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THE
MONTREAL MEDICAL JOURNAL.

A Monthly Record of Medical and Surgical Science.

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Original Communications.

ABSTRACT OF A CLINICAL LECTURE

DELIVERED AT THE MONTREAL GENERAL HOSPITAL, JUNE 18TH.

BY T. JOHNSON-ALLOWAY, M.D.,

The first case I bring before you to-day, gentlemen, is one of recto-vaginal fistula :

R. II., aged 32, married six years ; two pregnancies at full term ; youngest child two years of age. Complains of pain in back and iliac regions, a burning sensation in vagina, and escape of gas by that passage.

The opening is situated in the lower third of the vagina, or just anterior to the sphincter ani muscle. As I pass my index finger into the rectum and turn the point of it upwards, you see it passes through an opening in the septum, into the vaginal tube. By this manœuvre we obtain a fair estimation both of the size of the opening and the strength of the sphincter ; also what has been left of that muscle after so grave an injury. The recto-vaginal septum may be perforated by a fistula in any part, but the site corresponds in quite a typical manner to the mode of its occurrence.

In the lowermost part of the septum are found those fistulæ which are left over after incomplete cure of total perineal ruptures, or after perforation of foreign bodies which have stuck fast in the rectum. Somewhat higher, from, say, 2 to 5 cm. above the anus, are found those fistulæ produced by pressure-necrosis during difficult labor, and they generally correspond

to the position of the bony exit of the pelvis—the point of the sacrum, or coccyx.

The upper peritoneal portion of the septum is the site of perforations resulting from encapsulated exudations in Douglas's pouch bursting through rectum into the vagina, or the rupturing of an extra-uterine pregnancy through both tubes.

The case before us belongs to the first class I describe; that is, the abnormal communication is due to necrosis of the soft parts as a result of long-continued pressure of the head during her first labor. The size of these pressure-necroses fistulæ varies very much; this one is about the average, being about 2 cm. in its longest diameter, which is in the direction of the long axis of the vagina. The mucous membrane of the posterior wall of the rectum protrudes through the opening into the vagina, and, as you see, carries with it a rolling border of the mucous membrane of the anterior rectal wall as well.

The opening, you will also see, is not in the centre of the passage—in fact it rarely is; it is situated to the right of the posterior columna rugarum, which sometimes overlaps it as a valve. The nature of such a blemish as this involves the loss of the most important function of the rectum. The patient cannot prevent gases and liquids passing from the bowel into the vagina, and thus renders her life most miserable. Our object, therefore, is to restore the recto-vaginal septum by operative means. And operative treatment is indicated in cases except those resulting from cancerous ulceration. The best time to operate is about six to eight weeks after labor.

I do not intend here to relate to you all of the different methods of repairing such an injury; time would not permit; but will demonstrate the method I intend to adopt in the present case by means of this little model of potter's clay. Previous to repairing recto-vaginal fistulæ and ruptured perineæ, by Tait's flap-splitting, it was thought necessary always to divide the sphincter and whatever remained of the perineum right up to the fistulous opening, and undoubtedly it was the proper method to pursue.

I do not think in this case, however, it will be necessary to

do more than forcibly stretch the sphincter so as to paralyze it for a short time while union is going on. After having done this I split the recto-vaginal septum with this obtuse-angled scissors until I have reached quite an inch above the upper portion of the fistula. I now pass silk-worm gut sutures in such a manner as to draw down that portion of the split anterior rectal wall above the fistula, over it, and thereby seal it. At the same time the sides of the perineum are drawn together with the sutures. After having thus demonstrated to you the operation on this model, I will perform it on the patient which has just been brought in anaesthetized. I would say, however, that complicating the recto-vaginal fistula, this patient has an old bilateral laceration of the cervix, which I will first repair by means of Emmet's trachelorrhaphy, occupying but a few moments.

In performing these flap-splitting operations you will often find large dilated veins running across the surface of cleavage. It is best to cut them through completely, as, if left and are afterwards transfixed by the needle, may give rise to a troublesome hæmatoma in the wound. This patient's bowels will be, from to-morrow, kept very loose by saline purgatives, and the sutures removed on the ninth or tenth day. Rest in bed, however, will be enforced for another week.*

The next case, gentlemen, is an exceedingly interesting one. Her history is as follows :

M. L., aged 48, married twenty-eight years ; thirteen children, youngest five years of age. Frequent and painful micturition, dysmenorrhœa, and profuse menstruation.

In brief, the conditions here are bilateral laceration of cervix, enormous hypertrophy of posterior segment of cervix, ectropion and cystic disease. The uterus is lying in the well of the pelvis, in the third degree of retroversion ; easily replaceable, though enlarged and hard—old-standing chronic metritis. The perineum is destroyed down to the sphincter and the vaginal walls prolapsed. We have, considering all these conditions, a

* Perfect union, with complete closure of fistula, was found on tenth day after operation.

very bad state of affairs, though, fortunately, easily remedied. As regards treatment, we will do well to consider the various conditions *seriatim*. There is first to attract our attention the cervical laceration, which, from the extreme ectropion and hypertrophic disease, will not admit so well of Emmet's trachelorrhaphy as of Schroeder's supra-vaginal hysterectomy. Then we have to deal with the lacerated perineum and an injured pelvic floor. Tait's flap-splitting method will be most suitable here. Finally, we have to deal with the still prolapsed and retroverted uterus, and the two operations that I have spoken of will in no wise give this woman, with more than ordinary intra-abdominal pressure, relief. In order, therefore, to obtain a good result for her, we will have to perform Alexander's operation—that of shortening the round ligaments. By this latter procedure we draw the uterus, ovaries, and broad ligament-folds well forward, and we do away entirely with the injurious effects of intra-abdominal pressure, by changing the direction of its force from the anterior to the posterior face of the uterus and broad ligaments. Therefore, after the round ligaments have been shortened, the whole intra-abdominal pressure will have been directed behind the uterus, into the posterior half of the pelvic cavity, and will tend, if anything, to support the uterus and broad ligament.

We have now completed Schroeder's operation on the cervix and Tait's on the perineum, and my house surgeon tells me that we have absorbed twenty minutes in so doing; we will therefore have ample time to go on with Alexander's operation.

The field of operation, you see, is treated, as regards preparatory toilet, in the same way as for a laparotomy.

I stand on the opposite side of the patient to that on which I make the incision.

First find the spine of the pubis, and cut down upon it with one stroke of the knife, continuing the incision upward and outwards about half an inch to the inside of Poupart's ligament to the extent of one and a half to two inches in length. On finding the ring and separating slightly its pillars, the round ligament will rise up to the surface, covered with a mass of fat

which appears to me to be an off-set from the subperitoneal fat, as it is exactly like it in appearance. This, gentlemen, is the structure we are in search of. You will always know it by its white, pearly, glistening appearance, about the thickness of two ordinary lucifer matches placed side by side, and capable of being gradually drawn out of the opening by slight traction with the fingers. We have now drawn out about four inches of the ligament, and you will notice that it becomes gradually thicker and more pink in color as it approaches the uterus. Five or six silk-worm gut sutures are now passed, taking in the wound thickness, half the ligament, and the pillars of the opening. A small drain made of a few strands of silk-worm gut is placed in the lower angle of each wound, the slack of the ligament cut and torn away from its distal attachment, and the wound dressed with sublimated gauze, etc. The drain will be removed on the third day, the sutures on the fourteenth, and the patient retained in hospital for four weeks.

REMARKS ON ANTISEPTIC EYE-SURGERY.

BY F. BULLER, M. D.,

Professor of Ophthalmology McGill University; Ophthalmic Surgeon to the Montreal General Hospital.

(Read before the Ontario Medical Association, Toronto, June 6, 1889.)

Shortly after "Listerism" began to be recognized as a substantial improvement in the art of surgery ophthalmologists commenced to seek for means of applying similar methods in ophthalmic surgery. Unfortunately the great principal of Listerism, which is absolute cleanliness, was for a long time over-shadowed by the elaborate and ever changing details of its application. I well remember at that time hearing the subject of antiseptic eye-surgery discussed by several leading ophthalmologists of that period. The general opinion seemed to be that the anatomical and physical conditions of the eye were such as to render the methods of Lister wholly inapplicable in ophthalmic practice. So soon, however, as the great principle on which all antiseptic surgery is founded came to be generally recognized ophthalmologists the world over commenced to pay more strict attention to cleansing measures, both in operative cases and in all affections of the

eye attended with unhealthy secretion. They soon found, too, that some of the so-called germicidal substances could be applied in efficient strength to the eyelids and conjunctiva not only without danger but with palpable advantage in the presence of certain morbid conditions. Such drugs as boracic acid, carbolic acid, and solutions of perchloride of mercury were used on account of their reputed germicidal properties, not only in purulent affections of the cornea and conjunctiva, but as a preventive of suppuration in all major operations on the eye.

Antiseptic eye surgery in its widest sense includes—1st, the treatment of all inflammatory affections of the eye of a presumably septic character or in which the tissues or secretions or both contain micro-organisms supposed to be active agents in the inflammatory process. 2nd. The use of antiseptic precautions before, during and after operations on the eye for the purpose of preventing suppurative inflammatory action. I do not intend to speak of the first-class of cases except to state in a general way that I am fully convinced by my own experience in the treatment of this class of eye diseases that many eyes can be saved by strict attention and the free use of antiseptic remedies that would perish if left to nature, or such routine treatment as the text-books of a few years ago contain.

Everyone who has had much experience in operating on the eye must have observed that suppurative and ulcerative complications nearly always occur if they are going to take place at all, within a comparatively short time after the operative interference. In operations which involve penetrating wounds of the eyeball, such as the extraction of cataract, the formation of pus is sometimes noticed within a few hours after the operation, and I may say as far as my own observation goes, I believe this complication seldom, if ever, occurs later than twenty-four hours after the operation.

Another striking fact is the promptness with which union of the cut surfaces takes place when the eye is in a healthy condition. This, too, is, as a rule, a matter of only a few hours. In addition to this we have the unquestionable and no less important fact that the more recent the wound the more favourable are the conditions for septic action.

It follows from these observations that if we can in any way manage to keep the eye free from septic influences for the space of twenty-four hours, we carry it safely through the most dangerous period. This at least is true, if, as most of us now believe, suppuration can be shown to depend on septic influences, and especially so if the septic influence is from without, as it undoubtedly is in nearly every instance.

The only possible way of proving the actual value of antiseptic eye surgery is that of comparing results obtained under this system with those obtained when no special precautions are used. The comparison would be most complete if made on a large scale by the same operator with all other circumstances unaltered. For obvious reasons these conditions can never be entirely fulfilled. We can, however, institute a comparison between the antiseptic and the older methods, with other conditions approximately the same, and in this way conclusions may be drawn which will give us a fairly accurate idea of the relative value of the two methods.

Operations for the removal of cataract afford the greatest scope for making such comparisons, and for this reason I will give a *résumé* of the cataract operations which I have performed during the past two years, that is from May, 1887, to May, 1889. The number, though not very large, is, nevertheless, perhaps sufficient to justify this attempt to illustrate the subject of my paper. During the period just mentioned I have removed ninety cataracts by the various methods of extraction now in vogue.

The great majority of these were senile cataracts and the operation usually employed was the one known as sclero-corneal extraction with iridectomy. There are, however, in the series, cataracts of almost every variety, such as congenital, lamellar, traumatic, and soft cataract in early adult life of unknown origin. I do not think the value of the antiseptic method is materially modified by introducing these into the series because I am fully persuaded disastrous results are relatively quite as frequent in operations for the removal of these as in the more common senile cataract.

I will not give details as to the exact amount of vision attained in each case for the reason that many of them were hospital patients and most of these were discharged from the

hospital without an accurate record of vision having been made. Moreover the records of visual acuteness commonly given in the statistics of cataract operations are seldom of much practical value because they do not by any means represent the final results. It often happens that an eye, which at the time of the patient's dismissal appears most unpromising, ultimately turns out very satisfactorily, and vice versa.

Vision of $\frac{1}{10}$ or $\frac{1}{5}$ after a successful operation may often be vastly improved and perhaps brought up to the normal by a secondary operation, and as a rule illiterate persons are satisfied with imperfect vision and do not return for any secondary operation. I may here state that in private practice I do not consider any cataract operation satisfactory, if the eye is otherwise healthy, unless the patient ultimately gets sufficiently good vision to admit of reading ordinary print. But in making up statistics of cataract operations I would, if classifying according to visual results, divide into four classes:—

- 1.—Good result $V \Rightarrow \frac{1}{10}$.
- 2.—Satisfactory result $V = \frac{1}{10} - \frac{1}{15}$.
- 3.—Unsatisfactory result, $V = \frac{1}{15} - \frac{1}{100}$.
- 4.—Bad result, $V < \frac{1}{100}$.

As in the present instance I am not giving a precise statement of the visual results I shall classify as follows:

1. *Good result.*—All cases in which no complication occurred likely to prevent the eye from attaining its maximum vision. For instance, a senile cataract is removed, no complications of any kind result from the operation. The fundus oculi is subsequently seen perfectly by the ophthalmoscope in all its details. Yet V. only $\frac{1}{10}$. There is found to be a central chorio-retinitis of old standing, accounting for the defective vision.

2. *Satisfactory result.*—All cases in which complications occurred after the operation, and fairly attributable to it, which would obviously prevent the eye from attaining its maximum vision but without greatly impairing its usefulness.

3. *Unsatisfactory results.*—All cases in which serious complications arose in consequence of the operation and caused diminution of vision, but not such as to prevent the patient from seeing sufficiently well to get about.

4. *Bad result or failure.*—All cases in which complications occurred of so serious a nature as to prevent the patient from regaining sufficient vision to see his way about.

