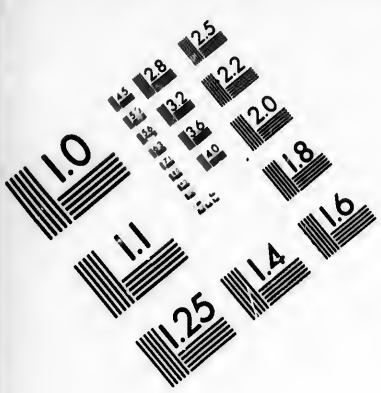

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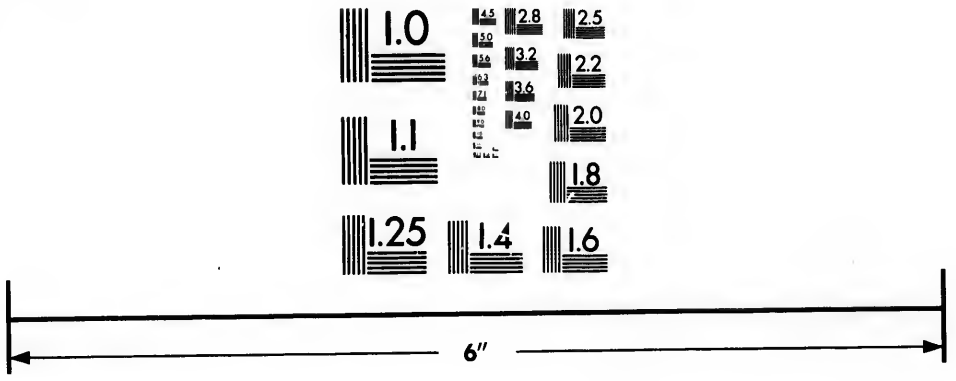

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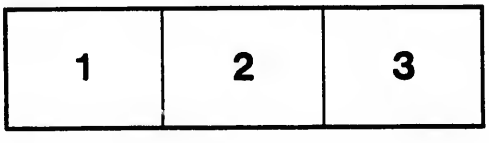

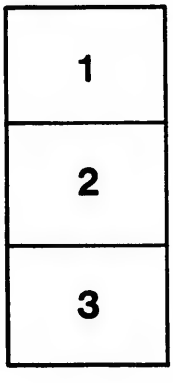

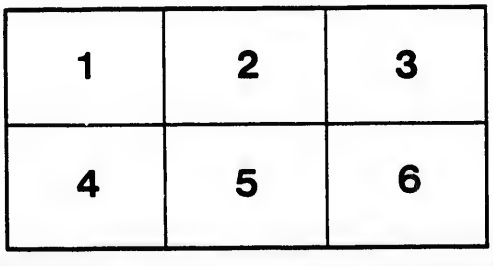

MONTREAL GENERAL HOSPITAL.

Condensed Reports of Cases in Dr. MacDonnell's Wards.*

October 4th.—The session has opened with an unusual number of instructive cases in the clinical wards. During the fortnight previous to the opening of the session, five of the beds were occupied by cases of pleurisy with effusion. In four, early aspiration was resorted to and with satisfactory results. One of the cases, that of a man of 30, was interesting from the fact of the fluid having escaped notice for a long time, and from the length of time the patient went about with one side of his chest completely full of fluid and his heart apex displaced to the right of the sternum. Another patient in a similar condition walked to the hospital from the end of St. Antoine street. In one case the fluid partially disappeared spontaneously.

On the 30th September a very interesting case of pleurisy was brought in. Here the cause was traumatic, the patient having had a large stone fall upon his chest some six weeks ago. The distension of the right pleural cavity was extreme. The heart beat two inches beyond the nipple line, and the liver could be felt two inches beyond the costal border. Dyspnœa was very urgent. The temperature was slightly raised. Aspiration showed the presence of pus, and, accordingly, resection of a rib was performed by Dr. James Bell.

The internal treatment of these cases of pleurisy with effusion has consisted of the administration of iodide of potash three times a day, and of concentrated doses of sulphate of magnesia in the morning.

Typhoid Fever.

