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CANADA
MEDICAL & SURGICAL JOURNAL.

## ORIGINAL COMMUNICATIONS.

*A Case of Cystic Degeneration of the right kidney; with Fungoid growth in the bladder.—Obstinate Hæmaturia.—Death.* By ARTHUR A. BROWNE, B.A., M.D.

J. A., aged 62 years, had suffered from intermittent attacks of Hæmaturia for a considerable time when he came under the care of Dr. Fenwick last summer. He had been previously attended by Dr. G. W. Campbell, with whom Dr. Fenwick had a consultation on the case soon afterwards. In July last he came to Dr. Fenwick's house, about 9 o'clock, one evening, to have his urine drawn off, as he could not make water.

Dr. F., passed a large-sized catheter, without difficulty, and drew off a large amount of urine deeply tinged with blood. This attack of hæmaturia subsided under the Fld. Ext. Ergot, and iron, which was afterwards changed to small doses of turpentine, which he had before taken on Dr. Campbell's prescription, and which he maintained did him more good than anything. His urine was examined about this time, as soon as it became free from blood, and it was found to contain no albumen or tube casts, but there were present a few cells, resembling pus cells, a large quantity of granular matter, with abundance of phosphates, and a few crystals of the oxalate of lime. The crystals of the oxalate were very small in size. The amount of urine passed was about normal daily. This attack of hæmaturia subsided almost completely, but was followed by another, which came

on in the month of October. This also gradually improved, and he first came under my care during the illness of Dr. Fenwick, in December, 1873. At this time he was losing a very small amount of blood, and seemed comparatively well. His appetite and spirits were good, and he held to the turpentine in which his faith seemed to increase. At this time paroxysmal pains in the back and loins, and in the left leg, especially in the thigh and calf,—from which he had suffered from the first,—appeared to become aggravated and he complained very much of their disturbing his rest at night. He was ordered frictions with stimulating and anodyne liniments, but they seemed to do him no good. Being an old sailor, he prescribed hot oakum as a local application. This, warmed on the stove, and applied to the painful part, seemed to relieve him more than anything—and being his own idea, it was most faithfully carried out. On the 18th of January he sent for me, in the evening, as he could not rest from the pain which he was suffering.—About this time he began to lose more blood, but not in any very large quantity, and he complained that the Ergot which he was now taking, increased his trouble. He now began to suffer from an incessant desire to make water, and he complained that between the pain he suffered, and having to get up so frequently to pass water, that he was fairly worn out.

About the first week in February the bleeding came on again and was very free, large worm-like clots being passed, with considerable pain and straining. The constant desire to make water still continued, and now there was a constant dribbling which annoyed him extremely. On the 13th of February Dr. Craik kindly saw him, and prescribed Gallic acid gr. v, every hour, and as dry a diet as possible. From this time Dr. Craik saw him daily, and he continued to improve steadily. After this, all went on well, until the evening of the 3rd of March, when he was found about 9 o'clock, lying insensible on his bed. Soon after this he had a convulsive attack, and Dr. Craik was hurriedly summoned.

He sent for me soon after, and on my arrival, the patient was lying insensible on his bed, his face pale, pupils moderately dilated, and sluggish, and his breathing stertorous. In a few minutes he had a paroxysm, in which he tried to raise himself up, and in which his head and right arm worked convulsively. He had another fit in about an hour, and after that, two more, and at 1.15, a.m., of the 4th of March, he died.

*Post-mortem.*—This was kindly performed by Dr. Roddick, 15 hours after death. The body was well nourished, and the muscular development was very good, especially when it is remembered that he had been losing blood almost constantly for the last few weeks of his life, besides the severe attacks of hæmaturia, from which he had suffered, during the previous months. The kidneys and bladder only, were examined.

The right kidney was found to be much distended, and on cutting into it, a large quantity of turbid urine escaped. The secreting substance of the organ was much diminished in thickness, and what was left of it contained about 7 or 8 cysts, whose size varied, the largest being about the size of a large marble, and the smallest about the size of a small pea. The contents of these cysts consisted of a yellowish opaque fluid, and their walls were thick and glistening. At one end of the kidney was a solid deposit, of a whitish-yellow colour, about the size of a pigeon's egg,

The right ureter was distended with fluid, and was about the thickness of the finger of an ordinary man. On examination, it was found to be obstructed at its entrance into the bladder, and the narrowing of its calibre at that point was due to the thickening of the coats of that organ. The obstruction was not complete, however, and the urine could be forced through it by using a little pressure from above.

The left kidney was comparatively healthy, although here also, the secreting substance had undergone some absorption. The left ureter was pervious throughout its whole length.

The bladder was about half full of turbid, bloody urine, and several fibrinous clots were found in it, most of which were gradually becoming disintegrated. The coats of the bladder were much thickened, especially at the base, behind. This thickening was so great at the orifice of the right ureter as to have almost completely stopped the flow of urine through it. On the left side, close to the neck of the bladder, there was a fringe-like fungoid growth, about two inches long. It was very vascular, and was probably the chief source of the hæmorrhage.

The prostate gland was much enlarged.

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*A Case of Spina Bifida.* By GEORGE A. BAYNES, M.D., Montreal.

A short time ago, I was called in to see a child which had just been delivered by a midwife. On my arrival, I found it dead, but the parents and friends had stated that it lived some two hours. In appearance the child was well made, and everything was natural, with the exception that the spine at the junction of the lumbar and sacral vertebræ lacked the spinous processes and laminæ, causing a large opening, from which protruded (2) two inches of the spinal cord, including the cauda equina.

The tumor burst of itself, during a convulsion, soon after birth; it was very thin, inflammation, seemingly, having been present. I endeavored to take away the specimen, but the parents would not hear of it, although they allowed me to cut down and examine it. This is to be regretted as it was a very perfect case, and would have made a beautiful preparation.

Hydrorachitis is dropsy of the membranes of the Spinal Medulla, and rarely if ever takes place without Spina Bifida, but it is possible for either to be present separately. The lack of the spinous processes of one or more vertebræ, with the vertebral arches inclined toward one another, so form-

ing only a very small space between them, or the entire absence of the spinous processes and laminæ, or their wide separation and consequent removal of support to the membranes of the cord, enables the membranes to protrude, and so form a tumor varying in size, according to the amount of serous fluid which is secreted, which under the circumstances is generally in excess. The disease generally comes on in the latter weeks of fœtation, but may not show itself until a few weeks after birth, and then only be of the size of a pea, but as the disorder increases, the tumor enlarges, sometimes growing to the size of a fœtal head, but generally not becoming larger than an orange. The tumor is either soft, flabby and fluctuating, or tense, elastic and shining. You can sometimes by gentle pressure reduce the size of the tumor but it soon fills again upon removing the pressure. You may have a single cyst, or it may be multilocular, and it contains a fluid resembling synovia, or sometimes pus, but generally the contained fluid is thin and limpid, saline in taste, and uncoagulable.

The spinal cord and nerves are variously affected by the lesion. The cord may be softened or hardened, sometimes diminished in size; the nerves are always displaced, and sometimes dragged out of the canal as it was in the case I had myself, in which they exhibited a most beautiful plexiform arrangement.

Prescott Hewett says: "The connection which generally "exists between the cord or the nerves and the walls of the "sac, is a point of the utmost importance. Some cases are "related by various authors, in which neither the nerves nor "the cord had any connection with the sac, these parts fol- "lowed their usual course down the spinal canal, but in by "far the greater number of cases that have been placed "upon record, the nerves presented some kind of connec- "tion with the sac. Of 20 preparations of Spina Bifida "occupying the lumbo-sacral region, which I have examined "in various collections, I have fonnd but *one* in which the "nerves were not connected with the sac. But if the tumor

"occupies partly the lumbar and partly the sacral region, "then generally the cord itself and its nerves will be found "naturally connected with the sac."

M. Cruveilhier believes, from his dissections, that this connection is constant.

SYMPTOMS.—If the child survive any time, the symptoms vary according to the extent of the lesion, and if hydrocephalic.

Paralysis usually exists of the parts supplied with nerves below the seat of lesion, sphincters, &c. If the cyst is inflamed or undue pressure is exercised convulsions are sure to come on, and then it may burst, or it may suppurate and turn to an abscess.

PROGNOSIS.—Before birth fœtal health is not injured. But few children survive more than five or six months, death resulting as above stated either by convulsions or rupture of the sac. A few instances are on record in which the patient, however, lived some time; in one case, life was preserved to the 55th year; and on another occasion, in a young female, to 30 years, but she was anaemic, and frightfully deformed by lateral curvature. If the lesion be in the cervical region, it is more fatal than in the dorsal or lumbar or sacral.

Hana reports a case of rupture of the sac during measles, followed by a complete recovery, but a spontaneous cure similar to Hana's, is a very rare occurrence.

*Treatment.*—Pressure, puncture, ligature and injection have all been successively tried, and been combined one with another. Sir. A. Cooper reports cases treated by pressure alone, and by pressure and puncture combined, which have proved successful, so also has Abernethy. The smaller the tumor the more likely you are to have a favorable result, but if it has a broad base with a large cleft, or if it is of an immense size, the only thing that we can do is as far as possible to reduce pressure on the sac, and then to apply support, with the view of preventing ulceration and rupture.

A case occured under the care of the late Dr. Fowler of

Melbourne, upon which he operated at a few weeks old, by puncture alone. Upon withdrawing the fluid he described every symptom of dissolution as taking place. The pupils became dilated, the whole appearance denoted utter prostration, and nothing but the active employment of stimulants restored animation. The sac was quite reduced, but gradually filled again; he lived to the age of 21 years. He had paralysis below the seat of the lesion, passing all his evacuations involuntarily. The tumor was situated in the dorsal region. I think if pressure had been used, after the puncture, there would have been every chance of a happy termination to the case.