On this basis then how does it stand with the ninety cases now under consideration? I find there are 76 good results, or 84.4 per cent.; 12 satisfactory results or 13.3 per cent.; 2 unsatisfactory results or 2.2 per cent., and no failures. Most of these operations were done under the influence of cocaine, and I think this has had something to do with results being better than were usually obtained before the days of cocaine, for there is no doubt operations on the eye are now performed with much greater deliberation and precision than was the case where no anæsthetic, or such anæsthetics as ether or chloroform were used; and there is, moreover, no doubt but that the patient's general condition is much more favorable after cocaine anæsthesia than it used to be after the profound disturbance so often seen in consequence of the administration of a general anæsthetic.

In my own experience I have never had so long a series of cataract operations without loss of one eye as the one now presented, and I am quite inclined to attribute this unusual success to the strict use of antiseptic precautions rather than to increased skill in operating or any other collateral circumstance. Compared with the cataract statistics of other ophthalmic surgeons as we find them in current literature of a few years ago, my results are certainly more favorable as it is not uncommon to find the failures amounting to five and even ten per cent.

I will not go into details of the ninety cases just referred to but at the same time I cannot refrain from calling attention to the remarkable absence of suppurative inflammation in the whole series.

In only one instance there was a dense yellowish infiltration of the vitreous humor which had the appearance of a suppurative process, and when the patient disappeared from observation vision was reduced to qualitative perception of light. The eye, however, was beginning to clear up and about six months later the woman's husband wrote to say that she could see quite well again.

The two worst results were in both eyes of the same patient,

a debilitated hard-working man, of intemperate habits, with thin flaccid cornea. There was an interval of six months between the two operations and in both the course of events was the same. For three or four days all appeared to be well, then, for no obvious reason an insidious iritis set in, resulting in nearly complete occlusion of the pupil. Subsequently an iridotomy gave vision $=\frac{1}{2}\frac{2}{6}$ with one eye, and with the other vision was $\frac{1}{2}\frac{0}{6}$ without further interference.

In these operations I prepare the patient in the following manner :

Fifteen or twenty minutes before the operation one drop of a four per cent. solution of cocaine is instilled into the eye. Immediately before the operation the patient's face and eyelids are thoroughly cleansed with soap and water and then with solution of perchloride of mercury 1-5000, and the eye is also flushed with the same. Then another drop of cocaine is instilled and the eye again flushed with solution of the perchloride, 1-10,000, and the same solution is used during the operation as much as may be necessary.

I always wash each instrument to be used, with alcohol immediately before and after the operation. After the operation a thin layer of cotton soaked in the 1-10,000 solution is laid on the lids and over this a light compressure bandage applied in the usual way. I have not found any injurious effects from the perchloride used in this way unless it were once perhaps a little transient opacity of the cornea and twice a slight eczema of the lids which disappeared in a few days.

Among other ophthalmic operations for which antiseptic precautions are essential to success I would especially mention the operation of inserting an artificial vitreous, and also plastic operations involving both skin and conjunctiva of lower lids, in which latter the conjunctival secretion is particularly prone to contaminate the wound and prevent union by first intention.

CASE IN PRACTICE—TETANUS INFANTUM.

BY ED. EVANS, M.D., LA CROSBY, WISCONSIN.

Infant, five days old, lies on back, with eyes closed, mouth slightly open, tongue pressed against teeth and interspace filled with frothy saliva; face contracted, and of a muddy, yellowish hue; slight cyanosis of lips; respirations are fast and very irregular (62 per minute); the head is held straight; the neck is stiff, so that the body can be lifted from the bed by placing the hand behind the head. The eyes are examined with difficulty; they are slightly rotated upwards; pupils are equal and normal in size. The arms are pressed to sides, the forearms flexed on chest, and the hands clenched, the thumbs in the palm. There is spasm of the diaphragm, irregular in intensity and rhythm. The abdominal muscles are somewhat rigid. The umbilicus is moist and slightly red, but not inflamed-looking, and no sign of pus. The thighs are flexed on trunk; the legs and feet are also flexed, as are the toes. There is no jaundice of the trunk or limbs. Pulse 150, heart steady and regular; temperature 101.5° F. There is persistent rigidity of all the muscles, paroxysmally intensified. Attempts at passing the finger into the mouth, stirring the limbs, or moving the clothes causes firm closure of the mouth, jerking of the muscles of the face and limbs, and a paroxysmal increase of the rigidity, during which the respirations become more impeded and the cyanosis is increased. Examination of the head reveals nothing abnormal.

The first symptoms were noticed about twelve hours before, when the child refused to nurse and was cross and fretful. It gradually grew worse, and in a short time the jaw became rigid and respirations impeded. It had the first "spasm" about six hours after illness was first noticed. During the night it grew rapidly worse and had opisthotonos twice. The nurse treated it for "spasms" with hot bath, etc.

It was an easy labor; the child was remarkably robust and fat. The bowels were regular and it passed urine all right. (She was attended by a midwife.) As it was impossible to give anything by the mouth, I gave gr. ii chloral hyd. by enema, to be repeated, and ordered perfect quiet.

The child died four hours later, apparently from exhaustion. The muscles relaxed a few minutes before death. Duration, seventeen hours. The slight jaundice I noticed in face rapidly increased till it spread over head and trunk before death, being very marked in face, but little, if any, in limbs. An hour after death the body was quite warm and rigor mortis very marked. An autopsy was refused. The child belonged to healthy parents. The sanitary conditions about good. It had not been exposed to cold in any way. There did not seem to be any intestinal irritation up to the time of the attack, and after I first saw the child the bowels moved twice, the stools being normal in color and consistency. The jaundice which appeared so rapidly was scarcely noticeable when I saw the child five hours before death. The nurse remarked on the very rapid emaciation during its short illness.

I might mention incidentally that a few months ago two horses died in the vicinity of idiopathic tetanus, and a few days previous to this case a gentleman of the city died of traumatic tetanus.

Retrospect Department.

REPORT ON THE PROGRESS OF OPHTHALMOLOGY.

BY FRANK BULLER, M.D.,
Professor of Ophthalmology, McGill University.

G. Martin of Bordeaux has labored assiduously to prove that migraine is an arthritic disease which only appears in cases of partial contraction of the ciliary muscle. He has found astigmatism present in nearly all cases of migraine, often marked by a partial contraction of the ciliary muscle. Very low degrees of astigmatism suffice to set up faulty action in the ciliary muscles and thus cause migraine. In the majority of cases, the astigmatism amounted to less than one dioptre. The prolonged use of atropine was often necessary to discover the actual degree of astigmatism, the spasmodic action yielding only after several weeks of atropinization. Before the use of the drug both eyes might appear to be astigmatic, but afterwards the static astigmatism would commonly be found in one eye only; to overcome

this, the irregular contraction of the ciliary muscle had induced an apparent astigmatism in the other eye. When only one eye is affected the hemicrania is confined to that side.

The development of migraine, according to this authority, depends on three factors :

1. A constitutional anomaly, arthritis.
2. Partial contraction of the ciliary muscle.
3. Upon accidental causes varying with each case.

Martin bases his views upon a long series of clinical cases given in detail, and concludes from them as follows: " Our theory of astigmatism as the cause of migraine ophthalmique therefore rests upon a number of proofs. First, upon the constancy of astigmatic contraction ; secondly, upon the confinement of the unilateral migraine to the side of this contraction ; and, finally, on the good effect of cylindrical glasses."

[Our experience of the use of atropine in correcting errors of refraction would lead us to believe that in this country comparatively few patients would submit to the long course of atropine that Martin has found essential.—F.B.]

Causes of Myopia.—Risley has found several instances of originally hyperopic eyes eventually becoming myopic. He refers this remarkable change to the presence of astigmatism. It may here be stated that Sattler's views regarding the influence of astigmatism in causing myopia have not generally been accepted.

The real cause of the development of axial myopia is as yet by no means settled, notwithstanding the many theories advanced in explanation thereof. One of the latest of these theories is that propounded by Weiss of Tübingen, whose anatomical investigations as to the cause of myopia led him to believe that the optic nerve is not exposed to any strain by the movements of the eyes when the piece extending from the anterior end of the optic canal to the insertion at the globe is long, but that such strain results when this portion of the nerve is short. This strain accounts for the tissue changes at the extreme end of the optic nerve. When, however, the growth of the body has ceased, the influence of this strain as a cause of myopia ceases.

Purulent Ophthalmia.—Aldfield (Prevention of Contagious Diseases of the Eye during the first week of life, *Berliner Klin. Woch.*, No. 14, 1888) recommends “irrigation of the vagina with solution of corrosive sublimate during parturition, and as soon as the child’s head appears he washes the face and eyes with ordinary water and then covers the child’s face with a folded cloth so that the vaginal discharges cannot come in contact with the child’s eyes.” [This procedure is not likely to be generally adopted, and in view of the very small percentage of new-born infants that suffer from ophthalmia neonatorum, even when no special precautions are taken in the way of prevention, it would hardly seem to be necessary. If, however, the accoucheur has any reason to suspect venereal disease in the parturient woman, some such precautionary measures should on no account be neglected, and would doubtless often save the infant from a dangerous disease of the eyes.—F.B.]

In the treatment of acute purulent ophthalmia, Hoor recommends, in the early stages of the disease, ice compresses to the lids and frequent washing of the conjunctiva with a solution of permanganate of potash. In the treatment of this disease the condition of the cornea must be carefully watched; if ulceration appears cold compresses are contra-indicated. Frequent cleansing of the conjunctival sac with warm, unirritating antiseptic solutions is, however, essential. Mules treats blenorrhic conjunctivitis by washing the everted lids and brushing them with alcohol; he also washes them with corrosive sublimate 1×2000 . Whatever may be the choice of remedies in the treatment of purulent ophthalmia, the chief element of success lies in scrupulous cleanliness and thoroughness in the application of the antiseptic selected. The treatment should never be left to uninstructed attendants.

Granular Ophthalmia.—The operative treatment of granular ophthalmia (trachoma) seems to be growing in favor. Peunow favors scraping out the granulations with a sharp spoon. When they form a fold he excises this before scraping out the remaining granulations. When they cannot all

be scraped out on account of marked infiltration (*trachoma diffusum*), he presses out the remainder with the fingers or the forceps. In this manner Peunow treated 180 patients, whom he divides into three groups. The first (43 patients) comprises those cases in which the trachoma-granules had developed upon the sound or only slightly hyperæmic conjunctiva. The results were excellent. The treatment lasted from ten to thirty days; the spoon was used from one to three days. All were completely cured; no relapses thus far, though some were treated more than a year ago. In the second group (102 patients), trachoma with marked hyperæmia and swelling of the conjunctiva and muco-purulent discharge. Length of treatment, fifteen to sixty days; the spoon was used from two to five days. Fifty patients were completely cured; in thirty-two there was thickening of the palpebral conjunctiva, while in the remainder there was thickening and unevenness of the conjunctiva generally; in three some granulations remained, as they lay deep in the tissues and could not therefore be perfectly scraped out. Third group (35 patients), trachoma with scars of the conjunctiva and corneal complications; length of treatment two months and more. In some cases there remained unevenness and pannus, which yielded to jequirity.

Staderini has made a careful study of the trachomatous process, and has uniformly discovered the presence of germs, which he calls the trachomacoccus, closely resembling the gonococcus, but much smaller. Introduced beneath the conjunctiva it produces trachoma, especially in poorly nourished animals. This author has always found the specific coccus in groups of three to nine, abundant in the protoplasm of the lymph cells of trachoma, rarely in the fibrous tissue of the granules, or in the connective tissue of the conjunctiva. As regards treatment, he recommends daily brushing with sublimate solution 1 to 500, together with the instillation twice daily of a solution of the same, 1 to 2000. When there is much discharge, nitrate of silver may be used alternately with the sublimate. Creoline has been found to act beneficially in the treatment of granular ophthalmia; a one or two per cent. solution is said to possess

powerful antiseptic properties without causing any lasting irritation. It may be used as an instillation several times daily; stronger solutions may also be applied to the everted lids, but the excess should be washed off before replacing the lids.

Ectropion.—For senile ectropion of the lower lid, Boucheron recommends excision of the tarsus, which is performed through the conjunctiva. A strip of tarsus 1 mm. wide is allowed to remain. In total ectropion he excises the whole tarsus with the exception of this strip, but in partial ectropion he only removes a portion of it.

Trichiasis.—For the relief of trichiasis, Van Milligan divides the edges of the lid longitudinally between the lashes and the meibomian glands, thus making a wound 3 to 4 mm. wide, becoming narrowed at each extremity, into which he transplants a corresponding strip of mucous membrane from the lips, keeping it in position with a bandage. [This operation, if successful, would have the advantage of giving a perfectly smooth surface to the edge of the lid, which is more than can be claimed for those operations in which a portion of integument from the upper lid is similarly transplanted either with or without pedicle.—F.B.]

Diagnosis of Lachrymal Fistula.—J. Scheff, in an article on the differential diagnosis of fistula of the cheek and gums below the inner canthus, and lachrymal fistula, states that the former is never situated exactly at the infra-orbital margin, but below it, and can be probed only downward and backwards.

