed, then, when the patient moves, the apparatus moves also, and the relation between the points of attachment for extension is a constant one, and the force exerted unvarying, no matter how the patient may move. I wish to illustrate this point by a reference to cases 4 and 5. In case 4 extension by means of weight and pulley had been employed for some time, but the discomfort was so great that the mother was constrained to allow relief at times by its removal. The muscles stoutly resisted the weight and the leg was kept flexed. There was elevation of temperature, restless nights, poor appetite, and steady decline of the patient's condition. Three days after the splint was applied the following note was made: "Splint worn with much comfort, readjusted to-day, and extension made in the line of the axis of the body; sleeps better, appetite and spirits improved" (when first applied the leg was left flexed at an angle of 150° , and extension made in the line of the deformity). Immediate and uninterrupted improvement has marked this case since the splint was applied. The mother reported that the little girl slept better the first night after its application, though the force making extension was not half that employed previously.

In case 5, a young man, extension by weight and pulley had been employed for many months, and for some time previous to my first visit had been used intermittently. The leg and joint were extremely tender, and the patient unable to do anything to help himself. Within a few days from the time when the splint was applied making moderate extension—not more than two pounds—he was able to rise from the bed or couch without assistance, and to walk without discomfort. Since that time his course has been one of steady improvement, except for a few days, when his splint was broken and had to be taken off. He went to bed, and extension was applied by means of weight and pulley, with the result that his rest was unsatisfactory, and that there was an increase of tenderness in the leg. A return to the splint gave relief as at first. I do not believe that rest for the muscles and other structures about the joint—true physiological rest can be obtained by the use of a weight that will tire out the muscles and compel them to relax. The condition in any vital organ is

the very opposite of that of rest under such circumstances; it is not rest, but exhaustion. If it be granted that the force of extension overcomes the muscular contraction, and that they lie passive thereafter, still no rest for the joint is thereby secured, for the ligaments or other structures about the articulation must now mount guard and do duty in resisting the force that had overcome the muscles. The ideal condition of rest is attained when no structure about the joint is called to exertion; and a very slight force that is constant and that secures the movement of the limb in harmony with the body is sufficient for this purpose, and is better than any device having some of its attachments to the body and some to a stationary object other than the body. While it is granted that there are circumstances under which it is good treatment to keep the patient confined to bed, yet the time so spent should be as short as possible, and it should not be admitted as good treatment except while correcting deformity, becoming accustomed to splint, recovering from the effects of operation or for other purpose requiring but a short period of confinement.

By means of a portable fixation apparatus more complete and effective rest can be obtained for the diseased structures than can be secured by keeping the patient in bed. By its uses better hygiene can be employed, and the ennui may be avoided that is the necessary concomitant of weeks or months of lying in bed.

The kind of apparatus employed is of great importance, as will be seen by comparison of some of the splints before us.

I shall describe only two splints; these, in my opinion, embody the principles in construction that enable us most successfully to meet the indications for treatment. First, I shall describe the American portable traction splint—a modification of that introduced to the profession by Davis, and enabling me, better than any other one instrument would do, to describe the American methods of treatment.

Fig. 4 shows this splint in use. The band about the pelvis is iron, padded and covered with leather. It must be strong enough to carry the weight of the patient, and yet be such that it may be moulded to fit the body. The stem is steel and fixed immovably to the pelvic band.

In fig. 5 the stem is $\frac{3}{8}$ in. by $\frac{5}{8}$ in., the nar-

row part being placed toward the leg. The perineal straps are attached in front and behind in such a way that they may be shortened by aid of buckles. The stem is carried three or four inches below the foot, and a part bent at a right angle is shod with leather, and comes into contact with the ground. The other foot requires a boot with a patten or thick sole to correspond with the stem. Strips of adhesive plaster are secured to the thigh and leg, by bandage and buckles attached at the lower ends, so that straps attached to the foot-piece may be employed to make extension.

It acts as a perineal crutch, the weight of the body falling on the perineal straps is transmitted through the band to the stem, and the foot-piece, which is the part of the crutch in contact with the ground. The stem is secured immovably to the pelvic band, and the leg is secured to the stem by two straps. The weight of the body coming alternately upon the sound leg and upon the perineal crutch, the entire leg, from the toes to the hip joint is kept from jar or concussion, because the foot piece at the end of the stem extends three or four inches below the foot so that the diseased limb does not come into contact with the ground. The sound limb is raised to the same level by a patten of the required height. It may seem that in walking, flexion and extension must cause movement at the joint; but if it is considered that the entire splint is jointless, it will be seen that movement of the limb cannot occur unless the perineal straps move backward and forward upon the surface of the perineum, or the soft parts move with the straps upon the bones beneath. That the former of these does not occur, is attested by the fact that patients walk about every day bearing the entire body-weight upon the perineal straps without any inconvenience—a thing quite impossible if at every step the straps were being drawn like saws over the surface of the perineum. Though some movement of the soft parts upon the bones does, no doubt, occur, yet it is so slight and so infrequent that practically this splint secures a condition that very closely approaches complete rest for the joint. The movement in flexion and extension occurs in the lumbar region. The traction, which occurs through the straps attached at the foot of the splint and buckled into the adhesion-plaster

secured to the sides of the leg by bandages, further aids in fixing the joint.

The muscles around every inflamed joint are on guard to prevent movement, and by their contraction injurious intra-articular pressure is caused. The most potent agent for doing away with injurious muscular contraction is such fixation as will prevent movement, and therefore take away the necessity for the muscles being constantly on the alert.

No means ever employed is more effective for the accomplishment of this end than the Thomas posterior hip-splint.

The Thomas splint (Fig. 7), as I employ it, consists of two iron bands, one to go about the upper part of the chest, and the other about the pelvis, and having an iron stem fixed to these bands behind, and extending down over the gluteal region and the posterior aspect of the diseased leg. This stem is to be bent to correspond to the deformity, and then securely fixed by bandages to the leg. All parts of the splint are padded and covered with leather.



Many patients do not like it so well as the American splint, because of the necessity of using crutches while the Thomas splint is in use.

The fixation secured by it is most complete, and as there is doubt whether traction for the purpose of extension accomplishes any useful purpose other than that of fixation, the objection brought against the Thomas splint that it makes no provision for extension does not seem to be well founded. Dr. Lovett, of Boston, showed at the last meeting of the American Orthopædic Association an addition made by him to the Thomas splint by which he was able to employ extension. By reference to case 1, it will be seen that I modified the Thomas splint in such manner as to make extension and to correct external rotation. When it is considered that the Thomas splint seldom weighs less than five

pounds and that it is held in its place, not by firm grasp about the body, but by being firmly secured to the leg, it will be seen that there is considerable extension weight constantly acting while in the upright position.

I seldom use the Thomas splint if a case is seen early, and there is little deformity or no fixed deformity. If it be such as arises simply from reflex contraction of the muscles, and disappears when the patient is under the influence of chloroform or ether, then I prefer the American splint. It gives satisfactory results, and is less objectionable to the patient and his friends. Cases 1, 3, and 6, illustrate fairly those in which I prefer the Thomas splint.

It presents one marked advantage in the treatment of deformity—it can be bent to fit a limb, however much it may be flexed or adducted. By the fixation it secures, muscular spasm soon subsides, and then the splint may be partly or entirely straightened and the limb secured in the improved position.

In cases where there is marked flexion with adduction or abduction, adhesions and contracted muscles about the joint, I prefer the plan adopted in case 3, viz., under an anæsthetic to cut the contracted muscles or their tendons, and bands of the adhesion, as far as possible, and then by the use of moderate force to correct the deformity, fix the limb in plaster of Paris till the wounds are healed, and then apply such splint as the circumstances demand.

Failing to correct the deformity by the means pointed out, it is better to perform osteotomy than to employ great force in breaking up the ankylosis, as in many cases, when much force has been employed, the old trouble has been lighted up with renewed violence.

The operative treatment, which may be set in contrast with the mechanical, will come under arthroectomy or excision. The former has not been often performed for disease at the hip, but is commended by McEwan, Barker, and Croft, as true conservative surgery. They operate in the early stages of the disease with the hope of eradicating the tuberculous process before much harm has been done to the joint structures.