The cases this year have been of much greater severity than those we have been accustomed to meet, and the mortality has been high. The following notes may prove interesting:—

High Temperature.—A very severe case, occurring in a strong, healthy servant maid, showed a tendency to hyperpyrexia. The thermometer registered 104½° to 105½° for the

* I am indebted for the reports from which the following are condensed to Drs. England and Campbell, house-physicians, and to my clinical clerks Messrs. Adams, Hamilton, Bowes, Murray, McKechnie and Inksetter.

first four days, and neither antipyrin nor antifebrin had any effect whatever. After the first week in hospital the fever abated. There were three distinct rigors on the twentieth day, for which no cause could be found. The patient eventually recovered.

Meteorism.—In the case of a strong man of thirty, who was brought to the hospital in about the middle of the fever, delirium having been very severe before admission, meteorism developed to an extraordinary degree. The abdomen became greatly distended, and brought such pressure upon the chest as to increase the respirations to 56 and to displace the heart and liver. The passage of a long rubber tube brought away a quantity of gas and gave temporary relief. We found it a good plan to leave the long tube in the bowel. However, we failed to avert the fatal result. The autopsy showed that death was the result of typhoid fever without any perforation or peritonitis.

Delirium Ferox.—A Hungarian, aged 35, was brought to hospital in a state of wild delirium, and became so unmanageable that it was necessary to lodge him in the padded room. The diagnosis was very doubtful, but after a few days the high temperature and the character of the evacuations enabled us to decide upon the nature of the case. Murchison mentions just such another case. He was called in to see a German gentleman, who was supposed to be mad. After four days of slight malaise, which had attracted little notice, he passed suddenly into a state of acute maniacal delirium, requiring two men to hold him down in bed. He was thought to be suffering from an attack of insanity, but with these symptoms there was pyrexia, quick pulse, temp. 102°, dry tongue, diarrhœa, but no spots.

Profuse Rash.—The case of a workman from Lachine is notable from the profuseness of the rash. Upon the chest and abdomen the general appearance reminds one of measles. The symptoms were very severe, the system being apparently overwhelmed by the intensity of the poison. There was deep stupor and incontinence of urine and fæces. At the time of death the rash was distributed over all the body.

Syncopal Attacks.—A female patient, one of those from Point St. Charles, suffered in the beginning of the fever from several

attacks of fainting. Stimulants were freely used and recovery from the fever took place, though very slowly. I lost a patient some years ago from sudden and unexpected syncope in the course of typhoid fever. This mode of death has been reported as occurring in acute pneumonia, and in diphtheria it is a common occurrence.

Anterior Poliomyelitis Acuta.

An interesting case of this disease was that of Maggie L., aged 14, who was admitted on the 14th July with sudden loss of power in the left leg. The family history was somewhat neurotic, a sister having suffered greatly from chorea. Six days before admission she was obliged to give up work, owing to a great sense of fatigue. Twenty-four hours afterwards, after walking a short distance, her left leg became quite powerless. She had to be carried home, and has been unable to walk since. There was no loss of consciousness and no pain.

State on Admission.—Marked anæmia; slight pyrexia, the evening temperature running not higher than 100° for the first few nights; slight headache and loss of appetite. There was double vision on the day before the first attack. Pain was never present. All four limbs were enfeebled, as well as the muscles of the back, but in a different degree. The left leg was completely paralysed and its knee reflex abolished, but sensation was unimpaired. The right leg could be feebly moved, and its knee reflex was not quite absent. Superficial reflexes are absent in both lower extremities; no ankle clonus. At the time of admission the hospital batteries were undergoing repair, so that electrical tests could not be applied. However, shortly afterwards it was found that there was no response to the faradic current and a feeble one to the constant in all but the left leg. The weakness extended from the left leg to the right leg, to the left arm and hand, then to the right arm and hand. Lastly, the neck and back muscles became affected. The sphincters and muscles supplied by cranial nerves were never affected.

October 7th.—The patient has now been in hospital over two months, and there is considerable improvement. The anæmia has diminished, general nutrition is improved, and the para-

lysis has disappeared, the change for the better being most noticeable in the muscles of the back, which seem to have been the first to recover, but in the left leg there is no change. There is at present no muscular atrophy, but probably this may be deceptive, owing to the fatness of the patient.

Uræmia.