Disease of Lachrymal Sac.—The pernicious effect on the eye of secretions retained in the lachrymal sac in cases of chronic dacryocystitis has long been recognized. In order to study the effect of the bacteria of the lachrymal sac upon the conjunctiva and lac-sac, Widmark introduced the lachrymal secretion from three patients into the eyes of healthy persons seven times in all. With the exception of slight lachrymation and injection lasting only a few hours, no change was noticed. He therefore thinks that the bacteria are harmless when the conjunctiva and lachrymal sac are healthy, and assumes that an obstruction to the flow of tears may perhaps be the cause. In this connection it must be observed that in

chronic dacryocystitis the conjunctiva is constantly exposed to the unhealthy secretion, which in the experiments gave rise to only transient irritation. Under these circumstances the chronic conjunctivitis and tendency to suppurative disease of the cornea is sufficiently obvious. Widmark has also made cultures in cases of serpiginous ulcers of the cornea, and has found streptococcus pyogenes and micrococcus. In 25 cases of blephoradenitis examined, he always found the streptococcus pyogenes. When gelatine containing bacteria is introduced into a pocket-like wound of the conjunctiva, a pustule is the result; and when a culture emulsion of staphylococcus pyogenes is injected under the conjunctiva, a local infiltration with catarrh of the conjunctiva ensues. The author thinks that the phlyctenula conjunctivitis and blephoradenitis are due to infection, the same micro-organisms being the cause in both.

Ocular Muscles.—The correction of faults in the muscular functions of the eyes is a subject which has in the past few years received a great deal of attention and excited much discussion among ophthalmologists. The nomenclature as well as the principles advanced and advocated by Dr. Geo. T. Stevens are fully accepted by some and almost entirely rejected by others. There seems, however, to be a growing conviction that many cases of asthenopia and headache can be satisfactorily treated by graduated tenotomy of the ocular muscles, where a surplus of power in certain muscles is found associated with deficiency of power in their opponents. In a paper read before the last meeting of the American Ophthalmological Society by Dr. Webster of New York, and entitled "Some Tenotomies for the Correction of Heterophoria, with Results," he arrived at the following conclusions:—

1. No person should have tenotomy performed simply and solely because he is the subject of heterophoria; that is, unless some annoying symptom, local or general, is present that *may* be due to the want of harmony in the action of his ocular muscles. There must be a reason for the operation in addition to the existence of the condition to be corrected.

2. Very slight degrees of heterophoria may and should be

corrected where troublesome symptoms exist which may be due to the too great use of nervous force in co-ordinating the eyes.

3. It is well that all other means that afford any prospect of relief should be tried before resorting to a tenotomy, although no time should be lost by unnecessary or dilatory treatment.

4. Tenotomies for the correction of heterophoria should always be performed under cocaine, so that the effect of the operation may be accurately measured and properly limited.

5. In judiciously selected cases, where the operation is properly performed, the average results will be quite as satisfactory as the results of most other surgical operations.

Webster had operated on four patients who were epileptics. The epilepsy was not cured in any case, though the fits were temporarily suspended in one case. In another case the fits were favorably modified, though the epilepsy was organic. In a third case there was temporary improvement, but later the patient was worse than ever. In the fourth case the fits had been suspended for over six months, and the operation was done more for the relief of asthenopia than for epilepsy, and with very good result. He further says: "There can be no objection to restoring the proper balance of the ocular muscles, when it has been lost, in cases of epilepsy and chorea, but, judging from my personal experience, it does not cure either disease. Aside from the cure of the disease, however, enough good results in relieving asthenopic symptoms to justify the procedure."

One or two hysterical cases were operated upon at Dr. E. C. Seguin's suggestion with surprisingly good results. One gentleman, a civil and mining engineer from the west, had come to Dr. Seguin with a diagnosis of "incurable spinal disease." Dr. Seguin found spinal irritation of extreme degree. He had been unfitted for business "by semi-periodical paroxysms of excruciating pain, in which he made contortions (semi-involuntary), which had been termed convulsions." Webster says: "I found him in one of these attacks when I went to his room prepared to operate on one of his interni. I sat with him over an hour, during which the agony, the plaintive cries, and the apparent convulsions continued without remission, the patient constantly

writhing in the most intense pain, until Dr. Seguin arrived, and we gave him chloroform and divided the tendon. From that time to the present, so far as I can learn, he has had but one attack, and that a very mild one, and after sufficient psychical abuse to account for a recurrence.”

The majority of cases operated upon and relieved were cases of headache, varying in degree, character and location.

A lengthy discussion followed the reading of this paper. Referring to the case of the engineer just cited, Dr. Seguin said: “The man, it seems to me, was subject largely to delusional, nervous suffering, and the question will arise, whether the operation did not do good partly by “suggestion,” as well as it may have helped in a psychical way.”

Another case was one in which all the muscles of the eyeball were remarkably feeble, and in which dizziness, attacks of a fainting nature, and confusion of mind were the chief nervous symptoms. In this case all efforts at correction proved unavailing. That was one of the cases which brings up the question strongly in the mind of the neurologist, whether the condition of the eye muscles might not be the result of neurosis and the general condition of the patient. This patient was anæmic and had a feeble heart. Seguin is inclined to the opinion that in many cases unsuccessfully treated by tenotomy of the ocular muscles, the failure is due to faults in the general condition rather than to asthenia of one or more of the ocular muscles, and although not over-sanguine as to the results to be obtained in many nervous cases from tenotomies, he intends to prosecute further enquiries in this direction. He defines his position as neutral between the extravagant claim that neuroses are curable by tenotomies and the adaptation of spectacles, and the position which assumes that these means are useless.

Dr. Henry D. Noyes objects to such expressions as exophoria, orthophoria, etc., “because they tend to lump things together and mislead as to the real state of muscular equilibrium.” The objection is hardly a valid one, because the complete clinical record which must be made in every case of known muscular fault before remedial measures can be adopted shows not only

the faulty tendency, but also the relative power of all muscles whose actions can be measured with prismatic glasses. Dr. Noyes believes that insufficiencies of the external recti are by far the preponderating troubles to be dealt with, and endeavors, when at all practicable, to relieve the difficulty by the use of prisms rather than by tenotomy. He would not operate at all unless fully satisfied that there was a considerable excess of muscular power in some one direction so that he could interfere with an over-strong muscle for the benefit of a weak one. He is convinced that a large proportion of cases of defective muscular action are mainly due to nerve exhaustion and not to pure muscular error, that the symptoms on the part of the muscles are developed in consequence of nerve exhaustion, and they are not suitable cases for tenotomy. The same conclusions have been arrived at by others who have had much experience in dealing with this class of cases.

Sexual Organs and their Relation to Eye Disease.—Mr. Henry Power, in a lengthy paper (*Trans. of the Ophth. Society of the United Kingdom*, Vol. VIII.), sums up as follows: In males, the excessive excitement of the sexual organs in youth occasions various subjective symptoms in one or both eyes—as muscæ, photopsiæ, asthenopia, and loss of accommodation, together with blepharospasm, and, at a later period, possibly retinitis, retinal hemorrhages, and white atrophy. That in young women, the epoch of the installation of menstruation may be attended with conjunctivitis, both phlyctenular and follicular, and ulcers of the cornea, with special disposition to the development of keratitis consequent on constitutional taint. That amenorrhœa, especially if suddenly induced, may be followed by hemorrhage into the anterior chamber or into the vitreous, iritis, irido-choroiditis, optic neuritis, and white atrophy of the optic disc. That dysmenorrhœa may be accompanied by conjunctivitis, keratitis, episcleritis, as well as by inflammation of the uveal tract. That the menopause is often accompanied by effusion into the vitreous, and by a disposition to glaucoma, by paresis or paralysis of the ocular muscles. That pregnancy is often attended during the early months with asthenopia, and

towards the close with albuminuric retinitis with its consequences (hemorrhages and white patches on the retina); and that if delivery is attended with copious hemorrhage, loss or great impairment of vision, with white discs, may occur. That in the puerperal state we may meet with embolism, which is sometimes of a septic character, and may rapidly lead to loss of the eye. And, finally, that in lactation—if we may be allowed to include that process in the consideration of the sexual organs—we find asthenopia, great tendency to suppuration of the cornea on slight scratches, and lachrymal diseases to be of common occurrence.

The Prognosis as to Life in Renal Retinitis.—Mr. Simeon Snell (*Trans. Oph. Soc. of the United Kingdom*, Vol. VII) relates eight cases bearing on this subject, only one of which lived longer than one year after the retinal disease first came under notice. Mr. Snell remarks: "The prognosis of the retinal lesion is truly that of the renal disease, and does not think that English writers insist sufficiently on the point that in certainly the majority of cases the presence of the retinal changes betokens such a grave condition that the period of existence is limited. In the renal retinitis of pregnancy the prognosis, however, is by no means so serious, partial or complete recovery commonly taking place under these circumstances."

QUARTERLY RETROSPECT OF GYNÆCOLOGY.

PREPARED BY T. JOHNSON-ALLOWAY, M.D.,

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The Perineum; its Anatomy, Physiology and Methods of Restoration after Injury, by HENRY O. MARCY, M.D., &c., Boston.—A voluminous and profusely illustrated paper appearing in the January number of the *Amer. Journal of Obstetrics* by Dr. Marcy is well worth careful study. It is, however, altogether too exhaustive and minute in detail to make an abstract notice of with justice. Dr. Marcy says in conclusion: "My method differs from others in the following particulars:

1. The dissection of the posterior third of the vagina, not its mucous membrane, from its vulvar attachment, carried as deemed necessary into the recto-vaginal space, and the retention of the flap.

2. In rectocele with prolapse, the closure of the deep layers of post-vaginal fascia by a continuous buried animal suture, taken either in single or double stitch.

3. In lifting forward the vagina from its vulvar attachment, the retracted transverse perineal muscles with their connections can be reached and closed also by a deep-buried suture, making in this way a true restoration of the pelvic floor.

4. Coapting all superficial surfaces by a buried animal suture, applied in a blind, continuous stitch from side to side, covering the same when dry with iodoform-collodion.

5. The application of lateral supports, pins external to the sutures as a splint to hold the parts in complete apposition without strain.

6. In complete ruptures, the lateral dissection, the joining of the rectal and vaginal edges with buried sutures, and then finishing the operation as in incomplete ruptures."

In the above, taken with the diagrams, we have the gist of Dr. Marcy's exhaustive paper; and although the author states that his method differs from those of others, we cannot admit the statement to be exactly correct. The operation described by Dr. Marcy as original is simply Tait's "flap-splitting" method as applied to the lacerated perineum. The addition of deep-buried sutures, as a method, belongs to Werth, and we think the application of supporting pins a superfluity, entailing much suffering to the patient during convalescence. As regards the animal sutures used by Dr. Marcy, whether from kangaroo or other animal, no man can prove them to be absolutely aseptic unless they have been previously boiled, and as silk-worm gut will best undergo this process, it should be chosen before all others. We would also draw Dr. Marcy's attention to the fact that few men now even think of applying more than *one* perineal suture in performing the primary operation.

Psychoses and Gynæcological Operations. (CHARLES W. FILLEBROWN, M.D.)—The appearance of psychosis after operations upon the female genitals has only lately been observed by operators. The causative relation of the operation is by no means clear, and the analysis of cases only renders the associa-

tion as cause and result more and more difficult to comprehend. Naturally we look first for some evidence of predisposition, either in the family history or in the history of the patient. In some cases we certainly do find a predisposition, but in others the psychosis is attributable only to the operation. We cannot overlook the possibility of the co-existence of organic cerebral disease, or the occurrence of embolism or hemorrhage; and, again, in cases where the patient has suffered great losses, or where a long, painful illness previous to the operation has weakened the nervous system, as well as the whole constitution. We must attach some etiological importance to this general condition.

Prof. Werth of Kiel, who read a paper upon this subject before the Gynæcological Congress of Halle last May, reported six cases of psychosis following operations. In 32 total extirpations of the uterus two cases occurred; in 160 ovariectomies, two cases; in 36 oöphorectomies, two cases. In five cases the mental disorder assumed the form of melancholia, and in one mania. In two cases the disorder made its appearance five and eight days respectively after the operation; in two cases after two or three weeks; and in the two remaining cases the disturbance developed after discharge. Of these six cases, three recovered—one after fifteen days, one after four months, and one after eight months.

In the discussion which followed this paper, Säger of Leipsig considered the psychosis in these cases latent, and the operation the exciting cause. He was of opinion that careful inquiry into the family history or that of the patient would probably show some evidence of predisposition; further, that the presence of psychological symptoms should not alter the treatment indicated by the local condition. Martin said that the gynæcology played no particular part in the causation of psychosis. He claimed that it was seen after other surgical operations in both men and women.

The author concludes with the following:—

1. Gynæcological operations can produce psychosis in patients free from hereditary predisposition.
2. Where there exists no predisposition, the mental derange-

ment is transitory and the prognosis is good. In predisposed patients the prognosis is unfavorable.

3. Mental disturbance appearing later than four months after the operation is probably independent of the latter.

4. The development of psychosis is probably limited to those cases in which the convalescence from the operation did not run a normal course.

5. The existence of a predisposition to psychosis in a patient ought not to deter the gynæcologist from carrying out the treatment indicated by the physical condition.

6. In cases of really insane patients, operations should only be performed when the physical condition endangers life or renders it insupportable."

Dr. Shepherd of Montreal recently published a paper on this subject, giving cases of psychosis following operations in men. There seems to be some relationship between these cases of psychosis following surgical operations and the cases of so-called puerperal insanity. It is well recognized by all observers how little is understood concerning the etiological nature of this form of insanity, and it would appear that the puerperal traumatism or process had the same relation to "puerperal insanity" that the gynæcological operations had to the psychosis following.

Dr. Hirst reports six cases of puerperal insanity occurring within the period of eighteen months.—(*American Journal of Obstetrics*, Feb. 1889.)

Surgical Treatment of Retroversion of the Uterus with Adhesions, with New Method of Shortening the Round Ligaments.