As for ligature, it is almost certain to prove fatal for the following reason, that in 99 per cent the cord or nerve filaments are connected with the sac. Injection with iodine was introduced by Dr. Brainard in 1848, and has been in use to some extent since, but not with the favorable results that Dr. B. warranted. He directs the operation to be performed in the following manner:—

1. To draw off no more serum than the quantity of fluid injected.

2. To make the puncture in the sound skin, subcutaneously by the side of the tumor.

3. In evacuating the contents of the sac, if symptoms of irritation supervene, to re-fill it with distilled water. The patient should be on his side or face during the operation, and if the weather is warm, use evaporating lotions to the part and head. As soon as the tumor is flaccid support by pressure, and continue for weeks after the cure is complete; and lastly, inject as often as necessary, but be careful to see that all irritation has subsided from the previous operation.

# HOSPITAL REPORTS.

## MONTREAL GENERAL HOSPITAL.

*Case of Tuberculous Disease of the Epididymis—Tuberculous Abscess of Kidney—Effusion into the Ventricles. Coma.— Death. — Autopsy.* Under the care of Dr. REDDY. Reported by Dr. J. C. CAMERON, Assistant Surgeon, Montreal General Hospital.

E. M., aged 26, a strong muscular vigorous man, was admitted to the Montreal General Hospital on the 6th of April, 1874, suffering from swelled testicle. Upon examination the Epididymis of the right testicle was found to be hard, swollen, and painful. No history of recent venereal disease nor of Syphilis could be elicited, though he admitted having suffered from Gonorrhœa, some nine years ago. He has always been a healthy man, accustomed to hard work. Some days ago while walking along the street, he slipped and gave his back a violent wrench in recovering his balance; ever since then, he has had severe pain in the back and right side, and right testicle. He never had any pain or swelling in the testicle previously, although a hard lump had been noticed for some time. Perfect rest was ordered, the testicle was suitably supported, and Tinct. Hyosciam, M. xxv, was administered every fourth hour. The testicle was strapped on the 10th, and again on the 12th, with the effect of reducing its size and making it much less painful; Chloral in twenty grain doses at bed time, was ordered, as he had slept but little for two nights. On the 12th he complained of headache, which was soon followed by nausea and vomiting; these symptoms were attributed to biliousness, especially as he said that he had been subject to such attacks frequently. A blue pill at night followed by a seidlitz powder in the morning, was ordered. On the 13th he felt somewhat better, his bowels having been freely moved, still the vomiting continued at longer intervals, and

the sleeplessness persisted. Twenty grains of chloral were given at bedtime, but without effect.

On the 14th, vomiting ceased, but the headache became more severe, the pain being chiefly supra-orbital. He seemed to be more flushed and feverish.

The following mixture was prescribed :

Potas. Chlor. 3i ; Acid Hydrochlor dil 3iij ; Aquæ ad oz. vj, oz. ss ter die. Four ounces of wine were ordered.

On the 15th, his manner was confused and uncertain ; he appeared dreamy and complained greatly of frontal headache ; no paralysis ; pupils quite normal ; dozing constantly. Temperature, 99 3-5. Pulse 56.°

16th.—Condition more dull and stupid. A low, muttering delirium existed, from which he could be roused by calling loudly to him. Mustard was applied to the back of the neck, with directions to apply a blister, should the dulness persist.

17th.—His condition being but little improved, a blister to the nape of the neck was ordered. Dr. Reddy gave it as his opinion that extensive effusion into the ventricles of the brain was rapidly occurring.

18th.—Rather more intelligent and bright, but still very unsatisfactory, urine dribbling away in bed. A catheter was passed to determine whether retention existed or not ; but only about four ounces were drawn off. This specimen was tested and found to contain 50 per cent. of albumen, while under the microscope pus cells and epithelial scales were found in abundance, but no casts. As his bowels had not been open since the 13th, a pill contsining Ol. Tiglii mj. calomel grs iij was administered, and the following mixture prescribed: Pot. Iod. 3i; Pot. Brom. 3ii ; Ext. Physostig, grs. iii. Syrup oz. i. ; Aquæ ad oz. vi ; oz. ss., every three hours.

19th.—Bowels opened freely once ; constant, low muttering delirium ; consciousness more impaired ; muscular twitchings : pulling at the penis ; knitting of the brows ;

busy movements of the hands, constantly slapping the abdomen or rubbing the brows; and stertorous breathing, were particularly noticeable.

20th.—Condition unimproved, but still no paralysis, stertorous breathing; jactitation; pupils inclined to dilate. Pulse 110. Two ounces of gin were substituted for the four ounces of wine, and the following mixture prescribed: Potas. Acet. 3ij; Tinct. Digital 3iii; Aquæ ad oz. vi, oz. ss 4 q. h. Hot bottles were applied to the feet, and a large poultice of mustard and linseed to the loins.

Towards evening, the delirium became wilder and more excited; consciousness and articulation were completely lost. Pupils equal but dilated; pulse 120.

21st.—8 a.m., delirium still continuing; pulse 120.

2 p.m.—Pupils widely dilated, the left a little more than the right. A specimen of urine was again tested, and found to contain about 30 per cent of albumen and pus in greater quantity than before. The back of the head was shaved, and a blister applied over the occipital region.

11 p.m.—Pulse 130, and faint; breathing hurried and noisy; pupils dilated; eyeballs insensible to light and touch.

22nd.—About 3.30 a.m, he died.

AUTOPSY 10 hours after death:

*Heart*—firmly contracted; quite normal,

*Lungs*—Hypostatic congestion; scattered miliary tubercle found in the pleura and in the upper lobes of both lungs; the apices were both puckered. No collections of recent tubercle could be discovered.

*Spleen* enlarged and softened.

*Kidneys—Right*, large and pale; pyramids quite obliterated. An abscess with raised edges, evidently tuberculous, involved the whole of the upper half.

*Left*, congested; pyramids faintly marked. No abscess or tubercle present. The external surfaces of both kidneys were puckered by old cicatrices.

*Right Testicle—Epididymis*—was large, swollen, and

covered with small yellow spots. When cut into, it was found to be filled with masses of cheesy tubercle.

*Brain—Membranes*—tense and sinuses congested.

*Substance*, rather pale and anæmic, but quite firm and hard.

*Lateral Ventricles* distended to their fullest limit with a a clear, transparent fluid. The effusion was evidently rapid and recent, as no softening of the brain substance could be detected.

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*Case of Syphilitic Disease of Larynx.—Urgent Dyspnœa.—Laryngotomy.*—Recovery.—Under care of Dr. Ross. Reported by Mr. RICHARD MCDONNELL.

E. C., aged 21, was admitted on the 4th April, 1874, under Dr. Ross's care.

*History.*—Two years ago, she experienced a slight difficulty in speaking. This amounted to no more than an inconvenience, and received no attention whatever, until just before last Christmas, when she entered the Montreal General Hospital. At that time, the voice was very weak, and the breathing slightly labored. At the end of six weeks, being considerably improved, she returned to her daily employment, that of a servant. The malady, however, returning with increased vigor, she was again admitted.

The course of the disease was characterized by a total absence of pain in any part of the body, the larynx alone being but slightly tender on pressure. There has been considerable emaciation. Never any dysphagia. Regurgitation of fluids through the nostrils has taken place during the last three or four months. Night sweats have also occurred, especially during her previous stay in the hospital.

No family history of any kind can be ascertained, her parents having died while she was at an early age. States that she has never had primary syphilis, has always been in good health, and catamenia have been regular.

*Present Condition.*—The most prominent symptom is

the stridor, which accompanies both inspiration and expiration, and is so loud that it can be heard outside the ward. Voice weak, and very indistinct. On examination of the throat, the tonsils were found to be rather red, and remains of extensive ulceration existed in the upper and back part of the mouth, including the soft, and a considerable portion of the hard palate.

A sore was situated over the upper portion of the sternum, as large as a quarter-dollar, and covered with a hard crust. A probe passed into this, struck upon diseased bone. The inguinal glands were enlarged and indurated. An extensive superficial cicatrix covered the right elbow, having been caused, as the patient told us, by a burn. No syphilitic nodes existed on the long bones.

Slight cough, expectoration thick, glairy, and adherent to the vessel. Pulse 92, small and feeble. The right pupil dilated. This, the patient says, is its normal condition.—Appetite not very good.

April 4.—A laryngoscopic examination was attempted but without any definite result, the patient being very restless and gagging. Ordered steam inhalation.

April 6.—Voice slightly improved, prescribed:

R. Pot. Iod. 3ii.; Tr. Hyoscy. 3iv.; Aq. ad 6 oz. Tablespoonful terdie.

April 10th.—Not quite so much stridor. Examined with laryngoscope, and succeeded in getting a very satisfactory view of the interior. The parts above the vocal cords were not redder than is natural, but appeared thickened and corrugated, presenting, as it were, irregular roughnesses. No œdema of this region or other evidence of acute Laryngitis. Both vocal cords were extensively ulcerated, the line along each one consisting of a series of uneven jagged notches. During attempted phonation, it was seen that the cords approximated but very imperfectly.

*Diagnosis.*—As the result of this examination it was decided that the dyspnœa was the result of a grave and advancing ulcerative disease of the interior of the larynx.

That this was of a syphilitic nature was also inferred with almost certainty, from its peculiar nature, and from the other evidences already mentioned; although the existence of the primary disease was never admitted.