October 9th.—There are three cases of uræmia in ward 11, each showing prominently a special feature of that condition. On the evening of the 7th of October a man, aged apparently about 50, was brought to the hospital by the police in a state of profound coma. The breath was not alcoholic. The small quantity of urine which was withdrawn by the catheter was heavily loaded with albumen. He was well purged with croton oil, and put into a hot air bath. Subsequently, pilocarpin was given by hypodermic injection (gr. 1-6) with a very good result. Convulsions had occurred also. In twenty-four hours the coma had disappeared, but he was still in a very stupid condition, unable to speak and breathing noisily, owing to the flapping of his lips. To-day, *i.e.*, 48 hours after admission, there is still great mental confusion, though he is able to say his name. At the clinic it was noticed that the respiration, which had previously been noted as slow, had now a rhythmic character, and was inclined to be of the Cheyne-Stokes variety.

October 10th.—The improvement was but transient, the convulsions recurred with increased violence and death ensued.

It was confidently expected that marked renal changes would be found at the autopsy, but such was not the case. No cause of death was found, unless the kidneys were diseased to an extent merely recognizable with the microscope. The symptoms present, the convulsions, the coma, the scanty urine loaded with albumen, rendered any other diagnosis than that of uræmia highly improbable. The body being unclaimed, it was injected with preservative fluid before the kidneys were removed, and consequently their finer structure could not be examined, but they were of normal size and appearance.

What was the cause of the convulsions and the coma? 1. There is a slight chance of its being due to early renal changes. 2. A poison, e. g., alcohol or opium,—against this

interpretation is the fact of his complete recovery from the original coma and the recurrence of the convulsions.

The second case showed evidences of uræmia in a milder degree. The patient had had evidences of chronic Bright's disease for some years, dating from an acute nephritis nine years ago, which directly followed an attack of erysipelas. At present there are albuminuria, hyaline casts, and general dropsy, but the most important symptoms are the persistent frontal headache and the attacks of vomiting to which he is subject.

The third case, that of a baker, aged 34, was also one of chronic uræmia, and its principal manifestation was extreme dyspnœa. At first there was orthopnœa, but after a few days treatment this subsided. There was no dropsy. The patient for a long period had regarded himself as an asthmatic. It was difficult to determine whether these attacks were due to true asthma or were merely evidences of uræmia.

Progressive Muscular Atrophy.

Two cases have been in hospital lately. The first case, that of a woman long past middle life, illustrates two points in connection with the etiology of the disease, its origin in fright, and its occurrence in members of the same family. The wasting began two years ago, immediately after she had experienced a shipwreck on the Atlantic. Eight years ago she had been under my treatment at the Montreal Dispensary for ulceration about the knee, which was thought to be syphilitic. The family history is interesting. The father died from the effects of an accident; the mother, an uncle and an aunt all died of "paralytic strokes." Two sisters of the patient died at the ages of 47 and 50, having suffered from a disease said to be exactly similar to that of the patient.

The occurrence of progressive muscular atrophy in families has been reported. Recently, the following notices of this point have fallen under my observation. In the last number of the *Revue des Sciences Médicales*, Lichtheim reports the history of a family of four brothers, three of whom suffered from progressive muscular atrophy; and in the same journal there are two other histories of families—in one two sisters developed the disease shortly after puberty. In a history

reported by Herringham in *Brain*, the family tree, representing five generations, shows that 19 male members were atrophic; the remainder, to the number of forty-six, including all the women of the family, entirely escaped.

An interesting family tree will be found in a paper by Dr. Osler in *Seguin's Archives* for 1881.

The second case did not show such marked symptoms. The wasting and the loss of power began after an illness, which was characterized by pain in the stomach and vomiting. The wasting was very rapid. The patient was a street car driver, and suffered much hardship in the spring from the exposure to cold and wet incidental to his calling. He had been three months ill previously to admission. The right arm and shoulder first became weak, and there were such sensations as pricking, tingling and formication, and the symptoms extended to the forearm and hand. Within two days the left arm and hand became similarly affected. In two weeks the legs became affected, but to a much less degree. There was considerable pain and tenderness on pressure in the calves of the legs and the inner side of the thighs. The upper extremities are much wasted, the lower less so. There is dull pain in the arm and shoulder on both sides and exaggerated tenderness of the muscles of the arm and forearm. The extensors of the fingers and thumb are wasted, but there is no wrist drop. Patellar reflexes are normal. Fibrillar tremors are elicited by percussion over the shoulder muscles.

After a month's residence in hospital there was marked improvement.

Nov. 5th.—The progress of this case is such that a diagnosis of progressive muscular atrophy cannot be entertained. Improvement is distinct. Most probably it is a sub-acute poliomyelitis, and the sharpness of the attack at the outset rather favours that view.

