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# THE CANADIAN PRACTITIONER

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## Original Communications.

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### CASE OF VAGINAL HYSTERECTOMY.

BY K. N. FENWICK, M.A., M.D.,

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KINGSTON, ONT.

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VAGINAL hysterectomy is now a recognized and successful operation for a disease which, for a long time, was the opprobrium of gynecology.

Before this, the high amputation of the cervix was the best that could be done; but, sooner or later, the disease was sure to return, and, of course, prove fatal. Some even now prefer the high operation to vaginal hysterectomy, but limit it to cases seen very early, and which are not very extensive.

Vaginal hysterectomy does not always prevent recurrence of the disease, but it offers the best results, and the only hope of permanent recovery. It stands to reason that a complete operation must be more successful than a partial one, and where the whole organ with the disease is removed the chances of non-recurrence are better than when only the cervix is amputated.

The immediate mortality from the operation is small, if properly per-

formed, and the remote benefit is amply evidenced by the experience of a score of German and American operators.

The immediate dangers are from hemorrhage and shock ; the remote from peritonitis and septicemia. Pean and Richelot have done much to lessen the former by the use of clamps, which shorten the time of the operation, while aseptic methods have greatly aided in diminishing the dangers of the latter.

The arguments in favor of the clamp are the saving of time at the operation, and so lessening the danger of shock ; shortening the time of sloughing afterwards, and hence a quicker convalescence ; lessening the danger of infection, as by ligatures ; more favorable drainage ; less danger of injuring the uterus ; not so much traction on the tissues ; more firm compression, and so less danger of slipping than the ligature ; the chance of including diseased tissue which subsequently sloughs away ; and, finally, to the inexperienced the clamp offers a better prospect of success, as less skill is necessary for their application.

I think any one who has seen or done the operation by both methods would always prefer the use of clamps, although I am aware it has been urged against them that they are uncertain, may slip, and so give rise to secondary hemorrhage ; that they are uncomfortable and painful ; that they prevent proper closure of the peritoneum, and so favor septic infection and adhesions to viscera ; that the sloughing surface is larger than with the ligature ; that the wound must be disturbed in removing them ; and, finally, that the use of clamps is not as surgical a procedure as the ligature.

The following case will illustrate the steps of the operation, and some peculiarities of the method employed : Mrs. T., æt. 41, suffering from cancer of the cervix, was kindly referred to me by Dr. Saunders last September for operation. There were the usual symptoms, and I found the disease affecting the posterior lip of the cervix, while, from constant contact with the vagina, an ulcer, about the size of a half-dollar, was found on the posterior wall of the vagina about one inch below the vaginal attachment of the cervix. She was etherized, placed in the lithotomy position, and every antiseptic precaution used. Sims' speculum and lateral retractors were employed. Just before cutting, the cervix was pushed up so as to mark with the eye its attachment to the vagina. The cervix was held firmly with a strong volsellum, and drawn down, while the vaginal attachment was severed by curved scissors behind, in front, and finally at the sides, keeping close to the uterus, so as to avoid injuring the bladder or ureters. Douglas' pouch was opened, the finger passed round the left broad ligament, and the peritoneum in front incised on the point of the finger. A sound was held in the bladder as an additional precaution. The fundus

was not retroverted, nor was the introduction of a sponge necessary to keep up the intestines. A pair of Carstens' clamps was applied to the left broad ligament, and the tissues cut through close to the uterus, while the same was done on the right side, and the uterus removed. Iodoform gauze was carefully inserted between the clamps, and the usual dressing, with a T-bandage, applied. The clamps were removed at the end of forty-eight hours, the vagina gently washed out with bichloride solution (1-3000), and iodoform gauze reapplied. The recovery was uneventful, the temperature never rising above 99°, and there was no pain requiring even a single dose of morphine. In two weeks she was again etherized, the ulcer on the posterior wall of the vagina was excised, and the wound closed with catgut ligatures. This healed rapidly, and she left for home in just a month from her admission, feeling very well, and in good spirits, the parts being quite healed.

# Selected Articles.

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## ELIMINATIVE AND ANTISEPTIC TREATMENT OF TYPHOID FEVER.

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By W. B. THISTLE, M.D., L.R.C.P. LOND.,

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IN an article on this subject which appeared in THE CANADIAN PRACTITIONER for April, 1893, I introduced to the profession a form of treatment which seemed to follow closely upon our knowledge of the nature and *modus operandi* of the infective agent, and which in my hands had given exceptionally good results. In connection with that paper, I published histories of thirteen consecutive cases, with the average attainment of normal temperature and establishment of convalescence on the eleventh day. Another noticeable feature in that series was the complete absence of accidents of any kind, and of the usual unfavorable and distressing symptoms. Since then my experience and that of my friends who have given the treatment a trial has been such as to increase my confidence in its efficacy, and to establish, even more securely, the correctness of the views I then put forward.

I now beg the liberty of returning to the subject, and of presenting an additional number of cases. Before doing so, however, I may be permitted, as in my former paper, to outline briefly the nature and pathology of the disease, and so to clear the way for discussion.

It is now well established that typhoid fever is the condition which follows infection of the organism by a specific form of bacillus. What concerns us more particularly is the manner in which the bacillus brings about the changes which we attribute to it, for it is only from a knowledge of that kind that we can work out a successful treatment. The bacillus entering the body would, under ordinary circumstances, be carried quickly through the stomach and upper bowel until its onward course becomes somewhat retarded by the ileo-cecal valve. In this situation the intestinal

contents are perhaps most alkaline. This region is, therefore, most favorable to bacterial growth. Multiplication occurs with extreme rapidity, so that the intestinal contents in a few days teem with countless numbers of fungi. They are, however, by no means confined to the intestine, but are conveyed by the absorbents into the follicles in the intestinal wall, and through the radicals of the portal veins to the liver, and so on through the system generally. They may be found in the solid viscera, tissues, and fluids throughout the entire body. That the main culture is, however, in the intestine is borne out by the fact that immense numbers are in the evacuations, and that infection is universally attributed to unsterilized fecal matter. Keeping pace exactly with this process in the bacillus is the production and accumulation of a chemical substance—a bi-product, which is a necessary element in the vital activity of the bacillus. By separating this substance from cultures, and experimenting with it, many of its properties have been determined by Brieger, Novy, Sims-Woodhead, and others. It was found to produce local, as well as what may be called constitutional, effects. Sims-Woodhead likens it, acting locally, to a "caustic." Its first and mildest effect is to stimulate the cells of the parts, causing them to become swollen, and to increase in their rate of multiplication. If, however, the toxine is allowed to remain long in contact with the cells, or if it is in sufficiently concentrated form, instead of irritation and increased activity, the cells lose their vitality and necrosis takes place. As examples of its constitutional effect, we may instance fever, delirium, tremor, lethargy, or its mydriatic action on the pupil. If a large dose be given to an animal, it speedily dies narcotized; if a somewhat smaller dose be given, and repeated for a time, the animal gradually merges into coma, and shortly dies. The toxine is, in fact, the weapon of the bacillus, without which it would be a harmless particle of vegetable protoplasm.

The symptoms generally are determined by the amount of poison in the body, and, in the case of different individuals, by a varying degree of susceptibility, or a varying degree of virulence in the poison itself. The local disturbance is determined by the quantity of the poison in contact with the tissues, to its degree of concentration, and to the length of time it remains in contact. It is by noting these facts regarding the toxine that one gets the key to the situation. Look, for example, at the case of the intestinal follicles; why is it that the tissues here suffer to such an extreme degree? Surely not from any selective action of the bacteria, but rather from the fact that the follicles are in close proximity to the main culture, and are surrounded by lymph sinuses into which empty the lacteal ducts of the surrounding villi. Each follicle is, in fact, the reservoir to which is conveyed both poison and bacteria absorbed from the intestine. The bacteria and poison carried to other parts of the body produce, in a minor

degree, the same results. Molecular death is much increased wherever this poison is present, but, as a rule, ulceration takes place only in the intestinal nodes. The reason seems clear ; the bacilli invading the follicle are at first precisely in the same position as a similar colony in like tissue in any other part of the body, and after having given rise to a certain degree of disturbance would, as in the other situations, be overcome by the tissues, seldom giving rise to necrosis *en masse*. But the anatomical conditions being different, the lymph tissue in the intestinal follicles wages unequal war, since reinforcement both in the way of fresh bacilli and of poison absorbed from the intestine is constantly arriving, carried by the lacteals of the surrounding villi, until, eventually, the poison becomes so concentrated that all resistance is overcome, and the follicle undergoes necrosis. The slow percolation of the fluid through the follicles aids in their destruction, as it favors concentration and prolongs the period of contact.

As a corollary to this, it appears that ulceration of Peyer's patches is by no means an essential or necessary result of typhoid infection. For, if the base of supplies should be cut off, the bacteria already in the follicles might reasonably be expected to produce the same results, and disappear in the same manner as a like number of bacilli located in similar tissue in any other part of the body.

The treatment which I advocated in my first paper, and to which in the series of cases I have to report I adhered throughout, is based on this conception of the pathology of the disease. It consists, first, in eliminating, as speedily as possible, both the main culture and toxine in the intestine, and also the poison held in solution in the body fluids throughout ; second, in diluting as much as possible the toxine which is in contact with the tissues, and in that way controlling, to some extent, its destructive or irritant defects ; and, third, in the use of substances which will destroy the bacilli still remaining in the intestine, or retard their rate of multiplication.

Elimination is accomplished by securing free and thorough evacuation of the bowels daily by the use of purgatives. This daily purgation, as much as seems necessary, keeping in view the evidence of toxemia, is continued until the temperature becomes normal. There can scarcely be doubt about the possibility of clearing the intestine of the bacteria and poison which it contains. Argument to prove that point seems scarcely necessary. Since the evacuations constantly contain bacteria, and of necessity their generated poison, it follows that purgation must result in elimination of both ; and, if the process is constantly repeated, there is a continued disappearance of bacteria and poison, which would otherwise be absorbed and carried throughout the body. In fact, by the agency of purgatives there is a frequent withdrawal of an additional dose of poison,

which in the absence of any such procedure must surely have gone to increase the amount already in the tissues. But purgatives do much more than simply empty the intestine. They, at the same time, cause a copious flow into the bowel; by their use the body fluids are drained into the intestine. The amount which can be drained off in this way is very great, and, in order that we may have some idea of it, let us calculate on the basis of Lauder Brunton's experiment, by which he demonstrated that in four hours, by injecting a solution of magnesia sulphate, he was able to produce a secretion almost equal to one drachm to every square inch of intestine acted upon. But we scarcely need to enter into a calculation, as the amount of fluid which follows the exhibition of a cathartic is sufficient evidence. The important point is that the body fluids from which this secretion is derived hold in solution both the poison which has been absorbed from the culture in the intestine and that produced by the bacilli located in the various tissues of the body.

There are many somewhat indirectly beneficial results to be obtained by free elimination. The weakness of typhoid patients, which is of the same nature as the weakness of a drunken man, disappears or grows less, keeping pace to a great degree with the lessened toxemia. In a similar way, anorexia, nausea, or inability to digest and assimilate food, in every case, in my experience, grows less and less if elimination is free and continually secured. My patients have, in every instance, been able to take large quantities of nourishment, and without difficulty. Owing to the improved capacity in this respect, while, on the one hand, large quantities of fluid are constantly drained off, on the other hand this fluid is replaced by a large quantity frequently ingested and assimilated. So exhaustion from the frequent and copious evacuations is prevented. We may say that an exchange has simply been made. The body fluid with its contained poison is replaced by a like quantity without that element.

In addition to the large quantity of food taken, I invariably direct that the patient be given water in large quantities at frequent intervals, with the twofold object of aiding the elimination of poison by its diuretic and flushing action on the kidneys, and of keeping up the volume of body fluid. Thus concentration of poison is prevented, which must inevitably result if the ingestion of fluid does not keep pace with its withdrawal. By preventing this we are following the plain teaching of pathology, since the destructive effect of the poison is increased in proportion to its concentration (Woodhead). This practice of dilution is inseparably connected with the practice of free and continuous elimination by purgation.

As to the other factor in the treatment, *i.e.*, the use of antiseptics, I hold it in light esteem when compared with elimination and dilution. Yet in all my cases I have used intestinal antiseptics, and, I believe, with a



great deal of benefit. It seems to me that if one can completely deodorize the intestinal contents by the use of salol it must do this through its destructive action on the ordinary intestinal bacteria, and very likely will act in the same way on the germs of typhoid, if occupying the intestine. In this connection, I should like to point out that much larger quantities of antiseptics can be used, if associated with free purgation, without their toxic effects arising, than if given alone.

In a departure from tradition and teaching such as this treatment, while one may be disposed to give full credit to its logical correctness, yet there are questions which must be answered in a satisfactory manner before it can be applied with confidence. In my first paper I dealt with several of these, more particularly and at length with the supposed greatly increased liability to perforation and hemorrhage involved in the use of purgatives. Keeping in mind the pathology of the disease, let us first notice the question of perforation. This, of course, presupposes deep ulceration, a condition the occurrence of which in cases seen early, and where free elimination has been secured throughout, is directly opposed to the inferences of pathology. I have already in this paper expressed the opinion that intestinal ulceration is by no means an essential in typhoid fever, and depends upon the retention of the poison. So that in cases seen early, and where elimination has been properly secured, we are not even confronted with this difficulty, and may proceed to purge as freely at a late as at an early stage of the disease, in so far as the danger of perforation is concerned. Many cases, however, come under observation late in the course of the disease, and in these cases, where the poison has had full play, and where there are other signs of intoxication, we must suppose the presence of ulceration.

In dealing with this question I may be permitted to quote from my former paper: "Suppose the ulceration to be deep at the time the patient comes under observation, are we then to allow the caustic to continue in its work of cell destruction, or are we to attenuate and remove it in the way indicated? Certainly, the latter plan seems the reasonable one to adopt. It is, however, objected that ulceration is, perhaps, so deep that any increase of movement, consequent on purgation, may cause rupture. Let us here notice what follows on the administration of a purgative medicine. There is increase of peristaltic movement; but here we must remember that we have made no radical change, but have simply increased the rate of existing movement. Moreover, by purgation, we get rid of irritating matter and gases which were, perhaps, exciting violent peristalsis. And, again, it may be urged that, to accomplish this removal, we must increase the expulsive movement still further; not necessarily so, as at that portion of the intestine, for purgatives act chiefly by virtue of

their power to produce free secretion. Consequently, the process partakes largely of the nature of a flushing out. Not only does purgation not increase, but it can be proven that it actually diminishes the danger of perforation. It is obvious that the more the intestine is distended, the thinner those structures which form the floor of the ulcer become. Now, this condition of distension is common in typhoid, and depends on paralysis of the intestinal muscles resulting from the action of the toxine on the nerve centres. Hence, if by purgation the cause of the paralysis be got rid of, there is a return of muscular tone, which is the condition least favorable to the occurrence of perforation. Let us now turn to the question of hemorrhage. Hemorrhage can, of course, only occur from a vessel laid bare by the process of ulceration. At the outset, I should like to draw attention to two facts touching arterial hemorrhage. Gowers, speaking of the pathology of cerebral hemorrhage, says: 'The force that ruptures an artery is the pressure of the blood within it.' And, again, 'Healthy veins may give way under extreme pressure, but arteries do so seldom, perhaps never.' Accepting these statements, then, and applying them to typhoid fever, we have the two factors in the production of hemorrhage—the toxine corrodes the arterial wall, the blood pressure ruptures it. If we remove the toxine from contact with the vessel, and diminish the intensity of its action, we certainly, as in the case of the intestinal follicle, limit the extent of damage to the vessel wall. But it is claimed that increase of movement in the intestinal wall may cause laceration of the exposed artery. In other words, we are asked to believe that a vessel whose wall is so fragile that it may be broken by the slight increase of vibratory movement in the membrane in which it is lodged is, at the same time, if freed from this extra movement, capable of sustaining the blood pressure. Then, again, is it really a fact that increase of movement in the intestine involves strain upon the vessel which ramifies in its wall? One can understand readily enough how the vessel might be stretched, and possibly torn, as a result of paralysis of the muscular wall of the intestine, and its subsequent distension by gas. Purgation, then, to my mind, in no case causes rupture of an artery, but at all times tends to prevent its occurrence." In case, however, one should decide against purgation, on account of its supposed danger, he must accept the responsibility which the alternative involves of maintaining *in statu quo* the very condition which makes him apprehensive of danger.

In connection with the application of the principle of elimination there are several minor questions. First, in the event of the presence of diarrhea, are purgatives indicated? The occurrence of diarrhea must be a response to some irritant, and if it continues, and is associated with evidence of toxemia, we cannot infer that there is complete elimination of the

exciting cause. In short, we simply follow the practice so general in, for example, either the symptomatic or mycotic diarrheas of children, and control the diarrhea by giving a purgative. Because there are several watery stools in a day, it by no means follows that sufficient elimination is being secured, for the flow may be simply from the lower bowel, leaving the contents of the ileum untouched. Supporting this view is the fact that the diarrhea is so often associated with indications of pronounced toxemia, whereas the same number of movements in response to a purgative is followed by a marked loosening of toxemia. With reference to this very point, a recent case is of interest. There was persistent diarrhea during the second week, associated with tympanites, elevated temperature, and intense headache. Attempts had been made to control the flux by opiates, etc., but without success. The movements were as many as fifteen and sixteen per day. I advised three grains of calomel, and asked the physician in attendance to note well the character of the motions which followed. He did so, and reported the passage of an unusually large and extremely offensive stool, together with a large quantity of a jelly-like substance. Subsequently, there was cessation of the diarrhea, and marked improvement in every respect. The purgative was repeated, and the patient became shortly convalescent. Second, is there danger of exhaustion from frequent and prolonged purgation? I have already pointed out that if patients are relieved from the poison, the appetite and power of assimilating food remain good. It is quite common to have patients take sixty ounces of nutritious food daily, in addition to large quantities of water. I have, in practice, experienced no trouble whatever from exhaustion following upon purgation.

I have now to report twenty-nine new cases, making, in all, forty-two consecutive cases. In the second series the treatment was practically the same as in the cases reported last year, with the exception that I gave myself more liberty in the choice of purgatives. I have used calomel, magnesia sulph. pil. cath. co. U.S.P., Rochelle salts, pulv. sedlitz, and cascara sagrada. Purgation begun vigorously, and continued until the temperature became normal, was the rule of treatment. It was also considered important to secure elimination as quickly as possible. I do not wait until next day; but a few hours after having given calomel or pil. cath. co., followed by pulv. sedlitz, excite the reflex by a glycerine enema. I have not noticed any difference in the effects produced by the different purgatives. All are alike useless, if they fail to purge. As to the antiseptic effect of calomel, there is not the slightest evidence. I have in several cases seen it given continuously in large doses without purging, and without producing the slightest effect on the symptoms. It is in many cases impossible to keep up purgation by the use of calomel alone. But,

if the dose of calomel be followed in two or three hours by a sedlitz powder, there is usually no difficulty. Occasionally, the gums become sore, and it becomes advisable to substitute pil. cath. co. or magnesia sulph. for calomel, or, if but slight results are desired, a drachm of elixir sagrada may be given. The difficulty has never been in the way of preventing too vigorous action, but rather in securing sufficiently free movement. In looking over my charts, I find that five or six movements per day in response to purgatives has been about the rule until the symptoms somewhat abated, when purgatives were reduced to produce three or four movements. But if there were any aggravation of the symptoms, freer elimination was induced as quickly as possible, for I considered time an important element in this treatment. Salol has been given in nearly all cases in five- or ten-grain doses every three or four hours. With every capsule or powder, the patient was instructed to take a large draught of water.