W. GILL WYLIE, M.D. (*Amer. Jour. Obstet.*, May 1889.)—

Dr. Wylie's method consists in opening the abdominal cavity, catching up the round ligaments with forceps about midway between the cornu of the uterus and the pubic bone, then forming a loop with the ligament and tying this loop with three ligatures so as to considerably shorten the length of the ligament. He says: "Given ten cases of retroversion with adhesions which have been subjected to what I may call the preparatory treatment with rest, boroglyceride cotton pledgets, and etherization to reach an approximate diagnosis and to enable me to exclude

those cases of endometritis and enlargement with retroversion simulating fixation by adhesions, it will be found, on opening the abdomen, that nine out of the ten cases are in reality cases of salpingitis complicated by retroversion and usually chronic endometritis; that in the majority the adhesions which fix the uterus are mainly in the broad ligaments, these ligaments being rolled back over the ovaries in such a way as to displace the fundus backward. The peritoneum covering the fundus may have adhesions binding the uterus backward, but as a rule the fundus is comparatively free, the fixation being chiefly caused by the change in the broad ligament. In about one out of the ten cases the tubes and ovaries are free, or are only slightly affected by adhesions, the adhesions not being sufficient to close the fimbriated extremities of the tubes, and the ovaries not at all or only slightly fixed by adhesions; while the fundus of the uterus is fixed by adhesions binding it to the posterior wall of the pelvis, to the rectum, etc. It is evident that the exudations in this case were not due to the extension of the uterine disease from the uterus out through the tube to the peritoneum, but that the endometritis had been accompanied by such a severe metritis as to cause inflammation and exudation on the peritoneum covering the uterus, and resulted in adhesions and fixation to the tissues in direct continuity with the walls of the uterus. Now I know that by careful treatment, notwithstanding these adhesions, some of these cases can be cured by local treatment without resorting to either laparotomy or forcible means of breaking up the adhesions; but in many cases all such treatment fails, either from the difficulty of getting the patients to submit to the treatment or the obstinacy of the endometritis, and the only way to ever reach a certain diagnosis after failure of local treatment is to open the abdomen. I maintain that laparotomy is in such cases safer than the old plan of *attempting* to break up the adhesions, either with or without ether, by means of a repositor or by any forcible means applied through the vagina."

We cannot see where Dr. Wylie's method has advantage over the operation known as hysterorrhaphy—that of attaching the

fundus of the uterus to the anterior abdominal wall by means of sutures passed through the broad ligaments, close to the entrance of the Fallopian tubes, including part of the round ligaments, and then through the peritoneum and subperitoneal tissue of the anterior abdominal wall. The procedure of Dr. Wylie is, however, a departure, and deserves notice, but whether it will become an advance or not in operative surgery, time will decide.

Two Cases of Primary Epithelioma of the Vulva and Vagina.
PAUL F. MUNDE, M.D.—Dr. Mundé gives the following short report of this rare disease :

“ While a number of cases of primary malignant disease of the external genital organs of the female and of the vagina are on record, they are still sufficiently rare to justify reporting and illustration. This is particularly true of the vagina, of which location Kuester collected only twenty-two cases, to which Olshausen added two. I myself have seen two cases, the one here reported, and one two years ago in a girl of 24, where a freely bleeding and secreting growth of the size of an almond projected from the posterior vaginal pouch. I excised it as deeply as I dared without opening Douglas’s pouch, but it soon returned and I again excised it, this time opening the peritoneal cavity. I closed the wound at once with catgut, and the patient, although confined to her bed for some time by a cellulitis and pelvic abscess, eventually made a good recovery and remained well. The microscope showed the growth to be a true epithelioma. Epithelioma is more common on the vaginal walls than medullary infiltration. The posterior wall is most frequently affected. Only in the early stage, when complete extirpation is possible, can a cure be expected. Schroeder has dissected off the entire vaginal wall down to the rectum and united the edges of the wound, including the rectal wall, and drained. Out of three cases one died of sepsis ; the second recovered, and two and one-half months thereafter there was no recurrence ; the third was still too recent when reported to admit of a conclusion as to the ultimate result. When a radical cure is impossible, the sharp curette, thermo-cautery, or some styptic, with subsequent dressing with iodoform and tannin powder, is

all that can be done to make the patient comfortable. Carcinoma of the vulva occurs about once in thirty-five to forty cases of cancer of the female sexual organs. Epithelioma is by far the most frequent variety, and remains local a long while, not infecting the inguinal glands until quite late. When it involves only the labia or mons veneris, it can usually be radically removed without difficulty; but when it has spread to the urethra, as in the case here reported, it may be necessary to remove more or less of that canal to reach sound tissue, and contraction of the urethra, or, if the neck of the bladder has been injured, incontinence of urine, may ensue. In the matter of diagnosis, only occasionally is it necessary to differentiate between epithelioma and lupus. The microscope will easily settle the question.

“I. EPITHELIOMA OF VAGINA—Mrs. E., 54 years, no children, consulted me on January 26th, 1889, for an ulceration of the right labium majus, which had developed during the past six months. I diagnosed it an epithelioma and advised immediate extirpation. The inguinal glands were not involved. On January 30th I excised the whole mass with the knife, finding it necessary to remove all of the urethra outside of the pubic bones. The wound was stitched together with catgut suture and united by first intention, except the lower portion, which closed by granulation. The patient was discharged cured on February 25th, and, so far as I know, remains well. The microscope showed the disease to be epithelioma without a doubt.

“II. PRIMARY EPITHELIOMA OF THE VAGINA.—A. V. was admitted to Mt. Sinai Hospital on January 27th. She had been treated for a vaginal discharge for six months. I found a friable, spongy, easily bleeding mass of the size of an orange growing from the posterior wall of the vagina, not involving the cervix, and extending to about one inch from the vaginal orifice. Its character was readily apparent. On January 30th I removed it with the constrictor wire, scraped the wound smooth, and cauterized it thoroughly with the thermo-cautery. The patient was discharged on February 12th. On April 11th she presented herself at the Polyclinic with a mass as large as and

much more offensive than the one removed two months before. She had become cachectic, and nothing could be done for her but to alleviate her discomfort and prolong her life for a time."—(*Amer. Jour. Obstet.*, May 1889.)

Foreign Bodies in the Bladder.—Dr. Ellison, of Canisted, N. Y., reports in the February number of the *American Journal of Obstetrics* a remarkable case, where a thread spool had been passed by a young girl (aged 12) into her vagina and from there ulcerated gradually into her bladder. It took over one year to do this, and was found lying in the bladder imbedded in a phosphatic calculus. This case is interesting in proving the sexual precocity of the patient, and also that so large and clumsy an instrument as a spool could be introduced past the vulva of so young a girl. The foreign body was removed by section of the vesico-vaginal septum.

Indications for Vaginal Hysterectomy in Cancer of the Cervix. C. THEIM.—(*Trans. German Gyn. Society.*)—Most authors were agreed that in carcinoma total extirpation must not be done when the parametria and the other adnexa are clearly infiltrated with cancer; that the result was too unsatisfactory, and out of proportion to the gravity of the operation. Fritsch has defined his standpoint in the sentence, "to perform hopeless operations is an inhuman sport." But we may assume, for the honor of German gynecologists, that they have operated only quite exceptionally in such cases. At all events, inhuman reasons cannot be alleged in the cases of men like B. Schultze and Brennecke, both of whom, but especially the latter, are well known to have pleaded for confining the indications for total extirpation in carcinoma within the limits of technical possibility. Olshausen has demonstrated that in Berlin relatively more operable cases of carcinoma come under treatment than in Halle. This fact is most noteworthy. In Berlin, with its large number of prominent gynecologists, every woman knows where to apply, when, for instance, she suffers from atypical uterine hemorrhages; hence inoperable cases are relatively few. In Halle, the conditions are less favorable, and as for Jena and Breslau, Schultze and Fritsch complain of the alarmingly large percentage of in-

operable cases. In small country towns the prospects are deplorable. In the first place, the women bear the hemorrhages for months without complaining to anybody ; then they ask older women, who, of course, assure them that it is the change of life ; then a midwife who professes some knowledge of gynæcology is consulted ; and finally the family physician is asked to prescribe something for the hemorrhage, and if he, as is unfortunately the case at times, complies without making an examination, more months pass before the woman comes to the operator, usually when it is too late. When in such terrible cases total extirpation is performed, not with the hope of affording the woman radical cure, but as the safest and best palliative relief, it truly cannot be considered an inhuman measure. The very large number of other palliatives in so-called inoperable cases of carcinoma proves, as does the multiplicity of infallible remedies in diphtheria, that there is no panacea against these diseases, and that in a long series of cases all together are of no use. In carcinoma, before a satisfactory point is reached with any of the palliative measures—for instance, cauterization with concentrated chloride of zinc—so long a time elapses that the relatives do not leave the patient in the institution until its conclusion, especially when they are informed that actual operation has not been done. So long as irrigation and tamponing of the cancerous cavity with disinfectants can be done according to rule with the aid of the speculum, the women are fairly comfortable ; but whenever, after discharge from the institution, this manipulation is left to the patient, or to the equally unskilled midwife, the old misery recommences. Many sloughing cases of carcinoma constitute a *noli me tangere*, even for the usual palliative measures. As soon as they are touched, proliferation and sloughing become excessive. After total extirpation we generally attain, in from three to five weeks, a cicatrization which frequently becomes so firm that in relapses there is no longer any ulceration, but only a formation of tumors in the cicatrix. The women then die of secondary carcinoma of internal organs, or of general cancerous cachexia, and frequently are spared to the last that most horrible of all symptoms—sloughing. If, after certain palliative mea-

tures, isolated instances of improvement of prolonged duration, or even apparently complete cure have been attained, this proves, in the author's opinion, only that such cases were not inoperable and would have had an all the more favorable issue after total extirpation. Two years ago the author performed a total extirpation on a woman, although the left parametrium was immovably infiltrated and the patient had been refused operation four months before in some out-of-town gynæcological clinic. This woman is still alive and enjoys good health. Even should she still suffer a relapse, the speaker would count the case among the best results from all his total extirpations, because a similar effect is, unfortunately, not always to be reported after operations undertaken with apparently good prognosis. But should she remain permanently cured, this would prove that we are not always able to distinguish old inflammatory parametric thickenings from cancerous infiltrations. Then it would be safest for a woman to try the total extirpation at all hazards. The speaker will continue to do this operation, even in so-called inoperable cases, whenever it appears to him technically feasible, and he hopes that many others will do the same, particularly where the operation appears comparatively simple.—(*Amer. Jour. Obstet.*, Feb. 1889.)

Suppurative Disease of the Uterine Appendages. H. J. BOLDT, N.Y.—There has been recently quite a revolution and there is now marked difference of opinion concerning the justifiability of surgical interference in diseases of the uterine adnexa. It is true that very many women have been deprived of their ovaries or tubes without having been benefited; in fact, not a few feel worse than they did previously. Many a patient, if she presented herself to the same surgeon to-day, would not be subjected to the knife at all, or the operation in some cases would be done differently. As some have gone to extremes in operating, others, again, are going to extremes in the opposite direction, instead of keeping the medium and selecting the cases for operation with greater care. Diseases of the uterine appendages may be roughly divided into three groups—1st, those in which an operation is unjustifiable; 2nd, where it is wise to watch the

patient and keep her under constant treatment to see what benefit may be derived and then decide upon the course to be pursued ; 3rd, those cases where delay is not only unadvisable but dangerous. A remark may not be out of place here with regard to cases occurring in private practice, especially among our better class of patients, namely, that in such cases there is altogether too much hesitancy on our part to interfere with the knife. It is very true that many cases of acute salpingitis recover without operative interference ; but even if they do get over the acute attack, what is the condition of such patients in the future ? Do not the majority remain invalids from pelvic disease ? It cannot be too strongly urged that we open the abdomen in every case of *active* pyo-salpingitis, from whatever cause it may arise, except under positive contra-indications, to be noticed below, or when the tubal trouble is complicated with another disease which in itself will destroy life in a *short* time, as advanced phthisis, carcinoma, etc. The question arises : Can we *always* make the diagnosis of pyo-salpingitis ? This, of course, must be answered negatively ; yet, from personal observation, often corroborated by subsequent operation, I say that it can be done in most cases, and I think that a careful observer, experienced in this line of work, will not often fail. The conditions which we must differentiate are usually hydro- and hæmato-salpinx ; if, however, the tube or tubes are much distended, ovarian and parovarian cysts must also be considered. The history of the case is of the greatest importance in the differential diagnosis. There are many operators who consider it unjustifiable to operate for hydro- and hæmato-salpinx, yet as it is unfortunately impossible for one to always make the positive diagnosis before operation, I still adhere to the opinion expressed in a paper read three or four years ago before the physicians of the German Poliklinik, where I held that even cases of hydro-salpinx should be operated upon if they give rise to serious morbid symptoms, which cannot be alleviated by other treatment, because even the simplest and most inert fluid may become purulent after any inflammatory condition set up in the walls of the tube, or from the extension of an endometritis.