Aortic Aneurism.—In the case of a man aged 50, a lumberman, there are well-marked evidences of the presence of an aneurysm of the ascending and transverse arch. The patient applied first to Dr. Major, the laryngologist, for the relief of his hoarseness, and was by him referred to me. The left vocal cord was paralysed. An interesting point in the case is the presence, in a very marked degree, of the sign on

palpation of tracheal tugging, an evidence that the tumour is in contact with the trachea or one of the large bronchi, and also that consolidation of the contents of the sac has not far advanced. The clanging cough and the dyspnœa have been much relieved since he began the iodide of potassium treatment.

Acute Spinal Meningitis.—Bridget M., aged 10, caught a severe cold on the 11th of August, 1889. Hitherto she had been in very good health. The father is a drunkard, but there is no history of nervous disease in the family. Four days afterwards she had refused to eat her meals, had a severe attack of vomiting, which was followed by constipation and severe headache. For the next three or four days she was very feverish and was said to be delirious. She then seemed to improve slightly, but the gait was staggering and the articulation became thick and indistinct. The mother states that on one occasion she observed that the child was squinting. The patient was admitted to hospital on the 21st August, when she appeared to be in very great suffering. The body was held continually in one position on the side, with the back stiff and the head well retracted. The abdomen was hard and scaphoid. Meningeal streaks were readily obtained. Pressure on the legs caused great pain. Reflex action generally increased; bowels very constipated, but there is no disturbance in the function of urination; pulse, 120–140. Respiration (20–24) is somewhat irregular at times, but is not of the Cheyne-Stokes character; no dyspnœa. During the 85 days of illness the symptoms varied slightly. Emaciation and debility increased. Pupils varied in size at different periods. The fundus, which at first was quite normal, showed optic neuritis a few weeks before death. There were no signs of paralysis. Death occurred before the irritative stage was passed. Patellar reflex disappeared as the disease advanced. There was no continuous vomiting, general headache or paralysis of cranial nerves, hence it was thought that the disease was seated in the spinal and not in the cerebral meninges.

Of the clinical features of the case, the most remarkable is the range of temperature, which appears in rhythmic waves. The first fifty-six days in hospital might, by the chart, be divided into sections of four days each, and on the evening of the first

day of each section the temperature ran to 101° or 102°; then on the three remaining days it went down to a lower degree, until on the fourth night it was normal; then a rise to 102° and a gradual fall in the next three days. The pulse was frequent (120) during the period of elevated temperature, but fell to 90 and 100 when the temperature fell to normal.

The following abstract of the post-mortem changes is furnished by Dr. Wyatt Johnston, pathologist of the hospital: "Emaciation extreme. Cerebral ventricles are distended and contain seven ounces of fluid. Slight turbidity and œdema of pia at base of brain, not extending along the sylvian fissure. No lymph. No tubercles found in microscopic examination of the vessels of the perforated spaces, arteria profunda cerebri, sylvian arteries, or choroid plexus. No cerebral pachymeningitis, or disease of the bones of the skull. Slight optic neuritis. A severe and extensive pachymeningitis throughout entire spinal canal, involving sheaths of spinal nerve roots. Abundant fibrinous exudation between dura and bones, which has partly organized. Spinal pia œdematous. Spinal cord normal, except for slight grey degeneration in postero-internal tracts. Peripheral nerves (sciatic, ant crural and brachial plexus) in both sides normal. No disease of bones of vertebral column. Localized emphysema of left lung, with recent pneumothorax. No tubercle anywhere. Cause of pachymeningitis not detected."

The pleumothorax, I take it, must have immediately brought about the end, because it is unreasonable to suppose that in the state of extreme debility in which she passed the last three weeks of her life, she could have stood the shock of the sudden entry of air into the pleura.

Diseases of the Stomach.

Gastric Ulcer (Oct. 31st).—A well defined case of gastric ulcer, and two of cancer of the stomach, have lately been in the wards.

The case of ulcer occurred in a young married woman, aged 23, who entered on the 28th August, with epigastric pain, aggravated to an intense degree by food, and relieved

by free vomiting. The ejected matter consists of partly digested food and a quantity of slimy mucus, with here and there streaks of blood. These symptoms have been present for the last seven months, and are thought to result from the debility which followed a difficult labour a year ago. There had been one sharp attack of hæmatemesis. In the middle of the epigastrium there is a spot of exquisite tenderness.