Excision is a classical operation which has met with much favor, and one would expect that, under the impetus given to operative surgery by the introduction of antiseptic methods, this

operation would show a record that would place it much beyond question. Some of the latest opinions from good authorities, however, are given against the operation. Howard Marsh thinks it unjustifiable in the early stages of the disease, and that it promises no better results than treatment by rest in the later stages—(*Diseases of Joints*, p. 319). Mr. T. Holmes says, "Excision ought to be very rarely, indeed, required, if the disease were treated properly in the commencement." Macnamara thinks that, if, after a careful trial of other methods in children, the case still does badly, then excision should be performed. In adults, if operative interference be imperative, he prefers amputation (p. 428). The report of the Clinical Society, before referred to in this paper, is adverse to excision unless other means have failed to secure the favorable progress of the case. (Macnamara, p. 429).

When matter is present it should be removed by aspiration or by incision.

SUMMARY.

The practice advocated in this paper may be briefly summed up :

1. Constitutional treatment, such as is employed in other wasting diseases, is of prime importance in all cases.
2. In early stages of the disease, treatment by rest for the joint is indicated.
3. Rest can be better obtained by employing a portable fixation apparatus than by any means requiring confinement in bed.
4. Deformity, if not fixed by adhesions or contracted muscles, may be corrected by the use of portable splints.
5. Deformity, maintained by contracted muscles and adhesions about the joint, may frequently be corrected by myotomy or tenotomy, and the adhesions broken up by using a moderate degree of force.
6. When deformity cannot be so corrected, osteotomy should be performed.
7. If faithful trial of these means fail to give satisfactory results, excision or amputation should be performed.
8. Pus, or sequestra, when known to be present, should be removed by operation.

DR. DOUGLASS has been appointed jail surgeon, in place of Dr. Clarke, deceased.

ECTOPIC GESTATION, WITH REPORT OF THREE CASES.*

BY T. K. HOLMES, M.D., CHATHAM.

Competent physicians differ widely in their estimate of the difficulties surrounding the whole question of ectopic gestation. Thomas says a positive diagnosis is generally difficult and often impossible. Hanks affirms that ninety-five per cent of these cases can be recognized. Dr. Joseph Price says a differential diagnosis is extremely uncertain. Dr. Van der Veer says many cases give no symptoms until rupture occurs, and quotes Tait and Formad in confirmation of his assertion. I believe that he who has had considerable experience of these cases, and is familiar with the literature of the subject, will still feel the need of more light to guide him in his perplexity in a very large percentage of the cases he sees, and that absolute certainty of correct diagnosis is the exception during the first few weeks or before rupture occurs.

There always comes a time when it is easily recognized, but it is frequently after that knowledge has ceased to be of much value to the patient. My object in presenting this short paper is to keep an important subject before the profession here, and to gain for all whatever a discussion may reveal. My experience is limited to what the management of three cases affords, and as the subject has been attracting much attention recently, both here and in Europe, I have thought this a favorable time to arrange my notes, and to detail some points in my experience. Few subjects are of greater importance to the general practitioner, because he is liable to meet these cases quite unexpectedly, and unless prepared to diagnosticate the condition, and to adopt promptly the best plan of treatment, he cannot hope to see any of them recover. On the other hand, a correct diagnosis at a time when to be right is of the utmost importance, and the adoption of one or other of the recognized methods of treatment, ensure the saving of much suffering and many lives.

The obscurity and doubt connected with these cases should only serve to arouse every physician to greater care, and to the avoidance of hasty and superficial investigation of cases, that may involve such dreadful consequences.

When ectopic gestation occurs, it is because

of an abnormal condition of some of the female generative organs, although it may not always be possible to know what this is. It is probable that any change that prevents or retards the movement of the unimpregnated ovum towards the uterine cavity, so as to allow time for the migration of the spermatozoa beyond the normal place for impregnation to occur, is a common factor. Such influence is exerted by desquamative salpingitis, pelvic cellulitis, uterine flexions, and other ailments that favor sterility, which it is well known often precedes this form of gestation. It seems very probable that the destruction of the ciliated epithelium of the tube, which occurs in salpingitis, is a common cause of tubal pregnancy, by retarding the ovum and by affording a surface for development more nearly resembling the endometrium. Whatever the cause may be, it is admitted by all that the fœtus may be developed in any part of the tube, in the muscular walls of the uterus, or that it may be sustained by attachment to the abdominal viscera. Ovarian pregnancy is admittedly very rare, and some good authorities deny its occurrence. It is possible that the ovum may be attached so near the uterine end of the tube that it may enter the cavity of the uterus, and be discharged *per vias naturales*, but when it occupies this position it more frequently distends the tube and uterine tissue upwards, until it ruptures into the peritoneal cavity, when in consequence of the great vascularity, death of the patient invariably, or almost invariably, results from hæmorrhage, before surgical means can be undertaken.

Extra-uterine tubal pregnancy is the variety of the greatest interest to the surgeon, because it is almost the only form he is likely to be called upon to treat, and the one that offers good hope of successful results. Mr. Tait's views as to the pathology are so reasonable that it is difficult to doubt their correctness, and supported as they are by his great experience, I feel bound to adopt them. He believes that a foetal ball developing near the middle of the tube terminates in one of two ways: it either ruptures into the general peritoneal cavity, directly, or into the broad ligament between the folds of peritoneum of which it is composed. In the former case, the conditions favorable to coagulation being absent, hæmorrhage goes on

* Read before the Detroit Medical Society, April 7th, 1897.

unchecked until death occurs, or until surgical interference arrests it; while in the latter case conditions favorable to coagulation obtain, and hæmorrhage is less likely to prove fatal. In the former case the blood is so diffused as to give very uncertain physical signs of its presence; in the latter case the blood is clotted, circumscribed, and can be recognized as a distinctly defined tumor; in the former the ovum always dies, in the latter it generally dies at the time of rupture.

Success in treatment will depend upon correct diagnosis before rupture takes place, and I believe most cases can be made out pretty certainly before that accident happens, if sufficient care be exercised in the investigation. Physicians see comparatively few of these cases, and the subjective symptoms not being very characteristic, it is not surprising that so many go on to a fatal end without a serious effort to solve the difficulty. Irregular menstruation and pelvic pain are the most common subjective symptoms, but these pertain to women so commonly that one is led to prescribe without a physical examination being thought necessary, and in the meantime, while we are waiting for our drugs to set matters aright, our patient is approaching a catastrophe that has no parallel in life. He who would be right in these cases must be willing to bring all care and thoughtfulness to bear on them, and must not be satisfied with a few superficial questions and a haphazard prescription. The subjective symptoms are usually well enough marked to direct attention to the possible affection, and should lead to a thorough physical examination when the true condition may become known. Pain is not confined to the place of foetal development, but may be felt most severely about the rectum or along the nerves of the thigh. In one of my cases the first complaint was a severe pain extending from the kidney to the iliac fossa, and it gave me the idea that it was due to the passage of a renal calculus. When the growth of the foetal mass has become sufficient to cause pain, there is usually a good deal of tenderness there on pressure, and this may interfere somewhat with the examination, but even with considerable tenderness, an enlargement may generally be felt by palpation in the region of the distending tube externally. There

can be felt, per vaginam, an enlargement at one side of the uterus, and a bulging downwards of Douglas' *cul de sac*, the whole enlargement conveying a sensation of bogginess, not having the hardness of a fibroid, nor the softness of an abscess or a cyst. The uterus is somewhat enlarged, pushed to the opposite side, and the cervix is often crowded upwards behind the pubic bones.

As growth goes on, these physical changes become more marked, symptoms due to pressure are more distressing, pains become paroxysmal, blood may flow from the uterus, the whole or portions of the decidua may be discharged. Rupture usually occurs between the tenth and fourteenth week in the more common form of extra-uterine foetation, and the symptoms then are truly appalling.

The patient is suddenly seized with violent pain in the abdomen, she becomes pale and cold, an indescribable look of anxiety and distress marks her countenance, her pulse fails, and she is evidently in the very jaws of death before her terrified friends can summon aid. If she survive the shock and the hæmorrhage, she slowly rallies after some hours, and the subsequent progress of the case will depend on circumstances. If the foetus die it may become absorbed, or may be converted in a lithopedium, or the bones may undergo a change by saponification into adipocere. Fatal peritonitis may supervene, or an abscess may form and discharge externally. If the foetus live, it may go on to full term, or a repetition of the collapse may occur from a fresh rupture, and another hæmorrhage.