Of these forty-two cases several were furnished by medical friends who were good enough to give the plan a trial. A number of these were, however, treated under my direction. The list includes hospital and private patients, perhaps a majority of the latter.

*Analysis of cases.* Cases came under observation on an average on the fifth day. I have no fatalities to record. Average attainment of normal temperature and entrance on convalescence on the twelfth day. Relapse or recrudescence occurred in three cases. No hemorrhage. No perforation.

Delirium occurred in only one case—a little girl—while under treatment, and, when present when patient came under treatment, very shortly disappeared.

Tympanites in no case occurred during the course of treatment; and when present, when the patient was first seen, very quickly disappeared.

In fifteen cases rash was noted. In seven cases spots were present on the abdomen when the temperature was normal, and convalescence had begun. Bathing was had recourse to only for the purpose of cleanliness. Routine sponging once or twice a day; but in my own cases never required for the reduction of temperature.

*Remarks.* Forty consecutive cases of typhoid fever, without death or accident of any kind, is an extremely good result. And when we consider the duration of the fever and the comfort of the patient, instead of the usual distressing symptoms, this record is without a parallel, I believe, from any system of treatment. The fact that, in seven of this series of cases, the rash, perfectly typical, was coincident with normal temperature and convalescence surely proves that typhoid fever can be aborted.—

*Medical Record.*

## NON-OPERATIVE TREATMENT OF PERITONITIS.\*

BY FREDERICK TREVES, F.R.C.S.,

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BEFORE dealing in detail with this matter, a very brief reference may be made to the treatment as carried out in bygone years. Inasmuch as peritonitis, as an individual disease, was not recognized until the beginning of the present century, even the most elaborate review of the subject cannot extend very far back.

An excellent account of the treatment of the disease, as practised in England eighty years ago, is to be found in a gossiping tract on *Peritonitis*, by Thomas Sutton, M.D., late Physician to the Forces, and Consulting Physician to the Kent Dispensary. His lines of treatment were as follows: first, absolute rest; second, purgatives; third, abstinence from food; fourth, cold to the abdomen; fifth, blood-letting in the acute cases; and sixth, opium to be given only occasionally and very sparingly. Dr. Sutton was not a believer in opium in peritonitis, except in the presence of intense pain. He made a great point of securing an action of the bowels when possible, and made frequent use of sulphate of magnesia. Benjamin Travers, writing in 1812, advocated the same measures. He considered an evacuation of the bowels to be a matter of primary importance, but he appears to have relied largely upon enemata, and to have inclined towards warm fomentations.

### I. REST.

Absolute rest in the recumbent position appears to be the first obvious indication. The knees may be flexed over a pillow to lessen the tension on the abdominal walls, and to favor the patient's instinct to assume that posture. The upper part of the chest and the ever-restless upper limbs should be protected by a woollen jacket, and no reasonable restraint offered to the patient's inclination to hold the hands above the head. This favorite posture, by acting upon the lower part of the thoracic wall, assists

\*Abstract from Lettsomian Lectures on Peritonitis, delivered before the Medical Society of London, January, 1804.

also in diminishing the tension within the abdomen. It is cruel to insist that the hands should be kept beneath the bedclothes. The state of misery in peritonitis is acute enough without being increased by purposeless and rigid formulæ. Cold hands do not cause death, but as on exposure they tend to become cold they should be covered up. The wretchedness of restlessness has a natural relief in little movements.

## II. FEEDING.

The old rule of eighty years ago of giving as little food as possible by the mouth cannot be improved upon. The stomach is not in a condition to receive nourishment, and what is taken usually remains unutilized, and is returned unchanged. The practice sometimes met with of laboriously plying the patient with teaspoonfuls of this meat extract or of that recalls the legend of the Danaïdes, who spent their energies in pouring water into pitchers without bottoms. Two extremes are to be avoided: The first is the rigid, unreasoning, and often needlessly cool prohibition of food of any kind by the mouth; and the second is the reckless and intemperate use of ice or iced fluids.

Thirst is often a most terrible symptom in peritonitis. It is not always quite relieved—at first at least—by rectal injections. The patient is ready to give his life for a drop of cold water. If he takes it he is sick, but he is much relieved. This little indulgence does not introduce anew the symptom of vomiting; it is there, but it is latent, and the drop of cold water only makes it evident. The patient will not die of vomiting, and simply because a rigid exclusion of all fluid by the mouth does not render the symptom apparent it does not render it non-existing. The man would sooner vomit than endure his thirst. Very often great relief is given by allowing a fairly copious draught of fluid, which is soon rejected, and which—as it were, by washing out the stomach—leaves the patient for a while infinitely comforted. On the other hand, the perpetual sucking of ice is as bad as the perpetual teaspoonful of useless jelly or decomposable meat juice. The filling of the stomach with iced water does undoubtedly add to the general depression of the patient, especially when vomiting has been brought into abeyance by morphine.

The right course appears to lie between these two extremes. There should be no rigid formula except this—let the patient take as little food as possible by the mouth. If there be a raging thirst, let him have a little ice—and very little suffices—or a little iced milk and soda water; or if, as is common, the inclination lies towards something warm, let him take a few spoonfuls of hot water or of weak tea made hot, or of beef tea at a like temperature. It is not the nourishment that is needed (and I imagine that the nourishment in beef tea is merely an ancient but cherished fiction),

but some fluid in the stomach. It is better, within reasonable limits, to be guided by the patient's own instincts than by a blind formula founded upon a doubtful physiology. This same physiology has added very much to the miseries of death from peritonitis.

As regards actual feeding—in the usual sense—that should be carried out by rectal injections. The injections should be small in amount, should be weak, should be made of some peptonized meat extract or infusion, should be given slowly, and should be of the temperature of the body. An injection of two to two and a half ounces of peptonized beef tea with half an ounce of brandy appears to answer well, and may be given every three or four hours. Thirst is better relieved by an injection of half a pint of warm water, given alone, than by diluting the nutrient enemata to that extent. I do not think that nutrient suppositories are so well suited for cases of peritonitis as is the ready-made fluid injection. Irritability of the rectum may be, to some extent, met by washing it out now and then, and by a weak injection of cocaine. In the more advanced cases, the sphincter begins to relax as the loss of power progresses, and then, very usually, nothing can be retained. It is undesirable to harass the last hours of a dying man by nutrient enemata, simply because it is the custom.

If there be diarrhea, or if the bowels be acting freely, then rectal feeding cannot be adopted; but, fortunately, in these cases the vomiting is slight, as a rule, and fluid and a certain amount of nourishment can be taken by the mouth. It is, perhaps, needless to add that in cases, with or without diarrhea, in which there is no vomiting, all that is given may be given by the mouth. Much complaint is often made by patients with peritonitis of the horrible state of the mouth. The tongue is dry and stiff, and such sense of taste that remains is only capable of appreciating a bitter nastiness. Something can be done to relieve this by keeping the teeth brushed, by washing the mouth out with a 1 in 80 carbolic lotion, or with a mixture of eau de Cologne and water, by actually cleaning the tongue and by keeping it moist with glycerine and water.

### III. OPIUM.

Here, again, the old practice appears to be the best. Give as little opium as is possible. In the early stages of acute peritonitis, and especially in the perforative forms, and in those depending upon appendix troubles, morphine in the form of a hypodermic is absolutely necessary. In the worst instances it may certainly avert death from shock. Under its influence the patient revives, and the more intense symptoms become greatly modified. Morphine should never become a feature in the routine care of peritonitis. It masks the symptoms, hinders the natural process of cure, and hampers treatment. The indication for it is actual pain, and

not mere restlessness and misery. In the really septic forms very little morphine is called for, and often none at all. Its evil effect in the after-treatment of cases of abdominal section has been amply demonstrated. In quite hopeless cases there can be no objection to its free employment, but in other instances the administration and the dose of the drug must be sanctioned and measured by one symptom—pain.

I have noticed that in those who are dying of general peritoneal sepsis a greater sense of relief usually follows the hypodermic injection of strychnine than attends the use of morphine. The strychnine appears to act as a stimulant would—the patient revives for a while and feels more hopeful under its influence, his moanings cease, his miseries are less unendurable, and for the twentieth time he thinks he may get better.

#### IV. APERIENTS.

At the commencement of the century, the use of aperients was a necessary element in the routine treatment of peritonitis. By aperient treatment may be understood the obtaining of an action of the bowels by either drugs or enemata. After a certain number of years the practice altered, and the dictum went forth that when any signs of peritonitis were present aperients were to be absolutely forbidden.

Within the last few years the more ancient method has been revived, but it has been revived with very radical modifications. To Mr. Lawson Tait the profession is indebted for this return to an almost forgotten practice, and, above all, for the employment of that practice with the new element of discrimination. Mr. Tait's measure has been frequently spoken of as "the treatment of peritonitis by aperients," and it has been assumed by some (and probably with disaster) that a purgative is necessary in every case of peritoneal inflammation. Mr. Tait's precise words on this subject are as follows:—"I have never said that the purgative treatment will cure peritonitis, for peritonitis, once if it is completely established, is a practically incurable disease, and almost uniformly fatal." It is on this very point that the centre of the position with regard to this treatment turns.

Aperients can never be adopted in the routine treatment of peritonitis. In the larger proportion of cases this measure is entirely useless, and in the great series of the septic forms it is more or less impracticable. In most of these septic examples enemata of any kind may be administered, and purges of any character may be given, and the probability is that the bowels will not act at all, and if they do respond it is more than probable that the treatment will not affect the prognosis in the least, and certainly not in the patient's favor. If the aperient could eliminate the fatal poison which is circulating in the patient's system then good may follow, but even the most enthusiastic advocates of purging cannot credit their drugs with this power.



There is no doubt but that there is within the intestine an amount of noxious or poisonous matter which remains harmless so long as the viscus retains its normal condition, but which may lead to septic symptoms if certain changes are induced in the wall of the bowel, or possibly in its contents. This has been especially shown in connection with the potentialities of the colon bacillus, and it is clear that these noxious elements include not only simple chemical substances, but also various micro-organisms and their hurtful products.

Some gross disturbance in the complex mechanism of the bowel wall is needed to render the poisonous contents of the intestine acutely poisonous, and to favor its ready introduction into the system. Of the effect of a thorough evacuation of the alimentary canal in such an instance surgical experience can testify. Such a case as the following must have come within the knowledge of every surgeon who has dealt with many cases of intestinal obstruction. Some years ago 'I was called to see a vigorous man of forty-five who had suffered from acute intestinal obstruction for some three days. I opened the distended abdomen, and I recognized that peculiar faintly-stinking peritoneum with which such operations soon make one familiar. Immediately beneath the incision was revealed a single omental band which had caused the trouble. This was divided and the abdomen was closed. The operation lasted a few minutes. Still the man died, and the necropsy revealed no perforation and no gangrene of the bowel, and no abnormal change in the peritoneum save a little stickiness. The patient died, not because his bowels were obstructed, but because that obstruction allowed septic matter to be absorbed from his intestine. His trouble was not outside his bowel, but within it. Had I made an opening in the gut and allowed the poison-loaded viscus to relieve itself, the result may have been different. Such an operation would have been comparable to the washing out of the stomach after an active poison has been swallowed.

It is a fact that the most successful treatment of acute obstruction of a certain grade is that which provides for a thorough evacuation of the loaded gut. A blindly-executed enterostomy, with an utter ignoring of the cause of the obstruction, has been attended by better results than have operations in which the agent of the obstruction has been discovered, after elaborate search, and has been satisfactorily dealt with. This treatment of acute obstruction, by the evacuation of the bowel before all things, we owe to Benjamin Travers, the father of intestinal surgery. In cases of strangulation of a certain degree he insisted that the bowels should be cut into and emptied, even after the obstructing band had been removed. He considered that the operation was not complete until this had been done; he urged that safety was only to be obtained by an evacuation of

the gut, and he supported his views by numerous cases and experiments.

Another illustration of these selfsame points is afforded by perityphlitis. In a previous section of these letters I have shown that those cases of perityphlitis in which there is diarrhea, or in which the bowels act naturally or under the influence of aperients, are attended with a much lower mortality than are the cases in which constipation is marked. In my own experience, I am convinced of the value of the aperient treatment in the earliest stage of these cases, and of the pursuit of the same measure throughout in selected instances. In some cases, however, nothing within reason will bring about an action of the bowels. The subjects of repeated attacks of perityphlitis are aware themselves of the evil effects of constipation, and many of them have learnt that they can ward off an attack, or minimize it, when it comes, by a prompt aperient.

A further illustration of the subject, from the same standpoint, is afforded by that alarming intestinal condition which is sometimes met with after abdominal operations, and which was at one time spoken of as peritonitis. The exact nature of this condition was, I believe, first recognized by Dr. Malcolm. It has been fully dealt with subsequently by Olshausen and Verchère. The former writer has applied to it the convenient name of "pseudo-ileus." The symptoms are these: On the second or third day after a not necessarily severe abdominal operation, the abdomen becomes distended, the patient becomes uncomfortable, and complains of "wind." The distension increases; vomiting sets in. At first only the contents of the stomach are rejected; very soon the matter becomes bilious, and finally there is copious "coffee-grounds" vomiting, and this may present a feculent odor. The vomiting tends to become worse and worse, and is much more copious than is common in peritonitis. The pulse becomes smaller and feebler, the temperature usually sinks, and exhaustion increases with alarming rapidity. On the fourth or fifth day after the operation the patient may die. At the necropsy the peritoneum may be found to be practically unchanged, or to exhibit so trifling a degree of peritonitis as not to account for the symptoms, nor for the fatal result. Various explanations of this condition have been given. There is no doubt that the nervous disturbance which attends any abdominal operation leads to some degree of intestinal paralysis. This paralysis, attended, as it is, by vasomotor changes in the bowel wall, is favorable to the absorption of septic matters from the intestine. The paresis may be slight and may disappear spontaneously, or it may subside if the distension of the bowel can be relieved by the introduction of a rectal tube. If it persist, it appears to permit of a filtration through the intestinal walls of septic materials, of bacteria or of their products. These latter are readily taken up by the peritoneum, and a septicemia commences. This is the explanation given by

Olshausen, Verchère, and others, but it is not accepted by Dr. Malcolm. Anyhow, it was pointed out by Mr. Tait, and has been made evident to most surgeons who have followed his teaching, that if an action of the bowels can be obtained at the outset of the symptoms, either by the administration of a purgative or by an enema, the trouble, in a large proportion of cases, passes away, and the patient makes a good recovery. It cannot be said that this good result follows in all cases, and it is evident that the purgative, like the emetic given in acute poisoning, can only bring about an arrest of the symptoms within certain limits.

On both theoretical and clinical grounds, the thorough emptying of the intestine before any abdominal section is performed may be regarded as absolutely essential.

#### V. BLOOD-LETTING.

This measure of treatment may, with advantage, be more extensively employed. It is no longer likely to be used in the unreasoning and mechanical fashion of bygone days. In robust forms of localized peritonitis, blood-letting is attended with admirable results. In perityphlitis, the application of half a dozen leeches often acts with magical effect. In the older accounts of the treatment of peritonitis by bleeding, no good appears to have followed in cases in which the inflammation was diffused, except, perhaps, in some examples due to injury. On theoretical grounds, this is precisely what would be expected.—*British Medical Journal*.

[Mr. Treves' remarks on the operative treatment will appear in our next issue.—ED.]

## Clinical Notes.

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### TWO CASES OF DIPHTHERIA TREATED BY ALKALINE SOLUTIONS OF HYDROGEN PEROXIDE.

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BY W. B. THISTLE, M.D., L.R.C.P. LOND.

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FOR a time peroxide of hydrogen came into very general use as a local application to the throat in diphtheria, and had almost supplanted other local medication. But after a time it was noticed that the number of cases in which laryngitis occurred was much increased, and that, in many cases, while the thick membrane disappeared, there still remained either a very thin film, or a much-reddened and irritable condition of the parts. In many instances the burning and pungency of the solution was complained of. This irritating tendency of the peroxide was conceived to be a source of danger, inasmuch as an irritated and inflamed larynx offered a favorable soil for the growth of the neighboring bacilli, should they happen to be transplanted. Moreover, a simple laryngitis, occurring in this connection, was a cause of much anxiety. This, together with other disagreeable features mentioned, led to a very extensive abandonment of the peroxide in the treatment of this disease. However, since it is undoubtedly a most powerful germicide, and, moreover, is not poisonous, it seemed to Dr. Lewis Smith, of New York, a pity that so valuable an agent should fall into disuse. With the assistance of Squibb, the chemist, he undertook to do away with the irritating properties without in any degree interfering with its germicidal action. He found that, as sold, the substance is acid, and in many cases highly so, and to the acidity is ascribed the irritating properties. It is necessary, in order to handle and keep the fluid, that it should be acid. But, if the solution is rendered alkaline, although it cannot be kept, yet, if used at once, it is as destructive to germs as ever. He, therefore, recommended that two solutions should be kept at the bedside; one of the undiluted peroxide of hydrogen; the other, soda bicarb., grs. v. to  $\bar{3}$ i. Equal parts were placed in the spray and at once used. A fresh solution to be again made for the next application. Litmus used to determine reaction.

I have recently treated two pronounced cases of diphtheria, occurring in the Victoria Hospital, after this method, to my entire satisfaction.

CASE 1. C. G., æt. 11 years. Pharynx, soft palate, and tonsils were covered with a thick, grayish-white membrane. The tonsils were much swollen and the surrounding tissue red and angry-looking. Headache, coated tongue, with moderate elevation of temperature; no albumin; knee-jerk present; Klebs-Loeffler bacillus in membrane.

*Treatment.* Alkaline peroxide of hydrogen to be sprayed on throat every hour, excepting hours between 10 p.m. and 6 a.m., when the spraying was done every two hours. Free purgation by dose of calomel daily. Acid nitro-mur. dil. and liq. strychnia mixture every four hours. The throat was quite clear on the third day, and entirely without the red and irritated appearance usually seen after so frequent application of a strong solution.

CASE 2. Winnie B., æt. 6. Throat covered with thick membrane, especially thick over tonsils, posterior pharyngeal wall, and over posterior surface of uvula. The necrosis was deep, and there was decided tendency to hemorrhage. No albumin; no loss of knee-jerk; temperature moderately elevated; coated tongue, and headache. Klebs' bacillus in membrane.