I desire to lay particular stress on the fact that, when we have reason to suspect suppurating disease in activity, without evidence of free communication between such diseased tube and the uterus, the abdomen ought to be opened; even though our diagnosis prove erroneous, not much harm is done to the patient, except that she is deprived of her liberty for a period of three to four weeks, to allow comparatively firm healing of the abdominal wound; besides this there is only the restriction of diet for from ten to fourteen days. The danger of an exploratory incision by a careful and experienced surgeon is almost nothing. If our diagnosis is correct, as it should usually be, what immense advantages are gained by the patient: in the first place, it rids her of the pains which in the majority of cases accompany this condition (pyo-salpingitis), although one must not look for the cessation of the old pains immediately after operation; sometimes a number of months or even one or two years may pass before the full benefit is felt—changing her from an invalid to a healthy being. Secondly, the danger from rupture of the diseased tube is removed—an accident almost necessarily fatal, unless with immediate operation, the risks of which are far greater at that time than if done earlier. In fact, if done prior to such accident, the danger is very slight. Although a prominent German operator's mortality from salpingo-oöphorectomies is very great (over twelve per cent.), we must bear in mind that his cases were extremely unfavorable, having waited very long before determining on operation. It is against this too long waiting that I would protest. Why let a patient suffer when we have from history, examination and observation satisfied ourselves almost with positiveness that she is suffering from a disease not amenable to ordinary treatment? I call to mind a patient who was referred to me, and whom an esteemed colleague examined for me, because another very prominent gynæcologist had advised the patient against operation. The poor woman was such a great sufferer that I declined any further attempt at ordinary treatment; the gentleman who had referred her to me, several other physicians, and myself having tried it for some time without obtaining the slightest benefit. I operated,

and proved the justifiability and correctness of our diagnosis—pyo-salpingitis dating from abortion. The patient is now fully restored, a picture of health. When we have opened the abdomen for a suspected pyo-salpingitis, and find that such is not present, but that we have an hydro- or hæmato-salpinx to deal with, shall we close the wound, leaving the tubes intra-abdominal in this condition in which we find them, because some say that it is wrong to do a laparotomy for such disease? I say *no* most emphatically, provided I satisfied myself that the tube in question is at some point *firmly* occluded as the result of adhesive inflammation. No matter what the contained fluid may be, the tube ought to be unhesitatingly removed, for it is certainly of no further use to the patient, and only jeopardizes her health, if not her life. By what right should we allow such appendages to remain? On the ground and with the belief that the blood or serum, whichever the tube may contain, will be absorbed, which may be possible; but does that restore the patency of the occluded tube? Or, if we aspirate the fluid from the tube, may it not refill? If we leave it alone, we run the risks previously mentioned in such conditions; these chances must all be taken. No one will venture to say that such an organ, once firmly occluded from the results of adhesive inflammation, can ever again become permeable; compare the old pleuritic adhesions which are found daily in autopsies—can such pleuræ, after having become firmly adherent to the chest-walls, detach themselves? The condition of an occluded Fallopian tube is pathologically similar. The question will now naturally be asked, How may we recognize whether a tube is so firmly occluded as to require removal, and when can we with probable safety for the patient leave it undisturbed? The answer is quite simple; the appendage is taken in the left hand, and with the thumb and forefinger of the right hand it is gently manipulated or stroked towards the uterine opening of the tube, care being taken not to handle too roughly lest it rupture; whether the contained fluid be diminished or not will decide the permeability of the tube, and also the further procedure. I have on my record but two instances in which I regret that I interfered, both occurring

in the beginning of my work of abdominal surgery. The first was a case of catarrhal salpingitis, with frequent occurrences of local peritonitis. The adhesions in this case were very extensive, and had it not been for the kind assistance of two experienced abdominal surgeons, who were also good enough to examine the patient previously and then advised operation, I should doubtless have abstained from completing the operation. This patient died of general peritonitis on the sixth day. In the second case, the same condition called for operation, with equally extensive and dense adhesions, the patient dying on the third day from septic peritonitis. With my present views, I think it very doubtful that I would be induced to remove the appendages at all in such cases, especially if the patients were near the menopause.—*Amer. Jour. Obstet.*, March 1889.

Extra-Uterine Foetation ; Abdominal Section Eight Months after Death of Foetus ; Recovery.—DR. CULLINGWORTH reported this case to the Obstetrical Society of London, Dec. 5th, 1888. The patient was 27 years old ; her last confinement happened five years ago. In April, 1887, she menstruated for the last time. In July she quickened and continued to enlarge and feel the movements of the foetus till December, when she suffered for an hour with labor-pains. Then the movements ceased, and the abdomen decreased in size. Seven months later she was admitted into hospital. An abdominal tumor lay behind the uterus, an eight months foetus was found in a sac composed of the left Fallopian tube and broad ligament. The liquor amnii and umbilical cord had disappeared. The placenta lay in front and was removed without hemorrhage. The foetus was firmly adherent to the sac-wall. A portion of the sac was removed, the remainder being stitched to the abdominal wound and drained. The sac closed in well ; a small piece near the incision sloughed. The patient made an uninterrupted and aseptic recovery, the temperature during convalescence never exceeding 100.4°.

Intestinal Occlusion after Ovariectomy. W. HIRSCH. (*Arch. f. Gyn.*, xxxii, 2.)—According to Hirsch, occlusion could take place in three different ways : First of all, it may be of direct origin ; the gut is included in cicatricial tissue. Secondly, it

may be of indirect origin, the occlusion occurs here independently of the wound-surfaces, which heal without implicating the gut ; but the irritation attending the operative procedure and that of the antiseptic fluids used in irrigating the abdominal cavity induce an aseptic peritonitis ; the adhesive bands resulting inclose the intestines in the omentum and hinder peristalsis. Any external agency, such as blows or pressure upon the abdominal walls or the impaction of fæces, may then determine occlusion. He reckons as in the third class all cases of occlusion not dependent upon inflammation. The accident is purely mechanical, as kinking, catching of the gut between the pedicle and abdominal wall, or between the pedicle and the pelvic wall. A mixture of all these causes is frequently concerned in the etiology. In cases of the first two classifications the occurrence takes place only after the lapse of some time ; the patients die of occlusion after the wound has healed, and time for convalescence to set in has arrived. The purely mechanical occlusion occurs shortly after the operation, ere the process of healing is completed. An acute and chronic form of occlusion may nevertheless be observed after ovariectomy. Observations were too limited to determine what part previous pathological processes in the intestines play in the production of obstruction, but this factor is theoretically very probable. In one thousand ovariectomies, eleven deaths were due to this trouble according to Spencer Wells. The time of occurrence varies, generally developing shortly after operation ; instances are recorded where the first symptoms showed themselves years afterwards. The symptoms are those usually associated with this affection. In some of Hirsch's cases the pulse and temperature remained normal throughout. The diagnosis is so difficult as to make secondary laparotomy a procedure extremely hazardous. It had been done once in the fourteen cases reported by H. with successful result to the patient. The diagnosis approaches nearest certainty only where there is distinct stercoraceous vomit and the bowels remain confined. All other symptoms are those attending an ordinary peritonitis. Diagnosis is also easier in cases where the trouble supervenes some time after the operation. The occlusion occurs most fre-

quently at the abdominal wound. In occlusion of the small intestine the symptoms are the more violent; Jaffé's test for indican in the urine will also show an increase of that substance where the trouble is in the small, while it remains unaltered when the occlusion occurs in the large intestine. The prognosis is extremely unfavorable. Of H.'s fourteen cases all but one, upon whom secondary laparotomy had been performed, died. A number of authorities are quoted to show the advantages of various prophylactic measures. If occlusion has once set in, choice must be made between two operations—laparotomy or colotomy. The choice depends upon the degree of certainty with which the site of the occlusion is located, and whether the procedure will guarantee against a recurrence of the strangulation. If the site be positively known, and there are slight prospects of reducing the occlusion, and if the latter be in the colon or rectum, an artificial anus must be established. Success depends essentially upon a timely operation. In those cases where, by reason of great debility or unwillingness of the patient to appreciate the necessity for operating, repeated washing out of the stomach with Hebe's apparatus may be resorted to, leading to moderate success; in some cases it may possibly produce spontaneous correction of the evil; three cases of ileus were cured by this procedure by Kussmaul, and other cases are reported which were relieved to a considerable extent. A case is reported in which a patient suffering from great tympanites was held head downward on the sixth day, when a great quantity of gas was suddenly expelled from the anus. Medication consisted of the administration of narcotics, principally excessive doses of opium. A detailed history of fourteen cases of the malady under consideration is presented by the author, illustrating various phases of occlusion; in one case the latter being apparently due to the pressure from large masses of fat in the mesentery.—*Amer. Jour. Obstet.*, March 1889.

Oöphorectomy in Australia. T. CHAMBERS, M.D. (*Brit. Med. Jour.*, May 25th, 1889.)—Dr. Chambers, in his presidential address at Sydney, N.S.W., made some very remarkable statements. First he spoke of Oöphorectomy in cases of OVARIAN

PROLAPSE, and reported the following case : A patient, aged 25, and married two years, came under his care. When five months married and four months pregnant she was thrown from a carriage and fell on the lower part of her back ; much shock and hystero-epileptic fits followed, with abortion within a week. The fits recurred at every period, and also at every attempt at sexual intercourse. At the end of nine months, hystero-epileptic attacks took place spontaneously between the periods, at gradually lessening intervals, and finally they occurred weekly. On examination, which proved very painful and nearly caused recurrence of the fits, both ovaries were found prolapsed and fixed by adhesions in Douglas's pouch. After grave deliberation it was decided to operate. On September 23rd. 1886, Dr. Chambers removed both ovaries and tubes, which were bound down by old adhesions in the recto-vaginal pouch. The ovaries were studded with cysts of various sizes, and the tubes were enlarged and filled with a sanguineous fluid. The attacks at once ceased, the patient made an excellent recovery, and is now in good health. Dr. Chambers then discussed Oöphorectomy for MENSTRUAL OR OVARIAN EPILEPSY. He believed that epilepsy was associated with menstruation and ovulation, and depended wholly upon deranged function of the sexual organs. He quoted a case in point with recovery after operation. He then spoke of Oöphorectomy in cases of UTERINE FIBROID, and related cases. In cases of CHRONIC OVARITIS the operation should be performed. Dr. Chambers next turned to cases of CONGENITAL ABSENCE OF THE UTERUS AND VAGINA, where the ovaries as well as the external genitalia remain well developed. He cites a case of a married, well-formed woman, complete in all except uterus and vagina, where attempted intercourse brought on "inward convulsions." Dr. Chambers removed both ovaries, one of which was large and cystic. Some months later this patient wrote to say that she had no more suffering, and that intercourse was not only possible but quite satisfactory. Dr. Chambers gives the following remarkable table of results :—

Diseases.	Number of Operations.	Cured.	Greatly Relieved.	Died.
Ovarian prolapse	11	10	1	—
Menstrual epilepsy	6	4	2	—
Uterine fibroids	10	9	1	—
Chronic ovaritis	11	9	1	1
Congenital absence of uterine and vagina	4	4	—	—
Salpingitis with fluid in tubes	8	8	—	—
	50	44	5	1

Nearly all of Dr. Chambers' cases had had "fits" of some kind, and were cured by the operation. But the most remarkable statement of all is that congenital absence of the uterus and vagina with well developed ovaries is much more common than generally supposed. This statement we do not think correct. Müller of Berne says*: "If under this designation we mean complete absence of every trace of this organ in the pelvic cavity, the anomaly is an extremely rare one. It has been found with extensive general malformations, acephalia, cardiac monstrosities, and others which render life impossible, but the absence of rudiments of the womb at all events is extremely rare." So that as Dr. Chambers has met with four cases of congenital absence of the uterus and vagina, he himself must be "Munchausen" or the women of Australia somewhat of a risky matrimonial investment. We also notice that Dr. Chambers has not had occasion to resort to drainage in any of his fifty cases, which is certainly remarkable, especially so considering that he has had only two per cent. mortality, lower than Tait himself.

Uses of Curette. (A. F. CURRIER, M.D., in *Gaillard's Medical Journal*.)—Congestive and inflammatory conditions of the tubes or ovaries may be associated with copious uterine hemorrhage. Unless the process extends to the uterine mucous membrane curetting will do no good. As a matter of fact, the uterine mucous membrane is first involved in a very large number of cases, especially in those in which the disease has an infectious origin. Curetting for such cases may serve a very

* Cycl. Obstet. and Gyn.

useful palliative purpose. Uterine congestion and hemorrhage may attend disease of the pelvic peritoneum and cellular tissue. That this disease occurs in more or fewer cases irrespective of disease in the tubes and ovaries cannot be doubted, though to what extent is still an unsettled question. The great mass of clinical evidence which has been accumulating in the last few years certainly proves that disease of these organs is the principal factor in pelvic disorders far more frequently than would have been admitted ten or even five years ago. In the acute forms of this disease curetting should be performed, but in the chronic, degenerated condition of the mucous membrane which frequently results from them curetting will be efficient. Uterine displacements, especially posterior ones, are frequently attended by hemorrhage, and this is apt to be unusually troublesome during the menstrual epoch. The most rational explanation for such bleeding seems to me to be the stasis which must exist in the venous system of the pelvis, at least in many of the cases. This is one of many facts which puts greater importance upon uterine displacements than is now the fashion in many quarters. A continuation of this condition of course implies hypernutrition of the uterine mucous membrane, and curetting becomes a means for at least temporary relief. The radical cure must come from a restoration to the normal mechanical conditions, except in the few cases in which the pelvic apparatus and its dependencies all apparently adjust themselves to the situation which is forced upon them. I do not recall any instance of this kind in which atrophy and sterility have not resulted from a failure to restore the normal conditions to the circulation. The most violent uterine hemorrhage may occur from uterine polypi, and retention of fragments of placenta and decidua. For the first of these a cure will come after the cause has been removed; for the second the curette will act with a promptness and efficiency which can be equalled by nothing else. To summarize, it may be stated that if uterine hemorrhage accompanies degeneration, infiltration, hyperplasia, or chronic inflammatory changes of the mucous membrane, there is no treatment which offers such satisfactory results as careful and thorough curetting, performed under anæ-

thesia and with antiseptic regulations, and followed immediately by the application of an astringent or caustic antiseptic solution—such as tincture of iodine, carbolic acid, or nitrate of silver (60 grains to the ounce). Mucus and muco-purulent discharges from the uterus, especially in connection with chronic catarrhal inflammation of the glandular system of the cervical mucous membrane, are also readily checked by the use of the curette. This operation is so simple and usually so painless that it seems strange that it is not more generally adopted. It is with me almost a daily operation, and one from which I never have seen harm result. Like all other operations, it should be done antiseptically, and preferably within a week after the cessation of the menstrual flow, as the normal pelvic congestion has then subsided. It is far more satisfactory than simply swabbing away the discharges with cotton, drawing them out with a syringe, or covering them with a layer of iodine or other astringent. An antiseptic astringent should be applied to the curetted surface, both to prevent toxic absorption and to supplement the work of the curette.