She left the hospital almost free from any gastric symptoms on the 3rd October. The treatment consisted of physical and physiological rest, a diet of milk with soda water exclusively, and at first a mixture of carbonate of bismuth, carbonate of soda and tincture of belladonna. When improvement had well set in, Fowler's solution in five minim doses was administered.

Cancer of the Liver (probably) Secondary to Cancer of the Stomach.—F. O., carpenter, aged 55, admitted August 29th, 1889; no distinct family history of cancer. For some years had been liable to slight attacks of dyspepsia, but with this exception had enjoyed good health until four months before admission, when he began to suffer from pain at the epigastrium and upper part of the abdomen, flatulent distension after food, and vomiting, the latter presenting the following characters: it was not present every day; there were intervals of several days when he was entirely free from it; the vomiting followed at a considerable interval after the taking of food, and the quantity ejected at a time was stated to be as much as several pints; the vomited matter consisted of a sour smelling, sometimes watery, sometimes slimy fluid. On several occasions before admission it was noticed to be of a dark brown color with a sediment ("coffee ground"). The pain was never in any way affected by the vomiting. The bowels have been obstinately constipated. These symptoms increased rapidly in severity, and soon the patient lost appetite for food and became rapidly emaciated. In June last he first noticed that the upper part of the abdomen was prominent and hard. There has never been any jaundice nor have the legs been at any time swollen.

On admission patient was very thin; weighed 129 lbs (former weight 167 lbs). The skin is somewhat lemon-coloured, but

there is no jaundice. The liver is enlarged in the right mammary line, measuring eight inches, and extending quite four inches beyond the margin of the ribs. In the middle line the edge of the liver reaches to within two inches of the umbilicus. There is marked tenderness on pressure over the liver, the surface of which is smooth, but just in the upper line a small nodule can be felt. Percussion over the left hypochondrium gives an unduly tympanitic note. The abdominal veins are not dilated. There is no ascites whatever. Splenic dulness is not increased. Tongue large, flabby and coated. Suffers continuously from pain, mainly in left hypogastrium, which is increased by food and not relieved by vomiting. The attacks of vomiting occur at intervals of two or three days, and are of the characters above mentioned. Since his admission there has not been any "coffee-ground" appearance of the vomited matters.

October 31*st*.—Since admsssion there has been very severe pain in the upper part of the abdomen and recurrent attacks of vomiting. There has not been any loss of weight. The ejected matter does not contain hydrochloric acid.

Salol Test.—Dr. England reports that he found the salicylic re-action in the urine two hours and a half after he had administered twenty grains of salol by the mouth.

Cancer of the Pylorus; Very Rapid Progress; Death; Autopsy.—Alexander E., a sailor, aged 57; admitted October 15th, complaining of severe abdominal pain, frequent vomiting and obstinate constipation. He states that he was in good health until about three weeks before admission, when the bowels became very constipated, and at that time he noticed that there was a painful lump in the epigastrium. A dose of castor oil freely moved the bowels, and after that the lump is said to have disappeared, but quickly to have returned. It was only fifteen days ago that he began to vomit, and he noticed that as soon as the vomiting set in the pain became very much worse. The bowels moved freely for about five days after the vomiting occurred, and then remained closed for the last ten days. Vomiting occurs usually about four hours after food. The ejected matter is liquid and the quantity got rid of is very great. He

states that his usual weight is 150 lbs. His present weight is 112½ lbs. No family history of cancer.

Emaciation is extreme; no jaundice, but complexion is very sallow; suffers extremely from pain in the epigastrium, which is markedly prominent and very tender on pressure, especially at a point about two inches from the umbilicus and one and a half inches from the middle line, where a hard nodule can be felt. The liver is of normal dimensions in the right lobe, but the left extends to within two inches of the umbilicus. The liver surface is smooth and its edge sharply defined.

October 30th (37th day of illness).—Vomiting has been continuously present and is very distressing. It occurs whenever anything is taken into the stomach, and consists of a large quantity of watery matter, which contains no hydrochloric acid. When salol (20 grains) is given by the mouth there is no evidence of the presence of salicylic acid in the urine for six hours, corroborating the evidence already stated as to the motor insufficiency of the stomach. The bowels are obstinately constipated, but can with great difficulty be made to move by castor oil and by enemata; tongue coated; constant desire to take food. Emaciation has been very rapid. In ten days he has lost fourteen pounds. Within the last twenty-four hours he has been in a moribund condition; very delirious, evidently dying by starvation.