Treatment as in first case, but it was more difficult to satisfactorily spray the throat. There was, however, improvement at once and continued, and in five days the membrane had completely disappeared. In her case also there was no sign of irritation.

There seemed to be as much gas given off with the alkaline solution as with the acid. I used the solution on my own throat, and can vouch for its mildness. I also, from personal experience, can testify to the pungent, irritating qualities of the ordinary solutions.

The peroxide, as received, was decidedly acid.

## CASES IN PRACTICE.

BY B. E. MCKENZIE, B.A., M.D.

**C**ASE 1. Deformity of leg and foot, the result of osteomyelitis. W. H., male, æt. twelve years. When two years old, had some inflammatory affection involving left leg. Pus formed, and incision was made near the ankle. At varying intervals, during the next year or two, operations were performed on the leg. The front of the leg is now marked by cicatrices extending more than half way to the knee.

There is deformity, as seen in Fig. 1. The lower end of the fibula extends about two inches lower down than that of the tibia, and is strongly bent inward, so that the foot is placed much inward from the direct line of transmission of the weight of the body through the leg, and, in walking, the external malleolus comes nearly to the ground. As age and weight increase, the lameness and pain in walking are increasing, because (1) the boy is becoming heavier, and (2) the deformity is growing worse.

There seems little doubt that, in the course of the disease, the growing section of the tibia, at its lower end, was so affected as to prevent further growth at that part. Consequently, the fibula continuing to grow the foot was shoved inward, and the fibula, chiefly, and the tibia to a less degree, forced into a curve at their lower extremities.

Admitted to the Victoria Hospital for Sick Children, December, 1891.

*Operation.* Excision of one inch of fibula, the lower section being made about three inches above the tip of external malleolus. An attempt, then, to place the foot in a correct position by manual force failed, and a section was made through the tibia one and a half inches from its extremity. The foot was then easily placed in position, but the lower fragments of the bones were found to be too far apart to permit of correct adjustment and coaptation of the upper fragments. The adjustment was so made as to permit the upper fragment of the tibia to be slightly outward of the lower, but having about half the cut surfaces in contact, while the upper fragment of the fibula lay inward of the lower, and not in contact. These fragments, however, were connected by a bridge of periosteum, which had been carefully preserved when the exsection of a portion of its shaft was done.

Next, the lower epiphyseal cartilage of the fibula was removed, in order that the deformity might not recur.

Careful asepsis was observed, iodoform dressing applied, and plaster of Paris employed to retain parts in position. No sutures, nails, or other method of direct fixation of fragments. Dressings not removed for three weeks, when wounds were found healed. Plaster of Paris again applied. Allowed to walk in March, three months after operation.

February, 1894. It is now a little more than two years since operation. There is no increase of deformity, and about two inches of shortening. Walks with a cork sole  $1\frac{1}{2}$  inches high, having scarcely a perceptible limp.



FIGURE 1.

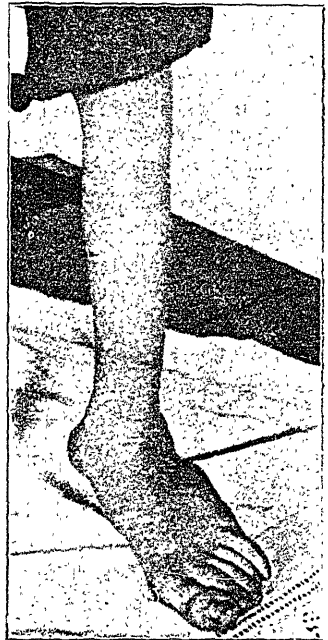


FIGURE 2.

#### TALIPES CALCANEUS.

CASE 2. Infantile paralysis.\* Tendon anastomosis. H.B., male, æt. eleven years. History incomplete. Lame from childhood, but not from time when he first walked. Left leg in all its parts is smaller and weaker than the right, but the paresis is most marked in the internal and extensor muscles of the foot. (Fig. 2.) The gastrocnemius, soleus, and

\*CANADIAN PRACTITIONER, March, 1893, p. 227.

posterior tibial muscles are powerless. The flexor longus digitorum, flexor longus hallucis, tibialis anticus, and peronei are active. The latter muscles are displaced one inch forward from their normal position behind the external malleolus.

*Operation.* An incision was made, extending three inches directly over the tendo-Achillis, which was found to be a mere fibrous cord about the size of a lead pencil. The tendon was split, the incision being continued down to the calcis. The tendons of the peronei were cut subcutaneously in front of the external malleolus, and the proximal portions drawn out from their sheaths were stitched into the tendo-Achillis, being drawn into the split and down to the os calcis. The tendon of the flexor longus digitorum was reached by dissection from the first incision, cut and sutured with the peronei. Silkworm gut was used in suturing the tendons.

Healing was satisfactory, and, three months subsequently, walking is much improved. He has increased power of raising the heel, though not sufficient to enable him to sustain his weight by raising the heel from the floor. His improvement in walking is not due entirely to the added power of raising the heel, but partly to his having a boot with two inches of cork sole to make up for the shortening, and raised higher at the inside, and also projected inward so as to prevent the inturning of the internal malleolus. Wears no brace now, and walks much better than formerly, when a brace was worn.



## CASE OF CARCINOMA OF THE PYLORUS, WITH CICATRIX OF AN ULCERATION ELEVEN YEARS PREVIOUS.\*

BY DR. MACCARTHY,  
BARRIE, ONT.

**J.** C., æt. 62, medium build, anemic. *Previous history.*—About eleven years ago I was in attendance on this patient for a very copious hemorrhage from the stomach. The amount vomited was large, and continued for three days. There was also a large amount of blood passed with the alvine discharges. The attack was sudden, with no previous history except a mild indigestion. There was no pain. The patient was left in a state approaching collapse. He, however, rallied, and had his health fairly re-established, until about two or three years ago he again commenced to complain of indigestion. He was an inveterate smoker. The symptoms of dyspepsia continued to increase until, about nine months before death, he commenced to complain of pain, more or less constant, two or three hours after eating. This pain was chiefly at the pit of the stomach, extending to the left side. Pressure over the pylorus did not cause pain during the progress of the case. Vomiting set in, and eventually became a constant symptom. Towards the end the vomited matters were often coffee ground. Passages per rectum were also often black, and that, too, when bismuth was not exhibited. Edema of both legs as far as the knees occurred during the last month, and during this stage also the temperature rose to about 101°. Albumin was not detected in the urine, though looked for on four or five occasions during the last fortnight.

The revelations of the *post mortem* were a rather large flabby anemic stomach, with an annular thickening around the pylorus, lessening its diameter, but not, by any means, closing it. This thickened condition extended some little distance from the pylorus, gradually merging into the more healthy tissues. There was no break of continuity of the mucous membrane in any part that could be distinguished, but there was a cicatrix situated on the posterior wall near lesser curvature, which I take to be the site of the ulcer of eleven years ago.

\*Read before the Pathological Society of Toronto.

All the remaining organs of the abdomen were healthy, except the liver, which was enlarged generally, and in the middle lobe had two hard nodules about the size of hazel nuts.

I have seen it stated somewhere, but I have not been able to put my hand on the authority, that an hemorrhage of the character above described followed several years after by cancer is merely a condition of cancer lying dormant, and remembering this, and having, as I thought, a case on all fours with such a description, I thus spoke of this case, and had I not succeeded in obtaining a *post mortem* would have had my belief confirmed ; but the cicatrix in this case being perfectly free and separate from the portion involved in the cancerous condition, it is quite evident that the cancer was only a recent development, and that the previous ulceration was merely one of a simple character.

## TUBERCULAR TESTICLE.

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BY GEORGE A. PETERS, F.R.C.S. ENG.,

TORONTO.

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THIS specimen is one removed by Dr. Cameron and myself from a young man, *æ*t. 19 (?). He was otherwise in good health, but had a tubercular family history. The other testicle was not at all, or but very slightly, affected. During life the enlargement, which was considerable, could be felt to be due almost entirely to deposits in the epididymis. There was no collection of hydrocele fluid, but the vas deferens was very distinctly enlarged, as is almost invariably the case in this affection. There was a very narrow sinus, discharging a small amount of watery pus, leading down to the epididymis at one point. An elliptical portion of skin, including the mouth of this sinus, was removed with the testicle, and is seen in the specimen. The duration of the diseased condition is uncertain, but it had existed for at least a year, and probably considerably longer.

On making a longitudinal section through the organ, it is found that, while the testis itself is not decreased in size, the epididymis is enormously enlarged, being the seat of large, bossy, caseous, nodular masses, which are distributed throughout the globus major, body, and globus minor, forming a crescentic mass which almost encloses the testis, and forms by far the greatest proportion of the whole organ.

Some of the craggy nodules in the epididymis are completely caseous, but the majority present caseous matter in small patches only. A somewhat remarkable feature of the specimen is that the body of the testis, while not enlarged, appears to be almost uniformly infiltrated by young gray tubercles about the size of sago grains. None of these, however, show any signs of caseation. The vas deferens is thickened to about three times its normal diameter, and, on section, a small quantity of yellowish, creamy matter may be squeezed from its lumen. The tunica vaginalis is adherent, at some points, to the testis, but there is no collection of hydrocele fluid.

In contradistinction to syphilitic deposits, tubercular nodules have a preference for the epididymis rather than the substance of the gland, but, in young subjects, transparent gray tubercles of small size may be found in the testicle itself, especially in the neighborhood of the corpus Highmore. Indeed, so rare is it to find tubercular disease of the testicle without some affection of the epididymis that Virchow has only observed one such case among adults, and one in a child of three and a half years. Tubercular infection of the testicle may occur at any age, but is much more frequently observed in subjects from fifteen to thirty-five years. Mr. Thomas Jones, however, showed, at the Manchester Medical Society, a tuberculous testicle removed from a child fifteen months old, who was also the subject of spinal caries. In this instance the body of the testicle alone was affected, the epididymis being free from disease.

In thirty *post mortems* made by Reclus upon men suffering from tuberculosis of the genital organs, he found deposits in the lungs in twenty cases, but only two per cent. of phthisical men were found to suffer from tuberculosis of the genital organs. The testicles are also frequently affected in spinal caries.

It appears certain that tubercle never exists long in the testes without a concurrent affection of the vasa deferentia, vesicular seminales, prostate, and bladder, and the disease frequently spreads to the kidneys before death ensues.

There appears to be an extraordinary difference of opinion among authorities of repute regarding the starting point of the disease. Nepven holds that miliary tubercles spring from the tunica adventitia of the blood vessels. Carling maintains that the disease is originally developed within the tubes of the testicle, abnormal nutrition in the cellular contents of the tubes inducing the formation of miliary tubercles in their walls. Malassez also declares that an affected tube, when drawn out, carries with it the granulation deposit which causes a symmetrical enlargement of the tube. Dr. Justus Gaule claims that tuberculosis of the testicle commences as a catarrh of the seminal tubes of the epididymis, and spreads thence to the testis. The nodules or tubercles, according to this authority, are formed of groups of seminal ducts plugged with the products of catarrhal inflammation, and tend to undergo caseous degeneration.

Rindfleisch, on the contrary, maintains that in tuberculosis the change is altogether interstitial, the tubuli seminiferi remaining quite passive. He holds, with Kundrat, that the tubercle cells arise chiefly from the proliferation of epithelium, especially of the blood vessels and their sheaths, and of lymphatic vessels.

## SURGERY OF THE GALL BLADDER.

A FURTHER SERIES OF CLINICAL REPORTS.

BY JAMES F. W. ROSS, M.D.,

Lecturer in Gynecology in the Woman's Medical College; Gynecologist to St. John's Hospital, Toronto General Hospital, and St. Michael's Hospital.

**C**ASE 1. Mrs. L., æt. forty-seven. Married for twenty-eight years, and the mother of four children. First noticed pain in the right side fourteen years ago. After a sudden severe onset of pain, she noticed a lump in the right side; it has not grown since that time, but has recently become more painful.

On examination in June, 1892, I discovered the lump of which she spoke, and diagnosed it as a distended gall bladder. It was rounded and smooth, with lateral movement across the body and no movement from below upwards, rotating from a pedicle above. She complained of a stinging pain in the part, that came on at varying intervals. I advised laparotomy for the removal of a gallstone that I felt sure was obstructing the cystic duct, but the patient passed from my hands and was lost sight of.

In February, 1894, she again presented herself, stating that she had now come prepared for operation, having tried all sorts of remedies in the interval. On referring to my notebook, and again examining the case, I found the condition identical with what it was when she was first seen.

Operation February 15th, 1894. I made an incision just below the ribs on the right side, through the rectus muscle, and brought the gall bladder into the wound. This is the incision I have invariably used in my later cases for the removal of gallstones. The gall bladder was then punctured with a trocar, and about a pint of clear, unstained mucus removed. This decolorization immediately indicated the long-continued impaction of a stone in the cystic duct. In cases of recent impaction this decolorization is never seen. I removed two gallstones free in the gall bladder, and found a third firmly impacted in the cystic duct. After a great deal of difficulty I was able to enucleate the stone from its bed, in

which it had become encysted, just as a stone is found encysted in the wall of the urinary bladder. Considerable bruising of the tissues was unavoidably produced during these manipulations. The stone slipped out from a bed, leaving behind a roughened, thickened surface, just within the mouth of the cystic duct. The gall bladder was then fastened to the wound, and the deep stitches were inserted. As soon as the stone was removed from the cystic duct, bile began to flow through the gall bladder, and the dressings were saturated with it from the very first.

On February 27th, I found pus discharging from the gall bladder, and instituted daily washing by means of a small catheter. This was passed well up to the cystic duct, and a stream of water was allowed to flow until it came out quite clear. Flakes of mucus mingled with purulent discharge were thus forced out of the gall bladder through the external wound. Boracic acid solution was used to disinfect the cavity. This suppuration of the gall bladder is something unusual, but no doubt occurred in this case on account of the violence required to enucleate the encysted calculus. The purulent discharge soon ceased, and the patient is now, at the present writing, in the best of health. The sinus has completely closed within the last three or four days.

During the first week slight jaundice set in, caused, no doubt, by the absorption of bile through the ulcerating surface at the site of the impacted stone.

CASE 2. Mrs. C., æt. about thirty-five. Had been suffering for nearly two years with periodical attacks of jaundice, chills, and fever, and almost constant pain. The pain was of a paroxysmal and spasmodic character, and was referred to the neighborhood of the gall bladder. The first onset of the pain was sudden. From the nature of the pain and the symptoms, I concluded that there was impaction of a stone in the common duct, and that the jaundice was produced by the plugging up of the duct at the sides of an irregular calculus by a mucous secretion ; that after the washing downwards of the mucus, sufficient bile was able to escape to relieve the jaundice. Bile was found in the urine at the time of the attacks, and the stools were clay-colored. As the patient was in a wretched condition of health, I advised operation.

The operation, on March 19th, was the most difficult that it has ever been my lot to perform ; it consumed about four and a half hours of time. The omentum was found adherent to the under surface of the liver, and this had to be separated before the gall bladder could be brought into view. The gall bladder was very much contracted and empty. Three stones could be felt in the common duct through the dense adhesions. Owing to the adhesions, it was impossible to outline the duct accurately enough to warrant incision for the purpose of removing the stones. Dur-

ing the separation of the adhesions, the duodenum was slightly torn. I then considered it advisable to open the duodenum further and endeavor to remove the stone through the gut, but this could not be accomplished. After opening the duodenum, the exact position of the duct, deep among adhesions, could be made out, and direct incision into it was made. One stone was found near the opening of the duct into the duodenum, surrounded by a granulating cavity covered with crumbling, phosphatic matter, just as we often see the urinary bladder covered with phosphates when inflamed. The remnants of the stone were pushed on into the duodenum by means of a director, one faceted and smooth stone was removed, and, during the manipulations, another small stone slipped back into the gall bladder, and could not be again reached. The flow of bile was now free through the duct. The duodenum was stitched carefully by Halstead's sutures, so that the peritoneal edges were brought into accurate approximation. The common duct was also stitched, but, owing to its friability at the part lately occupied by the roughened, phosphatic deposit, it was impossible to prevent a small leakage of bile. The leakage was, however, very slight, and, had it remained so, would probably have done but little harm. A drainage tube and iodoform gauze packing were inserted to the bottom of the pouch left after the separation of the adhesions, and the wound closed in the ordinary manner.

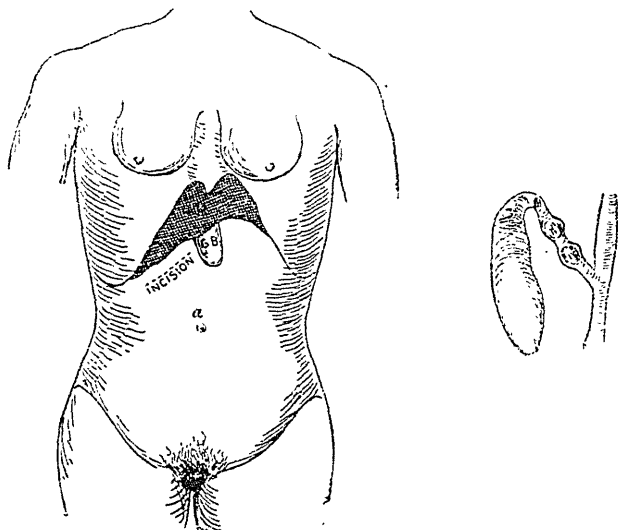
The suturing of the common duct was done as carefully as hands could do it, assisted by intestinal suture needles and a trained assistant. Hiccoughing set in within an hour of the termination of the operation. During the severe vomiting and violent hiccoughing I fear some stitch in the duct must have torn loose, as the quantity of bile issuing from the drainage tube became suddenly augmented. The pulse became rapid, and the patient died, with all evidence of combined peritoneal irritation and shock, about fifty-six hours after the operation.

Incision into the common duct must always be attended with greater risk than simple incision into the gall bladder, because the walls of the common duct are apt to be friable and degenerated, owing to the long-continued presence of an impacted stone. All stones that have lain in contact with the walls of either the common or the cystic duct appear darker in color and rougher on the surface than those that lie in the gall bladder. The surface of such stones is honeycombed, as if parts were dissolved by the action of fluid poured out around them as a consequence of the irritation produced by their presence.

CASE 3. Miss E., æt. twenty-four. Three years ago, while calling on a friend, patient was suddenly attacked with pain at the pit of the stomach. The friend not being at home, she was forced to return on the street car, and did so suffering great pain. The attack lasted for two or three hours.

Ever since that time she has been subject to attacks of pain, occurring every five or six weeks until within the last six months, during which time she has been comparatively free from pain. Each attack of late has been of short duration.