It is stated by writers that patients usually think themselves pregnant, but not one of those under my care could be convinced that she was so, and I feel doubtful if a patient's statements in this respect are of much value from a diagnostic point of view. Having, by direct means, reached the conclusion that ectopic gestation exists, the diagnosis may be more thoroughly established by indirect means. It is often easier to decide what a thing is not than to tell what it is, and by a process of exclusion, we may eliminate all, or nearly all, of the conditions that resemble this, and so fortify our position, and facilitate the subsequent management of the case. Ovarian, parovarian and fibroid tumors

have histories of their own, and cellulitis, suppurative or otherwise, pursues a course peculiar to itself, and not likely to be mistaken. Other conditions, such as abscess of the tube or broad ligament, pelvic hæmatocele, dermoid cyst, retroversion of the gravid uterus, may perplex us, but they all have distinctive characteristics, and may be eliminated from the list of possible conditions. Of the various methods of treatment, only two are worthy of consideration, viz. : 1st, destruction of the life of the fœtus by electricity, and 2nd, removal by abdominal section. Each has its advocates, and both have afforded good results.

Circumstances connected with individual cases should determine the treatment. A patient with unsanitary surroundings and an unpractised surgeon, other things being equal, would be more likely to recover under the electrical treatment, whereas a laparotomy done under favorable circumstances, and by a skilful operator, offers probably as good a chance of primary recovery, and a better chance of escaping secondary complications. These remarks apply to all cases before the twelfth week which have not ruptured.

Views which I now entertain, but which greater experience may induce me to modify, lead me to the following conclusions: If the diagnosis be pretty certain before the twelfth week, and before rupture seems imminent, use electricity. If rupture occurs, and symptoms indicate arrest of hæmorrhage and probability of rally from shock, wait for reaction, and then perform laparotomy. If symptoms point to continuation of bleeding, open the abdomen and control it in the only way possible, *i.e.*, by ligating the vessels in the broad ligament. If the fœtus be dead, and there are indications of danger from its presence, open the abdomen and remove it.

Case 1. March 16th, 1886. Mrs. J. A. H., æt. 39 years, has a good family history, and is a large, well-developed woman. She has had two children, aged respectively 15 and 17 years, and no miscarriages.

Four years ago I performed perineorrhaphy for laceration that probably occurred at her first labor. She had retroversion of the uterus which, owing to adhesions, resisted all forms of treatment.

On March 16th, 1886, I was called to see her on account of a sudden attack of severe pain in the rectum, from which she soon recovered, but continued to complain of pain and great tenderness in the right iliac fossa. Palliative treatment was used, and after the tenderness abated somewhat, a distinct enlargement could be felt in the right iliac fossa, and a vaginal examination revealed a tumor on the right side of the uterus, the neck being pushed to the left, and there was a great fulness in Douglas' *cul de sac*. After watching the case a few days longer, I expressed the opinion to her and her sister that she was suffering from extra-uterine pregnancy, but the patient assured me that there was no possibility that she was pregnant, and that some other cause must be sought for her illness.

The menses had been regular; but this was not an uncommon thing in her case, and after careful consideration I still felt uncertain as to her true condition.

I asked for a consultation, and Dr. Donald McLean, of Detroit, was selected, but the next day, and before Dr. McLean was sent for, she was seized instantaneously with severe pain in the abdomen, and her friends thought she was dying. I saw her fifteen minutes later, and found her pale, cold, and pulseless, and apparently in a dying condition.

Hypodermic injections of ether, and the use of morphine in the same way, were used, and after a few hours reaction set in, the deadly hue passed partially away, the pulse returned at the wrist, and the immediate danger was over. Dr. McLean saw her in this unfavorable state, and it was decided to wait a short time for further rallying before attempting an operation.

There was some improvement for the next five days, but a rise of temperature and some nausea then began to be observed, and it was thought unsafe to wait longer.

Dr. McLean was again sent for, and performed abdominal section. The operation was quickly and, I need not say, skilfully done, but owing to her long illness and great weakness, she did not rally well after the operation and died next day. The extensive and firm adhesions made the operation unusually difficult, and altogether the case was a very unfavorable one for a surgeon to deal with. The enlarged, tender, and retroverted uterus from which this lady had long

suffered, the pelvic pain that had tormented her for years, and my own want of familiarity with ectopic pregnancy, all combined to delay a correct diagnosis, and when I had made up my mind as certainly as I could regarding the true condition, I allowed the patient's assurances to unbalance my decision until rupture occurred, and after that I believe any plan of treatment must have failed in her case. Adhesions were so extensive and so firm that complete removal of the sac was impossible, and the placental tissue was carefully separated and removed, and a drainage tube put in after the whole cavity had been thoroughly irrigated.

I think the rupture occurred into the broad ligament, for the sac still contained the amniotic fluid, which would not have been the case if rupture had taken place into the peritoneal cavity. There was complete adhesion between the visceral and parietal peritoneum at the point of incision, and the foetus escaped with the first gush of amniotic fluid. It was, I think, about fourteen weeks old.

Case 2. Mrs. J. N., æt. 39 years, good family history, married, and has had two children, the younger born twenty years ago, and her confinement then was followed by a long and severe attack of fever. In 1887 there was a history of ectopic gestation, from which she gradually recovered without treatment directed to that condition. The uterus remained fixed and Douglas' sac full and hard, but her general health improved, and she remained pretty well until September, 1889, when she had what her physician considered acute gastritis, and from which, under his care, she recovered. Pain and swelling in the iliac fossæ next set in, and it was on this account that her attending physician placed her under my care about three months before she died. There was a hard mass on each side of the uterus easily felt externally; the uterus was immovable, the cervix being pushed far up behind the pubic bones, and the whole pelvis was filled with some solid substance.

The history of the illness in 1887, and the present condition of the pelvic organs, led me to the belief that ectopic gestation had existed then, and that the presence of the dead foetus had set up the condition described. Two days after she came under my care, there passed from her while urinating the substance here exhibited,

and which will be seen to resemble foetal bones that have undergone change into adipocere. The discharge was attended with great pain, but although I questioned her closely, she could not tell whether it came from the vagina, the rectum, or the bladder. It was covered with mucus and some blood, and the nurse said she broke some of the larger pieces in attempting to examine them. After this she suffered almost constant pain about the lower part of the abdomen, the hard masses increased in size, the abdomen became greatly distended with gas, which could not be evacuated naturally, her strength gradually failed, and she died on the 15th of January, 1890.

The autopsy showed the whole of the greater omentum adherent to the anterior abdominal wall. It was about an inch in thickness, and could with difficulty be separated from the viscera it covered. The uterus and appendages, and indeed all the pelvic organs, were so matted together that it was impossible to discover with certainty evidences of the supposed ectopic gestation, but as the adipocere was discharged more than three months before the patient died, the locality it came from may have become obliterated. The uterus is somewhat enlarged, the left side much thicker than the right, and there is a cavity in the muscular tissue of the fundus near the uterine end of the tube. This may have contained the adipocere.

The left Fallopian tube contained half an ounce of pus.

I sent a specimen of the adipocere to Dr. A. B. McCallum, University of Toronto, for examination, and received the following reply:

Biological Dept., University Toronto,
April 3rd, 1890.

DEAR DR. HOLMES,—In regard to that specimen of adipocere, I can only say that, on examination, it revealed no definite evidence of having been derived from bone, although fine sections of the mass showed regularly here and there cavities which might be interpreted as the transsections of the original Haversian canals. Outside of and between these cavities the substance was homogenous. Yours sincerely,

A. B. MCCALLUM.

Case 3.—

ECTOPIC PREGNANCY—OPERATION AT 14 WEEKS
—RECOVERY.