Purgative Effects of Glycerine.—DR. F. F. MILEEFF, in *Novosti Terapii*, details his experience concerning the use of small glycerine enemata and suppositories in habitual constipations of various kinds. The main results of his observations may be condensed as follows :

1. In those cases where accumulation of fæcal masses takes place in the lower portions of the large bowel, a rectal injection of one or two drachms of pure glycerine in an adult, and of one-half to one drachm in a child, is invariably followed by stools occurring in two or three minutes.

2. The fæcal masses do not show any signs of liquefaction or even softening ; still, owing to lubricant properties of the drug, the act of defecation proves to be fairly easy and comfortable.

3. The enemata do not give rise to the slightest painful or unpleasant sensations about the rectum. Neither do any phenomena of rectal irritation supervene, even on a prolonged employment of the injections.

4. The purgative effects of glycerine should be attributed to

its stimulating action on the nervous and muscular apparatus of the large bowel, which action is probably determined by the drug greedily extracting water from the intestinal mucous membranes with its nerve-fibres. The desiccation irritates the latter, and thus exacts a reflex contraction of the intestinal muscular coat. The hypothesis finds a strong support in the fact that any dilution of glycerine with water markedly weakens its purgative action, and that the more in proportion the larger is the amount of water added.

5. Glycerine enemata are especially indicated (*a*) in the constipation of pregnancy, where ordinary water enemata are inconvenient on account of their considerable bulk, which causes discomfort to the woman; and (*b*) in infantile constipation caused by unduly prolonged feeding on milk alone, and associated with fæcal accumulations in, and consecutive distension of, the sigmoid bowel. In cases of the kind, glycerine enemata are very useful on account of their energetic action in the intestinal muscles, and convenient because of their small bulk.

6. As to glycerine suppositories (containing half a drachm of the drug each), they are said to act well (in five minutes or so) only in such cases where no pure glycerine enemata were previously employed, otherwise they remain inactive. Hence he commences the glycerine treatment of constipation with suppositories (a piece at bedtime), and passes to enemata as soon as the former cease to secure the desirable result.

7. As regards the apparatus for the enemata, any special contrivances are superfluous. He uses for the purpose an India-rubber urethral syringe with a piece of thick walled elastic tube on the nozzle.

Dr. Grewcock, in *London Med. Recorder*, says he "found out quite accidentally a novel method of applying glycerine," which is "equally efficacious with the clyster. . . . If a piece of cotton wool alone, the size of a nut, is well saturated with glycerine, and inserted as a suppository, in a short time a copious motion is produced."

Laparotomy for Tubal Disease—Re-operation fourteen days after for symptoms of Peritonitis and Intestinal Obstruction. (DR. E. S. STEVENSON in *So. African Med. Jour.*)—Mrs. L.,

aged 38, V-para, one miscarriage, has been suffering for fourteen years. She was under treatment in London for constant pelvic pains more than twelve years ago, and since that time has been continually ailing; she cannot lie or sit down without great pains, and has excruciating pains when her bowels are open. Six months ago she became seriously ill with severe pelvic pains and hemorrhage, which has continued ever since. Two months ago she was again laid up with the same symptoms. I found her suffering from disease of the right appendages, and advised operation, to which she readily consented. On Dec. 28th, 1888, I operated. On opening the peritoneal cavity I found the right tube much enlarged and adherent to the uterus and surrounding parts. On trying to separate the tube it burst, and its contents, a clot the size of a small orange and dark blood, escaped into the cavity. On drawing out the parts, I found the tube split longitudinally in its whole length and the fimbriated extremity torn. This part was found closely adherent to a coil of intestines, its fimbriae spread out, covering a spot the size of a five-shilling piece, and firmly adherent. Great care was required to remove this, and free oozing took place. The right ovary, which was cystic, burst on being pulled out, and was also removed. The left annexures were also removed. The cavity was well irrigated with hot water, and, on account of oozing, a glass drainage-tube inserted. The patient recovered rapidly, and on the tenth day she felt all right. The wound was well healed, and all the pains which she had suffered constantly from previous to the operation had left her. On the eleventh day the patient committed an indiscretion, and soon after felt worse, with vomiting, constipation, severe griping pains, tympanitis, pulse quick and hard, tongue dry, and general tenderness over the abdominal walls. The vomiting became very urgent, and on the fourteenth day after the operation Mrs. L. appeared to be sinking. Feeling sure that I had to deal with peritonitis and intestinal obstruction, I concluded to reopen the abdomen. The wound was healed all through. At first it was found impossible to map the parts, there being a general glueing of parts together. Fortunately the adhesions were recent and easily parted. The intestines were engorged and dilated, especially in the pelvic cavity, and there several

soft fibrinous bands had to be torn. The large omentum, instead of floating on the surface of the intestines, was twisted like a loose rope, and dipped into the abdominal cavity down to the back. The whole of it was glued to coils of intestines, and was at its extremity firmly attached to a coil deep down. This adhesion required considerable force to free it. The whole part of the twisted omentum was ligatured and removed, and the cavity freely irrigated with a 1 in 3000 solution of corrosive sublimate, and a drainage-tube left in. Six hours after the operation the bowels were moved by an enema of turpentine and hot water, and a long rectal tube frequently passed in to allow the escape of flatus. Immediately after the operation all symptoms of obstruction and peritonitis left her, and she soon got over the shock of a second operation. The bowels were kept open daily by turpentine enemata. I must mention that after the first operation the same course was pursued, with the exhibition of salines, and the rectal tube was freely used. This intestinal obstruction was due to the omental adhesions. The firm, deep-seated adhesion was, I have no doubt, attached to the intestinal wall whereon the tube had been glued, and which at first accounted for the unbearable pain the patient felt when the bowels were relieved. This case demonstrates the rapidity of formation of inflammatory bands in peritonitis and how easily intestinal obstruction can take place after laparotomy. The patient is now up and about, feeling well and strong.

Pelvic Peritonitis ; Forced Dilatation and Curetting. (DR. WALTON.)—The lesions of the endometrium constitute an important factor in the etiology of diseases of the Fallopian tubes, peritoneum, ovaries and parametrium, though it does not follow that this is the only way by which the inflammatory element is transmitted from the uterus to the neighboring organs. Septic infection, after having been located in the endometrium, is propagated principally by the lymphatic vessels. Pelvic cellulitis, phlegmasia alba dolens, and the great majority of puerperal accidents are caused by the absorption of septic germs. Contagion is acquired rapidly on account of the existence of traumatic lesions caused by parturition or abortion. While the so-

called puerperal septicæmia can be transmitted directly by the uterine parenchyma, the lymphatics, or the veins, the same condition is not propagated apart from the puerperal condition. Catarrhal inflammation and gonorrhœal infection have a tendency to invade the uterine mucous membrane. After having produced the lesions of the womb, there is extension to the tubes, salpingitis being first produced and then perimetritis. The initiatory agent of inflammations of the mucous membrane is always a microbe. This micrococcus, located in the folds of the mucous membrane, gives rise to symptoms of endometrial inflammation, which indicate active treatment for their relief. To cure this inflammation and avoid subsequent pelvic peritonitis, dilatation, curetting and antiseptic precautions are indicated. The following conclusions result from the author's experience :

1. In non-exudative pelvic peritonitis the pain, which is the principal symptom, may be relieved by dilatation.

2. In the exudative variety forcible dilatation by facilitating the return circulation may check the progress of peritoneal infarctions and assist the absorption of exudates.

3. In circumuterine or pelvic abscesses, which are usually nothing more than cysts of the tubes, it is possible, by dilating the womb, to evacuate the cysts by way of the uterine canal.

4. In cases of puerperal septicæmia the septic symptoms will disappear under this treatment. No other is so efficient for the disinfection of the cavity of the uterus and disposing of the products of infection.

5. Reflex symptoms, such as vomiting, are immediately relieved by forcible dilatation.

Hysteropexia for Prolapse of the Uterus.—DR. M. POLAILLON reports a case of prolapse of the uterus of long standing, in which he had performed hysteropexia, or abdominal fixation of the uterus. The patient was a woman aged 50, eight years past the menopause, in whom prolapse caused violent lumbar pain and dysuria. The prolapse was complicated with cystocele. On opening the abdomen he experienced the greatest difficulty in bringing up the uterus, which was studded all over with small fibroids. He passed several sutures through it, and fixed it to

the abdominal parietes. The operation was carried out with the strictest antiseptic precautions, but the day following the operation the patient complained of abdominal pain, and was sick. A week later she succumbed to peritonitis. At the autopsy no sign of union could be seen in the abdominal wound, and the sutures maintaining the uterus in apposition with the abdominal wall had given way. The peritoneum was the seat of a general inflammation. He attributes his want of success to the absorption of the catgut sutures, which he will discard in any future operation in favor of metal or silk. M. Terrier, however, has performed the operation five times with catgut sutures without their having given way.

The relation of the above case is an instance of the thoughtless, pedantic things some surgeons will at times do. That a surgeon will perform hysterorrhaphy using catgut ligatures is beyond all comprehension. Here we want a ligature of strength, of long duration, and absolutely aseptic; the very opposite of all these characters we have in catgut. It is being almost entirely discarded by Montreal surgeons; in strength it is unreliable, and it is absolutely impossible to make it any more aseptic than a sponge-tent—neither can be boiled. These two characteristics make it dangerous as a ligature, and it should be used no more.

Elytritis and Blenorrhœal Endometritis. (DR. FRITSCH.)—Make a mixture containing equal parts of chloride of zinc and water; twenty grammes of this mixture are combined with a litre of water; this is heated to a temperature of 30°R., and is used by irrigation in the treatment of blennorrhœal vaginitis and endometritis twice daily, being continued during the menstrual period. About ten irrigations are usually required. If the disease has extended to the cervical canal, the mucous membrane of the uterus, and the tubes, the discharge will soon recur. In such cases the uterine cavity should be cauterized with concentrated solution of chloride of zinc, and a pencil of iodoform should be introduced at suitable intervals within the cavity. Bandl's method of treatment is the following: The speculum having been introduced, a fenestrated canula is passed within

the cervical canal as far as the os internum ; then a 10 per cent. solution of sulphate of copper is passed within the canula, the latter being rotated so that all portions of the mucous membrane shall receive the copper solution through the fenestra. After the canula has remained in position a few minutes, it is to be removed and a tampon introduced within the cervix. Such applications should be made every three or four days, irrigations of a very weak solution of sulphate of zinc being used during the intervals.

During Dr. Macan's inaugural address as president of the British Gynæcological Society for the present year, he drew attention to the rapid strides in importance the bimanual method of making pelvic examinations was obtaining. And in discussing the subject, he gave the following account of uterine massage as introduced by Thure Brandt of Stockholm some twenty years ago, and practiced in the treatment of pelvic inflammation with adhesions. Brandt not being a medical man, the method was not taken up by the profession until quite recently. Bandl of Vienna lately gave it a trial, and through him it has gained some popularity with the profession. The method is practised as follows :

“The treatment itself consists of two parts, the first being the elevation of the uterus. To carry this out the aid of a skilled assistant is necessary, whose duty it is with one hand to elevate the uterus from the vagina, and to keep it in a state of anteflexion, while his other hand is laid on the abdomen exactly over the uterus. The latter hand indicates to the operator the exact position of the fundus. Standing now at the foot of the couch or sofa on which the patient is lying, the operator lays his two hands, strongly supinated, flat on the abdomen, the fingers being pointed towards the pubes, and grasps the fundus between them, its position, as already said, being indicated by the hand of the assistant that is on the abdomen, while the fingers of the other hand of the assistant, which are in the vagina, prevent the fundus being pushed out of reach of the hands of the operator. Having firmly grasped the uterus, the operator raises it steadily upwards in the abdomen, in the axis of the pelvis, watching the

face of the patient the whole time. This is necessary, as the slightest expression of pain is an indication to desist or to go more slowly. In this way the uterus can be elevated as much over its normal level as it had formerly been prolapsed. When the uterus has been elevated as far as is possible it is allowed to slip gently from between the hands, and sinks slowly in the abdomen. The duty of the assistant is now to receive the uterus as it descends on his finger which has remained in the vagina, and to keep it in a condition of anteflexion. This movement of elevation is repeated two or three times at each sitting, a few minutes' interval being allowed between each, during which time the assistant massages the fundus in order to arouse it to contraction and thereby lessen its bulk. The second movement now follows and consists of forcible separation and forcible closure of the knees. To carry it out the patient should be placed in the recumbent position, and closing the knees and thighs should elevate the sacrum from the couch, so that the body rests on the elbows and feet only. While in this position the operator forcibly separates the knees, the patient resisting as much as possible. This is repeated about three times. The contrary movement is now practised, the patient lying with the knees widely separated, and the operator bringing them forcibly together. This is also repeated three times, and closes the sitting. The patient now turns over gently on the face and remains in that position for from five to ten minutes. It is well, when it is possible, for the patient to remain in the recumbent position for the first few days of the treatment, but this is not essential. The treatment is repeated daily till the cure is effected, the time required varying greatly, but being usually from four to eight weeks."

Reviews and Notices of Books.

The Physiology of the Domestic Animals. A Text-Book for Veterinary and Medical Students and Practitioners. By ROBERT MEADE SMITH, A.M., M.D., Professor of Comparative Physiology in the University of Pennsylvania. Philadelphia and London: F. A. Davis, publisher.