Autopsy.—"Great distension of stomach. A zone of ulceration extending around the entire circumference of the pylorus. On section the gastric wall in its entire structure is infiltrated with scirrhus, which has also extended into neighboring organs, the right kidney and supra renal capsule, the glands about the pylorus, the retro-peritoneal and retro-thoracic glands at the level of the diaphragm. The œsophagus at the cardia and bile ducts are slightly pressed upon by these enlarged glands. The growth has directly extended to the capsule of the liver beneath the left lobe, but no secondary nodules occur in the liver substance." (Dr. Johnston's report.)

Herpes Zoster in Connection with Disease of the Spine.—A

woman past middle life was admitted, complaining of pain in the lower part of the lumbar region. No cause could be discovered in the abdomen. but there was found a prominence of the spine of the dorsal vertebræ, in the neighborhood of which there was very marked tenderness upon percussion. After being two days in hospital, there appeared an eruption of herpes zoster, which began at the prominent spine and ran down the side of the chest and abdomen in the direction of the umbilicus.

Recurring Tonsillitis as an Evidence of the Rheumatic Diathesis.—In the case of a young man who had his first attack of rheumatism (with endocarditis) there was a history of five distinct attacks of acute suppurative tonsillitis.

Pneumonia.—Nov. 9th, 1889. Three cases have been in my wards during the last week. The first of left apex pneumonia resolving rapidly, the second a more serious case, one of right apex and left base, which ran a more protracted course,* and in the third, a fatal case, the disease involved the whole of the left lung except the apex, and the middle lobe of the right lung as well. The respirations were very rapid, 80 and 90 on the day after admission. Death occurred the day after the crisis from œdema of the lungs. Loud mucous rales pervaded both sides of the chest. There was throughout no expectoration. The most interesting point in the autopsy, the discovery that a fibrinous exudation, distinctly croupous, occupied the trachea, in fact, a membraneous tracheitis existed. There was commencing acute tubular nephritis on one side. There had been albumen in the urine.

Cirrhosis of the Liver.—A woman aged 63 died in 24 ward of the effects of portal obstruction. She had entered the hospital on July 26th. A history of spirit drinking; venous stigmata; a moderate amount of fluid in the peritonæum; extent of liver, dulness in right mammary line, 2½ inches; the splenic dulness had increased to four inches in the axillary line. Had suffered from bronchitis and shortness of breath upon exertion for the last seven years, as well as from pain in the left inguinal region.

* Dec. 5th, 1889. The consolidation never underwent any resolution. The patient, aged 44, an alcoholic, died in the fourth week, from the results, apparently, of the concomitant bronchitis.

After some weeks residence in hospitals he went home, but returned in a fortnight much worse. It was now noticed that at about two inches below the costal margin a firm body could distinctly be made out upon palpation, and this was thought to be the edge of a large liver. Contact of the finger caused no pain. Appetite bad; much thirst, and latterly vomiting. Jaundice appeared about three weeks before death, but was transient. A week before death there was wandering, and at the end she was comatose.

Autopsy.—Peritonæum contained 330 ounces of fluid. The liver was typically cirrhotic (wt. 1100 grammes*). It is probable that a quantity of serum must have collected between diaphragm and upper surface of the liver.† There is no other explanation of the fact that the edge of the liver had been felt not only by me, but by many of the members of the class, extending a good three inches below the ribs. The spleen was enlarged (wt. 460 grammes*). Emphysema of the lungs and small spots of pulmonary hæmorrhage. A pedunculated ovarian cyst, as large as a fœtal head, was found at the brim of the pelvis. Kidneys large; veins full.

Supposed Syphilitic Gumma on the Cortex of the Brain.—A man aged 25 was admitted with sore throat on 1st September, 1889, and it was found that he was just recovering from a chancre of the glans, and that a few weeks previously he had had a swelling in the groin. The primary sore made its first appearance in July, 1889, and on the 7th October he was seized with a "fit," which began with a twitching and up drawing of the left angle of the mouth, and afterwards he lost consciousness and was taken to the hospital in the ambulance, but soon discharged. On the following day, while resuming his occupation (an hotel servant), a similar seizure took place. Recovery was rapid, for I saw him a few minutes after the occurrence, and he had recovered himself completely. The bystanders told me that there was "working" of the face, that he had suddenly turned

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* Normal weight of liver is 1490 to 1700 grammes, and that of the spleen is 140 to 200 grammes.