On Sunday, March 18th, 1894, she was suddenly seized with pain that gradually became worse, and towards five o'clock in the afternoon she was forced to send for some chlorodyne. The pain increased, and she called in her physician. He saw her again on Monday, Tuesday, and Wednesday. A consultation was then called, and the patient was removed to the hospital. I saw her on Wednesday afternoon, and found her in intense agony. The temperature was elevated, pulse about 80, expression of the face pinched, and pallor present. On examination of the abdomen, an enlargement was found just under the tip of the ensiform cartilage (see plate). After examining carefully, I came to the conclusion that the case



was one of distension of the gall bladder from obstruction of the cystic duct. There was no jaundice present, there was no bile in the urine, and the motions of the bowels were not clay-colored. I saw her again on Thursday morning, and, owing to the continuing severity of the pain and the tension of the lump, determined on immediate operation. Patient stated that whenever the pain came on the lump would appear, and when the pain left her the lump would disappear so that she could not feel it. Though not jaundiced at any time, she said that her skin had been darker than was natural to her.



On Thursday afternoon, March 22nd, 1894, I made an incision at the lower border of the liver, and brought an extremely tense gall bladder into the wound. A small gray point was to be seen at its tip, the point furthest away from the circulation. This gray spot looked exactly like the gray spots frequently seen on intestine strangulated in a hernial sac. I feel satisfied the gall bladder would have burst had the tension been left unrelieved much longer. The gall bladder was so tense that one was almost afraid to touch it for fear that it might burst. A large quantity of fluid was drawn from it after puncturing it with a trocar, and the fluid was dark and treacly, and indicated that the obstruction of the cystic duct had been but recent. A small stone was found free in the bladder itself, and two stones were found caught in the cystic duct (see plate). These were stripped out by placing the forefinger of each hand above and below, or in front and behind, the cystic duct. By a little gentle pressure they slid downwards like peas out of a pod, until they reached the gall bladder, from which they were removed by the scoop. The gall bladder was then fastened to the wound, and the wound closed in the usual way. The patient has made an uninterrupted recovery.

As soon as she was able to speak after the effects of the anesthetic had passed off, I asked her if the pain of which she had complained so bitterly, a pain that shot through to the back and up between the shoulders, had disappeared. She said "yes," that it had entirely gone, and she felt relieved.

The continuous sutures fastening the gall bladder have not yet come away, and the sinus is still discharging. Bile began to flow about twenty-four hours after the operation.

# Progress of Medicine.

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## MEDICINE

IN CHARGE OF

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### SEVERE JAUNDICE FROM BACILLIARY INFECTION.

M. Hanot has reported many observations which demonstrate the infection of the liver of the coli bacillus, a condition which is followed at times by intense jaundice, accompanied by elevation of temperature. He has been able by puncture to prove the presence of the micro-organism during life, and has placed beyond all doubt the important rôle played by this microbe in such cases.—*L'Union Médicale*.

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### INFLUENZA PNEUMONIA.

Albu, of Renvers' clinic, discusses (*Deut. Med. Woch.*, February 15th, 1894) the questions whether there is a special form of pneumonia in influenza, and what relation there is between croupous pneumonia and influenza. Influenza pneumonia is really a broncho-pneumonia, like that seen in other infective illnesses—diphtheria, enteric fever, etc. The clinical picture is not as definite as in croupous pneumonia. The following points are noted: (1) Evidence of a preceding attack of influenza is generally present; (2) percussion dullness may be absent, or only present for a short time, shifting its position; bronchial breathing may be the only physical sign; moist sounds are most constantly present; (3) the sputum is never typically rusty; (4) the fever usually sets in without shivering, and the temperature rises gradually; (5) the course is less acute, the infiltration disappears slowly, and convalescence is retarded. The accompanying pleurisy has several peculiarities: (1) It is more frequent than in

croupous pneumonia ; (2) absorption takes longer ; (3) empyema is less frequent, only occurring when the streptococcus is present. The streptococcus empyema is comparatively unfavorable. The author says that the frequency of this streptococcus infection is characteristic of influenza ; the infiltration affects single lobules, but it may become confluent ; it is softer, poorer in fibrin, richer in cells, and may have the character of a purulent fluid. The occurrence of abscess and gangrene has been noted. In one of the author's cases small abscesses were found on the right lower lobe. If such a necrotic focus abuts on the surface, it may produce a pneumothorax. The author relates such a case in a girl, aged 23. Influenza bacilli were found in almost pure culture in the sputum, and no pneumococci. Signs of pericarditis appeared, and, about ten days from the onset of the disease, a right pneumothorax. Puncture revealed later a streptococcus empyema. Opening of the empyema had to be delayed, owing to the critical condition of the patient ; a good recovery ensued. At first, a serous effusion was present, but the rupture of a necrotic focus made it become purulent. Croupous pneumonia is, in the author's opinion, a chance complication of influenza, due to a secondary infection with the pneumococcus. A double infection with the influenza bacillus and Fraenkel's pneumococcus may occur. A confluent bronchopneumonia may simulate croupous pneumonia.—*Epitome, Brit. Med. Jour.*

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#### THYROID EXTRACT.

Dr. P. Abraham recently reported to the London Medical Society the results of the administration of this remedy in 65 cases of psoriasis, 7 of eczema, 5 of lichen planus, 5 of lupus, 2 of chronic urticaria, and one each of prurigo senillis and adenoma sebaceum. Of the cases of psoriasis, 17 were thrown out, some improvement was noted in 18 (only 7 were under the thyroid treatment alone), the result was negative in 16, while in 15 the eruption increased during the use of the drug. Three cases of lichen planus were markedly improved, and the same number of eczemas were benefited. Neither case of urticaria showed any amelioration. He claims two lupus cases exhibited improvement. His general conclusions are that the ingestion of the thyroid glands has no constant effect in psoriasis and other cutaneous diseases, that it often produces marked constitutional disturbances, and that in a large number of cases the results were negative. In a few the trouble was aggravated, although in a certain number a distinctly curative effect was noticed.

It has been suggested that from its action on the horny layers of the skin, thyroid extract might prove of considerable service in ichthyosis and xeroderma.

## THE LINEA FUSCA IN CHILDREN.

Dr. Adersen, of Copenhagen, (*Horwitz's Gynækologiske Meddelelser*, Bd. 10, H., 1-2) has examined two hundred children with regard to the existence of the pigmented abdominal line reaching up from the pubes towards the navel, and which is regarded as characteristic of the first pregnancy. Of these one hundred and five were girls, ninety-five boys, of fourteen days to thirteen and a half years. Out of these children one hundred and twenty-eight had the characteristic linea fusca or pigmented median abdominal line of pregnancy. Of these seventy-six were girls and fifty-two boys. Its frequency increased with age. In half of them the color was quite pronounced, and in the other only indistinct. Brunettes seemed more predisposed than blondes, though not especially. In eight of the children the line reached above the umbilicus, and in some even up to the ensiform cartilage. Deviations to the right or left of the median line, as Professor Schoenberg has described in adults, were observed in several.

From this he concluded that this line of pigmentation is not to be included in the characteristic signs of pregnancy, as besides being found in children it may be observed in diseases of the genital tract, as, for example, in uterine myomata.—*Journal Cutaneous and Genito-Urinary Diseases.*

## INTESTINAL OBSTRUCTION DUE TO GALLSTONES.

Kôrte (*Deut. Med. Woch.*, February 25th, 1894) reports a case successfully treated by operation. A man, aged 52, had suffered from several attacks of biliary colic, calculi having been found in the stools. Six days previous to admission, he was seized with severe abdominal pain, after which no feces or flatus were passed. Vomiting, fecal during the past three days, then hiccough followed. On admission, he was moderately collapsed. There was no hernia, and nothing abnormal was felt either in the cecal region, or in the rectum. The sudden onset with early fecal vomiting, and with but slight abdominal distension, pointed to gallstones as the cause of the ileus. The abdomen was opened, and in some coils of intestine which had dropped down into the pelvis a gallstone was found at some twenty to thirty cm. above the ileo-cecal valve. The stone was removed by a longitudinal incision. The intestinal wall was tightly stretched over it. There was no ulceration or invagination of the mucous membrane. The course was very satisfactory, the bowels acting on the fifth day. The stone was rounded, and without facets. In addition to the above-named symptoms, the comparatively good condition of the patient is more or less characteristic of this form of ileus. A stone already present in the canal becomes arrested by a rapidly oncoming

attack of colic. The bowel above becomes paralyzed, hence early fecal vomiting. Opium was useless here, as in the author's other three cases, which were operated upon with two recoveries. The diagnosis may be very difficult, and, in the author's opinion, only to be based on probabilities. Operation must be decided upon in each case by the non-success of so-called expectant treatment and by the symptoms. The propriety of operating in the above recorded case, after seven days of obstruction, cannot be doubted.—*Epitome, British Medical Journal.*

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#### THE KNEE-JERK IN DIABETES MELLITUS.

Among one hundred and thirty-one cases of diabetes mellitus, Gröbl (*Neurolog. Centralbl.; Wiener med. Presse*) found the knee-jerks normal in one hundred and thirteen, and exaggerated in five. Three of the latter, however, presented not true diabetes, but merely the glycosuria of neurasthenia, and in them both the presence of sugar in the urine and the state of the reflexes were to be ascribed to the condition of the nervous system. Among the other one hundred and fifteen cases were nine of the severe type of diabetes mellitus. Of these nine the knee-jerks were exaggerated in two, which presented great weakness, and in which the urine contained large amounts of sugar and acetone, but in which, as in the course of treatment, the general condition improved, the excitability diminished, and ultimately the knee-jerks became normal. In four cases of severe diabetes the knee-jerks were abolished, or greatly enfeebled. The knee-jerks were also wanting in nine mild cases, but in two of these posterior spinal sclerosis co-existed, and in a third there was such an excess of adipose tissue as to interfere mechanically with the elicitation of the phenomenon. The knee-jerks were thus lost in ten cases among one hundred and thirty-one—7.6 per cent. It was further found that the knee-jerks may be preserved in the most severe cases, even in the presence of coma, while they may be absent in mild cases in which the sugar can be made to disappear by appropriate diet. It thus appears that symptomatically the knee-jerks have little or no significance, either diagnostically or prognostically.—*Medical News.*

# THERAPEUTICS

IN CHARGE OF

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AND

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## A NEW METHOD OF ARTIFICIAL RESPIRATION IN ASPHYXIA NEONATORUM.

Dr. J Harvie Dew, of New York, has described a new method of artificial respiration in newborn babes, which may be summarized as follows:

Grasp the infant with the left hand, allowing the neck to rest between the thumb and forefinger, the head falling over backwards; the upper portion of the back and scapula resting in the palm of the hand, the other three fingers to be inserted in the left axilla, raising the arm upwards and outwards. Then grasp the knees (or ankles, if baby is small) with the right hand in such a way as to hold them with the right knee resting between the thumb and forefinger, the left between the fore and middle-fingers. Next, depress the pelvis and lower extremities so as to allow the abdominal organs to drag the diaphragm downwards, and with the left hand gently bend the dorsal region of the spine backwards. Retain for two or three seconds, then reverse the movement, bring the head, shoulders, and chest forward, closing the ribs upon each other, and at the same time bring forward the thighs, pressing them on the abdomen. Retain two or three seconds. Repeat movements.

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## PRURITUS VULVÆ.

Dr. Ohmann-Dumesnil recommends the following:

R.—Hydrarg. Bichlor..... gr. iss.  
Ammon. Chlor..... gr. ii.  
Ac. Carbolic..... ℥i. (more or less).  
Glycerini..... ℥ii.  
Aq. Rosæ ad..... ℥viii.

M. ft. lot. Apply frequently.

### THE PROGNOSTIC VALUE OF THE INTOLERANCE TO CREASOTE IN TUBERCULOSIS.

M. Burlureaux claims creasote to be a valuable indication of the strength of the sick person. He claims for it, from a prognostic point of view, a diagnostic significance not second to tuberculin, and has been led to draw the following conclusions: (1) Patients not able to tolerate creasote in small doses are irremediably lost. (2) Patients tolerant of large doses have very hopeful chances of recovery. (3) But if after having tolerated large doses he suddenly becomes intolerant, and progressively so, the prognosis becomes, in proportion, less hopeful.

Patients with an ideal tolerance experience neither vertigo nor sweats, darkening of the urine, nor a pronounced after-taste of creasote, lumbago, nor fever. The most intolerant cannot take even the smallest dose without experiencing one or many of the symptoms.

The gravest symptom, *par excellence*, indicating poisoning is the sensation of cold experienced seven hours after the injection. The coldness is usually preceded by an elevation of temperature that commences soon after the injection. It goes on increasing until the seventh hour; then comes the sensation of cold. It goes on until the temperature becomes subnormal. Again, these phenomena may be reversed.

M. Burlureaux considers this intolerance an indication of the depreciation of the organism, and of a profound state of decay.—*Lyon Médicale.*

J.A.A.

### THREE CASES OF UMBILICAL HEMORRHAGE OCCURRING IN THE SAME FAMILY.

Dr. Thomas Taylor reports three cases of umbilical hemorrhage occurring in the same family (*The Bristol Medico-Chirurgical Journal*).

CASE I. 1879, Sept. 29th. Eighth child in an otherwise healthy family. Of the previous seven children six are living and healthy; the seventh died in infancy of whooping cough. There is no history of bleeding in the parents or their children, but the mother's first cousin lost two children from umbilical hemorrhage. This baby was large, and apparently healthy. Hemorrhage commenced thirteenth day; bleeding surface was dusted with tannic acid. Next day bleeding continued; tincture of matico applied in place of tannin. Hemorrhage being more profuse in the evening, strong perchloride of iron was applied, with a pad and bandage, which stopped the bleeding for twelve hours.

The following day, hemorrhage profuse; various remedies, including actual cautery, tried, with no effect. Child died three days after onset.

CASE 2. 1883, Dec. 19th Female, æt. eight days, and healthy looking. This is the tenth child; the ninth had no trace of bleeding from the umbilicus, and lived to be fourteen months old, when it died of diarrhea. Bleeding commenced suddenly on the eighth day. Pressure and styptics stopped the bleeding for a time. On its recurrence two harelip pins were introduced under the umbilical scar, one from above downwards and the other transversely, and a thread passed around underneath. This, for a time, effectually stopped the bleeding, with the exception of a little oozing at the points of entrance and exit of the pins. Two days afterwards free hemorrhage recurred, and the child died three days after the onset of the hemorrhage.

CASE 3. 1887, Nov. 10th. Twelfth child, apparently healthy. The eleventh was stillborn at full term. Labor natural. Cord came off seventh day. Three days afterwards a patch of dark-colored blood seen on the rag. On examination the navel looked pretty healthy, and the edges weeping serous fluid. Nurse directed to paint it with a solution of one ounce of tannin in one ounce of rectified spirits whenever she saw a trace of bleeding, and in the intervals to keep a rag soaked in the solution on the navel. Next day there was no bleeding beyond an occasional oozing; the rag was hardened into an artificial scab over the navel. Two days afterwards there was free bleeding, which was checked on removing the rag and applying the solution with a brush. On the following day nurse says the tannin solution restrains the hemorrhage much more effectually than either vaseline or Ruspini's styptic, with which she was supplied as alteratives. Next day a bruise found on the shoulder; no bleeding of any account afterwards. At time of writing the child is six years old, and a fine, sturdy boy.

Dr. Taylor thinks it curious that the disease did not show itself in any of the first seven children, and that none of the other children ever showed any symptoms of hemophilia. The mother never had any post-partum hemorrhage. Jaundice was not a marked symptom, though bruising was noticed in the first and third cases. The treatment with the solution of tannin in the last case was eminently satisfactory, and the tannin appeared to have more controlling influence over the hemorrhage than either of the other styptics that were tried, and perhaps the styptic renewed constantly, as it was in this case, had a better chance of acting directly on the bleeding point itself than when combined with pressure, as this could not be rendered effective, owing to the abdominal walls being in constant movement. It would be worth while in such cases to give chloride of calcium by the mouth, as suggested by Dr. Wright (*British Medical Journal*). He describes chloride of calcium combined with fibrin ferment as the "physiological styptic."



## ACUTE CATARRH OF THE STOMACH OR VOMITING OF PREGNANCY.

The following may be used :

R Phenate of cocaine . . . . . gr.  $\frac{3}{4}$   
 Subnitrate of bismuth . . . . . " xxx.

M.

Sig.—Make into five powders. Take one powder each morning, or, in the case of gastralgia, one hour before the time for the habitual attack of pain.—*International Medical Annual*.

## THE ADMINISTRATION OF SODIUM SALICYLATE IN ACUTE RHEUMATISM.

When for any reason sodium salicylate cannot be given by the mouth in acute rheumatism, Lémanski gives it in the form of a suppository, fifteen grains, with enough coca butter to make it up. One to be used five or six times a day.—*Lyon Médicale*. J.A.A.

## THE USE OF ICE IN ASTHMA.

Dr. Sangree has succeeded in cutting short a spasm in a severe attack of bronchial asthma by applying ice over the course of the pneumogastric nerve at the root of the neck. Five minutes after the application the spasm relaxed completely, and the patient slept, after having been four days without sleep.—*Bul. Gen. de Thérapeut*. J.A.A.

## RAPID MANUAL DILATATION OF THE OS UTERI.

In a paper read before the Section on Obstetrics, Pan-American Medical Congress (*American Journal of Obstetrics*), Dr. P. A. Harris, of Philadelphia, gave a description of a manual method of effecting rapid and extensive dilatation of the os uteri for parturient purposes, and described its advantages, especially in the treatment of placenta previa. He confines the employment of his method to cases of advanced pregnancy, when it is desirable to effect a prompt delivery. He presupposes the possibility of the full introduction of the index finger to its large diameter without much delay or difficulty.

The woman being anesthetized, he inserts the index finger to its largest diameter, the hand having followed in the vagina. The finger is then withdrawn so that its tip merely enters the os, and then the tip of the thumb is passed in beside the finger. When the tips of both index finger and thumb are thus within the ring, he keeps the index and second fingers (the second finger being sharply flexed) close together to form a notch from which the os-uterine ring cannot easily escape. The straightened and extended thumb, resting on the outer lateral half of the index finger,

is now carried as far from the tip of the index finger as the enlargement of the os will allow. The thumb is then retained on the index finger while the index and second fingers are forcibly flexed. When a little headway has thus been gained, slightly extend the index and second fingers; this will permit the extended thumb to travel farther from the tip of the index finger. Again hold the extended thumb firmly against the outer side of the index finger at this point, and again flex the index and second fingers.

Next, introduce the index and second fingers and thumb, keep the thumb in relation to the first finger as before, while the edge of the os will now rest on the dorsal surface of the sharply-flexed third finger. Next, introduce the third finger, and let the edge of the os rest on the fourth finger. After a slight continuance of the manipulations, the fourth finger may be introduced. As the dilatation may not yet be quite sufficient, make the os encircle the first row of phalangeal bones of the fingers and the second, or last, phalanx of the thumb; then extend the thumb and all the fingers, the tips of the fingers being, at the same time, flexed to lessen their encroachment on the intra-uterine space. After this, if necessary, make the os encircle the second row of phalangeal bones of the fingers and the first phalanx of the thumb, and extend. Complete dilatation, it is said, will have been accomplished by these manipulations in a comparatively short time.