Mrs. H. J., æt. 39 years; married, and has had six children, the last 6 years ago. Came

under my observation on the 20th of October, 1889, when I was sent for, on account of a severe pain extending from the region of the right kidney to the right iliac fossa. The pain came on quite suddenly, and was accompanied by a constant desire to urinate. The symptoms were so much like those of a renal calculus that I thought that to be the ailment, and prescribed accordingly. There was no failure in the pulse nor any sign of collapse, and she soon got relief, but as this was only temporary, I determined on a more thorough examination two days later, and at once discovered a slight enlargement in the iliac fossa, and could feel per vaginam a tumor as large as a small hen's egg on the right side of the uterus. Douglas' *cul de sac* was full, moderately hard, and uniform in contour, and the cervix was pushed to the left slightly. She had menstruated normally seven weeks before, and had a slight discharge of blood a month later. There was pain down the right thigh, the temperature was normal, and in all other respects she felt well. Partly by direct evidence, and partly by exclusion, I concluded the case to be one of ectopic gestation, and Dr. McKeough, who saw the case, was of the same opinion. I thought it a favorable case for the use of electricity, but after explaining the nature of the complaint and the proposed treatment, the husband and family declined to have it done, and sought other advice, so that for about six weeks I lost sight of the case, not hearing anything of it until December 6th about 10 o'clock in the evening, when I was asked to see it. It had undergone great change, the tumor being much larger, extending beyond the median line, and nearly as high as the navel. The cervix was pushed far to the left, and Douglas' sac was bulging very low in the pelvis; there was discharge of blood from the vagina, and I learned there had been intermittent pains all day, and that a complete decidua had been discharged in the evening; the patient was pale and depressed and the extremities cold; warmth and stimulants were used, and at 2 o'clock p.m. on the 7th I made an incision five inches long in the median line below the umbilicus, and at once saw a small rupture in the upper part of the sac, near the end farthest from the uterus. It was not larger than a pencil, and was occluded by a dark clot. It was in direct communication

with the general peritoneal cavity, and about a pint of clotted blood lay among the intestines in the vicinity of the rupture. I separated the sac from surrounding structures to which it was adherent, tied the tube and broad ligament close to the uterus, and cut the mass away.

The clots were removed and the cavity repeatedly washed out with warm water that had been boiled, and when the abdominal cavity was clean the wound was closed and covered by bichloride gauze, and a bandage put on. No adhesive straps were used, nor was a drainage tube inserted. The sutures were removed on the seventh day, and recovery was so rapid that she dined with her family on New Year's Day, or less than 3 weeks after the operation.

On examination of the sac, which I here exhibit, it showed the placenta attached to the upper side of the uterine end of the tube, and the rupture also on the upper side of the tube, but near the distal end. The wall is extremely thin at the point of rupture, and doubtless this thinness and consequent diminished vascularity, together with the smallness of the tear, favored spontaneous arrest of the hæmorrhage. I think also that the sac became filled with blood, and that its coagulation there, and its pressure from within, contributed to a same fortunate result. There was no amniotic fluid in the sac. Thomas says: "I know of but two cases of recovery after a rupture of an ectopic sac in this country. One of these occurred in the practice of Dr. Johnson, of Danville, Ky., and the other in that of Dr. Gordon, of Portland, Me."

Drs. McKeough, Tye, Fleming, and Backus, and Mr. Pearson, were present and assisted at the operation.

Selections.

UNNA ON A CASE OF TUBERCULOSIS CONVEYED BY EAR-RINGS.—A girl, *ætat* 14, of a healthy family, who became infected with tuberculosis by wearing ear-rings which had previously been worn by a woman who died of pulmonary consumption. Flat ulcers with undermined borders developed in the lobes of the ears, especially on the left side. There was also swelling and induration of the cervical glands on the left side, and dulness over the apex of the left lung. Tubercle bacilli were found in the granulations

of the ulcers and in the sputum. Acute phthisis supervened, to which the patient succumbed.—*London Med. Recorder.*

ANTIPYRIN is said to have a wonderful influence in increasing the solubility of caffeine, as well as of the salts of quinine. In this respect it resembles the action of sodium benzoate and salicylate. Twenty grains of caffeine and thirty grains of antipyrin form a perfectly clear solution with sufficient water to make 1 fluid oz. The combination might be found of service in the treatment of neuralgia and migraine.—*Medical Press and Circular.*

DIURETIC ACTION OF THEOBROMINE.—Gram in the *Therapeutic Monatsch.*, sums up thus:

1. Pure theobromine is with difficulty absorbed. When absorbed, it is a powerful diuretic, without acting on the heart. The diuresis is the result of a direct action on the kidney.

2. The salicylate of theobromine and soda is easily absorbed; it is a powerful diuretic, and not toxic. Only once, and then in a very weak patient, did it cause a slight vertigo.

3. The usual daily dose of the salicylate of theobromine and soda is about a drachm and a half. At one dose, more than 15 grains should never be given.

TRANSPLANTATION OF THE THYROID.—Lannelongue, arguing from the success which Horsley has had in preventing myxœdema after thyroidectomy, by grafting a portion of the thyroid in some other part of the body, thought that he might, by the same procedure, be able to ameliorate the defective mental and corporeal condition of those unfortunates who were born without a thyroid. He has, on a girl of 14, presenting all the appearances of myxœdema, grafted part of the thyroid of a sheep. The result of the experiment will be looked forward to with much curiosity.—*L'Union Médicale*, March 15, 1890.

CHLORALAMIDE.—Rosenthal, in the *New York Medicinische Monatschrift*, relates his experience with this drug in 28 patients, to whom 14 ounces were given in 185 doses. He obtained the best results in cases of nervous disease; it was useful in chronic cystitis, cancer

of the stomach, and diabetes mellitus; little or no benefit was obtained in the emphysematous, the asthmatic, and the phthisical. Chloralamide is to be preferred to sulphonal, if a speedy effect is desired; in most of his cases the patient was asleep within an hour of the administration of the drug. As chloralamide has scarcely any effect on the heart or respiration, it is a better hypnotic than sulphonal in cases which have any disposition to collapse. In two or three cases, slight headache and giddiness were complained of. The average dose is 45 grains; this should be given an hour before sleep.

SALICYLATE OF SODIUM IN GENERAL PRURITUS.—Dr. Wertheimer, in the *Müchener Medicinische Wochenschrift*, advises the treatment of general pruritus by means of a three-per-cent. solution of sodium salicylate, in doses of a tablespoonful thrice daily. This plan of treatment, he says, may be continued for some time, in the confident belief that it will not only promptly moderate the unpleasant pruritic symptoms, but also radically remove the underlying disease.—*N. Y. Med. Jour.*

ARTIFICIAL TONGUE.—Dr. Poncet, of Lyons, has invented an artificial tongue for improving articulation in cases where that organ has been extirpated. The apparatus consists of a "pocket" of soft rubber containing fluid, and jointed on to a plate which is fixed to the lower teeth. "A patient wearing this apparatus can eat and speak quite satisfactorily, and there is no dribbling of saliva, the latter being swallowed as in health."—*Edinburgh Med. Jour.*

METHACETINE.—Mahuert says that a dose of 4 to 6 grains lowers the temperature, and may be repeated two or three times a day. Perspiration occurs in fifteen to thirty minutes afterwards; the fall of temperature lasts two or three hours, when it again rises to its former height. The heart is not at all weakened, the blood pressure is increased, there is no change in the red blood corpuscles. In acute articular rheumatism, methacetine has not proved more efficacious than phenacetine. It relieves the lightning pains of tabes, headache, neuralgia, and chronic rheumatic pains.—*La Cronica Medica*, Feb. 5th, 1890.

ARISTOL IN SKIN DISEASE.—Aristol is made by combining iodine and thymol, *i.e.*, a solution of iodine in iodide of potassium is mixed with an alkaline solution of thymol. A reddish brown precipitate is formed, which is amorphous—aristol. It is insoluble in alcohol, glycerine, water; slightly soluble in ether and in oils. The advantages which this remedy possesses are an absence of toxic action, no odor, and easily applied. It is said to work well in cases of psoriasis, although its action is slow. The author claims for it a quicker and safer action in mycotic diseases; and it is particularly valuable in tertiary syphilitic ulcerations. In lupus its action is more thorough than that of any other remedy. If the foregoing be correct, there is a great future for this remedy, as the great advantage it possesses is its want of toxic properties. It may be used in the form of ointment, in the strength of 10 per cent. or more. Care should be taken to keep the drug itself in black glass bottles. In chancroid, the use of aristol has proven a signal failure.—*St. Louis Med. and Surg. Jour.*

A PECULIAR CASE OF EXTRA-UTERINE PREGNANCY.—A few days ago, Dr. Rosthorn, assistant at Professor Chrobak's gynecological clinic, operated on a case of apparent ovarian cyst. Eight weeks before, the woman had been delivered of an eight months' child, normal labor, and had been perfectly well until three weeks previous to the operation. The operation was made in the ordinary way, and the supposed cyst removed. At one portion of it a peculiar cord-like process was attached. Rosthorn examined the other ovary—it was normal—but, while examining it, a small hand slipped out from between the intestines. This was seized, and a full-sized child was removed from the abdomen, and to its umbilicus was attached a cord exactly similar to that found on the cyst. They then looked for the foetal membranes, and found them very deep and everywhere adherent to the intestines and peritoneum. The child's skin was nearly normal, though slightly macerated. Then the membranous sac was brought up and sewed to the peritoneum, just as the stump is treated in extra-peritoneal amputation of the uterus; the abdominal walls were united, and the sac dusted with salicyltannin.