That there was an urgent need for a work on the physiology of the domestic animals for the use of students of veterinary medicine few acquainted with the facts of the case will deny. Professor Smith had a rare opportunity such as occurs to few men in a lifetime now-a-days, viz., that of supplying a new and really needed thing; and, we regret to say, we believe he has in large measure missed the mark. Students of human medicine do not require such a work; but few practitioners, we fear, make much use of works of physiology of any kind, and the real *desideratum* was a work for undergraduate students as we actually find them in the schools of veterinary medicine on this continent. When it is remembered that in by far the larger proportion of such institutions the students spend but two years on the whole course of study, it becomes perfectly plain that their physiology must be prepared for them in at most but a moderate compass. But this book is a ponderous volume of 920 closely packed pages. How the class of students we refer to can be expected to read, understand and inwardly digest this huge mass passes our comprehension. We think it most unfortunate that Dr. Smith has seen fit to add another to the list of books that are too large for those for whom they are professedly written. It is a great and growing evil, and if this crowding of the mind continues, Who shall say what the result may be?

The general conception of the work is good, but has been much marred in the execution by lack of balance. We find more than three hundred pages devoted to "Food and Digestion," and but seventy to the "Circulation of the Blood." It is true that for the veterinarian the former subjects are of great, perhaps of paramount importance, so much have they to do with explaining actual disease; but will any one assert that

they are more than four times as important as is the "Circulation of the Blood" for example? Then, that a subject so important for comparative physiology as "Reproduction" should be dealt with in twenty pages greatly surprises us.

Discussion of chemical and physical principles largely in the abstract at the very beginning of a work, and apart from the actual subjects (chapters) in which their application is obvious, though not without precedent, has always seemed to us to be contrary to some of the well established principles of teaching as founded on the laws of our mental constitution. In practice it does not work well; it increases the difficulties of the student's already rugged path and tends to intellectual nausea and dyspepsia. The book is a good compilation of the physiology of the domestic animals as known. The author claims for it no originality, though we are sorry he did not lessen the bulk of his work, and if he did not make it in any high sense original, at least impart some degree of his own individuality to it. The teeming press of to-day sadly lacks books with individuality.

But though we have felt called upon to criticise this work upon its merits, we nevertheless feel that Professor Smith has done good service, if not for the undergraduates, at least for the practitioners of veterinary medicine. Those who will read may now learn in their own language enough of physiology as it is known to make the practice of their profession an intelligent study and not a rule of thumb routine. Though too lengthy in comparison with other chapters, those on "Food and Digestion" are excellent; so is that on "Locomotion," as was to be expected from the original work done on this subject by Mr. Muybridge at the University of Pennsylvania. The illustrations are abundant, wisely chosen and sufficiently well executed. It is to be remembered that the author's task was a new one and the difficulties great. With Prof. Smith we also lament that in comparative physiology the harvest is plentiful, but the laborers few; and such, we fear, must be the case till medical men perceive more clearly the true relations of the study of their great profession. Nevertheless, progress is now rapid, and the whole of medicine has before it a new, broader and better way.

The great question with regard to this work seems to be: Is the profession of veterinary medicine the richer by it? Unquestionably it is. It was a needed book. We should have preferred it different in many respects, but accept it thankfully notwithstanding.

The Cerebral Palsies of Children. A Clinical Study From the Infirmary for Nervous Diseases, Philadelphia. By WILLIAM OSLER, M.D., Fellow of the Royal College of Physicians, London. London: H. K. Lewis, 136 Gower Street, 1889.

This very valuable contribution to practical medicine is founded on the observations of no less than 151 cases of cerebral paralysis, an amount of material which far exceeds in amount any previously analyzed. In 120 of the 151 cases, the paralysis was hemiplegic in distribution, in twenty cases the hemiplegia was bilateral, and in the remaining eleven cases the paralysis was paraplegic. Out of the total of 120 cases of hemiplegia, the disease made its appearance in ninety-six before the end of the third year, fifteen of the ninety-six being congenital. It is important to note that in nine of these cases the child was delivered with the forceps. "In six of the cases the child is said to have been injured by the forceps, and in all the paralysis was either noticed at once or a few months afterwards without definite onset." In sixteen of the 120 cases there is a history of the palsy coming soon after an attack of one of the eruptive fevers. From these histories it appears probable that exceptionally convulsions may give rise to a cerebral hemorrhage which leads to a permanent cerebral palsy.

The second chapter deals with the symptoms and morbid anatomy of cerebral palsy of children (hemiplegic type). The author groups the lesions under three headings: 1. Embolism, thrombosis and hemorrhage. 2. Atrophy and sclerosis. 3. Porencephalus. It is pointed out that our knowledge of the pathological conditions underlying infantile hemiplegia is very defective. This is owing mainly to the fact that the great majority of post mortems have been made years after the onset of the disease, and when all trace of the primitive lesion has disappeared.

Chapters three and four are devoted to bilateral spastic hemiplegia and spastic paraplegia respectively. The final chapter deals with the pathology and treatment of the different forms of paralysis. Dr. Osler is of the opinion that hemorrhage is the cause in only a very small percentage of the cases. In those cases of palsy coming on at birth there is strong evidence that meningeal hemorrhage is frequently the cause, while a fetal meningo-encephalitis is probably the cause in a few of the cases.

In speaking of infantile hemiplegia coming on during the first two or three years of life, Dr. Osler says that we are called upon to explain "the mode of origin of sclerosis and porencephalus, the conditions present in the great majority of cases. A certain number of cases of infantile hemiplegia are due to hemorrhage, to embolism and aneurism, a few to tumor, as glioma or chronic tubercle; but, as we have seen, these form a fractional part. We require to know the pathological process lying at the basis of the convulsive attacks with coma, which come suddenly, or after a slight febrile movement, frequently succeed an infectious disease and leave a hemiplegia with too often its disastrous consequences—epilepsy and imbecility. In a large proportion of the cases the disease is such a clinical unit, with symptoms as marked and definite as those of infantile spinal paralysis, that we might expect a corresponding uniformity in the anatomical lesion. Unfortunately we are, so far as I can ascertain, entirely without information upon the state of the brains of children dying during or shortly after the attack; and the question resolves into an explanation of the conditions most commonly met with years after the onset, viz.: sclerosis and porencephalus."

The author then discusses fully the more important views advanced to explain the origin of these changes and tabulates his conclusions as follows: Infantile hemiplegia is probably the result of a variety of different processes, of which the most important are: 1. Hemorrhage, occurring during violent convulsions or during a paroxysm of whooping cough. 2. Post-febrile processes: (a) embolic; (b) endo- and peri-arterial changes, and (c) encephalitis. 3. Thrombosis of the cerebral veins.

We have only been able to point out a few of the more important points dealt with in this important monograph. It represents a vast amount of clinical and literary work and reflects the greatest credit on its author.

Society Proceedings.

MEDICO-CHIRURGICAL SOCIETY OF MONTREAL.

Stated Meeting, March 22nd, 1889.

WM. GARDNER, M.D., PRESIDENT, IN THE CHAIR.

Radical Cure of Hernia. — DR. SHEPHERD exhibited a patient on whom he had operated a year ago. The man, a blacksmith by trade, was 45 years of age, of intemperate habits, and very stout. He had had a swelling in the left groin since boyhood, which always disappeared on lying down. It gradually increased in size and entered the scrotum. It now could only with difficulty be reduced. Two years before had received a severe blow on the scrotum with a bar of iron; from this time the tumor rapidly increased in size and became irreducible. Latterly the tumor had become so large and troublesome that he could not do his work, and with difficulty could wear large-sized trousers. The tumor in the scrotum was larger than a good-sized foot-ball. He was sent into hospital and kept in bed some time. Operation for the radical cure of the hernia was advised, and the man having consented, the operation was performed on April 26th, 1888. An incision some eight inches long was made over the tumor and the sac reached. The sac was found to be very thin, and was with difficulty partially dissected out. Failing to reduce the hernia the sac was opened. The sac contained all the large intestines with the exception of the cæcum and rectum, and nearly all the small, besides a large mass of omentum. Several pounds of omentum were removed after ligature, and then an endeavor made to return the bowels. This was not easily accomplished, the abdominal cavity appearing too small to contain them. After manipulating the intestines for a considerable time without making much impression on the quantity outside the abdomen, the man was suspended by the

feet. This enabled Dr. Shepherd to reduce the small intestines first, then the large. The whole time occupied was nearly two hours. It was found that, in reducing the large intestines, when pushing them in a certain direction failed to diminish the quantity, as soon as they were pushed in the opposite direction they slipped in easily. When all the intestines were returned the abdomen was as tight as a drum, and it seemed as if it would not have been possible to introduce an inch more of bowel. Having taken so much time in reducing the hernia, Dr. Shepherd decided that it was better to sacrifice the testicle of that side, and so complete the operation as soon as possible. The sac was cut off and the ends of the ligature passed through the abdominal walls, as suggested by Mr. Barker of London, one through each pillar of the internal ring and then tied together; the canal, which, of course, was of large size, was then closed by two silk sutures which were passed through the conjoined tendon and Poupart's ligament, and the external wound closed with continuous silk suture. The patient was in fairly good condition after the operation, and quickly rallied. Next day there was some pain and tympanites. Small doses of salts were given frequently and the bowels freely moved. The recovery of the patient was uninterrupted and without special incident. He remained in bed some six weeks after operation, when he was discharged with a sinus still unhealed at the point of drainage. After a few weeks more he returned to his work, at which he has been constantly engaged ever since. There has not been the slightest return of the hernia, but the fistulous opening has never completely closed, and some few days ago Dr. Shepherd removed one of the silk sutures from it.

Dr. Shepherd stated that he brought this case before the Society because of the special interest taken at the present time in this subject. The operation performed was a formidable one, and relieved the man from a very disagreeable tumor which had seriously interfered with his occupation. The sacrifice of the testicle he did not regret, as he was convinced that in these large herniæ, cure could be more readily accomplished if the spermatic cord were cut, as the stump helped to close the internal

opening. The fistulous opening, he thought, was no doubt due to the silk sutures. One had already come away, and when the other was discharged he had no doubt the fistula would heal.

DR. BELL congratulated Dr. Shepherd on the satisfactory result obtained in a very unpromising case. He thought the fistulous opening might be caused by the continuous escape of peritoneal fluid. He had seen a similar case in Dr. Fenwick's practice and two cases of women operated on for femoral hernia; fistulæ remained for months. These, however, were completely cured by rest in bed. In the case of the women, he found that fistulæ only persisted when patient assumed a semi-erect position. He removed a silk suture from a sutured patella four months after operation. He formerly believed that the silk he used in suturing the intestines of dogs was absorbed, but now he thinks that after union the sutures are passed per rectum.

DR. TRENHOLME said that the case illustrated the advantage of hempen over silk sutures, as numerous observations show that hempen sutures are entirely absorbed. He has always advocated the advantage of using sutures of shoemaker's thread. He asked if Dr. Shepherd had failed to reduce the intestines would he have resected a portion to reduce the bulk?

DR. GARDNER asked why fistulæ should persist after hernial operations when they do not do so after abdominal section for ovariectomy, etc. He said that post-mortem examinations had shown that silk ligatures disappear from the pedicles after ovariectomies if the silk has been properly prepared.

DR. SHEPHERD, in reply, said that he believed the fistula to be due to the presence of a suture, because he had already removed two out of the three used in the operation.

Ligature of the Common Carotid.—DR. SUTHERLAND introduced the patient, a girl of 24, on whom he had performed ligature of the common carotid for arterio-venous aneurism. She was brought to the Montreal General Hospital on Sept. 3, 1888, having been accidentally shot in the neck by an ordinary parlor rifle carrying a bullet the size of a pea. The bullet entered the neck midway between the symphysis and angle of the lower jaw on the left side, passed across the neck, and was

found under the skin two inches below the right mastoid process, behind the sterno-mastoid. The right side of the neck was swollen, and a distinct pulsation and thrill was felt on placing the hand over the upper carotid triangle. With the stethoscope a distinct bruit could be heard. The thrill and pulsation of the tumor gave one the idea that the affection was an arterio-venous aneurism. The pulsation was arrested by compressing the common carotid on the neck. The patient was kept quiet for a few days, and the tumor and pulsation increasing, it was decided to throw a ligature around the right common carotid and then search for the wounded vessel. This was done, but failing to find the vessel, which appeared to be deep (probably the internal carotid), Dr. Sutherland determined temporarily to occlude the carotid by ligating it over a piece of drainage-tube after the manner suggested by Mr. Lewis of London, and await results. The patient did well for several days, but the ligature loosening, the pulsation in the aneurism returned, so the patient was again placed under ether and the carotid tied in its continuity above the omohyoid. The patient did well, the wound healing by first intention, except at the point where the bone drain had been. After three weeks she was discharged from hospital with the swelling in the neck much decreased and with the aneurism cured. The fistulous opening remained until January 12th, when the ligature came away, and then the opening rapidly closed. The patient is at present perfectly well.

Dr. Sutherland stated that with regard to the tying of the ligature over the rubber tube outside, it was a practice he would not repeat. Although it had the advantage of accustoming the brain to a lessened supply of blood, yet he considered that the retarded flow of blood in the main vessel might lead to a thrombus being formed in some of its anastomotic branches, and so interfere afterward with the nutrition of the part. He preferred ligature of the carotid to temporary compression, as the former was much more certain and not more dangerous.

Cyst of the Broad Ligament.—DR. WM. GARDNER exhibited a thin-walled cyst, of the size of a goose-egg, removed from a married woman of 25. The origin appeared to be from some

structure of the broad ligament other than the parovarium. The contents were thin and faintly colored. The ovary was healthy and not involved. The symptoms were pelvic pain and disturbance of the bladder.