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#### IPECACUANHA WITHOUT EMETINE.

Powdered ipecacuanha root, deprived of its emetic principle, emetine, is stated to have achieved great success in the treatment of dysentery. The virtues of ipecacuanha are well known in this direction, but have hitherto been marred by the distressing vomiting that accompanies large doses. Merck, of Darmstadt, has produced a powder from the root of the best Brazilian ipecacuanha, free from emetine, but containing the other constituents intact. This has proved of great service in British India, the chosen home of acute and chronic dysentery. Scruple doses may be taken frequently, without the usual vomiting. It is known as ipecacuanha deemetinisata.—*The Times and Register.*

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#### OLIVE OIL IN OBSTRUCTIVE JAUNDICE.

Oliver (*Lancet*, No. 3658, 1893) reports two cases of simple obstructive jaundice successfully treated with olive oil. The first patient complained of sudden attacks of severe pain in the upper part of the abdomen, which of late had become more frequent and severe, and had occasionally been attended with vomiting and followed by jaundice. On account of increasing debility the writer finally prescribed olive oil, beginning with one

tablespoonful in milk daily and gradually increasing the amount to six tablespoonfuls. With the exception of a slight attack of colic on the second or third day after the treatment with the oil was instituted, the patient had no further pain and no return of jaundice, and is now in better health than he has been for the last five years. Treatment was continued for several weeks after the disappearance of the symptoms, and, in addition to the oil, he was given two grains of calomel twice a week, and a few drops of extract of cascara sagrada every evening.

The second case, a woman aged 48, had been deeply jaundiced for ten months. The abdomen was retracted and the liver enlarged. She was very feeble, and her mind was depressed. As all other remedies had proved futile, she was given daily two tablespoonfuls of olive oil in warm milk. Within three weeks the jaundice disappeared, the stools became normal, and there was a remarkable improvement in the general condition. The author is unable to give any explanation of the action of the oil in these cases.—*University Medical Magazine*.

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#### ATROPINE AND MORPHINISM.

Koch (*Therap. Monatsh.*, November, 1893) records the case of a patient who frequently indulged in morphine, and to whom on five occasions he administered subcutaneous doses of atropine as an antidote. It always quickly arrested the profuse secretion from the skin, air passages, and intestine; also considerably diminishing unpleasant results due to the abstinence from morphine, and thereby assisting gradual discontinuance of the narcotic. One three-hundredth part of a grain of the sulphate should be given at first, the patient being watched for several hours. A second dose may be administered if necessary.—*British Medical Journal*.

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#### ICHTHYOL IN ERYSIPELAS.

Thomas (*Liverpool Medico-Chirurgical Journal*, July, 1893) refers to the treatment of erysipelas by ichthyol, and mentions four cases so treated, three of which were complicated by large surgical wounds. The onset of the disease was sudden, and the temperature high. As a result of the treatment, the disease was cured on the fifth day. In only one case was there sleeplessness. None required stimulants, and all experienced great relief from pain after each application of the remedy. Success in this treatment depends upon a very thorough rubbing of a strong ointment of ichthyol with vaseline or lanoline into the red area and into the adjoining healthy skin, covering the parts with a sheet of lint or the ordinary surgical dressing.—*Therapeutic Gazette*.

## DIAPHTHERIN.

Stabel (*Munch. med. Woch.*, September 10, 1893) has studied the germicidal and pharmacological actions of this new compound. Broth to which diaphtherin was added was inoculated with various kinds of microorganisms, and similar experiments were conducted with lysol and carbolic acid. The writer believes that diaphtherin is considerably superior to both of the latter germicides. Anthrax spores lost all power of growth after being in a 15 per cent. solution for three days. From a series of experiments on animals, he concludes that even the continued use of diaphtherin in man cannot be injurious, as it could not be used in sufficient quantities to be dangerous. It is especially adapted, on account of its non-toxic properties, to washing out hollow cavities where at present very weak antiseptics have to be employed. It is preferable in 1 or 2 per cent. solutions to other antiseptics where moist applications are required for a long time, as in burns, ulcers, etc. It only discolors the nails and hands when previously soaked in sublimate solution. Steel instruments cannot be put into it.—*University Medical Magazine.*

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## SYMPTOMS OF CORROSIVE SUBLIMATE POISONING.

Dr. Boxall thinks that the symptoms of corrosive sublimate poisoning are not so generally recognized as they should be. These symptoms are diarrhea, with tenesmus, and occasionally blood, as well as mucus, in the stools, accompanied by abdominal pain. In severe cases the colon, and, to a great extent, the small bowel, particularly in the region of the cecum, become ulcerated. He warns us, if these abdominal symptoms should occur, not to persist in the mercurial douche, and not to check the diarrhea abruptly by administering opium. There is often slight albuminuria, soreness of the gums, loosening of the teeth, occasionally vomiting, salivation, a red line at the margin of the gums, and a metallic taste in the mouth, but these are exceptional in comparison with the abdominal symptoms.

# OBSTETRICS

IN CHARGE OF

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## NEPHRITIS OF PREGNANCY.

Odebrecht (*Centralblatt für Gynakologie*, No. 30, 1893) relates the case of a primipara, aged twenty-seven, who caught cold at the beginning of her ninth month of pregnancy, and uremia set in, followed by convulsions and partial coma. The urine was scanty and completely coagulated. No pains had set in. The eclampsia ceased after large doses of morphia and wet packing. Twenty-four hours later the patient, perfectly conscious, declared that the movements of the child had ceased; the fetal heart sounds could not be heard. Five days afterwards a dead, macerated child was discharged. Two circumscribed effusions of blood of the size of a walnut were found in the placenta. In Odebrecht's opinion, they accounted for the death of the fetus. Neither casts, nor blood corpuscles, nor pus cells could be found in the highly albuminous urine. Hence the local disease was not acute nephritis, but rather the kidney of pregnancy, and the sudden chill increased renal congestion, setting up eclampsia and uremia in the mother, and killing the child through placental apoplexy.

This case is an excellent example of the relation between renal disease in the mother and death of the fetus.—*University Medical Magazine*.

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## HIGH TEMPERATURE AFTER LABOR.

Tournay (*Journal d'Accouchements*) publishes the statistics of the Brussels Maternity for 1893. The total number of labors was 440. Amongst numerous subjects of interest, Tournay notes that in only 28 cases was there rise of temperature over 38° C. (100.4° F.). The causes of the rise were: Various affections of the breasts, 6 cases; acute endocarditis, 3; uterine congestion, 3; septicemia, 3; obstinate constipation, 2; traumatism, 2; neuralgias, 2; enteritis, 2; bronchitis, 1; eclampsia, 1; tuberculosis, 1; cardiac disease, not precisely defined, 1; cause of rise of temperature unknown, 1.—*British Medical Journal*.

## DUHRSSSEN'S TAMPONADE OF THE UTERO-VAGINAL CANAL.

Siepen (*Deutsche medicinische Wochenschrift*) applied the forceps to the head at the superior strait in a xii.-para, after the labor pains had fully ceased for nine hours. After the extraction of the child there was copious hemorrhage, which did not cease after the manual separation of the placenta. As symptoms of acute anemia appeared, he tamponed the uterus with iodoform gauze by inserting the index finger of the left hand into the cervix, and placing the gauze in position with a forceps held in the right hand. After tamponing the uterus, the vagina was filled with cotton. The hemorrhage ceased. Both tampons were removed after twenty-four hours. The puerperium was normal.—*University Medical Magazine.*

## THE TRANSMISSION OF THE OVUM FROM THE OVARY TO THE TUBE.

Lode (*Archiv für Gynakologie*, Band xlv., Heft 2) first repeated the experiments of Kehrer and Pinner, injecting an emulsion of charcoal into the abdominal cavity of rabbits, and, like these authors, he was able, after a few hours, to demonstrate charcoal particles in the opened tubes.

He next substituted ova of animals for the emulsion, using the ova of *ascaris lumbricoides suis*. After a lapse of twelve hours large numbers of these ova could be seen in the dissected tubes. These investigations prove that the ciliary currents can propel the ova, not only from the ovary to the tube, but also from the abdominal cavity. They show that the fimbriated extremity of the tube need not be in contact with the ovary during the expulsion of the ovum, and that the external migration of the ovum is certainly possible.—*American Journal of Obstetrics.*

## PLACENTA PREVIA.

Rueder (*Munch. med. Woch.*, No. 33, 1893), after experience of twelve cases in the Erlangen Lying-in Hospital, agrees with Hofmeier that Braxton Hicks' combined internal and external version is the best treatment, directly the os has dilated till it can admit two fingers. Every practitioner who is already used to obstetric manipulation should follow that rule. A young or inexperienced doctor should first employ the iodoform gauze tampon; then he can safely wait until the cervix is sufficiently dilated to render combined version easy. In three of Rueder's cases there was central placenta previa; all the children died, but the mothers recovered, and the puerperium was always normal. In the four cases of placenta previa lateralis, all the children, as well as all the mothers, were saved. In the remaining five cases of placenta previa, the variety was marginal, and the mothers were all saved; but in three there was rise of temperature during childbed.—*British Medical Journal.*

## GALACTOPHORITIS.

Boissard (*Semaine Médical*, October 11th, 1893) draws a distinction between galactophoritis, which is an inflammation of the mammary ducts and acini, and lymphangitis, which attacks the connective tissue around the gland. Frequently the two forms are mixed, and some of the worst cases of fistulous tracts and frequent repetitions of acute inflammation are the result. Galactophoritis uncomplicated may arise from a very slight abrasion near the orifice of a duct, or it is possible that it may follow the entrance of streptococci or staphylococci into a healthy duct. The disease causes but little pain, slight feverishness, is seldom ushered in with rigors, and is attended with the discharge of free pus from the nipple. Milk containing pus, as compared with pure milk, is of a grayer or greener hue, and is not so quickly absorbed by wool kept against the nipple. It does not trickle freely from the nipple, but tends to clot around the part, being less fluid than pure milk. The child invariably suffers, rapidly losing weight, and developing diarrhea with green-colored stools. Death is almost certain. Boissard insists upon immediate cessation of lactation from the affected breast, or, when both glands are affected, altogether. He recommends that the patient be anesthetized, and pressure applied to the breast until every drop of pus is squeezed out. The pressure is applied from circumference to centre. When no more of the pus-charged milk escapes, the nipple and breast must be freely sprayed for half an hour with a solution of bichloride of mercury or naphthol. Then a compress must be applied and kept on until the next manipulations. Only three or four applications of this method are needed, and the disease is eradicated in a week. Any mere palliative treatment will certainly kill the child, and place the mother in great danger of suppuration of the breast.—*University Medical Magazine*.

## PUERPERAL SEPTICEMIA CURED BY HYPODERMIC ABSCESS.

Thierry, of Rouen (*Nouvelles Archives d'Obstét. et de Gynéc.*), observed a case in which a rigor occurred on the second day after labor. The curette was applied on the seventh, and one gramme of essence of turpentine was injected hypodermically. This was repeated twice on the eighth day. By the tenth day a phlegmon developed at the seat of the punctures. It was freely opened, and suppurated. On the nineteenth day the temperature, which had fallen, rose again, as the pus in the artificially provoked abscesses was pent up for awhile. On setting it free the fever disappeared, and the patient recovered. The injections were made into the extensive connective tissue behind the great trochanter on the right side. The site of puncture became indurated within a few hours. The

patient, it must be remembered, showed signs of improvement when this induration began, but convalescence was not steady until suppuration was established. Since 1860 it has been observed that general puerperal septicemia usually improved when subcutaneous abscesses formed and opened. Thierry, in 1888, provoked them artificially by setons, blisters, etc., but the subsequent inflammation proved hard to localize. He found that the subcutaneous injection of chemicals was more satisfactory. Fochier, of Lyons, first employed essence of turpentine, which is superior to sublimate, carbolic acid, or any other solution which has already been tried.—*British Medical Journal*.

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#### TREATMENT OF ECLAMPSIA.

Tarnier (*Journ. des Sages-Femmes*, February 1st, 1894) maintains that eclampsia represents a true poisoning of the blood. It is not caused by retention of urea or carbonate of ammonia in the blood. In eclampsia the blood is absolutely poisonous, as experiment has shown. On this account Tarnier holds that blood must be abstracted in a case of puerperal eclampsia. But then the patient would have less blood (and loss of blood is a great evil under the circumstances), and that blood would be as poisonous from the first as the blood removed. Hence the advantage of milk diet, which is, to a great extent, absorbed, so that the blood becomes diluted, increasing in bulk, with diminution of the proportion of poisonous material. Free purgation is also desirable for ensuring elimination of poison; Tarnier gives croton oil. Inhalations of chloroform are also beneficial; they calm the nerve centres, which are excited by the circulation of poisonous blood, and thus check, in a direct manner, the tendency to convulsions.—*British Medical Journal*.

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#### OXYGEN INHALATIONS DURING PREGNANCY AND PUERPERY.

Rivière has found, as the result of much experience, that inhalations of oxygen are of value under many circumstances, both for mother and child. This inhalation is serviceable in counteracting the evil effects of chronic or acute thoracic diseases during pregnancy, which so often causes abortion or premature delivery. In uncontrollable vomiting and anorexia, inhalations are also useful. After-delivery inhalations superoxidize the blood, which appears to enable the fluid to resist sepsis. When a pregnant woman is ill or weak, inhalations always profit the fetus, whose nutrition is thereby improved. Rivière goes so far as to contend that the method is of service in placental disease, or even in partial detachment of the placenta; it allows, he believes, more complete oxidization of the fetal blood in the diminished area of sound placenta that remains. Altogether, however, he



admits that inhalations are of more certain benefit for newborn children, whether they be emaciated from some cause which existed before birth, or continue to be thin for some period after delivery, owing to malnutrition.

Mr. Rivière details the following conditions as indicating the use of inhalations of oxygen :

(1) In the pregnant woman. To over-threatened asphyxia consequent on pulmonary or cardiac disease. Whenever nutrition is impaired or enfeebled through persistent vomiting which interferes with digestion.

(2) In childbed. To strengthen the patient, and enable her more efficiently to contend against the invasion of septic microbes.

(3) In the pregnant woman, but to act on the fetus. Whenever there is reason, either from a parallel or other condition in the mother, to suspect that the fetal blood is insufficiently oxygenated. In placental lesions which might produce a similar effect on the fetal blood.—*International Medical Annual*, 1893.

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#### BOROLINE.

Boroline, a combination of boracic acid with lanolin, is recommended as an excellent lubricant and emollient antiseptic in midwifery practice.

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#### ANTISEPTIC MIDWIFERY.

We extract the following from an article which appeared in the *British Medical Journal*, February 24th :

The application of antiseptic methods to all the various details and events of obstetric work is a large subject, and one worthy of more minute treatment than it usually receives in the text-books in common use by students. On this we cannot touch, but there are certain things which are so essential in every case, and are, we fear, so frequently neglected, that even at the risk of appearing elementary we formulate them as a routine to be followed in every lying-in chamber both by doctor and nurse : (1) The hands and wrists should be thoroughly cleansed with hot water, soap, and nail brush, and then soaked in some antiseptic solution, of which perchloride of mercury 1 in 1,000 is the best, whenever the patient's genitals have to be touched, and no lubricant should be employed which is not antiseptic ; (2) in an early stage of the labor the external genitals should be thoroughly cleansed with warm water and soap, and then swabbed with the same antiseptic solution, pledgets of cotton wool being used and no sponges allowed ; (3) during the progress of the labor the external parts should be occasionally wiped with pledgets of wool moistened with the antiseptic ; (4) the washing and disinfection of the external parts with soap and water, followed by perchloride, should be

repeated after the labor is over, and once a day afterwards ; (5) each time a diaper requires to be changed during the after-progress of the case, the outer parts should be wiped with a pledget moistened with perchloride solution ; (6) all instruments should be thoroughly cleaned by boiling, and be disinfected immediately before use either by perchloride, 1 in 1,000, or by carbolic lotion, 1 in 20 ; (7) whenever either the finger or an instrument has to be introduced, the vulvar fissure should be previously cleaned with pledgets of wool soaked in perchloride solution, 1 in 2,000 ; (8) the diapers should be clean, preferably either the "wood wool" or "sanitary" pads sold for the purpose ; but, if the ordinary diapers are used, care should be taken that they are boiled in the washing.

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#### SALIPYRINE IN THE TREATMENT OF UTERINE HEMORRHAGE.

The *Revue générale de médecine, de chirurgie et d'obstétrique* for November 15th gives a summary of an article by Dr. Kayser, published in the *Deutsche medicinische Wochenschrift*, who gives his experience in the treatment of a number of cases of uterine hemorrhage with salipyrine. He has employed the drug in sixteen cases, but in three of them the hemorrhage was too severe to allow of a sufficiently prolonged trial of it. In all but one of the thirteen other cases the use of salipyrine reduced the hemorrhage, no matter what its cause was, excluding cancer and abortion. In some of the patients the hemostatic effect lasted for several days after the use of the medicine had been suspended. It had no effect on pain. It was especially efficacious in cases of menorrhagia coming on at the time of the menopause. It was well borne in every case, but with two or three of the patients it caused a little ringing in the ears. It was given in powder or in the form of compressed tablets, in doses of fifteen grains three times a day. As nearly as possible, its administration should be begun on the day before a menstrual period is expected.

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#### PUERPERAL SEPSIS.

Dr. R. W. Murray, of New York, read an interesting paper on "Puerperal Sepsis" at a meeting of the Medical Society of the County of New York, January 22nd. He strongly advocates the use of antiseptic remedies, believing that it is only through antiseptics that asepsis can be secured. He referred to the good results obtained during the last few years in the Maternity Hospital of New York. The antiseptics used were corrosive sublimate, carbolic acid, and creolin, the latter being preferred by Dr. Murray.

We were somewhat surprised to learn that in the Maternity Hospital the urine was usually drawn with a catheter every eight hours; and certainly agree with Dr. Garrigues, who stated, in the discussion following the reading of the paper, that it was better to allow the woman to urinate naturally if she could. In the Burnside Lying-in Hospital, Toronto, the practice is to avoid the use of the catheter as far as possible. As a matter of fact, it is only used in a small minority of cases; and it has not infrequently been noticed that, when the catheter has been used in any particular case, other patients in the same ward are very apt to lose the power of voiding their urine. The necessity for this instrument frequently becomes infectious in consequence of certain psychological processes which we will not now discuss; and we think that *catheteristic* epidemics should not be encouraged or fostered by hospital authorities.

# SURGERY

IN CHARGE OF

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## NEW SURGICAL TREATMENT OF CHRONIC EMPYEMIA.

M. Delorme describes a new operation that is destined to replace Estlander's. It consists essentially in making a large flap of the thoracic wall, resecting several ribs to accomplish this. The flap is left attached at the upper part. The pleural cavity is thus exposed; the lung is then carefully peeled. It is remarkable that, as soon as a piece of adherent membrane is removed, the lung immediately expands—forms a hernia, as it were. After having carefully removed the false membrane, and scraped the parietal pleura, the flap is sutured and dressed. The results of the operation appear to have been most excellent.—*Méd. Moderne*, Jan. 24th, 1894.—*Lyon Médicale*. J.A.A.