Ordered, to continue her Potass. Iodid mixture and steam inhalation, and to have the throat sprayed several times daily with a solution of Potass. Chlorat, 3ii to viii oz.

April 13.—The patient's condition this morning seemed very much worse. Countenance bluish. Breathing very laboured, much more whistling and stridulous than before. There was a pause between each act, and it appeared at the commencement of expiration, as if some obstacle impeded the egress of air. Dr. Ross stated that if the dyspnœa increased, he must have recourse to Tracheotomy.

3.30.—Dyspnœa increased. Face quite blue. Extremities cold, pulse, 124, small and irregular; intervals between inspiration and expiration becoming gradually more and more lengthened. Pupils dilated. Dr. Ross was sent for and arrived, in about 20 minutes. At that time the symptoms had increased to such a pitch that death was imminent. Pulse 130, flickering, very long intervals between the acts of respiration. She was immediately placed in position for the operation, with the head thrown back and the neck projected forwards by a pillow. Upon doing this vitality was at once suspended. Heart's action stopped, and she lost all sensibity. Dr. Ross, assisted by Dr. Roddick, the then House Surgeon, at once proceeded to Tracheotomy. An incision ¾ inch long was instantly made in the crico-thyroidean space, partially including the cricoid cartilege. A double canula was introduced and after artificial respiration had been brought into play, consciousness returned. The patient was then placed in a semi-recumbent position. Her face soon resumed its natural colour, and the pupils their natural size. The heart's action was rapid, and pulsation was visible in the superficial arteries. Expiration was accompanied by a snuffling sound, owing to the accumulation of mucus in the tube.

5, p.m.—Pulse, 128. Patient cheerful and comfortable Surface rather cold.

7 p.m.—Pulse a little stronger. At intervals of about ten minutes, she coughs up a glairy, tenacious mass of mucus, tinged with blood. This is only partially ejected from the orifice, the remainder requring to be removed with a feather from the canula.

April 14th.—Passed the night well, and is reported to have enjoyed good sleep. Face slightly flushed. Complains of thirst. Pulse 90, fuller and stronger. Expectoration much less bloody. Temperature is normal.

April 15.—Pulse, 88. Temperature, 99 3-5°. Little expectoration. Has passed a quiet night, with very little cough. Respiration extremely irregular; at one time numbering 36, at another 18 or 20.

April 16., 11 a.m.—Pulse 90; temperature 100 2-5°. Has not slept well. Slightly feverish. Tongue coated and tremulous.

9, p.m.—Pulse, 91; temperature, 100°. Complains of Rheumatic pains in the right shoulder, for which Linim Hosp. was given.

April 17.—Pulse, 106; temperature, 100 1-5°. Coughing a good deal. Wished to sit up, but was not allowed. The bowels not having been open since the operation, castor oil was administered.

April 19.—Complains of pain in the right acromion process, and over the acromial end of the clavicle, which parts are also found to be tender. Tr. Iod, was applied. The breast has been treated with carbolic acid wash, and is considerably improved.

April 23.—Her condition has undergone little alteration during this period. The pulse has averaged 88, and the temperature 99°.

May 18th.—Is allowed out to visit her friends. She can now speak with difficulty and effort by placing her finger over the orifice of the canula, but the resulting voice is, of course, extremely rough and squeaky. When the canula is blocked up she cannot breathe at all. Ordered:—

R. Pot. Iod. 3ii ; Syr. Fer. Iod. 3vi ; Aq. ad vi. oz. Table-spoonful ter die.

She will soon be discharged from the Hospital, but, it is thought, will always have to continue to wear the tube.

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*Case of Diffused Abscess, extending over and around the Right Shoulder.—Death.—Autopsy.*, under care of Dr. Ross.—Reported by Mr. RICHARD MACDONNELL.

Patrick Morgan, æt 40, was admitted to the Montreal General Hospital on the 1st May, 1864, and placed under the care of Dr. Ross.

A man of low stature, swarthy complexion, and wiry frame. His expression of countenance indicates a low caste of humanity, and the little of his history that can be ascertained, accords well with his outward appearance. His present occupation is that of a railway laborer, he having previously been in the army, and served in the cavalry during the Crimean war. Has been for seven years a resident in this country. His habits have always been irregular, hard drinking alternating with fits of total abstinence. Early in his military career, he contracted gonorrhœa, which was followed by a stricture. At the commencement of the disease, instruments were frequently passed; but never during the last twenty years. Difficulty in passing water, without actual obstruction has, since that event, always existed. He denies ever having had syphilis, and indeed the sole indication of its pre-existence is an induration, with enlargement of the inguinal glands.

No family history of any disease can be obtained.

At an early age, he states, that he had typhus fever, and a few years ago a severe attack of ague. Never recollects having had Delirium Tremens.

About eight days ago he slept in wet clothes, in a barn, on the following morning awoke with a severe rigor, accompanied by intermittent, shooting pain—referred to the right

shoulder. The rigor is said to have lasted half that day. From this event up to the hour of his entry into the hospital no information of his doings can be ascertained. In fact, he cannot even remember where the barn was, why he slept there, or how he made his way to Montreal. States that he was not intoxicated at the time. The patient has a broken nose, and bears on his back scars caused by a flogging he received while a soldier.

*Present Condition.*—Much swelling exists all about the right shoulder, most prominent behind, over the spine of the scapula. The natural depressions above and below the clavicle are entirely obliterated, and the clavicle itself can, with very great difficulty be felt. The swelling is not circumscribed, and extends both behind and in front, full half way down the right side of the thorax. The parts are highly œdematous and readily pit on pressure. No distinct fluctuation can be felt. The surface of the tumour, with the exception of a small area under the middle of the clavicle, is not altered in colour. The right arm is very œdematous, measuring at the thickest part of the fore arm 2½ inches more than the same circumference on the right. The patient's general strength is very low. Without aid he is unable to sit up in bed. Complains of shooting pain in the affected shoulder, as well as of a benumbed sensation, down the right arm, extending to the tips of the fingers. Has had during the last two or three days great difficulty in making water. The urine is of a high colour. No albumen. The pulse is frequent (105), full and bounding. The temperature (at 3.30 p.m.) 105° F. Respirations 46. Tongue, dry and brown. Skin, hot and dry. Bowels, though hitherto regular, have not been opened for four days. Examined the heart, and found no organic disease. Castor oil was administered, and a linseed poultice over right shoulder. Was placed on milk diet, with 2 oz. wine extra, and the following mixture: R. Quiniæ Sulph. gr. xii; Tr. Ferri Mur. 3iii; Aquæ ad vi oz. To take one tablespoonful every four hours.

At 5 p.m. to-day (May 2nd), his general condition remained somewhat similar. Pulse 154; temperature 105 F. Respirations, 38.

May 3rd.—General condition worse.

10. a.m.—Although not actually shivering he complained of cold.

An exploratory incision was made over the infraspinous fossa of the scapula. A considerable quantity of blood and serum, but no pus, escaped from the wound. The pulse was extremely rapid, 160, small and weak.

Temperature 103 2-5; respiration, 32.

Died at 3 p.m.—No delirium preceded his death.

AUTOPSY—twenty-four hours after death.—Slight rigor mortis. General surface slightly discolored.

On reflecting the integuments, fascia, and pectoralis major, no matter was discovered; but upon dissecting off the strong, deep fascia which covers in the vessels lying in the triangular space above the pectoralis minor muscle, the first traces of pus were exposed. In this situation it completely surrounded the axillary vessels, and certainly could hardly, with safety, have been reached during life. The matter was thick, rather viscid, yellow, and not unhealthy looking. From the point above mentioned it was traced beneath the clavicle, surrounding the subclavius muscle, and along the course of the subclavian artery, and also downwards for some distance along the axillary artery into the axilla beside the vessel and the nerves of the brachial plexus, the pressure upon which, doubtless, gave rise to the sensation experienced by the patient down the arm. A large quantity of pus, (about 3 oz.,) was found on the posterior surface of the thorax, lying between the serratus, magnus and the subscapularis, accompanying the latter to the surface of the shoulder-joint. The joint itself was natural. All the cellular tissue in the parts around the shoulder were greatly infiltrated with serum.

*Thorax.*—Right lung, with the exception of the base of the middle lobe, all was crepitant, and floated on water.

This portion was quite airless, and on section was found to be darkened and congested. Adhesions strong, and of old standing, connected the right lung to the pleura, and upper to the middle lobe.

*Left Lung.*—Whole lower lobe, and a small portion of the upper lobe collapsed. These organs had not been examined during life, owing to the great prostration of the patient.

*Heart.*—Externally several large white patches, covering a great part of its surface. All the valves healthy. Large *ante mortem* polypi were found in both cavities.

*Kidneys.*—Right Kidney very large, slightly anæmic, but in other respects, normal. Weight 7 oz.

*Left Kidney* in a state of extreme atrophy. Its capsule, intensely adherent, was firmly attached to the adjacent structures. Size, about that of two thumbs. Weight 2½ oz. The whole structure was disorganized, and its parts could with difficulty, be distinguished. The surface was anæmic and covered with irregularities, while its internal structure was riddled with cysts.

Two of the pyramids displayed a dark green discoloration.

*Spleen.*—Enlarged and indurated. Weight 13 oz.

*Liver.*—Normal.

*Brain.*—Normal.

*Urinary Apparatus.*—A tight stricture was found one inch long, and situated at a distance of an inch and a half from the neck of the bladder. The prostate gland was enlarged and in its structure a false passage existed about half an inch long.