† Vide Murchison on Diseases of the Liver, third edition, p. 333.

round several times and had fallen to the ground. There did not appear to be any loss of consciousness.

On admission, on the 16th October, the tongue was found recently bitten ; mental functions obtuse ; severe pain on right side of head, from the centre of forehead to as far back as the right ear, throbbing and hammerlike, and much worse at night ; tenderness on pressure and great pain on percussion ; no optic neuritis. Ordered inunctions of blue ointment. In three days the pain in the head was nearly gone, and he was enabled to sleep all night, but tenderness remained some days after the pain had disappeared. He remained in hospital until the 9th November, and during that period there were clonic spasms of the right arm on several occasions, and it was once noticed that these slight clonic spasms affected the leg. No twitching of muscle was noticed after the 27th October.

A True Relapse in Typhoid Fever.—Genuine relapses are not very commonly met with. Murchison puts their frequency at 3 per cent., Maclagan at 13 per cent. The true figure lies between these extremes. John A., one of the cases of typhoid fever sent to us from Lachine, was admitted on the 4th October. The original disease was very severe, very tedious in its course, and it was not until he had been thirty-nine days in hospital that a normal night temperature was registered. The fever was high, the bowels had been somewhat loose, and the eruption was scanty. Convalescence was fairly established when the temperature began slowly and steadily to rise, until in four days it reached 104°, where it remained for about nine days with very slight lowering in the morning. At the outset of the relapse there was very severe frontal headache and pain in the right iliac fossa. On the sixth day of the relapse a rash appeared on the chest and abdomen, and remained for about a week. This rash was very profuse, better marked and of a darker color than the common typhoid rash, and almost was dark enough to classify among the " taches bleuâtres." Convalescence was gradual, but quite satisfactory.

Cheyne-Stokes Breathing with Hypertrophy and Dilatation of the Heart.—In the Hospital Reports already published

(Montreal Medical Journal, Vol. xviii., p. 296), mention is made of the case of a French-Canadian farmer, 60 years of age, who presented the physical signs of a large heart, and whose breathing was of the Cheyne-Stokes character. There was a history of rheumatism in recurring attacks, but no evidence whatever of valvular disease. The apex beat was one inch outside the nipple line, but there was no enlargement to the right of the middle line of the chest clearly made out during life. The heart's action was weak, diffuse and laboured, and the sounds distant. Pulsation was visible but not forcible in the external jugulars. The exact duration of the whole cycle, 1 minute 40 seconds; respirations, 44; period of dyspnœa, 40 seconds; period of apnœa, 40 seconds. No sphygmographic tracings could be obtained. At the end the symptoms seemed to undergo some improvement under treatment (tincture of digitalis, 20 minims, every four hours), but on the 19th day of his stay in hospital he dropped dead in crossing the ward (against orders). There were no evidences whatever of renal disease.

The autopsy, which was made by Dr. Finley, showed that the heart was greatly enlarged, with its left border lying an inch and a half outside the mammary line, and it weighed three and a half times the normal weight; the walls of both ventricles were somewhat thickened and firm, and the cavities were much dilated, the right containing loosely adherent ante-mortem clots; the tricuspid orifice was dilated to almost double its natural size, whilst the mitral was normal; the aortic valves, though slightly atheromatous, were perfectly competent, and the coronary arteries were healthy: the lungs were somewhat œdematous, but there was no pleurisy; the liver was of the nutmeg kind, and the kidneys had undergone cyanotic induration; there was hyperæmia of the stomach with eight or ten hæmorrhagic erosions, and œdema of the upper part of the small intestine. Microscopic examination showed that the muscular fibres of the heart were healthy, and that there was no material increase of connective tissue.

The sequence of events appears to have been hypertrophy of

the heart, dilatation of cavities, especially of the right side, which permitted tricuspid regurgitation and subsequent changes in the various organs, We have no cause to assign for the Cheyne-Stokes breathing except that of disturbed circulation in the respiratory centres.

Another interesting case in which Cheyne-Stokes breathing is marked is at present (Dec. 7th) in Dr. Molson's wards. In this case, as well as in both those which I have reported, mental derangement is a marked feature of the case, and in all three a similar unrestful state of mind is present. They could not be kept quiet, they must be continually getting in and out of bed, and although they did what they were told, yet they immediately repeated the offence the moment the attendant's back was turned.