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## THE EFFECTS ON DIGESTION OF THE REMOVAL OF THE GALL BLADDER.

This ablation, which has become quite a frequent operation, modifies the physiological conditions of digestion, in causing the flow of bile into the intestine to be continuous, when it formerly was intermittent. Küster once held that the absorption of fats would be much interfered with, and the operation would bring on general troubles as serious as any brought on by thyroidectomy. These fears have not been realized clinically, and Rosenberg, in a series of experiments done on dogs, has shown that the continuous flow of bile into the intestine after ablation of the gall bladder brings on only a very insignificant modification on the absorption of nitrogenous foods (93.50 instead of 95.75), and of fats (97.69 instead of 98.66). These figures show the average daily feedings given before and after the operations.—*Gazette des Hôpitaux*. J.A.A.

## ELASTIC CONSTRICTION AS A HEMOSTATIC MEASURE.

Dr. W. H. Elliott, of Savannah, at the recent meeting of the Georgia State Medical Association, addressed the association on this subject. He said the association was familiar with Esmarch's method, which consisted in putting on an elastic bandage from the periphery slowly and gradually, so as to empty the limb of blood, putting it on up to a point just above where the surgeon is going to operate. He then puts on a narrow elastic band at that point, so as to cut off the circulation from the limb entirely; then removing the compression bandage to go on with the operation, which he had fitly called "a bloodless operation." Esmarch was not the inventor of the bloodless operation, but surgeons were indebted to his genius for improving its technique, and for making this established method a popular procedure in surgery. The speaker then stated the two grave objections against the method as used by Esmarch, as advanced by Dr. Senn. The first objection was that forcible compression of the blood out of the tissues by an elastic bandage was liable to send into the surrounding tissues the elements of microbic and malignant diseases. Cancer cells may thus be scattered and disseminated through the system, or the cells of pus or of tuberculosis might be sent abroad to do damage elsewhere. The second objection raised was that the constricting of the limb with a tube or a narrow bandage at one point was liable to do injury, first, to the muscle, and, secondly, to the nerve. Dr. Elliott had used Esmarch's method, as modified by Dr. Senn, with great satisfaction.—*Medical Record*.

Senn's modification of Esmarch's method consists in :

- (1) Elevation (of the limb) instead of the application of rubber bandage for the removal of the blood prior to constriction.
- (2) The diffusion of the elastic constriction of the limb over an annular space of not less than two inches in width, to lessen the danger of injuring important structures passing beneath the constrictor (tourniquet).

Senn also advises that constriction be made with sufficient force to interrupt at once both venous and arterial circulation.

L.M.S.

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 SYMPTOMATOLOGY OF INTRACRANIAL TUMORS.

Dr. James Taylor, in an interesting lecture published in the *Lancet*, makes the following remarks regarding this subject :

As you are no doubt aware, the trilogy of symptoms which are supposed to be absolutely pathognomonic of this affection is represented by headache, vomiting, and optic neuritis. If you have those three present, the existence of a tumor is almost certain. The only condition I can imagine which might cause all of them and not be tumor is meningitis,

usually tuberculous; but the converse is by no means true, for you may undoubtedly have a cerebral tumor with not one of those three symptoms present. To this I shall again refer presently, but in the meantime let us consider for a moment the character of those three symptoms. The *headache* of intracranial tumor is not absolutely characteristic. It is, so far, at least, as our present knowledge goes, in no way localizing—*e.g.*, it is notorious that the headache in cerebellar tumor is very frequently frontal, sometimes occipital, often both. Its chief characteristic is that it is paroxysmal, and another distinguishing point is that it is frequently accompanied by vomiting without nausea. The local tenderness in the scalp which is sometimes present in cases of tumor is not to be confounded with the headache, and, whereas the former in many cases is significant, the latter is as yet without localizing influence. The vomiting of optic neuritis may also be described as sudden and paroxysmal, as occurring without nausea, but as being frequently associated with headache. It is to be carefully regarded and treated, for a severe attack of vomiting is often the immediate precursor of death. The last of the three—optic neuritis—is the most important. Optic neuritis may be present, for example, in albuminuria and lead poisoning, and, also, it is said, in anemia without tumor; but in the great majority of cases there is no doubt that it is indicative of intracranial tumor. It also is not localizing, although I believe that the optic neuritis of cerebellar tumor is, in its characters, frequently at least suggestive. There is no doubt that, in many cases of cerebellar tumor, the neuritis is particularly intense, being accompanied by numerous hemorrhages, and by the peculiar fan-like arrangement of glistening white spots radiating from the macula, which is common in albuminuric retinitis. This form of neuritis I have seen much more frequently associated with cerebellar tumor than with any other variety, although, as I have said, it is not pathognomonic, only suggestive. So much for the general symptoms of tumor. I shall now briefly consider the symptoms associated with growth in different parts of the brain or cerebellum. Growths in or encroaching on the cortex are characterized more than others by localized pain on pressure over the scalp at the place corresponding to the underlying tumor. The more superficial the tumor, the more marked is this symptom. Localized convulsion—*i.e.*, convulsion starting in some particular segment of a limb—although not present in all cortical tumors, is also present only in a tumor in which the cortex is involved. This convulsion may be only slight twitching, and nothing more; it may also be local cramp, which ceases before it has extended; but, on the other hand, it may begin as either of these, and gradually go on to a convulsion which affects the whole body and abolishes consciousness. After such a fit there is usually local paralysis, most marked in the part in which the con-

vulsion started. All these statements have been illustrated in the history of the first case I showed you to-day, in which the tumor was in the cortex itself. Tumor in the white matter of the cerebrum may have the general symptoms already referred to. Its special characteristic is a slowly increasing paralysis, commencing in one limb. There may be no fits, and little or no headache. If the growth encroaches on the posterior part of the internal capsule, there may be anesthesia, and even hemianopia. The part of the body paralyzed will, of course, depend upon the position of the tumor. It is in such tumors that not infrequently all the three usual symptoms of tumor—headache, vomiting, and optic neuritis—are absent, especially if the tumor is a slowly growing one. The distinctive symptom of tumors of the pons and medulla is the involvement of one or more of the cranial nerves, and it should be remembered that often marked evidences of paralysis may be present before any of the classical symptoms of tumor declare themselves. Especially is this true when the growth is an infiltrating one, and when, so to speak, the structures are slowly strangled, and their functions gradually abolished. In such cases it is not uncommon to have little or no headache, and optic neuritis is probably as frequently absent as present. As regards the cerebellum, there are two distinct classes of tumor in regard to their symptoms—viz., those in which reeling is present, and those in which it is not. In the former class the symptoms are, as a rule, though not invariably, much more severe, and are believed to depend upon an involvement of the middle lobe. In the latter class of cases the symptoms may not be obtrusive. Occasionally, headache and sickness, but nearly always optic neuritis, will be present, but often in such a way as not to excite suspicion, and this is a class of cases in which the diagnosis is apt to be missed. One point of interest, perhaps of importance, is the state of the knee-jerk in cerebellar cases. In some cases it is unusually brisk, chiefly in those, I believe, in which there are reeling and unsteadiness; in others it is absent, either constantly or at times, and always difficult to elicit. In two cases with such symptoms which I have examined *post mortem*, the tumor was in the lateral lobe, not affecting the middle lobe at all. Smell, also, is not uncommonly abolished in cerebellar cases. Whether this is a result of the intracranial pressure on the olfactory lobes, or whether it is due to a condition of these nerves analogous to that which abolishes the function of the optic nerves, it is not easy to say. That it is due to any involvement of the actual centre is very unlikely.

# GENITO-URINARY AND RECTAL SURGERY

IN CHARGE OF

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## A PLEA FOR MORE FREQUENT AND EARLIER COLOTOMY IN PAINFUL MALIGNANT DISEASE OF THE RECTUM.

Strauss, of St. Louis, in *Mathews' Medical Quarterly*, says: The most signal advance in the surgery of the rectum of late years is the doing away with the idea that intestinal obstruction is the only indication for colotomy. In fact, the indications are varied and many. In the last decade surgery of the rectum has made great progress, and especially in the treatment of malignant diseases. From a surgical aspect, the various countries differ as to what the treatment shall be. England, so noted for her conservatism in everything, and surgery as well, has come to treat most of her cases of malignant diseases by making an inguinal colotomy, save in the very limited number of cases where an excision is indicated; that is to say, where the contiguous tissues are not as yet involved. They seldom make a Kraske, and rarely or never make a full-fledged one, holding, in the vast majority of cases, that an inguinal colotomy meets every indication for which an operation is made, and that, too, with much less risk to life than a Kraske, or any modification of it. Surely no better evidence could be produced for the making of an operation than the fact that the English surgeons advocate and make it. And, further, that there is a consensus of opinion not only among themselves, but among the continental surgeons as well, that the majority of cancerous cases should be early colotomized. Inguinal colotomy is always advised at St. Mark's Hospital, London. There have been more colotomies made in that institution than any other hospital of any other country, and the results have been carefully studied and noted by Mr. Allingham, jr., who has become the champion of this operation. Mr. Bryant says that the operation has been too much regarded as a *dernier ressort*, and, as a consequence, was only carried out when all other measures had been tried and



proved to be useless, and that he wishes to combat this idea, and favor its earlier and more frequent performance.

He gives three reasons for colotomy: (1) Relief of pain by doing away with the function of the rectum. (2) Extending the lease of life. (3) The risk of the operation has been minimized. Allingham reports sixty-eight colotomies and only two deaths. Cripps, forty-five with one death. Reeves, sixty-five without a death. He by no means advocates colotomy in all cases—only those in which nothing else can be done. He quotes from Kelsey the following paragraph, which expresses in a very forcible way a very trite aphorism:

“If colotomy will put thirty pounds of flesh on a cancerous patient, and cause such an amount of relief to his local symptoms as to make him believe himself entirely cured; if, by removing the chief cause of local irritation, it will tend to retard the inevitable increase in growth, and if the artificial anus is not a cause of mental or physical annoyance, why delay giving the patient the advantage of it at once, and why put off an operation with less than one per cent. mortality until in the midst of intestinal obstruction the mortality becomes thirty or fifty per cent.?”

He refers to the experience as expressed in the current literature of the past year, and shows that there is a great tendency to resort earlier to colotomy—even the Germans are doing it—and concludes as follows: “It only remains for us to ascertain which holds out the better prospect of relief in any given case. In some it will be a Kraske or some of its modifications, in others colotomy; and before another half decade has passed, I believe that the general rules laid down for selecting the method of treatment will be generally agreed upon throughout the surgical world. I think it safe to say that colotomy, in the near future, will be made earlier, and more often, for the reasons, to recapitulate: First, it extends the lease of life, and second, it makes life tolerable. To me this is an established fact, a demonstrated verity.”

#### SUPRAPUBIC CYSTOTOMY IN URETHRAL IMPERMEABLE STRICTURE.

Dr. Lindfors (*Hygiea*) read a paper on this subject before the recent Congress of Scandinavian Surgeons, in which he gave the details of two cases. Catheterization was impossible, and urgent indications forced him to make a vesical fistula. The first case was that of an elderly man with prostatic hypertrophy and ankylosis of the hip-joint, where a suprapubic fistula was done with very good functional results. He improved so much that he was discharged. He died later of senile marasmus. The second case was a young man with an inflammatory stricture and various symptoms which indicated operative measures. He then presented the indications

for operation for vesical stricture. He, like Guyon, is not in favor of modern prostatectomy, as is so often done by American surgeons. In the discussion Dr. Rovsing reported a case of inflammatory stricture of fifteen years' duration where resection of the urethra was done with very good functional results.—*Journal Cutaneous and Genito-Urinary Diseases.*

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#### AFTER TREATMENT OF EPICYSTOTOMY.

D. Borelius (*Hygiea*) at the recent Congress of Scandinavian Surgeons read a short paper on three cases where he had sutured the bladder wound after suprapubic cystotomy. The wound healed in a short time. After death of these patients from other causes, he examined the cicatrix from the interior of the viscus, and found that only the skin had healed. At the place where the sutures were applied to the bladder he found a small cavity filled with detritus, and of the size of a walnut. Its walls were irregular, and reminded one of a *vessie à colonne*. Hence, he warns against too much confidence in apparently complete healing after suturing of the bladder in suprapubic cystotomy.

[I can corroborate the fact that the wound made in the bladder does not heal kindly after suturing. It does much better when healed by the open method. It is a practice that should only be followed in a few selected cases, particularly where the bladder wall is perfectly normal.—E.E.K.]

# PEDIATRICS AND ORTHOPEDICS

IN CHARGE OF

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## BROMOFORM POISONING AND BROMOFORM IN PERTUSSIS (HOLDEN).

A child two and one-half years of age drank four grammes of bromoform, and a three-year-old child six grammes. In both swallowing of the drug was quickly followed by loss of consciousness, asphyxia, absence of apex beat, slow, small pulse, cyanosis, subnormal temperature, and pulmonary edema. Under free use of stimulants both recovered. While the first-mentioned case was under the influence of the bromoform a severe coughing paroxysm occurred. In the second case the disease was much less severe after the effects of the drug had worn off.—*Archives of Pediatrics*, March, 1894.

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## A CASE OF HEMORRHAGIC VARICELLA WITH PEMPHIGOID BULLÆ, ENDING IN DEATH.

In the *Archives of Pediatrics* for March, 1894, John Thompson, of Edinburgh, reports a varicella with unusual symptoms.

Patient, æt. thirteen months ; healthy parents ; ten children, all healthy. Child was at the breast, but had also been fed with bread and milk. Child had always been healthy, and had at no time any signs of syphilis.

Eruption appeared on November 26th, as a number of papules on head and trunk. During the day the child vomited several times. On the 27th these papules became vesicular. On the 28th the vesicles spread in many places to watery blebs, which were especially large on the back. 29th, back covered with large bullæ. Many of these had burst.

When the author saw the child he was in a state of extreme weakness, but was well nourished and well developed. Pulse 144, weak. Fontanelle depressed ; organ normal ; skin was livid all over ; eruption consisted of papules, vesicles, pustules, scabs, and slightly depressed scars. They were on face, scalp, trunk, and limbs, and had mostly small hemorrhage with them. They had all the appearances of varicella spots. There were none on mucous membrane. In addition to these small spots, there were a

great many large, irregularly shaped, rounded raw areas, left by the bursting of bullæ. Many of these measured from one to two inches across; most of them were hemorrhagic. They showed no sign of gangrene, although livid and unhealthy. The patient died a few hours after. No *post mortem* permitted.

The twin sister of the child had varicella eruption a day earlier than her brother. She did not vomit. Had an ordinary eruption of varicella, but eight or ten bullæ appeared on shoulders. In no situation was the eruption hemorrhagic. The child recovered rapidly.

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#### TUBERCULAR MENINGITIS CURED BY DRAINAGE.

Dr. W. Wallis Ord and Mr. H. F. Waterhouse read notes of a case of tuberculous meningitis in a child, aged five, relieved by drainage. The child was admitted in an apathetic condition, with double optic neuritis. From time to time she uttered a piercing scream, and the *tache cérébrale* was well marked. Symptoms of intracranial pressure having supervened, and the child being on the point, apparently, of passing into a condition of coma, Mr. Waterhouse trephined through the cerebellar fossa of the occipital bone, giving exit to a small quantity of fluid. A drainage tube was left in, and the wound was closed, the fragments of bone being replaced by Macewen's method. The child did well, and the symptoms subsided, though at one time the wound seemed to have been infected by tubercle. The question of diagnosis was discussed, and it was pointed out that for success to be hoped for it was necessary not to wait until the child was actually comatose.—*British Medical Journal*, March 10, 1894.

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#### HEART INFLAMMATIONS IN CHILDREN.

Octavius Sturges, in the course of his Simmerian lectures on this subject, points out that endocarditis alone is met with in children far less than in adults, and, were we to take *post-mortem* evidence alone, with remarkable rarity, cases of chorea alone excepted. The rheumatic heart inflammation of children, when pericardial, is always endocardial as well, and when endocardial is extremely likely, with the recurrence of rheumatism, to involve the pericardium also. Thus, in the heart as elsewhere—as in catarrhal inflammations and tuberculous development—the differentiation of morbid processes is less marked in the child than in the adult, and a common sympathy more apparent.—*British Medical Journal*, March 17, 1894.

# PATHOLOGY

IN CHARGE OF

**JOHN CAVEN, B.A., M.D., L.R.C.P. Lond.,**

Professor of Pathology, University of Toronto and Ontario Veterinary College; Pathologist  
to Toronto General Hospital and Home for Incurables.

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## MORBID ANATOMY OF BASEDOW'S DISEASE.

Joffroy and Achard have made complete investigation of six cases of this disease. As a result, they have concluded that nervous lesions are wanting, *e.g.*, in the bulb, restiform bodies, etc. This fact also tells against the nervous origin theory, viz., that in the thyroid body there are *always* present some lesions; even though they be not macroscopically visible, the microscope shows them. These lesions are various; interstitial sclerosis, edema, etc., have been found. Joffroy and Achard think that the morbid anatomy of the disease goes to prove that its origin lies in the morbid changes in the thyroid itself.—*Rev. Intern. de Bibliog. Med.*, etc., January, 1894.

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## THE MICROBIC SYNTHESIS OF TARTAR AND SALIVARY CALCULI.

Mr. V. Gallippe, in April, 1886, published the results of a microbiological analysis of tartar and salivary calculi in particular and calculi in general. These studies he has since completed, and they tend to demonstrate that the parasites found in these concretions or calculi are not present accidentally, but are really the chemical agents that bring about the precipitation of the substances which constitute them. The parasites preserve their vitality for several years, and may be isolated and cultivated. He experimented from December, 1885, to the end of February, 1890, trying to synthetically build up, through the agency of microbes, salivary calculi and tartar. At the end of this time, he found, in normal saliva, saturated with carbonic acid ( $\text{CO}_2$ ), quite a number of small concretions of variable densities.

By the aid of reagents he discovered that the organic part of these calculi was formed of a close network of micro-organisms which had determined the precipitation of the mineral constituents.

These micro-organisms vary according to the kind of calculus, and have retained their vitality and may again be cultivated. The calculi examined contained phosphates and carbonates of calcium and magnesium. It can readily be seen that the growth of such calculi may become enormous, provided the necessary mineral compounds are furnished in sufficient quantities.—*From the Microscopical Bulletin.*

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#### CONTRIBUTION TO THE PATHOGENY OF UREMIA.