The woman rallied, and now, seven days after the operation, is doing very well. A careful examination of the removed cyst showed that the tumor was merely the placenta coiled up, where it had been fastened to the left Fallopian tube, and the case now resolves itself as follows: There was an extra-uterine pregnancy, with the foetus in the left Fallopian tube, and this foetus was carried beyond term, and died. Throughout the time there were no symptoms from this extra-uterine pregnancy, and an intra-uterine pregnancy went on nearly normally at the same time. It cannot be established, though it is probable, according to the authorities here, that the two children were really twins, and one developed within, the other outside of, the uterus. Thus it stands without a parallel in the history of obstetrics, and the full report by Rosthorn will be looked forward to with great interest.—*Medical News, Vienna Letter.*

TUMOR OF THE PANCREAS, LAPAROTOMY, RECOVERY.—Patient, German, 45 years of age, mother of five children; good family record. About a year ago she was attacked with occasional spasms of the stomach, and one unusually severe attack was followed by gastric inflammation and then chronic gastritis. The latter was accompanied by constant vomiting of food, tinged with blood. Clotted blood occasionally passed from the bowels. For some weeks no notable change from the above symptoms occurred, except increasing emaciation. Six or eight months after the first symptoms the abdomen gradually swelled, until the body was enormously enlarged. At this time I, in my casual examination, thought it a case of ascites, dependent upon organic changes. Later, finding the heart sounds normal and the urine healthy, I examined her more closely, and diagnosed an abdominal tumor, probably from the pancreas, and concluded to tap her to verify the diagnosis.

After withdrawing the fluid, which was of a dark coffee color, containing numerous small bodies resembling hydatid degeneration, I found a growth in the epigastric region, extending over into the left hypochondrium. The tumor was hard, smooth, and globular, and could be freely moved about, but on respiration there was only slight movement of the growth.

My conclusions, based upon the history of abdominal pain, the gastric irritation, the copious and constant vomiting (which disappeared in the latter stages, proving that the tumor, from its own weight, had dropped down), and was no longer in contact with the stomach), the increasing emaciation, the dark grumous blood ejected from both stomach and bowels, the fact that the tumor was nearly stationary on respiration, the pale yellow coloration of the skin, the fluid drawn in the tapping (dark brown, turbid, colorless, alkaline, specific gravity 1.012) the stools containing considerable fatty matters—were that the growth was located in the pancreas.

When the abdomen was opened, the tumor was found closely adherent to the omentum, the transverse colon and stomach being bound to the latter by a fibrous attachment several inches long. A ligature was thrown around the attachments and the tumor removed entire, including the tail of the pancreas.

The case progressed satisfactorily, and the patient now attends to the household duties, and has gained several pounds in weight.

Microscopic examination shows the specimen to be sarcomatous, although there is evidence of a pre-existing hydatid, shown by the hooklets of that tumor with the cells of the spindle-celled sarcoma. Dr. James also found hydatid debris in the liquid first submitted for examination.—*Waldo Briggs, M.D., in St. Louis Med. and Surg. Jour.*, March, 1890.

ORIGIN OF DIPHTHERIA.—The identity of diphtheria with the disease of chicken, known as pip, has been very vigorously opposed. Nicati published in *Marseille Médicale* (1879, page 105), cases showing the transfer of contagion from chickens to children. Meuziès, Dethil, Pamard, Bouchard, and Teiler, published observations favorable to this opinion; Meuziès asserts on his personal observations that diphtheria is caused by the dejections of fowls. In Italy, Escolami and Pietra Santa assure us diphtheria among fowls is common. On the housetops many flocks of turkeys, chickens, pigeons, and rabbits, take up their residence, the excrements of which, washed by the rain, are carried into the wells containing the drinking-water of the people. In 1871, in Posilipo,

near Naples, Meuziès saw an epidemic of diphtheria attack the children of a colleague whose house and yard presented the above mentioned conditions. Of five children, four became sick and died. In another house there was a large dovecote; in that house a lady and four or five children were attacked by diphtheria, and three died. From these cases, the epidemic spread and became generalized.

The unfortunate professor, convinced that the diphtheria was due to the use of contaminated water, forbade his servant to use the water from the suspected well for culinary or drinking purposes, and ordered him to go to a neighboring well to get pure water; but the laziness of the servant defeated his purposes and caused an epidemic of diphtheria. The only child that did not fall sick was a suckling infant, who did not drink water; and a neighbour's child of seven years, who did drink the well water, took sick and died. Meuziès thinks that in every epidemic of diphtheria it is reasonable to seek the source of the trouble in neighboring chickenyards, dovecotes, dungheaps, and, above all, in barnyards and deposits of manure. The island of Skiatos, on the north of Greece, inhabited for about fifty years, has a population of about 4,000, and, with the exception of some fevers, it is very salubrious. Bild, in a practice of thirty years on the island, had never seen a case of diphtheria. But a flock of turkeys was brought to the island, and among them were several that clearly had diphtheria, of which they died; in a few days the disease attacked children, and rapidly spread over the whole island. 125 persons were attacked; the deaths were 36 during the summer and autumn of 1884. The objection raised by Liebermeister must be borne in mind, viz.: that diphtheria chiefly ravages cities and large communities in which there are no barnyards, chicken-coops, or pigeon-houses, and that the false membranes cast off by the sick birds are scattered over the fields in the country, where they are at the mercy of the first urchin who plays in the sand. From these facts we must conclude that the belief in the identity of the diphtherias of man and birds rests upon accidents which rarely occur, considering the frequency of both diseases.—*New Orleans Med. and Surg. Jour.*

THE
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TORONTO, APRIL 16, 1890.

THE WOMAN'S MEDICAL COLLEGE.

The Woman's Medical College, of Toronto, appears to be thriving. Its new building on Sumach Street, opposite the General Hospital, is about completed, and will be opened by a conversazione immediately before the commencement of the summer session. Its candidates at the various examinations are, as a rule, doing creditable work. There were 28 students in the school during the past session. It is expected there will be a large increase next year, as the secretary is receiving an unusual number of enquiries from various parts of Canada and the United States. The medical education of women has never been particularly popular with the profession in the country, nor, at the same time, has it met with any decided opposition. It appears to have come to stay, as far as Toronto is concerned at least.

SPRING EXAMINATIONS.

The examinations this spring do not present any very striking features. Those of the University of Toronto are probably the most thorough and practical in this province. The laboratory and hospital examinations in this institution have long been very satisfactory, and are improving from year to year. The examinations in clinical medicine and surgery, as recently conducted by Drs. McPhedran and O'Reilly, assisted by Drs. W. P. Caven and Peters, in the Toronto General Hospital, were especially worthy of commendation. Last year complaints were made that sufficient time had not been

allowed the students for this hospital work. The Senate thought the complaints were reasonable, and appointed the assistants mentioned, with results very gratifying both to Drs. O'Reilly and McPhedran and the students.

The examinations for the Medical Council commenced in Toronto and Kingston on Tuesday, April 9th. There are about 200 candidates in the primary subjects, and nearly the same number in the final. As usual they are, to a large extent, practical in character, and, taken on the whole, will prove satisfactory to the majority. The number of candidates are about the same as for the last two or three years. Among the universities, the largest graduating class will be from Trinity College.

THE MEDICAL COUNCIL OF BRITISH
COLUMBIA.

We publish in this issue a letter from Dr. McGuigan, of Vancouver, which gives some particulars respecting recent legislation in the far west. He, as President of the Council, knows whereof he speaks, and we must accept his statements without any reservation, and, as a consequence, withdraw the charge of apathy in connection with that body.

Our medical men who went out to the Pacific coast last summer were favorably impressed with the apparent status of the profession, both on the Island and on the mainland. The medical register of British Columbia contains the names of many that are well and favorably known to us in the east. Its Medical Council is constituted and governed very much like that of Ontario, and we believe it will do much to raise and maintain a high standard in the medical profession.