The bladder was healthy, though it showed slight thickening. It contained a few ounces of urine.

This case is of some interest as being an example of the formation of an acute abscess in a very unusual situation. No cause beyond ordinary exposure could be ascertained for its production. The only point where there was redness and excess of superficial pitting was just beneath the clavicle, towards the shoulder, and probably, if the patient had

survived, the matter here could have been evacuated, but the dangerous proximity of the important vessels, and the possibility of their displacement deterred from any attempt at reaching it in that situation, and the result of the autopsy, sufficiently proved the wisdom of this caution.

*Case of Typhoid Fever.—Remarkably high ante-mortem Temperature.—Autopsy.—Under care of* Dr. Ross.—Reported by Dr. J. D. Cline, House Apothecary.

E. F., 29, was admitted to the Montreal General Hospital 11th May, under care of Dr. Ross. Has been in French Marines, and recently occupied in this city as waiter, was of intemperate habits, drinking principally strong liquors.

He relates that about twelve days ago he had a chill, followed by a stitch in the right side, slight cough and considerable fever. The cough was attended with very little expectoration. When admitted he complained only of weakness. Tongue coated; pulse 90; slight cough; no abnormal physical signs in chest; no spots found in abdomen, or elsewhere, nor tenderness in right iliac fossa.

13th. Pulse 80; Temperature, 100°. Slight cough; very little expectoration. Ordered R. Pot. Nit. gr. x., Tr. Hyoscyam 3 ss. every four hours. Diet, milk and beef-tea.

15th. Cough more frequent. Pulse and temperature in morning 100 and 101 2-5°; in the evening 100, and 103°. Respirations 28.

16th.—Morning; Pulse 110; temperature 106°. Evening pulse 100; temperature 105°.

Liq. Ammon. Acet. 3ij. was added to the mixture.

17th.—Bowels open twice since yesterday. Stools diffluent, and ochre-coloured. Slight iliac tenderness now perceptible. Has slept pretty well up to this time. Morning, pulse 100; temperature 103°. Evening, pulse 104; temperature 103 3-5°.

18th—Tongue thickly coated in centre, red at tip and edges. Quite moist stools of same character as before. Iliac tenderness not increased. Abdomen somewhat tympanitic. Slept last night with aid of Chloral Hydrate, gr. xx.

Was ordered in place of above mixture Ac. Mur. Dil. oz. ss. in aqua Oj, of which a wine-glassful was to be taken every two hours. Morning, pulse 104; temperature 103-3-5°. Evening, pulse 100; temperature 105°.

19th. Tongue redder at tip, and becoming drier. Patient is becoming stupid and drowsy; mutters in his sleep. Tongue very tremulous. Pulse weaker. Cough continues. Morning, pulse 104; temperature 104°. Evening, pulse 112; temperature 103 2-5°.

20th.—Condition much the same. Mental faculties very dull. Morning, pulse 106; temperature 104. Evening, pulse 108; temperature 103 1-5.

21st. Tremulousness and jactitation marked. Eyelids and muscles of face twitched. No motion from bowels to-day. A shade of dullness at right base. Perspired freely this evening. Morning, pulse 115; temperature 103 4-5°. respirations 44. Evening, pulse 120; temperature 104 2-5°; respirations 44.

22nd. Last night was delirious and very restless, and with difficulty kept in bed. Continues in same condition to-day. The pupils are slightly dilated equally; there is no strabismus nor paralysis, nor any symptom indicating lesion in the brain. Two motions from bowels to-day. Poultices have been applied over the abdomen since the 17th. Tr. Cinchon Co. oz. ss. was added to-day to the acid drink. Morning pulse, 118; temperature, 101 4-5°; respiration, 38. Evening pulse, 126; temperature, 102 2-5°; respiration 34.

23rd. To-day patient is quiet, but in a state of extreme prostration. There is *subsultus tendinum*, and twitching of eyelids and muscles of face; pulse is very frequent and weak; passes his water involuntarily. Was ordered

4 oz. of wine. One motion from bowels to-day. Morning pulse, 120; temperature, 103 2-5°; respiration, 42. Evening pulse, 130; temperature, 101 4-5°; respiration, 46.

24th. Comatose; can be roused only by loud tone of voice; is unable to articulate; his eyes are half closed; passes water unconsciously. His wine was increased to 6 oz. His evening temperature, at 11.40 p.m., was 109 1-5°. At this time he was perspiring profusely. Was ordered 2 oz. brandy, but died at 12.15 a.m.

AUTOPSY, thirty-six hours after death.

*Brain.*—Perfectly healthy.

*Lungs.*—Congested, especially the right lower lobe. Here, also, scattered lobules were collapsed, the lower edge completely so. There was slight puckering at the apices.

*Heart and Liver.*—Healthy.

*Spleen.*—Very much enlarged, congested and softened. Weight, 20 oz.

*Kidneys.*—Natural.

*Intestines.*—The colon through its whole extent was very dark from congestion, and contained a large quantity of matter like coffee-grounds, mixed with clots of blood. The mucous-membrane of this part of the intestines was uniformly and intensely congested. There were no ulcers in the colon. The ilium near the ileo-cœcal valve presented the characteristic appearances of this part in enteric fever. The solitary glands, for some distance up the intestine, were enlarged, so as to be quite visible, and grayish. There were three or four Peyer's patches very much congested and ulcerated, the structure of the glands being quite sloughy. One patch particularly, about 6 inches from the cœcum, had a very deep and well-defined ulcer, and presented a deeply congested appearance, even on the outside of the intestine.

REMARKS.—Several circumstances tended at times to obstruct the diagnosis of this case. Many of the usual

symptoms of typhoid fever were absent. There was at no time any gurgling in the right iliac fossa; at no time much tenderness or tympanitis of abdomen; no spots, and no active diarrhœa. Notwithstanding the quantity of blood found in the colon, no blood had ever appeared in the stools. The temperature did not follow the range which is considered typical of this fever. The remarkably high temperature, about half an hour before his death, 109 1-5°, after a temperature of 102 3-5° in the morning, is remarkable. It was observed by the physician in attendance that it was the highest thermometrical record he had ever seen. It corresponds with what has before been frequently noticed—viz., that a very sudden and very considerable rise in temperature takes place in several febrile affections a short time *ante-mortem*.

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*Darwinism tested by recent researches in language.*

On Monday, May 11th, Dr. Bateman of Norwich delivered a very interesting lecture on this subject in Paris to a large Anglo-American and French audience. Sir John Cormock, who was in the chair, in a few remarks at the close of the lecture, amid the assenting applause of the meeting, said that he thought the lecturer had made good his anti-Darwinian position. Dr. Bateman chiefly insisted on the three following points. 1. Articulate speech is an *universal attribute* of man; all races have language and the capacity of acquiring it. In support of this proposition were cited the writings of Tylor, Lubbock, and Moffat the African traveller. 2. Language is a *distinctive attribute* of man; it consequently establishes the difference of kind between man and the lower animals, which Mr. Darwin is in search of. 3. Although physiologists—Gall, Broca, and others—have been for a long period trying to connect speech with some definite portion of the brain, they have hitherto failed; and, as science has failed to trace speech to a material centre—has failed to connect mind with matter—*speech constitutes a difference of kind between man and the lower animals.*—*The British Medical Journal.*

# Periscopic Department.

## SURGERY.

*Clinical Lectures Delivered in Middlesex Hospital.* By JOHN W. HULKE, F. R. S. On Cases of Strangulated Hernia.

GENTLEMEN,—No accidents are more deserving of your closest attention than strangulated ruptures, for it is scarcely an exaggeration to say that no two are alike in all their circumstances, and upon your prompt appreciation of these will mainly depend your patients' rescue from a condition which, when unrelieved by art, is so desperate, so nearly hopeless, that it well deserved the name our forefathers gave it—a "*miserere.*" There have been lately in Broderipp ward two cases which it will not be unprofitable for us now to review.

The first is that of a muscular, healthy carpenter, aged 27, who was admitted into Broderipp ward at 4 a. m., October 14, 1873. The right side of his scrotum was distended by a very large, extremely tense, globular swelling, which below concealed the testis, and above was continuous with an oblong portion in the inguinal canal. When he coughed, no impulse was communicated from the belly to the scrotal tumour. It and the belly were very tender, and so painful that he writhed restlessly about in bed and begged for something to be done speedily to relieve his suffering. He frequently retched. His face was pale, and its expression anxious. His pulse was quick and small.

He had had a rupture for many years; it had sometimes come down, and until now he had always managed to replace it. Latterly he had worn a truss. The rupture had slipped down at midnight; he could not get it back; it directly became exceedingly painful. He began soon after to vomit, and felt very ill.

At five o'clock when I saw him, he was at once placed

under the influence of chloroform, and, when complete relaxation was obtained, the taxis was tried for a few minutes. Not being successful, without further loss of time the hernia was operated on under a carbolised spray. A cut, about three inches long was made in the long axis of the tumour, with its centre over the depression which marked off the scrotal swelling from that in the groin. When the external inguinal ring, where the seat of the strangulation was expected to be, had been notched, and some tight threads of fascia transversalis upon the outer surface of the sac had been cut, another attempt was made to reduce the contents. It failed, and the sac, which was very thin and transparent, was opened. A coil of dark purple intestine came clearly into view. The finger could be passed upwards through the internal ring without meeting any obstacle, yet still reduction was impracticable. The impediment now appeared to be in the scrotum; and on passing downwards, at about one inch from the lower angle of the wound, a sort of transverse diaphragm was found dividing the scrotal part of the sac into an upper and lower compartment, which communicated by a small circular aperture. When this had been notched, and a recent adhesion of the gut just above it, had been separated, several coils of small intestine, almost black, and spotted with many small hæmorrhages, were easily drawn out of the lower compartment and reduced. They were lying upon the testis. The wound was washed out with a watery solution of 1 per cent. of carbolic acid, closed with wire stitches, and dressed antiseptically. He was ordered one grain of opium at intervals, the length of which was to depend on pain. The wound healed almost wholly at once; a very slight, inodorous, sero-purulent discharge oozed for a few days from the upper angle. The bowels first acted on the 21st, and until then he was restricted to milk diet. At the end of the month he was convalescent.