The phenomena of uremia (Meyer, *Arch. de Phys.*, No. 4, 1893), according to Brown-Sequard, depend not entirely upon faulty elimination by the kidneys of substances formed by the organism, but also upon an insufficiency or absence of a chemical change which the healthy kidney exercises upon the blood. Meyer demonstrates the truth of this in this way. Renal juice is injected into the blood of animals in which Cheyne-Stokes respiration has appeared as a result of nephrectomy. The respiration has become normal. Injection of normal blood—the physiological renal secretion—has the same effect, and blood from the renal vein, as would be expected, is most potent.—*Rev. Intern. de Bibliog. Med.*

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#### THE CO-EXISTENCE OF CANCER OF THE CARDIA AND OF THE DUODENUM.

M. Paul Courmont presented to the Society of Medical Sciences of Lyons gross specimens taken from a subject of double cancer. One tumor was at the cardiac end of the stomach, the other in the duodenum. During life, the diagnosis had been cancer of the esophagus, and the cancer of the duodenum, which had been felt on palpation, had been considered as a nodule of generalization in a gland. There were no subclavian glandular enlargements, though.

The tumor of the cardia was nodular, and obstructed the lumen of the esophagus. It had many of the characters of a primary tumor. The duodenal tumor was about the form of a mushroom, of the diameter of a silver dollar. It was fungous and soft. The common bile duct was not obstructed. The patient never had jaundice, and did not show any of those symptoms indicative of cancer of the head of the pancreas.

Was there here a graft from the first cancer, or must it be admitted that there co-existed two primary cancers? It is rather difficult to determine. It seems more probable, though, that the second cancer was a graft from the first.

## PROGRESS OF MEDICINE.

In the discussion which followed, M. Bard said that the histological examination alone could settle the question. Cases of multiple primary cancers are rare, and even those cases reported are not altogether authentic.

In his article (*Archives Générales de Médecine*) M. Bard pointed out that there existed but four or five authentic cases.

M. Lannois considered the absence of enlarged lymphatic glands a point in favor of the graft theory, as opposed to that of generalization.—*Lyon Médicale*.

J.A.A.

# HYGIENE AND PUBLIC HEALTH

IN CHARGE OF

WILLIAM OLDRIGHT, M.A., M.D. Tor.,

Professor of Hygiene in the University of Toronto; Surgeon to St. Michael's Hospital;

AND

E. HERBERT ADAMS, M.D., D.D.S.

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## REGISTRATION OF THE TUBERCULOUS.

The action of the various State and Local Boards of Health in regard to the subject of tuberculosis is one of transcendent interest. It marks a new era in sanitation, and means that, as years go by, tuberculosis will gradually become less and less a scourge, if not actually extinct. A disease which kills twelve per cent. of the population is something that is worth while to try to abolish.

The New York State Board compels the registration of all tuberculous persons, but does not attempt sanitary visitation and disinfection, except under certain conditions. The Philadelphia Board does not require registration, but simply attempts an active educational campaign in the matter of preventing the disease.—Editorial in *Medical Record*.

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## CHOLERA IN RUSSIA.

On the first of March, all the governments of the Russian Empire, with the exception of Volhynia, Koone, Plock, and Tchernigoff, were officially declared free of cholera.

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## THE ISOLATION HOSPITAL GRANT.

A civic deputation from Toronto have waited on the Provincial Government, urging the necessity and justice of an isolation hospital grant. The government promised to give the subject a careful consideration.

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## FOR THE PREVENTION OF BLINDNESS IN THE STATE OF OHIO.

A bill for the prevention of blindness in the State of Ohio has become a law. It has the following provisions: "Should one or both eyes of an



infant become inflamed or swollen, or show any unnatural discharge at any time within ten days after its birth, it shall be the duty of the midwife, nurse, or relative having charge of such infant to report in writing within six hours to the physician in attendance upon the family, or, in the absence of the attending physician, to the health officer of the city, village, or township in which the infant is living at that time, or in case there is no such officer to some practitioner of medicine legally qualified to practise in the State of Ohio the fact that such inflammation, swelling, or unnatural discharge exists. Any failure to comply with the provisions of this act shall be punished by a fine of not less than ten dollars, nor more than one hundred dollars, or imprisonment for not less than thirty days, nor more than six months, or both fine and imprisonment.

“This act shall take effect or be in force from and after its passage.”

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#### A COMMITTEE ON PUBLIC HEALTH.

The Committee on Public Health of the Massachusetts Legislature has reported adversely on a proposed bill to require patent medicine bottles to have on them a label stating the percentage of alcohol in the medicine, and also adversely on a bill requiring cans and receptacles used by milk dealers to be kept free from impurities.

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#### A RAID ON ABORTIONISTS.

On March 23rd the police of New York arrested sixteen advertising abortionists simultaneously in different parts of the city. The arrests were made at the request of the New York Society for the Enforcement of Criminal Law, which, through a skilful male and a female detective, had secured evidence for the prosecution of the offenders. Some of the accused succeeded in securing bail, the bonds in each case being fixed at \$2,500.

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#### SANITARY INSURANCE.

Dr. G. W. Reeves proposes, in the *Nineteenth Century*, a method of sanitary insurance which has the merit of novelty, and which seems not impracticable.

This plan is that any city or district may organize for itself a sanitary protective and insurance association, founded for the purpose of providing the public with a source of protection against unsanitary dwellings and surroundings. The definite objects would be :

(1) To examine into the sanitary condition of any building, previous

to tenancy, or after, and to afford skilled advice on hygienic matters or appliances, either on existing premises, or on the plans of proposed arrangements of new buildings.

(2) To issue certificates respecting the sanitary condition of dwelling houses and buildings.

(3) To provide the means by which a cleanly and wholesome state of dwelling houses and premises may be maintained.

(4) The sanitary registration of dwellings.

(5) The insurance of buildings against a defective sanitary condition.

—*Medical Record.*

## Editorials.

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### ELIMINATIVE AND ANTISEPTIC TREATMENT OF TYPHOID FEVER.

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WE publish in this number a reprint from *The New York Medical Record*, March 10th, 1894, of an article by W. B. Thistle on this interesting subject. Our readers will remember that a paper by the same author, on this subject, appeared in *THE PRACTITIONER* for April, 1893. In the first paper the author points out that, so far as the treatment of typhoid is concerned, the dictum "knowledge comes, but wisdom lingers," has been most apt. The profession still kept its attention fixed on that vague and intangible something called typhoid, instead of turning to the consideration of some plan to get rid of, destroy, or in some way mitigate, the effects of the parasitic growth which was now known to be the disease. By the long-continued efforts of generations of medical men, working in ignorance of the true condition, almost every medicinal or therapeutic procedure had been advocated, and in time discarded. The unfortunate patients had been bled, purged, sweated, bathed, starved, and fed. When one stops to consider, there are really not many therapeutic channels, if one might so term them. These soon became exhausted. Gradually, a deep-seated distrust of medicinal treatment possessed the medical mind and, curiously enough, this feeling became intensified the clearer the nature of the condition became. It was hard also to get away from the time-honored traditions and precepts. Even when the nature of the disease became as clear as noonday, this let-alone policy prevailed, in utter forgetfulness of the fact that, although the available therapeutic instruments may be few, yet, like the carpenter's axe and saw, if they are intelligently applied, marvellous results may be obtained.

We are sure that the revival of interest which these papers have created cannot fail to be productive of good. The author may be congratulated if he has succeeded in disturbing the lethargy and spirit of helplessness, with reference to this subject, which has possessed the writers and teachers of Europe, and of this country, if one may judge them by their books and

teaching. The quotations from well known and most recent text-books introduced by the author, as well as others which could have been cited, illustrate well this condition of mind. Osler's opening sentence on treatment, for example: "The profession was long in learning that typhoid fever is not a disease to be treated by medicines"; or in the latest edition of Fagge, 1891, we read (page 171) that "no method of treatment has yet been discovered by which the course of the disease can be shattered," and, on page 174, "No qualified man would think of giving ordinary laxatives in enteric fever." On the same page, the author actually congratulates himself that in the case of two patients who had died from hemorrhage while undergoing this let-alone treatment he had *abstained from interference!* It would seem, too, according to the author of these papers, that, in a negative way, we have been aiding in the production of the very condition we most dread; *i.e.*, perforation and hemorrhage. In a recent number of *The New York Medical Record*, Dr. Osler, in a note to the editor, reminds Dr. Thistle that he must not claim the credit of introducing purgation treatment in typhoid, inasmuch as Larroque, of Paris, in 1841, had advocated treatment by purgation. We have not been able to discover Larroque's article, but have read the very brief, but somewhat satirical, review indicated by Dr. Osler in *The British and Foreign Medical Review* for 1841. Dr. Osler does not state where the original paper may be seen. However, if Dr. Osler will read the recent paper, he will find that the author does not claim to have introduced purgation in the treatment of typhoid, but does claim to be the introducer of a plan of treatment directed against the bacillus and its toxic product.

This plan he divides into three parts: (1) Elimination of bacteria from the intestine, and of its toxic product, both from the intestine and, by drainage and flushing, from the tissues as well. Larroque, fifty years ago, knew nothing of the typhoid bacillus or of its product. True, he attributed the disease to the result of decomposition in the intestine, and, therefore, he was close to the truth, and his treatment logical. (2) The author advocates constant efforts to maintain the volume of the body fluids by taking at frequent intervals large draughts of water, as well as nutritious fluids, so as to compensate for that drained off through the intestine. This also facilitates the removal of the poison through the kidney. By this measure exhaustion is prevented, and the poison is kept in diluted and less harmful form. The author lays stress upon this second factor in treatment, holding that elimination can be successfully and safely carried out only when purgation is associated with the injection of large quantities of fluid. Not having seen Larroque's article, we cannot say whether he had such an adjuvant to his purgation; but since he knew nothing of the soluble toxine, nor of the colonies of bacteria producing it

throughout the tissues, it is altogether unlikely that he did. Moreover, the practice in those days was usually to forbid water entirely.

Then, coming to the third factor—the use of antiseptics. Here the author can certainly not claim originality; nor does he. But he points out that it is in association with elimination that antiseptics can be most successfully used; that much larger quantities of antiseptics can be given without danger if, after acting on the bacteria of the intestine, it is shortly carried out than if allowed to remain and become absorbed. We have here an original and valuable suggestion.

However, before leaving the remote literature, we might ask in vain for the disease in which the victims had not, at some time, been bled, purged, or sweated, and this, too, on a purely experimental basis.

Taken as a treatment directed against the bacterial culture in possession of the body, and based upon our present knowledge of the pathology of the disease, the author's plan seems strikingly new. This is particularly true with reference to the later generations of medical men who, while they have been well informed as to the nature of the disease, cannot but be impressed with the newness of a plan of treatment so diametrically opposed to all they had read or been taught.

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## THE MEDICAL FACULTY IN RELATION TO THE FINANCES OF THE UNIVERSITY OF TORONTO.

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THERE has been considerable misunderstanding with reference to the financial aspects of the relations which exist between the University of Toronto and its re-established Medical Faculty. It has been publicly stated that the finances of the University have been sadly crippled, chiefly by the actions of the Vice-Chancellor, in his worthy and successful efforts to establish a strong medical faculty. A complete refutation of such charges is found in the following plain financial statement, which we extract from a letter written by Prof. A. B. Macallum, which appeared in the *Toronto Mail*, February 24th: "In the year ending June 30th, 1887, the amount received by the University in the shape of fees for medical examinations and degrees could not be more than \$1,015; that is, 103 paid \$5 each, while twenty-five, for their degrees, paid \$20 each. The University paid \$705 to the medical examiners, as shown by the bursar's accounts. The University was benefited to the extent of \$310 only, and this in the year preceding the formation of the Medical Faculty. Now, in the financial report of the Board of Trustees, dated November 1st, 1893, page 26, the amount received from medical examinations and degrees is placed at \$3,453.75, and, on page 25, the fees received for the tuition of

medical students in the sciences taught in the Arts Faculty is stated to be \$2,020. The amount received as rent of a part of the west wing of the Biological Department is \$1,200. Adding these together, we get a total of \$6,673.75, all this for the year ending June 30th, 1893. Against this must be placed examiners' fees, \$1,550.80 (report of Financial Committee of Senate, page 11), and salaries to instructors purely for medical students, \$1,100; total, \$2,650.80. The University, therefore, netted, last year, \$4,022.95. Comparing this with what was netted in the year ending June 30th, 1887, immediately before the formation of the Medical Faculty, we see that the University was last year in better position by \$3,712, and all for an expenditure on the part of the University for which the Chancellor, after consultation with the architect on the amount of space used by the faculty, considered that \$1,200 as rent would be a just and adequate allowance."

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#### THE ELEVENTH INTERNATIONAL MEDICAL CONGRESS.

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**T**HE Eleventh International Medical Congress was held in Rome, March 29th to April 5th; and, at the time of writing, reports vary as to the amount of success which attended it. As to numbers, there were enough—possibly more; but the arrangements made by the local committee appear to have been good, and strangers were, as a rule, well looked after. In certain respects some of the visitors were "looked after" in a way not altogether pleasant, and not altogether cheap. However, there were a lot of Englishmen there; so, of course, there must needs be a certain amount of grumbling, and a certain amount of "writing to the *Times*."

The International Medical Congress is now generally regarded as a permanent institution, but it is a thing of modern times. The first congress was held in Paris in 1867; the year of its great exhibition. The committee in charge of the ordinary annual assembly of French physicians for that year conceived and carried out the happy idea of sending invitations to foreign members of the profession visiting the exhibition, asking them to attend the meeting and take part in the discussions. Over five hundred foreigners attended, and a number of foreign vice-presidents were appointed. The proceedings were conducted in French, and the meeting was highly successful. On the suggestion of a delegate from Italy, the congress was made a permanent institution, and Florence was selected as the place for the next meeting, which was held in 1869.

The third congress was held in Vienna, 1873; the fourth in Brussels, 1875; the fifth in Geneva, 1877; the sixth in Amsterdam, 1879; the

seventh in London, 1881; the eighth in Copenhagen, 1884; the ninth in Washington, 1887; the tenth in Berlin, 1890; the eleventh in Rome, 1894.

Of these, probably the most notable were the London and Berlin meetings. The London Congress had in attendance over three thousand members, including one thousand foreigners, and had as its president the eloquent and brilliant Sir James Paget. Professor Virchow and M. Pasteur delivered admirable addresses, and were received with an enthusiasm which was almost marvellous for cold, hard-headed Britishers. The Berlin Congress of 1890 was a gigantic, rather unwieldy, but highly successful affair. It is said that Professor Virchow, in the delivery of his presidential address, had an audience of 7,000 persons.

We have had one congress in America—held in Washington, 1887. A number of prominent American physicians extended a very cordial invitation to the members at the Copenhagen meeting, 1884, to come to the United States. The invitation was gladly accepted, and the Americans immediately went to work to organize a committee to make the necessary arrangements. This committee, although composed of able and representative men, was not acceptable to the American Medical Association. There were too many chosen from the eastern cities; there were too few from the “rural districts” and the “woolly west.” The “self-appointed” committee was unceremoniously snuffed out; a new “geographical” committee was appointed; a reorganization was effected. A fierce war raged between the two hostile camps, and many of the ablest American physicians would have nothing to do with the congress. The old world looked on in wonder and surprise—and mostly stayed at home. The misunderstanding which caused the trouble was most unfortunate. United America would have furnished a grand congress; divided America did as well as could be expected under the circumstances. The geographical committee worked with considerable zeal, and completed all the arrangements in a most satisfactory manner; and the comparatively few foreigners who attended were much gratified with the treatment they received.

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#### THE DOMINION MEDICAL ASSOCIATION.

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WE learn from the secretary, Dr. Starr, of Toronto, that the officers of the Dominion Medical Association are busily engaged in arranging for the next meeting, which will be held in St. John, N.B., in the month of September. It happens that there will be three important meetings of medical associations held in St. John during this year, namely, those of the Canadian Medical Association, the Maritime Medical Association, and the

New Brunswick Medical Society. We learn from the *Maritime Medical News* that there is a strong probability that all these meetings will be held at one time. This will insure a large and representative attendance of physicians resident in New Brunswick, Nova Scotia, and Prince Edward Island.

When the last meeting of the Dominion Association was held in Halifax the numbers in attendance were small. The meeting, however, was a fairly good one from a purely medical point of view, and an exceedingly delightful one from a social point of view. Our friends in the Lower Provinces have big hearts, and know how to entertain generously. A trip to the Lower Provinces from Western Canada is a very pleasant one, apart from any considerations connected with the meeting, and we desire again to urge our readers to keep this fact in view when making arrangements for their summer trip in 1894.

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### SYMPHYSIOTOMY.

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WE have heard much during the last two years about the resuscitated operation of symphysiotomy. The Italians grow enthusiastic over it; the French become almost hysterical about it; some of our American friends are inclined to become sensational over it; some of our Canadian brethren are somewhat excited about it.

Great Britain, as usual, is calmly conservative, and has worked up nothing in the shape of enthusiasm, hysteria, or sensationalism, with reference to the subject. A paper, written by Dr. Harris, of Philadelphia, was recently read at a meeting of the Obstetrical Society of London, entitled "A Plea for the Practice of Symphysiotomy, based upon its record for the last eight years." In the brief discussion which followed, no one expressed a decided opinion in favor of the operation except in an exceedingly small proportion of cases.

Dr. Horrocks reported one case of symphysiotomy which he had witnessed. Since the operation the woman had been unable to do any work, and was now in an infirmary. He thought that craniotomy or Cæsarean section would have been preferable.

Dr. Griffith, who has about three thousand cases of labor annually under his charge, stated that he had not yet found the conditions necessary for its performance present: that is to say, patient in labor, a moderate degree of contraction, with vera not less than three inches, the fetus



alive, and delivery impossible with the forceps properly applied. He believed the total risks of Cæsarean section were less than those of symphysiotomy. The most of the other members who spoke expressed the opinion that Cæsarean section was preferable to symphysiotomy.

It may be that the members present at the meeting referred to took a dark view of the operation, but we must certainly admit that their great practical ability and their large experience add very much weight to any opinions which they may express with reference to this important operation.

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## Obituary.

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JOSEPH WORKMAN, M.D., C.M.

OUR beloved and distinguished friend has gone at last—and yet too soon. He lived eighty-nine years—a long, long lifetime; but the time had not arrived when we felt that we could spare him. This lower world, with all its faults, never gives up, except under compulsion, and with the bitterest pangs, so good a man as Dr. Workman. Who was Dr. Workman, what did he do, and of what sort was he? ask his numerous friends between the Atlantic and the Pacific, and even beyond this continent. We would like to get all their answers and publish the gist of them. What a good book could be made!

He was born in the County of Antrim, Ireland, 1805, his ancestors having come from Gloucester, England, during the protectorate of Oliver Cromwell. Before his birth, and shortly after the close of the War of Independence, his father spent three years in the United States, teaching English in a college in Philadelphia, which afterwards became the University of Pennsylvania; but at the expiration of that time he returned to Ireland, where he remained until the time of his death, when a family of eight sons (including Joseph) and one daughter survived him. Mrs. Workman, the mother, lived to a great age—being 104 at the time of her death.