One of the complaints raised against it is that it should assume to examine the graduates of reputable Universities in Canada and Great Britain, before granting them a license to practise. This may seem a hardship or even an absurdity in certain cases; but it is exactly the system which prevails in Ontario, and, with all its drawbacks, we have found that it has been productive of good. The history of medical education in Ontario has shown that certain of her Universities, by various devices, endeavored to make smooth the paths of medical students

and open wide the gates of graduation. Degrees promised to become cheaper from year to year. What the University of Toronto and the Ontario Medical Council have done in opposition to mill-grinding is too well known to need any lengthy explanations from us.

While we are quite ready to appreciate the good points connected with the workings of provincial councils, we have to regret that there should not be some bond of sympathy between the various sections of the Dominion. There should be either a central examining board for the whole Dominion, or reciprocity between the different Provinces. There are so many obstacles, especially in Quebec, in the way of the establishment of a central board, that it is at present almost out of the question. Reciprocity between this Province and all, or at least most of the others, might easily be obtained if Ontario were so disposed. We have a big wall of protection thrown round us, which will not allow any physician from the outside to practise in our Province. The rule is beginning to work both ways, and our registered practitioners are being kept out of other Provinces. Is it possible to establish a reciprocity which will be so surrounded with safeguards as not to interfere with the high standard we are now trying to maintain? It might be well for our Council seriously to consider the matter.

Meeting of Medical Societies.

TORONTO MEDICAL SOCIETY.

The President, Dr. Atherton, in the chair.
Dr. Atherton—

TYPHOID FEVER, WITH EPIDIDYMITIS, PAROTITIS, AND PHLEBITIS.

Young man of 18, was convalescing from la grippe, when he again became ill, and his temperature rose to 104.2°F. This was at first thought to be a relapse. Antipyrin reduced the temperature to 102°F. For five or six days the temperature ranged from 101° to 102.3°F. This was accompanied by considerable headache, and slight epistaxis. A diagnosis of typhoid fever was then made. About the end of the first week he had pain and swelling of the left epididymis, and also orchitis. He had, two

years before, been struck on the testicles by a cricket ball. There was no diarrhoea. At the end of the second week rose-colored spots appeared. He then had phlebitis in the left leg, and during the third week a little diarrhoea. There was no great tympanites at any time. At the end of the third week he had pain and swelling of both parotid glands. At the end of the fourth week temperature fell to normal. During the whole course of the disease the temperature was irregular. Profuse perspiration. No gonorrhoea.

Dr. McPhedran—

HÆMOPTYSIS IN ACUTE TUBERCULOSIS

A young woman of 20, a household servant, had always enjoyed good health. For a week she had been rather under the weather, but not sufficiently so to prevent her doing her ordinary work. She was suddenly seized with hæmoptysis, which lasted for two days before she came to the hospital. The hæmoptysis persisted until her death, the second day after her admission. The blood was now profuse, now scanty. Owing to her condition, it was, of course, impossible to make any physical examination. There could not be elicited from her any history of any lung disease. There was no wasting.

Autopsy did not show any bleeding points, so that the hemorrhage was probably of capillary origin. The lungs were found filled with miliary tubercles. On the outer surface of the middle of the lower lobe of the left lung, there was found an old thick-walled cavity, not communicating with a bronchus, and with greyish semi-liquid contents.

Diagnosis lay between acute tuberculosis, and the rupture of a vessel in a cavity of old lung disease, which had become quiescent. As there was no history of old lung disease, and a rapidly ascending temperature, from normal to 103° in two days, the probabilities were in favor of the acute disease.

ARTHRITIC HÆMOPTYSIS.

The patient was an express driver, 51 years of age; a strong, robust man, a free drinker and liver, with a strong, tense pulse, and scanty, high colored urine. He was suddenly seized with profuse hæmoptysis—3 pints. This stopped spontaneously. In a few days he was again attacked, and was brought into hospital. His pulse was then very tense, urine scanty, and of

high specific gravity, and he was therefore given nitro-glycerine to relax the arterial tension, and magnes. sulph. to move the bowels freely. This had but little effect; the hæmoptysis continued for some days in small quantities, occasionally being quite profuse.

This would seem to indicate a local cause in addition to the general condition, so that this is not a true case of non-cardiac and non-pulmonary hemorrhage, as described by Sir Andrew Clark.

Dr. Price Brown remarked in regard to the first case that post-mortem examination frequently revealed the fact that there had been unrecognized tubercle in the lungs at some time, and that it had been cured.

Dr. Spencer spoke of the value of colchicum in arthritic hæmoptysis.

Dr. McPhedran said that the cavity in his case was most likely due to a previous broncho-pneumonia. Previously existing tubercle was usually denoted by cicatrices in the apex.

Dr. J. F. W. Ross presented a specimen of

PRIMARY CARCINOMA OF CORPUS UTERI.

The bladder was free, whilst the rectum was just commencing to be involved. When the case was first seen the disease was limited to the uterus, but the extreme age and debility of the patient, in his opinion, contra-indicated operation. Microscope showed the specimen to be a malignant adenoma, or carcinoma of the gland type.

EPITHELIOMA OF LABIUM,

removed by the knife from a patient of 84. The growth involved the clitoris, and there had been great pain. After the operation, the patient did well.

Dr. Geo. Acheson considered the first specimen very interesting, from a pathological standpoint, as being a primary carcinoma of the body of the uterus, a condition which was regarded as rare. There was no reason, however, why carcinoma should not originate there, for the uterus was provided with glands lined with epithelium, and a carcinoma was only a malignant adenoma.

Dr. Spencer asked whether it would not have been advisable to remove the uterus when the case was first seen. Dr. Ross said that the statistics of hysterectomy did not justify it.

DOUBLE UTERUS.

Dr. Spencer presented, for Dr. Bingham, a complete double uterus for a woman of 24, who had died of pneumonia.

Dr. J. F. W. Ross had seen a case of double uterus and double vagina. The patient refused operation, became pregnant, and bore several children without any difficulty.

OVARIAN TUMOR.

Dr. Cameron presented a dermoid cyst of the ovary, containing sebaceous matter, hair, and a single tooth—a cystic ovarian tumor, and a solid ovarian tumor, which had been associated with peritoneal effusion. There had been great difficulty in diagnosing whether this case was one of ascites, or of an ovarian tumor.

Hospital Reports.

OBSTRUCTIVE LARYNGITIS—TRACHEOTOMY—CONTINUANCE OF THE USE OF THE TRACHEOTOMY TUBE A NECESSITY—INTUBATION—RECOVERY.*

UNDER THE CARE OF G. R. M'DONAGH, M.D.,
L.R.C.P., LONDON, IN THE HOSPITAL FOR
SICK CHILDREN, TORONTO.

W. M., æt. 2, male; admitted March 10, 1890. The child had la grippe during the last week of January, and a cough troubled him for some time after; he had never been subject to croup, although his brother (3½ years old) frequently had such attacks. The boy's cough caused his parents some anxiety, and he was carefully watched in order that he might not catch more cold; when allowed out of the house at all he was well wrapped up. As time went on, however, these precautions were not so strictly adhered to, and on February 1st, a day when a cold, raw, high wind was blowing, the boy was in his father's shop, and every now and then slipped out for five minutes or so, bare-headed and thinly clad. The father remarked at the time that he fully expected the boy to have an attack of croup in consequence of his indiscretion. During the evening he was coughing somewhat; at seven o'clock he was eating some raisins when he suddenly choked, and breathing at once became difficult; a doctor was summoned, who passed a probang down the

*Reported by A. Primrose, M.B., Edin., Surgical Registrar to the Hospital.

child's throat and thus induced vomiting, which completely relieved the patient. The little fellow fell asleep, and slept soundly until 10 p.m., when he awoke wheezing and breathing with difficulty, making a "rasping sound" during respiration. This wheezing got worse during the following day, and at midnight two doctors held a consultation, one of whom attributed the condition to inflammation; the other appears to have suspected the presence of a foreign body in the air passages, due, in all probability, to the raisins. Hot fomentations were applied to the throat, but his symptoms were not relieved. During the next two days his breathing became more and more embarrassed: he used to lie with his head thrown far back in order to ease respiration. On February 5th, four days after the onset of these curious symptoms, his condition became so critical that it was decided to attempt tracheotomy as a possible means of relief. Accordingly at 2.30 p.m. on February 5th tracheotomy was performed with an entirely satisfactory result, the breathing was at once relieved, and, with the exception of some annoyance occasioned by a difficulty in keeping the tube from getting clogged, the patient got on nicely, and no further difficulty was encountered.