The next case is that of a large, heavy brewers' drayman, aged 23, also lately in Broderipp ward. He had had a rupture since childhood, but he had never worn a truss.

At long intervals the rupture had occasionally slipped down, but until now it had always been reducible. At four p. m., whilst hurrying to catch a train he felt it pass into the scrotum; and he was directly seized with great pain, followed by sickness. His attempts to reduce the rupture failing, and his suffering becoming very great, at 7 p. m., he was brought to the Hospital. When I saw him (four hours after the accident) the right side of his scrotum was distended by a very tense rupture, about a span long, separated by a shallow groove, at the external abdominal ring from an upper portion filling the inguinal canal. The scrotal part did not receive any impulse from the belly when he coughed. The testis could be plainly felt at the bottom of the scrotum distinct from the rupture behind it. He was bent double with pain in the belly and rupture—the latter, too, was so tender that he could not bear it to be handled; and he was sick. We at once gave him chloroform, then tried the taxis for a few minutes, and not succeeding by it, operated.

When the external ring, where the strangulation was expected, had been notched, an attempt was again made to reduce the contents without opening the sac, but this could not be effected. The sac, as thin as tissue paper and quite transparent, was then opened. It contained a large piece of omentum slightly congested, and behind this several coils of dark purple small intestine. The obstacle to reduction was found to be a couple of tight fascial threads crossing the neck of the sac and blended with it; after their division the intestine and omentum were returned without difficulty. The sac also contained about two ounces of bloody serum. Antiseptic precautions were taken during the operation, and the wound was dressed antiseptically. It healed almost entirely at once; there was a slight suppuration only in one suture-track. The first stool was not passed until the fourteenth day, when, the belly being rather uneasy, a simple enema was given, which brought away many scybalæ. About a week later, when quite convalescent, he

had looseness, with tenesmus, caused by impaction of faeces in the rectum. It ceased on their removal, and a couple of days afterwards he returned to work.

These, gentlemen, are pattern cases of large, acutely strangulated ruptures in young muscular subjects. In the first patient recourse was had to herniotomy five hours, in the second four hours, after the accident. To some of you this will perhaps have appeared a hasty proceeding, and you would like to ask me why we did not give the taxis a longer trial and put the patient into a hot bath; why the effect of a full dose of opium and of ice upon the rupture was not tried before operating—measures which you have known successful in other cases. The reply is, that when unsuccessful these measures have entailed a loss of time which in acute cases is very perilous; and here the ruptures were so tense, presumably therefore the strangulation so tight, that the chance of their succeeding was almost *nil*. It is in the less acute strangulations, where a few hours' delay in operating does not much increase the danger, that they find their proper place. Experience has only strengthened my conviction that abuse of the taxis has contributed in no small degree to swell the mortality after operations on strangulated ruptures. I speak not merely of a misplaced confidence in it by which precious time is lost, during which the patient's condition drifts into constantly increased dangers, but of injuries inflicted by the use of force, unwarrantable in degree and faulty in direction. Two cases which I watched with intense interest made a lasting impression on my mind. I will briefly relate them as warnings to you.

A young widow, ruptured four years, wearing a badly fitting truss, had her rupture slip down and become strangulated. For three days her medical attendant assiduously persevered with the taxis. At last she was brought into a hospital. In her right groin was a large, tense, tender crural rupture. She complained of a dreadful screwing pain in the belly at the navel, and of great thirst, and she vomited a pale, coffee-coloured, faecal-smelling fluid. The house-

surgeon put her into a hot bath and repeated the taxis, with the result that the contents of the rupture suddenly slipped up into the belly. She instantly cried out with excruciating pain above the pubis—she exclaimed that she thought her bladder had burst. Her face was pale, her features pinched and sunken; her pulse small, intermittent, weak, and so rapid that it could hardly be counted; and she retched with little intermission, bile-colored matters.

The sudden way in which the contents of the rupture went up into the belly, raised the suspicion that probably they might have slipped up through the crural opening still enclosed in the sack, and constricted by its neck (reduction *en bloc* or *en masse* as it was named by Claquet). It was ascertained by an exploratory operation that this mishap had not occurred. She died seventeen hours after the reduction of the rupture.

At the examination of her body the sac and the tissues around it were found in a nearly gangrenous condition. Six inches of the ileum were gangrenous, and in this part was a small hole through which fæces had run out into the peritoneal cavity. The pelvis contained about a pint and a half of a turbid, yellow, fæculent-smelling serum, and there were evidences of an intense general peritonitis. Had this woman's rupture been operated on early, instead of being repeatedly submitted to the taxis, she would probably have recovered; and even on the fourth day—by which time the contents had become gangrenous—had the taxis not been repeated, but herniotomy been done, and the sac opened, the gangrenous condition of the strangulated intestine would have been ascertained, a safe outlet for its contents might have been made, and recovery with an artificial anus been still possible. As it was, misuse of the taxis allowed the gut to become gangrenous, then burst it, and killed her.

Several years later I witnessed another case where I could not resist the conviction that the patient's death was directly due to violent manipulation. The rupture was umbilical, very large, of several years' formation, during which the

patient, a stout middle-aged woman, had been plagued with dragging pains, and with retching, which were relieved by simple domestic measures. At last strangulation occurred, and her condition growing desperate additional advice was obtained. Happening to go in, I saw the surgeon standing upon a stool bent over his patient, energetically kneading the rupture, with, as it seemed to me, a dangerous expenditure of force. She suddenly swooned, and in a few moments life was extinct. At the examination of her body, her stomach, much dilated and thinned, and partly drawn into the rupture and entangled in it by adherent omentum, was found burst; the rent was extensive, and the contents were diffused through the peritoneal cavity.

I have, also, several times found the skin red and ecchymosed and the cellular tissue so much more congested than nearer the sac, that I felt constrained to refer these disorders to external injuries, and not to any spread of inflammation from the rupture to the surface. The lesson which cases such as these and the two I have just related convey is that any handling of a strangulated rupture should be very gentle. The only justifiable taxis is a gentle, uniform, steady compression, combined with an equally gentle pushing in the direction of the channel through which the viscera have protruded from the belly. This, whilst far safer, is also much more efficient than the forcible jerky squeezing occasionally witnessed.

To return to our two cases. You will have remarked that they have several common features and one notable difference. Both patients were young muscular men; in both the local and also what are termed the "general" or "constitutional" symptoms were urgent; the nervous commotion, pain in belly, and sickness were great, and the morbid changes in the strangulated viscera were already very considerable, although so short a time as only four hours in one, and five hours in the other case, had elapsed. In the first rupture the intestine in the sac was even more excessively congested than in the second. Two circum-

stances conduced to this—first, the contraction of the inguinal ring consequent on the recent use of a truss; and next the existence of a double strangulation, one at the external abdominal ring, the other in the sac occasioned by the sharp edge of the circular partition which divided this into an upper and a lower compartment. You will recollect that the intestine in this compartment was even more congested and more spotted with extravasated blood than that in the upper space between this partition and the external ring. You will also have noticed that the intestine was directly in contact with the testis—in short, that the hernial sac was the tunica vaginalis testis (the obscuration of the testis by the rupture raised the suspicion of this before the operation),—the characteristic of the variety of rupture named "congenital," because conditioned by the persistent openness of the tube of peritoneum, which the testis draws after it in its passage from the loins into the scrotum in the eighth month of fœtal life, and which, soon after the testis has left the external ring, normally begins to be obliterated and converted into a solid fibrous band.

The partitions in the upper part of the sac, so frequent in congenital hernia (I have several times met with one, and more than once found two), probably have their origin in incomplete obliterations of the peritoneal tube. Their presence is an additional complication, and it may, perhaps, partly explain the much greater danger of strangulated congenital ruptures than of herniæ acquisitæ of similar bulk and at the same time of life—a circumstance so pointedly mentioned by Dieffenbach in his "Operative Chirurgie," a book I cannot too strongly recommend you to read.

In the second case the hernial sac was distinct. Formerly this would have been regarded as a *hernia acquisita*—one whose sac was a new bag of peritoneum pushed before them by the protruding viscera, but the early age at which the rupture first appeared, renders it very probable that it was really only a sub-variety of congenital hernia, in which the congenital peritoneal tube had been obliterated only just

above the testis, so separating its dilated testicular part (now the tunica vaginalis) from the tubular part above, which, remaining unclosed, admitted the intestine into it, and became its sac. In connection with this, I would refer you to Mr. Birkett's article on hernia in Holmes's "System of Surgery." The progress of both cases after the operation was all that could be desired. The symptoms of strangulation at once ceased, and those who saw only the calmness of the following day could scarcely realize the critical state which had so shortly preceded it. There was very slight febrile disturbance, and the wound healed almost wholly by first intention. How far this should be ascribed to the antiseptic precautions I cannot say, but I would lay great stress here, as everywhere in surgical operations, on the necessity of absolute cleanliness. To both patients opium was given, not in fixed doses and at stated times, but in quantity from half a grain to a grain, and at intervals entirely dependent on the existence and the degree of pain. This, which has been my practice many years, has afforded me very satisfactory results; it tranquillises, and it keeps the bowels quiet. In one of our two cases no stool was passed until a week, in the other till a fortnight had passed. This did not occasion us any anxiety, and the only inconvenience resulting from the prolonged inactivity of the bowels was a slight impaction of accumulated fæces in the rectum—an affair of very small importance. Do not take my remarks as a sanction to give opium necessarily in all cases, this would be a blamable want of discrimination. To some patients you would not need to give a single grain; to others you must give it boldly, but with judgment.—*Medical Times and Gazette.*

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*Clinical Lecture on Fever, delivered at St. Thomas's Hospital.*

By THOMAS B. PEACOCK, M.D., F.R.C.P., Senior Physician to the Hospital.