Young Joseph was bright and clever as a boy, and received a thoroughly good education. When he was twenty-one years of age he was employed in an ordnance survey of the British Isles. After a time he, with some other members of the family, came to Canada, and lived for a few years in Montreal. He studied medicine in McGill University, graduating in 1835, *i.e.*, when he was thirty years of age. He came to Toronto in 1836, and, for four years, conducted a hardware business on King street. When he was thirty-five years of age he commenced the practice of medicine. About

this time he was appointed Professor of Obstetrics and Therapeutics in the Toronto School of Medicine. He continued to practise, and retained his professorship until 1853, when he was appointed superintendent of the Asylum for Insane in Toronto. He held this position for about twenty-five years; and we are informed by those who had an intimate knowledge of the facts that he showed great administrative ability and rare tact, which, in conjunction with his untiring energy and ability as an alienist, enabled him to evolve a thoroughly well-ordered and admirably-conducted institution from a semi-chaotic condition of things.

When he resigned his position in the asylum, at the age of seventy-three, he was, in a sense, old—old in years, but full of energy, full of fire, full of sympathy, full of gentleness, full of goodness—a charming, lovable, and estimable man. He had an almost unique contempt for cant and humbug, and his criticisms of men and things connected therewith were terribly scathing. In a polemical contest the keenness of his satire, the sharpness of his sarcasms, the vigor of his denunciations, made him tremendously powerful—practically invincible—fortified, as he always was, with a righteous cause, for he would have none other.

After retiring from the active duties of asylum life his greatest pleasure, and chief work, was the study of scientific medicine. He contributed many articles in various American, British, and other journals, and furnished many translations from foreign journals—especially the Italian, of which he was very fond. He did all in his power to aid in building up various medical societies. He was president of the Canadian Medical Association in 1878; first president of the Ontario Medical Association in 1881; first president of the Toronto Medical Society in 1878; and also held prominent positions in other societies outside of Canada. Every one enjoyed his papers and addresses. His style of writing was especially happy—clear, bright, and trenchant; his words in debate or discussion were full of wisdom—sometimes kind and encouraging—sometimes sparkling with wit and humor—sometimes earnest and thoughtful—sometimes abounding in satire and sarcasm—sometimes armed with darts which pierced to the very marrow. His kind words were ever ready for the modest and unassuming—especially the young, apart from the exhibition of extraordinary ability in their efforts; his barbed darts were ever ready for the perpetrators of frauds, tricks, and shams—especially the old sinners.

The evening of December 26, 1888, will be long remembered by those who had the privilege of attending the largest and most interesting meeting of the Toronto Medical Society that has ever been held. The important event of the evening was the unveiling of a large portrait in oil of Dr. Workman, the work of the eminent artist, Mr. Foster. In addition to the local mem-

bers of the profession, there were present Dr. William Osler, of Baltimore, and the late Dr. James B. Hunter, of New York, who delivered interesting and admirable addresses. Dr. R. A. Reeve, who was master of ceremonies, did his work very gracefully, delivering at the same time a happy and appropriate address. Dr. Workman was deeply affected, and returned thanks in his own inimitable style for the honor which had been conferred on him by the society. The portrait now hangs in one of the society's rooms in the Medical Council chambers.

The doctor retained his mental faculties unimpaired until the end. During the last two or three years he was comparatively feeble, and since a slight stroke of apoplexy, a few months ago, was confined to bed. He contracted what appeared to be a slight cold, April 13, but on Sunday, the 15th, appeared to be doing well, and chatted cheerfully with a couple of friends who called on him. He grew worse, however, in the evening, sank rapidly, and died about nine o'clock. His funeral, April 17, was attended by his relatives and friends, including a large number of physicians.

A grand and good old man has departed. The records of his labors, which are at the disposal of his friends, fall far short of furnishing anything like an indication of the great and meritorious work which he accomplished. Fortunately, however, there remains for the many who loved and respected him something inexpressibly sacred—a memory of the spotless purity of his life, of the lofty nobility of his character, and of the wondrous kindness of his generous heart.

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## Book Reviews.

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IN the Mathews' *Medical Quarterly* we are pleased to welcome a new journal to the already long list. The first number appeared in January. It is specially devoted to diseases of the rectum, gastro-intestinal disease, rectal and gastro-intestinal surgery. It is edited by Dr. J. M. Mathews, of Louisville, Ky., an eminent specialist in this line. The diseases of the rectum have been common and frequent long enough, but sufficient attention has not been paid to them. A journal that will devote its columns to these diseases, and contain, besides, good original communications and selections from current literature on these subjects deserves to succeed. Its subscription price is \$2.00 per year, and if the future numbers are equal to the first it will be well worth it.

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ANNUAL OF THE UNIVERSAL MEDICAL SCIENCES, 1893. Edited by Charles E. Sajous, and seventy associate editors. Volume V. The following subjects are treated in this volume: General Therapeutics; Experimental Therapeutics; Electro-Therapeutics; Gynecological Therapeutics; Climatology; Balneology and Hydropathy; Hygiene and Epidemiology; Anomalies and Monstrosities; Anatomy and Physiology.

The first volume deals with diseases of the heart, lungs, and pleuras, stomach, pancreas, and liver, peritoneum and intestines, kidneys and bladder, etc., diabetes, fevers, rheumatism, and gout, and affections of the blood and spleen.

The book is full of information, and well up to date. The chapters on the infectious fevers are particularly valuable.

As a whole, the 1893 edition is well abreast with the most recent advances in the various departments of medicine, and the present volume certainly sustains the good reputation acquired by its predecessors.

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CONGENITAL AFFECTIONS OF THE HEART. By George Carpenter, M.D., London. 105 pages. John Bale & Sons, 87 and 89 Great Titchfield street, Oxford W., London.

This little book has been compiled by the author from the various demonstrations he has given to his outdoor clinic at the Evelina Hospital. It is written in a short and concise manner, and is illustrated by several cuts. Part of the work is taken up in describing the defects which occur in the development of the organ, and in tracing out the effects of such errors upon the cardiac septa and vessels. The diagnosis, prognosis, and treatment are included in the work. It is a very useful book to those in general practice, and meet those unpleasant cases. The typography and binding are excellent.

A GUIDE TO THE PUBLIC MEDICAL SERVICES. Containing information of appointments in the Home, Naval, West Coast of Africa, Indian, and Colonial Medical Services. Compiled from official sources. By Alexander Faulkner, Sergeant-Major. London: H. K. Lewis, 136 Gower street.

This little pamphlet is of undoubted value to any one who desires to enter any of the above services. It contains all the requisite information as fully condensed as is practicable without impairing its value.

THE AFTER-TREATMENT OF CASES OF ABDOMINAL SECTION. By Christopher Martin, M.B., F.R.C.S., Surgeon to the Birmingham and Midland Hospital for Women. Cornish Bros., New Street, Birmingham.

Mr. Christopher Martin's opportunities for making observations on this subject while assistant of Mr. Lawson Tait have been taken advantage of and put on paper in a very readable form, published originally in the *Birmingham Medical Review* in parts. The papers have been collected into a small monograph, handsomely bound.

Mr. Martin has followed very closely the teaching of Mr. Lawson Tait. He differs with him, however, on several points, and chiefly as to the value of antiseptic measures. We are glad to see that he agrees with most abdominal surgeons as to the uselessness of the thermometer as an aid to the diagnosis of peritonitis, and that he considers classical symptoms of peritonitis described by the older text-books to be very rarely seen in the peritonitis following abdominal operations.

THE STUDENTS' QUIZ SERIES: GYNECOLOGY. By G. W. Bratenahl, M.D., Assistant in Gynecology, Vanderbilt Clinic, New York, and Sinclair Tousey, M.D., Assistant Surgeon, Out-Patient Department, Roosevelt Hospital, New York. All the series edited by Bern. B. Gallaudt, M.D., Administrator of Anatomy, College of Physicians and Surgeons, New York.

This work is intended particularly for students, is nicely bound and well printed. The illustrations are largely diagrammatic, so that they can be more readily understood by the student. The work is taken up systematically, and is presented to the student in a very concise form. In such a work as this it is impossible to criticize the views of the different authors, or to enter into them in detail, and it is only possible to present the subject by adopting the medium course, and avoiding extreme views. If the student expects to find a classical list of symptoms, such as are given for each case, he will necessarily be disappointed, but it is desirable that he should be acquainted with all the symptoms that may occur, though they may not all be present in any one case. The same may be said regarding the classification of the differential diagnoses. The work is admirably adapted to the purpose for which it is written.

A PRACTICAL TEXT-BOOK OF THE DISEASES OF WOMEN. By Arthur H. N. Lewers, M.D., M.R.C.P., Obstetric Physician to the London Hospital. Fourth edition, with one hundred and forty-four illustrations. London: H. K. Lewis, 136 Gower Street, W.C., 1893.

This work has been so frequently favorably reviewed that it needs but little commendation from us. It is a work of great value to the student, and may be

used with much profit by the practitioner. The illustrations are good, and the arrangement of the book is admirable. We think that Dr. Lewers would do well to elaborate his remarks on ectopic gestation, as he has scarcely done himself justice. He refers the reader to many papers and discussions on the subject. With his experience in writing, he could present to the student a better pen picture of the subject than the student could glean for himself by making the search that is recommended.

We are glad to see that Dr. Lewers favors the supra-vaginal amputation of the cervix for cases of cancer beginning in the vaginal portion. He has now done the supra-vaginal amputation of the cervix for cancer twenty-two times without a death, and he feels satisfied that the operation is less fatal than that of total extirpation. We differ from him, however, regarding the uses of rapid dilatation of the cervix. When necessary to dilate sufficiently to admit the finger, he prefers using laminaria tents. We have dilated and explored many a uterus at one sitting, under chloroform (easily within half an hour from the commencement of the dilatation to the termination of the exploration), by using a sufficiently large tenaculum forceps to firmly grasp the cervix and counteract the upper pressure of the finger after the dilator has been removed. We believe the method to be the best that can be adopted. We have no use for laminaria or other tents.

Another chapter on diseases of the bladder and diagnosis of them would be an acceptable addition to this work, including the recent use of the cystoscope, the endoscope, and catheterization of the ureters.

The following books and pamphlets have been received :

- NON-MALIGNANT TUMORS OF THE LARYNX. By W. Schipplegrell, A.M., M.D. Reprinted from the *New Orleans Medical and Surgical Journal*.
- TRANSACTIONS OF THE AMERICAN PEDIATRIC SOCIETY. Fifth Session, held at West Point, N.Y., May, 1893. Edited by Floyd M. Crandall, M.D.
- A MANUAL OF THERAPEUTICS. By A. A. Stevens, M.A., M.D., Lecturer on Terminology and Instructor in Physical Diagnosis in the University of Pennsylvania, etc., etc. 436 pages; price, \$2.25. Philadelphia: W. B. Saunders, 925 Walnut street.
- THE YEAR BOOK OF TREATMENT FOR 1894. A Comprehensive and Critical Review for Practitioners of Medicine and Surgery. In a series of twenty-four chapters, by eminent specialists. In one 12mo. volume of 497 pages. Cloth, \$1.50. Philadelphia: Lea Brothers & Co., 1894.
- SYPHILIS OF THE INNOCENT, Clinically and Historically Considered, with a Plan for the Legal Control of the Disease. By L. Duncan Bulkley, A.M., M.D., Physician to the New York Skin and Cancer Hospital, etc. The essay to which the College of Physicians of Philadelphia, in 1891, awarded the Alvarenga prize. 400 pages. New York: Bailey & Fairchild.
- A PRACTICAL TREATISE ON NERVOUS EXHAUSTION (NEURASTHENIA), ITS SYMPTOMS, NATURE, AND SEQUENCE TREATMENT. By George M. Beard, A.M., M.D. Edited by A. D. Rockwell, A.M., M.D., Professor of Electro-Therapeutics in New York Post-Graduate Medical School and Hospital, etc. Third edition, enlarged. E. B. Treat, 5 Cooper Union, New York. Price, \$2.75.

## Medical Items.

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DR. A. R. HANKS, Blenheim, has been appointed associate coroner for the county of Kent.

PROF. HIRSCH, Professor of Medicine in the University of Berlin, died recently, at the age of eighty-three.

PROF. OSLER, of Baltimore, will leave about the end of May for Paris, where he expects to remain for some time.

DR. PYE-SMITH, of London, delivered the first Hunterian Society lecture, February 28th, on "Rational Therapeutics."

PROF. VON PETTENKOFER will resign his chair in the University of Munich at the end of the coming summer semester.

DR. T. CRANSTOWN CHARLES, Lecturer on Practical Physiology at St. Thomas, died in January, at the age of forty-five years.

DR. E. E. KITCHEN, of St. George, sailed for Europe about the middle of March, and attended the meeting of the International Medical Congress at Rome.

MR. HEBERT W. PAGE, of London, will deliver the Harveian lecture of the Harveian Society, London, in November and December next, on "Some Disorders of Nervous Function due to Injury and Shock."

DR. F. MONTIZAMBERT, medical superintendent of the St. Lawrence Quarantine, who has lived in Toronto during the winter months of the last three years, has been promoted to the position of General Superintendent of Canadian Quarantines.

DR. RICHARD C. NORRIS has been appointed physician in charge of the Preston Retreat, in the place of Dr. Joseph Price, resigned. The institution was endowed by the late Dr. Jonas Preston, and had as its first physician in charge Dr. William Goodell.

DR. DANIEL CLARK, superintendent of the Asylum for Insane, Toronto, read a very interesting paper, April 5th, before the members of the historical section of the Canadian Institute on "The Pioneer Gold Hunters of California." Dr. Clark was himself one of these pioneers, and his description of life in the diggings is said to have been exceedingly interesting.

DR. BROWN-SEQUARD, the eminent physician and physiologist, died in Paris, April 2nd, at the age of seventy-six years. He was at one time Professor of the Physiology and Pathology of the Nervous System at Harvard University. He returned to France in 1869, and was appointed a professor in the *École de Médecine*. In 1890 he made quite a commotion in the medical world by announcing his supposed discovery of a rejuvenating elixir, which he thought was going to do wonders in restoring exhausted vitality, especially to the aged.

DR. WM. LEISHMAN, the distinguished Professor of Midwifery in the University of Glasgow, died February 18th. He was born in 1833, graduated at Glasgow University in 1855, and was appointed Professor of Midwifery in 1868. He retained the position for twenty-five years, when ill-health compelled him to resign. He published his well-known work on midwifery in 1870. There have been four American and three English editions of this work. Dr. Leishman was engaged on a fifth edition when his health gave way, about a year and a half ago.

WE have to announce with very deep regret the death of Dr. J. R. Logan, one of the ablest of our young Canadian graduates, at his home in Grand Forks, North Dakota. He graduated at Trinity University, Toronto, in 1885, standing first in his year, and receiving the University gold medal. After spending a year at post-graduate work in Edinburgh and London, he settled in Grand Forks, where he practised up to the time of his death. As a medical practitioner, he achieved remarkable success, and rose almost at once to the front rank of physicians and surgeons in Dakota. He was honored in many ways by his professional brethren in his adopted country, and also received certain offices from the state. Among the many offices he filled, we may name the following: County physician; superintendent of the county board of health; city health officer of Grand Forks; secretary of the state board of medical examiners; representative of North Dakota at the International Medical Congress, Washington, in 1892. It is hard to conceive how he was able to accomplish so much work in connection with these various offices, when we consider the fact that, during his eight short years in North Dakota, he had, in addition, to attend to a very laborious practice. We learn from the local papers of Grand Forks that he was suddenly cut off in the midst of his work, as he was found dead in his office at 8 o'clock on the morning of March 25th. In private life he was much beloved by those who came into intimate relationship with him, and his numerous friends in Canada will bitterly lament his loss.

PORTRAIT OF DR. HODDER.—One of the most interesting events at the Medical Convocation of Trinity University, April 5th, was the unveiling of the portrait of the late Dr. Hodder, the first dean of Trinity Medical College. Dr. Hodder, who died in 1878, was certainly one of the most distinguished physicians that Canada has known, and his deservedly high reputation had extended far beyond the confines of this country many years before his death. His many friends in Toronto and elsewhere appreciate very highly the action of those who have presented this portrait to the University of Trinity College.



The artist is Miss Edith Hemming, who has lately come to Toronto from Ottawa, and there is a general consensus of opinion that her work in this instance is one of rare merit.

THE *Medical Chronicle*, of Manchester, England, has been transferred to the Owens College, and will in future be conducted by the professors and lecturers of the Medical School.

OPHTHALMIC HOSPITALS IN DUBLIN.—Endeavors are being made to bring about an amalgamation of the two ophthalmic hospitals in Dublin, the National Eye and Ear Infirmary and St. Mark's Ophthalmic Hospital.

FATAL FOOTBALL ACCIDENT.—Another fatal football accident has happened in England. Sub-Lieutenant Arthur William Richmond, son of Dr. Sylvester Richmond, of Kent County, received an accidental blow on the abdomen, February 9th, which caused his death in forty-eight hours.

TRINITY MEDICAL ALUMNI ASSOCIATION.—At the annual meeting of this association held in Trinity University, April 4th, the following officers were elected: President, Dr. G. A. Bingham; vice-presidents, Dr. Milner, of Toronto, and Dr. Milner, of Enniskillen; general secretary, Dr. E. Clouse; general treasurer, Dr. H. Pepler; auditor, Dr. Allen Baines. A very successful dinner was held on the same evening at the Rossin House.

THE physicians of the Prince Edward, Hastings, and Lennox territorial division held a meeting in Belleville, March 30th, and formed an association. The following officers were elected: President, Dr. Ruttan, Napanee; vice-president, Dr. McKenzie, Trenton; secretary-treasurer, Dr. Bowerman, Picton; executive committee, Dr. Eakins, Belleville; Dr. Macaulay, Frankford; Dr. Thornton, Consecon; Dr. Kidd, Picton; Dr. Spragge, Stirling.

UNIVERSITY OF PENNSYLVANIA.—The medical faculty of the University of Pennsylvania occupies a deservedly high position in the medical world. We learn from the *University Medical Magazine* that the total number in attendance during this session is eight hundred and one. Last year the number was eight hundred and forty-six, under the old regulations, which allowed students to attend the final examinations after an attendance on three sessions. The compulsory four years' course came into operation during this session, and the friends of that institution will be gratified to know it has not materially reduced the numbers of students, which are larger than those in any other medical school in America.

MEDICAL FEES IN FRANCE.—M. Dumontpallier sued a notary of l'Aisne, whose wife he had treated in 1892, before the civil tribunal of the Seine, to recover an honorarium of 1,500 francs. The lawyer, who had already tendered 700 francs, pleaded that this sum was sufficient. Hence the action. Having heard the advocates on both sides, the tribunal delivered judgment, basing its decision on the following grounds: "Seeing that in a question of medical fees the points to be regarded are the pecuniary situation of the patient, and the repute which the doctor may have acquired through his labors and his discoveries; and considering in the present case the position of the patient's husband and the medical eminence of Dr. Dumontpallier, the sum demanded is not excessive." The tribunal accordingly condemned the attorney to pay the fee of 1,500 francs in full.