After nine days an attempt was made to remove the tube, but dyspnoea was so marked that it had to be replaced at once in the windpipe. Two other unsuccessful attempts were made to remove the tube on subsequent days. The child was sent to the Children's Hospital, and was admitted under the care of Dr. McDonagh.

On March 12th, thirty-five days after tracheotomy, Dr. McDonagh examined the larynx under chloroform, but failed to detect any foreign body. O'Dwyer's tube was then introduced into the larynx, and the tracheotomy tube removed. He breathed freely through the laryngeal tube, but its presence caused an unusual amount of irritation, and brought about such constant and persistent coughing that at first it was thought that the tube would have to be removed; air was, however, entering the lungs freely. After a time the child got easier, and the cough became less and less troublesome, and he was left with the laryngeal tube in position. Next morning he was doing nicely, there

was still a slight amount of irritation, but he breathed freely and he was able to take nourishment, consisting of milk, custard, and jelly, without difficulty. He continued in this condition until the morning of March 15, three days after intubation, when he coughed out the tube; he breathed freely for an hour and a half; when dyspnoea again came on, and the tube was replaced. At 5.30 p.m. he again coughed the tube out, and since then he has been able to get on without it. He remained in hospital for another week, during which time his breathing was normal whilst he kept calm, but if excited at all, he got somewhat hoarse, and had a slight difficulty in his respiratory efforts. He returned to his home in the country on March 22nd. In a letter from his father, dated April 10th, it is stated that the child is practically quite well.

REMARKS.

It is difficult, if not impossible, to arrive at an accurate conclusion as to the primary cause of this child's trouble. We have a history of a patient, previously weakened by an attack of the prevailing influenza, exposed to influences which would readily account for an attack of inflammatory croup; we have, in addition, a history of choking whilst eating raisins, and because of the sudden onset of the symptoms, we are led to suspect the presence of a foreign body in the windpipe. It is possible that both of these causes were at work, and produced a general inflammation about the larynx which eventually led to almost complete obstruction by swelling, possibly œdema, of the parts. The sudden relief at first obtained after vomiting, induced by the passage of a probang, may possibly be accounted for by the dislodgment of the foreign body, whilst the subsequent very gradual development of dyspnoea was probably due to a secondary inflammatory process.

The case is also of interest in showing that in intubation we have a valuable method of treating those troublesome cases in which a patient, after tracheotomy, cannot dispense with the tube, and finds it impossible to breathe through the natural passages.

DR. JENNY K. TROUT, of Toronto, has given \$500 towards the new building of the Women's Medical College at Kingston, with a promise of \$500 more in November.

Pathology.

VEGETABLE MICRO-ORGANISMS IN CARCINOMA.

The necessity of full (strict) compliance with the postulates of Koch in proving the pathogenic character of any micro-organism has, within the last two years, received a notable illustration in the failure of Scheueilen's work on the so-called cancer bacillus to stand the test when called strictly in question. Van Ermengem has shown that the so-called "bacillus of cancer" is no other than the "bacille rose," a common non-pathogenic form, which is frequently found in air, dust, soil, etc., and sometimes occurs as an accidental impurity in cultivations of bacillus tuberculosis. Repeated inoculations with pure cultures of this organism into dogs, guinea pigs, and rats, failed to affect their health in the least. This signal failure, however, has not frightened other investigators from the field. In the *Centralblatt für Bakter u. Parasiten* of Feb. 28th, 1890, is a condensed report of the recent work of Koubassoff on the "micro-organisms of cancerous new-growths." Koubassoff's investigations were made upon 6 cancers of the uterus, 1 of the breast, and 5 of the stomach. The report is of work done on the stomach cancers only. In all cases he met with a peculiar bacillus, of which he made pure cultivations, and afterwards performed inoculatory experiments therewith in order to determine the presence or absence of pathogenic qualities in it. Other varieties of bacteria were to be found, and often in great numbers, but this particular sort was constantly present, and attracted attention by its peculiarities. Koch describes the organism as being a rodlet from $\frac{1}{2}$ to $\frac{1}{3}$ as long as the bacillus tuberculosis, and three or four times as thick. In the tissues it is found to have one end pointed, the other wedge-shaped; whereas in cultures both ends become rounded. It is mobile—movements taking place in but one direction, and takes up anilin colors lightly. Endospores are formed centrally under certain conditions, and cultures grow upon almost any of the nutrient media used in bacteriological study. Growth is slow and aerobic, and takes place best at a temperature of 20°C. In all cases animals inoculated with pure cultures died,

as did also those fed with the germ, the illness in the latter case being shorter than in the former. Guinea pigs died in one to two weeks, rabbits in one to two months, cats and dogs after two months. *Post mortem* examinations always showed the same results, viz., formation of nodules of greater or less size, sometimes ulcerated, sometimes not, occurring on the gastric and intestinal mucous membrane; sometimes in the liver, ovary, uterus, and spleen. The lymph glands in the abdominal cavity were also notably swollen, and were, at times, knotted together, at others, remaining separate. Histologically, these nodules are said by Koubassoff to resemble carcinomatous tissue. Symptoms of constitutional disturbance were also present, the most noteworthy being general emaciation, together with paralysis of the sphincters of the bladder and rectum. Whilst Koubassoff himself is evidently of the opinion that this bacillus which he has described is the cause of cancerous or, at any rate, some cancerous growths, the evidence is yet far from complete. Whatever the result of further investigation may be, certainly some very interesting additions have been made to our knowledge of mycology in connection with epithelial new-growths.

J. CAVEN.

PASSAGE OF MICRO-ORGANISMS FROM MOTHER TO FÆTUS.

Speaking with reference to the virulence of foetal blood in cases where the pregnant mother suffers from anthrax, Sternberg (Backria, 1885) quotes Branell, Davaine, and Bollinger, as authorities for the statement that there are no bacilli to be found in the blood of the foetus in such cases, and that it is non-virulent. He also says that Strauss and Chamberland have shown that occasionally an exception occurs, and the bacilli are found in the foetal blood. Further, in speaking of symptomatic anthrax (Rauschbrand), the same author affirms that it is to be distinguished from true anthrax (Milzbrand) by the fact that the foetal blood is virulent in it (Rauschbrand), and contains bacilli. Recently Simon (*Zeitschrift für Geburts u. Gynak.*), by microscopic observations, has found that the placenta does not form a "filtering apparatus" for the exclusion of micro-organisms from the

foetus. His observations were made on cases of anthrax, and the bacilli were found not only in the amniotic fluid and on the surface of the foetus, but even to a depth of several cell layers in the skin over the abdomen. Curiously enough no germs were found in the internal organs. The micro-organisms, however, were not in every case found invading the foetal structures to the same extent, and only in cases noted as of "remarkably" long duration was the body of the foetus itself invaded. The field of invasion varied according to the length of duration of the case, from the "maternal placenta" alone to the foetal placenta, liquor amnii, and skin of the foetus itself. These observations were made upon rabbits. The question, then, as to the virulence of the foetal blood is still undecided, in spite of these investigations, since the mere finding of the bacilli, even in the foetus itself, is no proof of their power of infecting. The fact noted by Simon, that there were none of the gross lesion of anthrax present, seems to point in the opposite direction.

J. C.

Correspondence.

Editor of CANADIAN PRACTITIONER.

It is to be hoped, now that some new blood has entered the Medical Council, that a move will be made towards its higher duties in connection with the practice of medicine. I refer to the establishment of an annual series of lectures, like the Gulstonian, Lumleian, and others. Scholarships for post-graduate work, original or experimental, and the printing and distribution by the Council of these to all members of the College of Physicians and Surgeons. I feel convinced that until some such return is made to the profession, the annual assessment will remain a source of discontent and a bar to the amity which should exist between the Council and its graduates.

I do not feel like taking up your space, or would write in more detail on the subject.

Yours truly,

J. E. WHITE.

Editor of CANADIAN PRACTITIONER.