GENTLEMEN,—During the last few weeks several cases of fever have been under my care in this hospital upon which

I propose to offer some remarks. Of these cases, three were cases of typhus and five of typhoid. Two of the cases of typhoid occurred in a mother and child. The mother was twenty-nine years of age, and was admitted into the hospital on the 28th of October, being then stated to have been ill for two weeks, but out of health some time longer. She had symptoms of low fever, a high temperature (103·6°), and much bronchitis; and was greatly prostrated. There were a few small, round, livid, non-fading spots about the upper part of the thorax and the lower part of the neck. The spots had disappeared on the 4th of November, or on the seventh day after her admission; but the feverish symptoms did not readily subside. The temperature continued high, and the prostration was so persistent that she was not able to leave her bed before Christmas-day, or the fifty-eighth day from her admission into the hospital; and she was not presented before the 4th February, or the ninety-ninth day from admission. The case was very obscure; but it was thought most probable that it was a case of typhus, which had passed its acme before it was admitted; but if so, the commencement of convalescence was imperfectly marked, and the duration of the attack was very much prolonged. The protracted convalescence might, however, it was thought, be due to the severe bronchitis with which the attack was complicated, and to the patient having been for some time before the occurrence of the severe illness very much out of health. At the end of November, however, we heard, what had been before denied, that there were other members of the family ill at home; and Mr. Donkin, the house-physician, went down to Greenwich, where the patient resided, and found one child convalescent from some sort of fever; and another, eight years of age, seriously ill. The child was removed to the hospital on the 28th of November, the report then being that it had been ailing for about a month, but seriously ill for two weeks. The child had symptoms of active fever, a temperature of 104°, and severe bronchitis. There was a copious

eruption on the trunk, very similar in appearance to that which had been observed on the mother. The child became much prostrated, and made a very gradual and slow recovery. She was not able to leave her bed before the 6th of January, or the thirty-ninth day from the period of admission; and was only presented on the 4th of February, or the sixty-eighth day from her admission into the hospital. There could be no doubt that the child's case was one of typhus and that confirmed the correctness of the diagnosis in the case of the mother.

In the third case of typhus the patient was a boy, thirteen years of age, admitted on Jan. 1st. At that time he was stated to have been ill eleven days. There was a copious eruption of livid spots on the skin and symptoms of high fever, the temperature being 104·6°. The spots disappeared in two or three days, and on Jan. 8th the temperature fell to 98·6°, and from this time he made a rapid recovery, being able to leave his bed on the 13th. He was discharged on the 27th, or the thirty-eighth day from the stated period of the commencement of the symptoms. In this case the nature of the disease was quite clear, and the case followed the course which it generally does in children. The diagnosis was further confirmed by the admission a few days after of a brother of the same patient, also presenting symptoms of typhus.

The cases of typhoid to which I refer were five in number. Of these, the first was that of a boy, aged twelve, admitted on the 4th of October, having been then ill for two weeks, but out of health for two or three months before. He had diarrhœa before he waa admitted, but was not so seriously ill as to be confined to bed. On the day of admission he had a high temperature. 103·7°, and was considerably prostrated; the diarrhœa continued, and the evacuations were passed in bed. The symptoms of fever were severe and protracted, the diarrhœa very persistent. He was constantly delirious, and subsequently became very torpid and difficult to arouse. There were never any

spots upon the skin. The attack was very prolonged, so that the convalescence was not established before the 16th of December, or the seventy-third day from admission, and he was not discharged before the 8th of January, or the ninety-sixth day from admission. During a large portion of his convalescence he was excessively fractious and diffieult to manage.

The second case occurred in a female, twenty-one years, of age, who was received into the hospital on the 8th of October, having been then ill for four days. In this case, though the fever was severe, the temperature rising to 106°, the chief symptom was prostration of strength, there being neither spots on the skin nor diarrhœa, and not very marked cerebral disturbance. There could, however, be no doubt that there was considerable intestinal disease; for even when convalescence was apparently fully established, a very small dose of castor oil, given after there had been no evacuation from the bowels for several days, was followed by frequent loose evacuations and a sharp recurrence of fever, which, however, subsided in two or three days. She was convalescent on the 28th of October, or the twentieth day from admission, and the twenty-fourth from the reported time of seizure; and she was discharged on the 19th of November, or the forty-second day from admission.

The third case of typhoid occurred in a probationer nurse at the hospital, twenty-five years of age. She had been in attendance on two cases of typhoid, in both of which there was diarrhœa, and in one the evacuations were passed in bed. Her attendance on these cases commenced about three weeks before her admission into the ward, and ceased about a week before; after which time she was employed in watching a surgical case in which there was a profuse and offensive discharge. About the same time she became poorly, and after four days she was so ill, suffering from diarrhœa and feverish symptoms. as to be incapable of attending to her duties. On the 14th October, or the

fourth day of serious illness, she was admitted into the ward. During the remainder of the attack she had no diarrhœa; indeed. evacuations were only procured by the employment of medicine. There were, however, spots coming out at the time she first came under care, and they continued to appear for ten days. Her temperature was high (103·8°), and she was much prostrated. She became convalesceut on the 11th November, or the twenty-eighth day from her admission into the ward and the thirty-first from the commencement of serious illness; and she was discharged on the 11th December, or the fifty-eighth day from admission.

The fourth case was admitted during protracted couvalescence. The patieut was a girl aged fourteen, who was admitted on the 12th December. and was stated to have suffered from typhoid for four months, without ever having become satisfactorily convalescent. She was excesslvely fractious and impracticable; had a very dry, harsh skin, a high temperature (103·2°), and hectic symptoms. The bowels were confined. Under the use of baths and the inunction of oil, the skin became moist and the symptoms subsided; and she was convalescent on Jan. 6th, or the twenty-fifth day from admission, and was discharged on thc 23rd of the same month.

The fifth and last case was a very obscure one. The subject of the disease was a young man aged sixteen, employed as a clerk, but who had recently been leading a somewhat dissipated life. He was admitted on the 22nd of Deeember, and was then stated to have been ill for four days. He had symptoms of active fever, and was delirious, and two days after admission became so violent as to require restraint. In two or three days he was quieter, but not entirely free from delirium. Before his admission he had not had any diarrhœa, but four days after the bowels became much relaxed, and he passed the evacuations in bed. The abdomen also became excessively tender and tumid, and the temperature rose to 103·6°. The breathing was rapid,

and he died exhausted on the 8th January, or the seventeenth day from the time of admission, and the twenty-first day from the reported period of the commencement of illness. There were not any spots at any time on the skin. On examination after death there was found general peritonitis, and a perforation of the ileum had occurred at a point between two and three feet above the cæcum. The mucous membrane was free from disease everywhere except at the seat of perforation and immediately above the ileo-cæcal valve. At the latter point two of the plates of Peyer were very distinct, and the mucous membrane above and around them was slightly reddened and somewhat abraded. As I have before said, the nature of this case was not obvious, hut it seems most probable that it is to be regarded as one of typhoid. Except some little pneumonic exudation, there were no morbid conditions found in the body except those in connexion with the alimentary canal; and though the intestinal disease was, except at the point of perforation, very slight, it is well known that in typhoid there is often no correspondence in intensity between the amount of mischief in the bowel and the degree of constitutional disturbance. Occasionally also perforation occurs in cases in which there is very little intestinal disease. Indeed, Chomel has recorded in his "Clinique Médicale" a case which is almost the counterpart of this.