Hæmoptysis from Mitral Stenosis.—On Nov. 18th one of our old patients reported himself for examination. He was pale and thin, and said he had suffered from slight cough and shortness of breath on exertion for the last three years. He had twice lately been in hospital with severe attacks of hœmoptysis, and he had somewhat the appearance of a phthisical patient, but further enquiry established the fact that the hœmoptysis depended upon quite a different cause. He had had acute rheumatism on several occasions, and again last winter in hospital, and, moreover, there had existed a systolic thrill, and at the time of examination a pre-systolic murmur which many of the students had an opportunity of hearing. The lungs were in a perfectly healthy condition.

Thoracic Aneurism.—Nov. 22nd—At to-day's clinic, D. J., aged 64, came for examination. This was the man who spent the winter of '85-'86 in the hospital with an aneurism of the descending arch, which projected in the back. There was localized sweating. (For full report see *American Journal of the Medical Sciences* for March 1888.) The symptoms are by no means as severe as they were four years ago. He has been taking ten grains of iodide of potassium every day since. Improvement was noted in the degree of dyspnœa and pain; the tumor was apparently smaller. The pulse was noted formerly

as being collapsing, but now it certainly has not that character. The improvement after the administration of the iodide showed itself at best for two years; during the last year he has felt feeble, and has suffered from paroxysms of very severe coughing.

Locomotor Ataxy: Symptoms suddenly developed after an Injury.—A man, æt 44, three months ago fell into a hole about six feet deep, coming down upon his feet. He did not feel at all injured, but two days afterwards he felt a severe pain in the back, which lasted two days, and was immediately followed by severe vomiting at short intervals for six days; then the gait became unsteady, and numbness in his feet and fingers was perceived; no pnin nor interference with sphincters of rectum or bladder; no history of syphilis. On admission, three months after the accident, the patellar reflex was found to be absent, and there was great wavering of the limbs on an attempt to stand upright with the eyes shut; gait is decidedly ataxic; never had any lightning pains. After a month's stay in hospital there was considerable improvement showing itself by an almost loss of the numbness and by a much improved gait, but after spending three weeks at his home, the numb sensations returned and the unsteadiness increased. On readmision, it was found that the gait was steadier than when he left, but there was no change in the knee reflex phenomenon. Neuro-retinitis present in both eyes.

Cancer of Stomach with secondary Cancer of the Liver and secondary deposits in the Peritoneum.—The patient whose symptoms are reported on page 451 in the last issue of this JOURNAL died on the 3rd of December. As was expected, the symptoms became more urgent, emaciation was rapid, and the pain very severe. Death appeared to have been caused by exhaustion. Three weeks before death ascites made its appearance, and this was the result of a recent peritonitis of cancerous origin, for the membrane was reddened and the inflammation appeared to originate in a mass of jelly-like foreign material in the pelvis between the rectum and the bladder. The stomach was not dilated. There was an ulcer at the pylorus and the tissues about were thickened, but a little finger could be passed through the open-

ing. This was in accord with the symptoms, for although there had been a history of copious vomitings, we had not observed any while he was in hospital. The salol passed through the stomach within the normal time limits (2½ hours). There was no hydrochloric acid in the vomit. The nodule we had felt through the abdominal parietes in the right mammary line was present, and there were very many more, but being situated flatly in the surface of the liver failed to make themselves perceptible. The liver weighed very nearly twice its natural size; spleen small.

The Co-existence of Cirrhosis of the Liver and Tubercular Peritonitis.—In the MONTREAL MEDICAL JOURNAL of May, 1889, p. 317, there will be found some reference to the coincidence of these two affections. On the 4th December, 1889, Dr. Johnston made an autopsy on a case which Dr. Molson had had in his ward, and which he had very kindly allowed my class to examine. The liver was very small and hobnailed, and the peritoneum studded with tubercle. There was also a deposit of the same material in both lungs.

The clinical history was briefly as follows: The patient, aged 49, was admitted on the 15th November with jaundice, ascites and œdema of the legs. History of spirit drinking. Present illness was said to have begun eight weeks ago with jaundice and pain at the pit of the stomach, which was followed in a fortnight by dropsy of the belly and afterwards swelling of the feet and legs. A brother died of dropsy and jaundice after an illness lasting five months. There were on admission, evidences of fluid in the peritoneum, enlarged abdominal veins, deep jaundice, subcutaneous ecchymoses, which were especially extensive over the inner side of the right thigh.

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