SIR,—In the last issue of your JOURNAL, in speaking of medical legislation in British Colum-

bia, you alluded to the rather unsatisfactory state of the Medical Act during the past year. What you said in that particular respect was all right, but when you go on to say that "the Medical Council was very apathetic in this matter" I assure you that you are entirely mistaken, and who ever informed you to that effect told you what was not correct. It would appear from your article that Dr. M. S. Wade, of Victoria, was the "champion" to whom the profession in British Columbia is indebted for the changes that have been made in the way of repeal of obnoxious and unjust sections of the Medical Act. As a matter of fact, Dr. Milne, our Registrar, and myself, as the two active officers of the Council, have been working incessantly since last spring to effect the changes that have now so happily been brought about, but we did so quietly, though none the less thoroughly, as the results show. We tried to obtain reciprocity with the General Medical Council of Great Britain, and that failing, we determined to ask for the repeal of the section in the Medical Act which allowed British graduates registered in Great Britain to practise in this province on the payment of a fee of only ten dollars for registration here, and we succeeded. I do not want to take any extra credit for what I did, inasmuch as all the other members of the Council did their duty in this respect faithfully and well. I may particularly mention Dr. John Davie, the brother of the Attorney-General of the province, whose aid was invaluable during the progress of the bill through the Legislature. Dr. Wade certainly wrote a pamphlet, and I have no doubt it had good effect in some quarters, but to claim that he did the work of the Medical Council is certainly ridiculous, and insulting to us as a body. Hoping you will give this insertion in your widely read JOURNAL, I am yours very respectfully,

W. J. McGUIGAN.

President B.C. Medical Council.

Vancouver, B.C., March 13, '90.

Editor of CANADIAN PRACTITIONER.

SIR,—In THE PRACTITIONER of 1st March is a clipping from the *Popular Science News* minimizing the "danger of contracting consumption in sleeping cars, when the berths have previously been occupied by those afflicted with

the disease." The statement is made that, "There is little proof that the bacillus tuberculosis retains its vitality outside of the body long enough to infect another person under such circumstances."

This statement is sadly at variance with the experiments of authorities cited by Whittaker of Cincinnati, in the first volume of Sajous' Annual of the Medical Sciences for 1889. By these it has been proved, that the bacilli in dried sputa retain their viability for periods varying from three to six months; and that dust collected from the walls of rooms, where sputum cups had not been used, had been capable of transmitting the disease to animals experimented upon; check experiments were made in these cases.

I have not seen the "absurdly impracticable suggestions" referred to by the *Popular Science News*, but it would certainly not be too much to expect the railway people to provide cuspidores made of hard rubber or other noiseless material, and instruct porters to hand these at night to passengers afflicted with expectoration, instead of having the expectoration stored in a handkerchief, and probably smeared from it upon the mattress or upholstered head-piece. These could also be protected by being enclosed in a cotton covering, as is often done by the very careful housekeeper with the drawing-room furniture.

Railway managers are generally desirous (in these days of competition) of promoting the comfort and safety of passengers.

I do not know that it would be too much to ask that, in a case where a suspicious case has been in a berth, the car conductor should report the fact, so that the wood-work of that berth could be washed down by the car-cleaner with some disinfectant solution.

Railway authorities should also be induced to provide means, and enforce regulations, for suppressing the filthy practice of spitting and expectorating on the floors of day cars. To say nothing of the sanitary part of the question, it is most disgusting for people to find themselves sitting with boots and skirts in contact with the excretions of a previous occupant. These deposits are also liable to become part of the atmospheric dust of such cars.

Yours, etc.,

WILLIAM OLDRIGHT.

Books and Pamphlets Received.

Field Hospital Service with the Army of the Potomac. By W. W. Potter, M.D.

A Dermoid Cyst of the Left Ovary. By W. W. Potter, M.D., and W. C. Krauss, M.D.

Transactions of the Medical Society of the State of North Carolina; 26th Annual Session, 1889.

Discussion on Craniotomy; reprinted from the transactions of the American Association of Obstetricians and Gynecologists, September, 1889.

Book Notices.

Neuroses of the Genito-Urinary System in the Male, with Sterility and Impotence. By Dr. R. Uitzmann, of the University of Vienna, translated by G. W. Allen, M.D.

The author deals with this subject in a commendable manner, avoiding the disgusting details of sexual perversions and abnormalities. The physician will find in the work reliable advice as to those cases in which something more than moral treatment is usually required.

Wood's Medical and Surgical Monographs. Vol. 5, No. 3, March, 1890. Wm. Wood & Co., New York.

In this number are contained Treatment of Cancer by Electricity, by J. I. Parsons, London; The Dreadful Revival of Leprosy, by Sir Morrill Mackenzie, M.D.; Diseases of Old Age, by Dr. A. Seidel, Berlin; Urinary Neuroses of Childhood, by Dr. Guinon, Paris; Varicose Veins of the Lower Extremities, by W. H. Bennett, F.R.C.S.; Uses of Electrolysis in Surgery, by W. E. Steavenson, M.D., London.

The Pulse. By W. H. Broadbent, M.D., Senior Physician to and Lecturer on Clinical Medicine in the Medical School of St. Mary's Hospital. Lea Bros. & Co., Philadelphia.

In this book Dr. Broadbent reproduces, with some amplifications and additions, the Croonian Lectures delivered by him in 1887 before the College of Physicians, of London. The work is especially valuable as the expression of opinion of one of the best known and most highly esteemed of English clinical observers; opinions based on the observations of a lifetime.

Sanders' Question Compend: Essentials of Examination of Urine. By Lawrence Wolff, M.D.
Essentials of Diseases of the Skin. By Henry W. Stelwagon, M.D. W. B. Saunders, Philadelphia.

The information contained is accurate, and tersely put. The volume on skin diseases is especially good. We must protest, however, against the arrangement in the form of question and answer. True, it is difficult for the student to seize all the salient points of any description of disease, but it should be part of his training to acquire this faculty, not only in disease as he meets it at the bedside, but also as to the description of it.

Personal.

DR. GEORGE A. PETERS left Toronto on April 4th for a trip to England.

DR. WILLIAM OSLER, of Baltimore, spent a couple of his Easter holidays in Toronto.

DR. A. T. CARSON, of Toronto, who has been in poor health for some time, started for Bermuda April 4th.

Births, Marriages and Deaths.

BIRTHS.

MILLMAN.—On March 30th, at 544 Spadina Avenue, the wife of T. Millman, M.D., of a son.

PHILLIPS.—On March 23rd, 1890, at 67 Ross street, Winnipeg, the wife of T. Graham Phillips, M.D., of a daughter.

ELLIS.—At 272 Dundas street, Toronto, on the 13th inst., the wife of Austin D. Ellis, M.B. (Aberd.), of a daughter.

MARRIAGE.

REESE—ROBINSON.—In Buffalo, on March 5th, by Rev. J. E. Williams, D.D., pastor of Plymouth M.E. Church, Mrs. Gertrude Reese, formerly of Buffalo, to R. H. Robinson, M.D., of Toronto.

DEATH.

NELLES.—At London, Ont., on March 21st, Amelia, beloved wife of Dr. J. A. Nelles.

Obituary.

JOHN HICKMAN, M.D.—We regret that an obituary notice, which should have appeared in THE PRACTITIONER some months ago, was mislaid. Dr. John Hickman was born in Port Hope, Ont., in 1845. After completing his academic education at Oberlin College, he commenced his medical course in the Toronto School of Medicine, and graduated in the University of Toronto in 1869. He spent three years with his father, Dr. Edward Hickman, at Bolton, and then went to Bergon Point, New Jersey, where he practised up to the time of his death, which took place June 7, 1889.

Miscellaneous.

THE INTERNATIONAL MEDICAL CONGRESS.—The tenth International Medical Congress, to which we have frequently referred, will be held in Berlin, August 4th to 9th. The profession of that city have sent assurances that the medical fraternity of this continent who attend the Congress will receive a hearty welcome.

A NEW MEDICAL FACULTY.—At a meeting of the Huron Medical Association, held three years ago this month, the following resolution was moved by Dr. Taylor, of Goderich, and seconded by Dr. Williams, of Clinton, and unanimously adopted:—

“That whereas a scheme has been proposed, having for its object the formation of a faculty of medicine under the direct control of Toronto University and in intimate relation to the General Hospital, the members of the Huron Medical Association desire to place on record their appreciation of the plan proposed, and their confidence that, if the same is carried out, the cause of medical education in Ontario will thereby be greatly perfected, and many of the well-founded objections to the present system removed; and that we assure the promoters of this scheme that they will have our hearty co-operation and sympathy in this effort to establish in close connection with our Provincial University a medical school, which shall afford the best known facilities for the study and investigation of medical science.”