The first remark which I have to make in reference to these cases is as to the diagnosis—that it is impossible to distinguish between typhus and typhoid from one or two symptoms, however important such symptoms may be, but that to ascertain the nature of each case we must take into consideration the whole history of the disease, its mode of origin, its course, the symptoms by which it is characterised, and the mode in which the febrile symptoms subside. A case of typhus usually commences suddenly and rapidly progresses, so that the patient is admitted into hospital at an early period, generally before the seventh or eighth day; and usually also the case undergoes a marked amendment,

if there be not any serious local complication, about the fourteenth day. Yet it will be observed that in two of the three cases to which I have referred the time of commencement of the symptoms could not be distinctly ascertained, but the patient had certainly been ill for an unusually long time when admitted. Indeed, in both the eruption had certainly been on the skin for several days when the patient was first seen, and was clearly passing away in the first case. In both of them the period of convalescence was very imperfectly marked, the amendment was very gradual, and the whole attack unusually prolonged. In the third case, though the time of seizure was more clearly ascertained, the period of admission was also unusually late, but the case followed the usual course, and the time of commencement of convalescence was well marked, and the progress to recovery was rapid. It is not uncommon to hear a case pronounced to be typhus because it is characterised by marked symptoms of cerebral disturbance and absence of abdominal disorder, or to be typhoid because the abdominal symptoms are predominant and there is comparatively little cerebral disorder. But nothing can be less to be depended upon than these symptoms as indicating the several forms of disease, and it not very nnfrequently happens that cases confirmatory of this remark are in the hospital at the same time. This was the case some time ago. In one case a middle-aged female was admitted, after a few days illness, with symptoms of fever, much prostration of strength, and profuse diarrhœ, but there was not any marked cerebral disorder, and she passed favourably through the attack, the diarrhœa ceased, and in about twenty-one days she was convalescent. Judging from the presence of diarrhœa and the absence of marked cerebral disorder, tbe case might have been supposed to be one of typhoid, but it was really, as indicated by the general symptoms and the eruptions on the skin, one of typhus. In the other case a young man was admitted after an obscure indisposition of three weeks' duration, with symptoms

of cerebral disturbance, but without diarrhœa or other evidences of abdominal disorder. This case might therefore have readily been mistaken for one of typhus, though in reality typhoid, the diagnosis being established by the appearance of the usual rose rash. Severe cerebral symptoms indeed very frequently occur in the early stage of typhoid, while diarrhœa is occasionally absent. The latter was the case in two out of the five cases referred to, though in one of them the bowels had been relaxed before the patient came under notice, and in the other the tendeney to intestinal disorder was indicated by the undue action of a small dose of mild aperient, even when convalescence appeared well established. The eruptions on the skin, differing as they do in the two forms of fever in the periods at which they make their appearance, the forms which they assume, and the course which they follow, were they of invariable occurrence, would afford a ready and conclusive means of establishing the diagnosis. But though the eruption probably occurs at some period of the attack in all cases of decided typhus, the spots in typhoid are very uncertain, being often absent in cases of otherwise well-marked typhoid. I find that in only thirty-seven out of forty-four fully reported cases of typhoid which have recently occurred, were there any spots on the skin; and it will be recollected that they were absent in two of the cases of which I have spoken—one of them being the most severe of the five cases, and the other a decided though not very severe case.

I have a few remarks to make in reference to the treatment of cases of fever. We are all agreed as to the importance of carefully regulating the diet of a patient in the active stages of the disease, and of rigidly enforcing his being kept in bed; but I doubt whether, in typhoid more especially, the importance of continuing the same precautions sufficiently long during convalescense is generally realized. Tee frequency with which relapses occur in typhoid is a peculiar feature of the disease, and probably they cannot be entirely prevented; but I believe they gen-

erally result from the patient being allowed to indulge his appetite too freely, or to leave the bed to soon; and I think that the very small proportion of relapses that have recently occurred in my cases—only two in sixty-five—has been mainly due to the unceysing care whieh I have taken to prevent either of these mistakes being committed. Probably the cessation of the symptoms of active fever indicates the period at which the mischief in the alimentary canal ceases to progress, but after this the ulcers take a long time to heal. I have known a patient die on the eightieth day, and the ulcers to be still not entirely healed. During the time that there are any remains of ulceration it is most important that the bowel should be kept as quiet as possible, and the patient be persistently fed on the lightest and most easily assimilable food, so that no accumulation may take place. For the same reason the food should be given only in small quantities, and at regular intervals. These rules I steadily enforce, however long may be the duration of the attack, while the tongue still continues furred, and there is and diarrhœa, or tenderness or inflation of the abdomen; and I confine the patient to bed, or at least to the recumbent position, till he has recovered considerable strength. I have known a patient die of perforation when he had apparently so completely recovered as to be allowed to leave the hospital, the untoward event having been caused by his indulging too freely in food, perhaps not of a digestible character. It is also of great importance to avoid exposure to cold during convalescence; for patients in the weekly state, which after severa typhoid is so very persistent, are very susceptible to cold, and readily suffer from bronchitis or pneumonia. All excitement of mind should also be avoided. I have know a patient, from neglect of proper care in this respect, suffer from acute and fatal cerebral inflammation wheu he seemed to have almost completely recovered.

There is some difference of opinion among practical men as to whether it is better at once to restrain the diarrhœa

in typhoid, or to leave it alone unless very severe. In the early stages of typhoid there is usually diarrhœa. As the case progresses the stools generally become less frequent and more consistant; and towards the end of the attack the bowels are usually confined, and sometimes very obstinately so. This would appear to indicate that the right line of practice is to leave the case alone, unless the diarrhœa be so severe as to imperil the safety of the patient, in which case it should, if possible, be checked. I, however, while refraining from giving astringents in cases of ordinary typhoid, regard the frequency of the evacuations as in part indicating the amount of stimulus and support which should be given to the patient, and I believe that this rule will generally ce found to answer.

When in case of tyyhoid the bowels become confined, much caution is required in the exhibition of aperients; enemata are always safe, and generally will procure sufficient relief; but sometimes, and especially when the patient is taking a fair amount of food, more free evacuation may seem to be required; and yet the mildest aperients may bring back the diarrhœa and cause a relapse. The rule which I generally follow is not to interfere so long as the patient is apparently not suffering from the bowels not being acted upon, and this even though several days should elapse; but if the patient complains much of sense of fulness, or experiences uneasiness or pain, and especially if the abdomen becomes tumid and tender, the bowels must be relieved. Under the circumstances I generally order a dose of calomel and opium. one or two grains of the former to one of the latter, and follow this by a small dose of castor oil and by an enema if necessary, and the effect of one or two doses of this kind is almost always to procure full and satisfactory evacuation, after which the symptoms generally entirely subside. You will recollect that in the case of the nurse the bowels were not acted upon for six days, at the end of which time threatening symptoms appeared, but entirely subsided under the course of treatment which I have men-

tioned. Similar symptoms also occasionally occur during even advanced convalescence from too much food, or food of any improper kind being taken, and they are best treated in the way I have stated.

The last remark which I have to make is in reference to the employment of stimulants in the treatment of fevers. Some years ago, under the influence of teaching which I cannot but regard as mistaken, stimulants were so largely given in fever and other forms of active disease as to constitute almost the whole treatment, and make it often difficult to decide, when patients were seen, how much of their condition was due to the disease under which they laboured, and how much to the treatment employed. Now, however, a more judicious system is followed, and stimulants are less constantly aud freely given. But there seems danger that in the reaction, the discontinuance of the use of stimulants should be carried too far. Believing, as I do, that the abuse of fermented beverages is the greatest social bane in this country, I should have been glad could I conscientiously have done so, to have recommended the entire abandonment of the use of stimulants in the treatment of fever and other forms of disease. To do so would, however, I believe, be to deprive ourselves of one of the greatest means of alleviation which we possess, though one which requires great care in its use. It would be very much more satisfactory if the employment of these and other remedies could be reduced to some definite and scientific rules; and endeavours have been made by the careful analysis of the results of the differnt methods of treatment to deduce such genèral rules. But the cases which we have to treat are so variable in their character that it is impossible so to classify them as to be sure that the cases compared are really similar and that the results obtained ane to be depended upon as exact. I fear, therefore, that we must be content still to leave to the judicious physician the choiee of the means of treatment to be persued in any given case, guided by his knowledge of the disease he has to treat, and

his experience of the results of the means employed in other similar cases. So far as the use of stimulants is concerned in the treatment of fever, it is impossible to lay down any general rules; but I believe them to be eminently beneficial when given when the active stage of disease is subsiding, and the patient's power is beginning to give way, with the view of upholding the strength while the disease is in process of cure. If the patient is much prostrated and the pulse weak, intermittent, or irregular, or abnormally slow, they may confidently be given; and if under their use the patient becomes less restless, the pulse improves in character, and the prostration diminishes, they may safely be persevered with. The amount of stimulus which is required must also be left to the discretion of the practitioner; but generally it is more advantageous if exhibited in small doses, repeated when the effect begins to subside. If a given dose exhibited at certain stated intervals seems to excite the patient, it does not follow that no stimulant is required; it may rather be that the dose is too large and the repetition too frequent. When the patient's strength becomes greatly exhausted, as it often does when the crisis of the disease is passing or passed, the very liberal exhibition of stimulants may be necessary; and as the weakness becomes less and more food is taken, the quantity may be greatly lessened; but I think it is a great mistake to suppose that because the patient can be got to take a large quantity of food, the use of stimulants is unnecessary. Food, as I have before said, may easily be given too freely. The best results ensue from the judicious combination of moderate amounts of food and stimulus, and this is especially the case at the period of early convalescence. In estimating also the desirableness of administering stimulants in any given case, the question to be asked is not simply whether the patient will recover without their use, but whether he will make an equally good and rapid recovery without them? Typhus and typhoid are diseases of very variable severity, and this is especially the case with typhoid, and there are some cases of both

forms which will do very well without any stimulant at all. But, on the other hand, I have not unfrequently seen, in cases of fever which have never been very severe, that the patient will go on from day to day without making any material progress so long as stimulants are withheld, while on the exhibition of a small amount of wine or spirit there has been a marked and quite unmistakeable improvement in the condition of the patient, and the case has afterwards steadily progressed to recovery. What I would wish to impress upon you is, not that you should make up your minds to give or not to give stimulants in cases of fever, but that you should hold yourselves free to have recourse to them, or not to use them, according to the apparent requirements of the several cases which you have to treat. There can be no worse fault in medical practice than to adopt a hard-and-fast rule as to the plans of treatment or special remedies to be employed in any form of disease. You should endeavour to make yourselves fully acquainted with the nature of the disease you have to treat and the condition of your patient, and then prescribe the course of treatment which you think will most conduce to his recovery.—*The Lancet.*

CANADA

# Medical and Surgical Journal.

MONTREAL, JUNE, 1874.

## "POOR MARGERY."

These two words which carry us back in imagination to the "Bridge of Sighs" have formed the heading to several articles recently appearing in our public papers concerning a tragedy which has just taken place in our midst. Margery Sleman was a poor girl who, having become somewhat deranged, was, as is usual in such cases, committed to the common jail to await either improvement in her mental condition or else final commitment to an asylum. In this wretched place she was put into a ward under the charge of a notorious woman. After the lapse of some time, being apparently better she was discharged upon the recommendation of the jail physician. She was afterwards seen by a lady who was interested in her, and by whom she was directed to a place where it was thought she would get a situation. From this time nothing was seen of her, nor could her whereabouts be ascertained, although it is said she was missed and search made for her by her friends. Finally, the body of a girl was discovered several days after in a shed behind the mountain, and proved to be that of "poor Margery." An inquest was held, and a verdict of "found dead without marks of violence," returned. We do not intend to notice the conduct of the inquest further than to draw attention to the fact that, though it was stated that the girl had previously threatened to destroy herself by poison, yet no post-mortem examination was ordered by the Coroner, and no evidence of any kind was adduced to show

by what means she had come by her death. Unfortunately it seems to be quite a useless task to urge upon our Coroner the real performance of his important duties, and such meaningless verdicts as that above given are of constant occurrence, the presiding officer seeming to be able by some means to set at defiance public opinion. But the point to which we would draw the attention of our readers, especially those in this Province and in this city, is the horrible results of our present means (or rather want of means) of dealing with the insane poor. Is it not shocking and revolting to all our natural instincts, our ordinary feelings of humanity, as well as contrary to our medical sense of reason, that an imbecile girl should be closely confined in a prison ward for the purpose of giving her mind a chance to improve? Is it not clear that we are thus voluntarily and basely taking away from her whatever remaining chance there may be of her intellect recovering? Is it not the acme of cruelty for a civilized community to treat as a criminal and make to live with criminals one whose only fault is to have been afflicted by the Divine hand? It is said, this confinement is but temporary and cannot be avoided: but is not thus that precious time worse than lost which, if devoted under the eye of an experienced physician to appropriate measures for relief might have been crowned with success? To our own shame, and to the special disgrace of our rulers be it said, this subject is not new. Time and again have cases of this kind, involving the greatest hardships, been commented upon both in this Journal and in the public prints, but hitherto all our efforts have resulted in vain; no action has been taken, and the evil still exists as a standing slur upon our boasted civilization. The startling revelations that have been again brought prominently to light owing to the tragic story of this poor girl's imprisonment, dismissal, and final lonely death, have served at last to rouse the people to a consciousness of the glaring ills that are allowed to remain unattended to in our midst. A public meeting has been held, and the cruelty of sending lunatics to jail, the

utterly unsuitable nature of the accommodation there afforded, the immoral results sure to follow from the companionship allowed, have been unsparingly denounced, and an urgent call is made for the speedy intervention of some appropriate measures to finally put a stop to the perpetration of this sin. We trust this agitation will not be allowed to die away, but will be proceeded with until some satisfactory action has been taken. Then, indeed, "poor Margery," will not not have died in vain.

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## A SMALL-POX HOSPITAL.

Again and again we ask, are we to have a small-pox Hospital?

The necessity for a distinct and separate institution for the segregation and isolated treatment of cases of small-pox is becoming every day more urgent. On a former occasion we alluded to the fact of the spread of small-pox to the general wards of the Montreal Hospital although every precaution was taken which was at that time deemed possible. Our exertions to get rid of the small-pox Hospital on that occasion resulted in what the Committee of management considered a sure and certain remedy.

The Fever Hospital was divided into two compartments by a brick wall. A door of entrance was broken into that part of the building farthest from the main building, a separate staff of Physicians was appointed, and every precaution resorted to with a view of preventing the spread of the disease. What have we now to report? signal failure. The disease has spread and we can report two cases of infection.

During the past winter a lady was sent into town with her little boy to have an operation performed upon him. She occupied a private ward and all went on well. She returned home with her boy after a residence of some weeks in the

Hospital. Four days after her return, this mother of a large family living in a healthy locality in the townships where no small-pox existed at the time, broke out with that loathsome disease and the result to her is, at the time we write, a question of God's mercy.

A second case comes to hand, an assistant nurse in one of the Surgical wards, takes the disease and has to be transferred to the small-pox department.

These are cases we can vouch for, there may be others of which we have no knowledge and in reporting them we must repeat the warning formerly given to the governing body of this institution. That in continuing to admit cases of small-pox into the present building allotted to that class of patients, they are marring the usefulness of one of the noblest charities on the continent.

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## MONTREAL GENERAL HOSPITAL.

We regret to announce the resignation as attending Physician to this hospital of Drs. Scott and Howard, two gentlemen who have faithfully and zealously performed their duties in connection with this charity for over a quarter of a century. In accepting these resignations, which were submitted at the Annual Meeting of the Board of Governors, the Board unanimously passed a vote of thanks to Drs. Scott and Howard for their long continued and valuable services—and at the same time requested them to continue as members of the Medical Staff act as Consulting Physicians to the Hospital. Subsequently the following gentlemen were elected as Attending Physicans to fill the vacancies created by the above resignations viz: Robert T. Godfrey, M.D., Professor of Surgery University of Bishop's College, and Thomas G. Roddick, M.D., Demonstrator of Anatomy, McGill University. We congratulale these gentlemen on their successful candidature and also the hospital authorities on

having secured the services of two gentlemen in whose hands we feel the best interests of the institution will be served.

John D. Cline, B.A., M.D., of Cornwall, Ont., has been appointed House Apothecary to the Montreal General Hospital. We beg to congratulate Dr. Cline upon this appointment, which further success has so closely followed upon his taking the Holmes' Gold medal at McGill University. We have been pleased to observe the increased value placed upon these important posts, the number of competitors for the resident appointments having been much larger, and the interest excited in the contests for them much greater than usual. Being bestowed only upon the most deserving men, the chance of one of these internal posts in the Hospital offers very great inducements for diligence on the part of students who may be intending competitors.

We have been given to understand that it is the intention of the Managing Committee to recommend that henceforth each of the three resident appointments shall be made only for one or two years, thus affording the great advantages of the institution to a much larger number of commencing practitioners. This scheme we would heartily favor. It is the one which is acted upon by nearly all the British and American Hospitals, and as far as we know is universally approved of.

## COLLEGE OF PHYSICIANS AND SURGEONS OF LOWER CANADA.

The Semi-annual meeting of the Board of Governors of the College of Physicians of Lower Canada, was held the 12th of May instant, in the rooms of the Jacques Cartier Normal School, Montreal. The following members were present:—Drs. Scott, Peltier, Howard, Rottot, Fenwick, Trudel, Robillard, Jackson, Blanchet, Russel, Tessier, Chamberlain, Gibson, Church, Weilbrener, Brigham, Duchesneau, Marmette, Tetu, Ross, Hamilton, Gilbert.

Dr. Hingston was elected Governor in the place of Dr. Smallwood, deceased. Drs. Ross and Roddick were elected members of the College.

The following gentlemen were admitted to the study of medicine after examination :—

James Ward, James Leprohon, Gaspard Turcot, Phillippe Gaillardet, Isaie Sylvestre, Jos. Robillard, Olivier Charbonneau, Honoré Massé, A. Lapalme. Joseph Sylvain, Achille Gauvreau, Israel Joncas, Arthur Vincelette, Joseph Etienne Bolduc, Adjutor Samson; Thomas Lambert, A. Methot, Edmond Barry, and A. Poulin. Mr. S. Levy was admitted to the study of Pharmacy.

The license of the College was given to the following graduates :—Arthur Patrick Shee, M.D., Laval; Phillippe Charest, M.D.. Do.; Edwin Turcot, M.D., do.; Charles Clement, M.D., do.; Louis Honoré Labrecque, M.D., do.; Samuel Pouliot, M.D., do.; Arthur Lyon, M.D., McGill; George Henry Christie, M.D., do.; Walter Sutherland M.D., do., James C. Cameron, M.D., do.; William A. Molson, M.D., do.; Alexander Proudfoot, M.D., do.; Léonidas Brunet, M.D., Victoria; Edmond Ouimet, M.D., do.; Joseph E. Berthelot, M.D., do.; Sévérin Lachapelle, M.D., do.; Herménégilde Jeannotte, M.D., do.; Louis D. Hébert, M.D. do.; Joseph Edward Scallon, M.D., do.; Arthur Roy, M.D. do; Charles Demers, M.D., do.; Louis Coyteux Prevost, M.D., do; Alfred Majeau, M.D., do.: Joel Laurendeau, M.D., do.; Frs, X. Mousseau, M.D., do.; Stanislas Lamoureux, M.D., do.; Avila Demers, M.D., do.; Télesphore O. Globensky Wilson, M.D., do.; Joseph Roy, M.D., do.; Alexander Germain, M.D., do.; Victor Moquin, M.D., do.; Théodore Phénix, M.D., do.; Louis Laberge, M.D., do.; Eugene Trudel, M.D., do.; Alfred Brossois, M.D., do.; Edward Férron, M.D., do.; Charles Desorcy, M.D., do.; Victor Elz. Brouillet, M.D., do.; Arthur Duval, M.D., do.; Israel Lemieux, C.M., M.D., Lennoxville · Asroum Duclos, C.M., M.D., do.; David Alexander Hart, C. M., M.D., do.; Joseph Campbell, M.D., Queen's College; Francis Rourk, M. D., do.

Alexander Munro was admitted to the practice of pharmacy after examination.