Membranous Cast of the Uterus.—DR. ALLEN exhibited a complete membranous cast of the uterus and gave the following history: Mrs. P., aged 26, married, had always enjoyed good health; menstruation had been irregular, giving rise to no special pain. One month after marriage, before leaving England, suffered from an attack which she says came on with abdominal pains, which lasted a few days, being followed by loss of something, but what I was unable to find out. Amenorrhœa followed from that date to the present attack. On 21st July, while walking on the mountain, was taken with severe abdominal pains and slight sickness, compelling her to return home at once and go to bed, where she remained ever since. The pains were greatly relieved by heat to abdomen and warm drink for a time. During the night of the 22nd they again returned, were very severe and bearing down in character, followed by loss of some blood towards morning. I was called in on the morning of the 23rd and found patient in bed, restless, slight flush of cheeks, temperature 99.5°, pulse 100 (regular), and bearing down pains, less severe than they were some time before according to her account. On examination, cervix soft and slightly dilated, membrane protruding into vagina, covered with some coagula. With the aid of Syms' speculum, with patient in Syms' position, membrane could be seen to be only slightly held in cervix, being removed by index finger without any force. Uterus contracted well and was entirely empty; no trace of a foetus could be found. Irrigated vagina once with warm Condy's fluid (very weak), keeping her in bed on light diet for a few days. Slight amount of blood lost during the first twenty-four hours, after which pulse and temperature became normal, remaining so. Three weeks later, when seen, felt well, after which date I lost sight of her, so am unable to give the subsequent history, which I regret very much. The membrane, on further examination, proved to be a complete cast of uterus, very thin in some parts.

DR. LAPHORN SMITH regarded the case as one of severe membranous dysmenorrhœa.

A Case of Uræmia.—DR. FINLEY exhibited a pair of hypertrophied and cystic kidneys about three times their proper size. The fibrous tissue was largely increased. The heart from the same case showed the left ventricle largely hypertrophied and dilated. Dr. Finley said he was not able to find any reference to cases of cardiac hypertrophy from cystic disease of the kidney.

DR. SPRINGLE stated that the patient was a man of about 53 years old, who had been taken suddenly ill in the morning; he was brought to the hospital in a moribund condition the same afternoon, and died in about ten minutes.

Esbach's Method of Determining Proteids in the Urine.—

DR. RUTTAN exhibited and explained Esbach's method of determining proteids in the urine, and showed how it might easily be applied to ascertain the relative proportion of serum-albumin and serum-globulin in urine. He expressed surprise that this method, though over two years old, was not used more by physicians, as it was extremely easy of application and occupied little or no time. It was time that the unscientific and misleading statements which appear in the journals regarding the quantitative relation of albumin in urine were replaced by more accurate and reliable observations. Such statements as 30 or 40 per cent. by volume of albumin conveyed no information whatever as to the actual quantity of proteids, not even of the relative proportion from one observation to the next. Dr. Ruttan said that it was obvious that the volume of precipitated albumin depended on whether precipitated in flakes or in granules, and this, again, depends on the time it is boiled and the amount and nature of acid used. Again, the specific gravity of the urine, the time elapsing before the observation is made, etc., all should be constant and should be stated before it is possible, by the old method, to convey even an approximate idea of the actual amount in the sample of urine. Esbach's method, though not absolutely accurate, is more nearly so than any other chemical method, and has the advantage of giving the actual proportion

of albumin by weight in any given sample of urine. Dr. Ruttan also referred to Dr. Grainger Stewart's observations on the significance of the relative proportion of serum-albumin and globulin in urine. These observations, though few in number, go to show that the globulin, if in excess or present alone, is significant of functional albuminuria.

A Method of Detecting Traces of Albumin.—DR. RUTTAN demonstrated a modification of Heller's test for albumin. Instead of floating the urine on the acid in a wine-glass, as Heller recommends, he proposed to warm both urine and acid in separate test tubes, then fill a pipette with the warm acid, and, with the end closed by the finger, introduce it to the bottom of the tube containing the urine, then by withdrawing the finger the acid will flow out and float up the urine. A sharply defined line of opacity at the junction of the two fluids indicates the presence of albumin. The advantage claimed for this modification of Heller's test is that the reaction is more sharply defined than in Heller's test, when but traces of albumin are present, and that in the warm urine the acid urates are not precipitated by the acid, so the only opacity that can occur at the line of contact is one due to coagulated albumin. Dr. Ruttan emphasized the necessity of filtering all samples of urine not perfectly bright before testing for albumin.

Modification of the Urinometer.—DR. RUTTAN also exhibited Squibb's urinometer, which consists of urine tube with flutings and a float with doubly conical bulb. The flutings prevent the float from adhering to the sides of the urine tube, thus lessening one of the errors inseparable from this method of taking specific gravity. This instrument is particularly useful for ascertaining slight differences in specific gravity, as when the sugar in urine is estimated by Sir William Roberts' method.

Stated Meeting, April 5th, 1889.

WM. GARDNER, M.D., PRESIDENT, IN THE CHAIR.

Dr. E. P. Williams was elected a member of the Society.

Nævus of the Face.—DR. W. R. SUTHERLAND exhibited a very marked case of nævus in a man of 60 years. It had existed

for twenty years ; formerly it was flat, but now the tumor was pedunculated in places and everywhere raised above the level of the skin. Dr. Sutherland remarked that in such extreme cases in an old man surgical interference would avail but little.

DR. BULLER could not see why even such a case as the one exhibited could not be cured by electrolysis. Nævi of the orbit are controlled and frequently entirely eradicated by electrolysis. In one case, however, optic neuritis set in after, and the eye was lost.

DR. HINGSTON agreed with Dr. Sutherland that interference in the case of a man of the age of the patient was uncalled for. In his practice he used the thermo-cautery in extreme cases like the one shown after removing the peduncles with the knife. The effect of the cautery is to substitute a white scar for the unsightly red blemish. In earlier stages of the affection, especially in young persons, he scarifies with razor or scalpel with close parallel cuts so as to deprive the spot of its circulation. He could recall one case in which he completely removed by this method a nævus covering the whole shoulder of a young girl.

DR. LAPHORN SMITH believed that since the hæmostatic effect of the positive pole has been understood, the electric method was the best for the treatment of such cases.

Dilated Fallopian Tube with attached Ovary.—DR. ARMSTRONG exhibited a dilated Fallopian tube which was removed from a married woman aged 37. She had had repeated attacks of severe abdominal pain, with tenderness on pressure and elevation of temperature. The operation was performed on the 24th of March. A chart was handed round, which showed that the temperature never rose above normal. The right ovary was displaced downwards behind the uterus and there held by inflammatory adhesions. Both tubes were more or less attached by the same method.

DR. GARDNER said that the specimen illustrated well the danger of trying to diagnose by digital manipulation the exact condition before operation, as such a tube filled with pus might easily be ruptured, especially if the examination be made while

the patient is under ether. His experience fully corroborates Dr. Lawson Tait's statement that if both ovaries be not removed, as Dr. Armstrong did in this case, a second abdominal section is, as a rule, necessary to remove the other ovary.

DR. HINGSTON was present at the operation, and fully agreed as to the necessity of immediate operation. He was opposed to all such operations when not absolutely warranted by the symptoms.

DR. TRENHOLME said he had seen the case before operation, but owing to the attachment of the ovary to the right cornua of the uterus was not able to make a satisfactory diagnosis.

Clot from the Internal Saphenous Vein.—DR. ARMSTRONG also exhibited a blood-clot having a circumference of three inches which he removed from the internal saphenous vein, just opposite the knee-joint. The vein was completely occluded on the proximal and distal side. It caused the woman a good deal of annoyance from becoming painful and inflamed, and its size exposed it to frequent injury.

Note on Shortness of the Umbilical Cord as a cause of Dystocia.—DR. LAPTHORN SMITH then read the following paper:—

The following remarks have been suggested to me by my having noticed at two labors occurring on the same day, a very long and a very short cord, which I now show you. The longer one measured when fresh just fifty inches, while the shorter one measured less than twelve. The only trouble which the short cord case gave me was that the placenta was retained for half an hour, which I attribute to the fact that whenever the cord is pulled upon either by the accoucheur or by such an accident as its being too short, irregular contractions are set up in the middle or lower segments of the uterus, thereby causing more or less a condition known as hour-glass contraction. The labor, the patient's third one, was remarkably rapid, occupying in all only two or three hours, and was terminated naturally with the exception that I introduced my hand within the os in order to remove the placenta. The long cord, strange to say, caused more trouble, for after leaving the head on the perineum for several hours, the patient being a primipara, I applied the for-

ceps, and as soon as the head was delivered I felt for a possible turn of the cord around the child's neck and found one. While undoing this, by slipping it over the child's head, I found that there were two other turns which I also unwound. By this time the child was quite black and the cord was pulseless. I practised artificial respiration for nearly half an hour before it breathed well.

Both of these conditions are recognized as offering considerable danger to both mother and child. Shortness of the cord, either absolute or owing to its being wound around the child's neck, may retard labor while the head is at the superior strait, while it is in the cavity of the basin, or while it is passing the inferior strait. And even after the head has passed, according to Cazeaux, it may arrest the progress of the shoulders. The latter author cites a case of his own in which delivery was terminated two hours after the expulsion of the head only after section of the cord had been resorted to, the foetus being dead. Dalmotte relates a similar observation.

Labor will generally terminate itself spontaneously, however, in one of three ways: Either the uterus will be forced down by the expulsive efforts of the mother, so as to bring the placenta near enough to the vulva to allow the delivery of the child; or the cord may be ruptured; or the placenta may be torn off. In a case observed by Malgouyre the latter accident happened and the placenta was expelled simultaneously with the foetus. In a case reported by Rigby the cord was ruptured two inches from the navel. In a case occurring in the practice of a *confrère* in the country, in which labor had been going on furiously for several hours without any progress, and in which he intervened with the forceps, the cord was so short that on the extraction of the child he was horrified to see it followed outside of the body by the placenta with the inverted uterus adherent. In spite of every effort and precaution he was unable to replace it, and the patient died.

In my opinion most, if not all, cases of inversion are due to tractions on the cord either owing to its being too short or to its being wound around the child's neck, or to the tractions of the

too hasty accoucheur. I cannot admit that inversion can take place from any kind of normal or abnormal uterine contractions. Not only does shortness of the cord, either absolute or by being wound around the child's neck, increase the pains of the mother and retard the delivery of the foetus, besides contributing largely towards producing inversion, but it is very hazardous for the child. According to Mayer, out of 3,587 confinements the cord was wound around the child's neck in 685 cases. Of these 121 were born asphyxiated. Of these latter 72 were restored by appropriate measures while 42 died.

Although the two cords I have shown you are respectively much longer and shorter than the average, they are by no means the longest or shortest on record. Baudeloque has reported a case in which the cord measured nearly 59 inches in length, and which was wound around the child's neck seven times; while Schneider relates a case in which the cord measured 118 inches and was wound six times round the child's neck. The shortest recorded was less than four inches long.

Discussion.—DR. WM. GARDNER said he had little or no experience with acute inversion of the uterus. He certainly could not agree with Dr. Smith that all cases were due to injudicious traction on the cord; many undoubtedly are, but chronic cases often arise from a depression in the uterine walls, from a tumor or local weakness. This depression increases until inversion, more or less complete, results.

DR. GIRDWOOD referred to a case of inversion three days after delivery, where the uterus projected out of the vulva when the patient sat up.

Fritz Bozeman Return-Flow Catheter.—DR. LAPHORN SMITH exhibited this valuable instrument, and pointed out its value for irrigating the uterus after manipulation of the uterus and cervical canal. He also stated that by this instrument the danger, which he contended was no imaginary one, of forcing fluids into the peritoneal cavity through open Fallopian tubes was avoided. The instrument is so constructed that constriction of the internal os will not prevent the return flow, and it possesses as well the advantage of being easily taken apart and cleaned.

DR. TRENHOLME did not believe in curetting the decidua after miscarriage, but if considerable quantity remain, the only safe plan is to remove it.

DR. ALLOWAY also agreed that curetting was not advisable except where there is considerable retention. He was inclined to doubt the patency of Fallopian tubes in endometritis. The passage of a sound through the uterine wall is a more common accident than is usually supposed.

DR. ARMSTRONG said that in his experience there is less danger of sepsis after miscarriages than of hemorrhage. The latter is often very difficult to control.

DR. SMITH, in reply, stated that Dr. Wallace of Liverpool had demonstrated to his satisfaction the patency of the Fallopian tubes in endometritis. He also did not believe in curetting after miscarriages, but preferred the use of the catheter exhibited.

Drain Sore-Throat.—DR. J. C. CAMERON read a short paper on this subject, in which he showed that when a number of cases of sore throat broke out in the same family, and when it was of a marked adynamic character and accompanied with a rash somewhat resembling scarlet fever, there was usually good grounds for suspecting the drainage of the house. He then gave the details of ten cases of sore throat which occurred in one family. Suspecting the drainage, it was examined and a defect in the ventilation of the soil-pipe was discovered. In six of these cases both severe tonsillitis and ulceration almost diphtheritic in character were present.

DR. BLACKADER said that in his practice about the same time he had twelve cases of tonsillitis followed by an erythematous rash in families residing in the same district. The rash was especially marked on hands and neck. The temperature reached 101° to 102°, and headache with pain in the back were symptoms common to all. The sore throat in the adults was diphtheritic in character; in the children it was severe and scarlatini-form. The only possible cause common to all the cases was the milk supply. This, however, on investigation, showed nothing to indicate that infection proceeded from this source. He could not trace the cases to bad drainage, but he did not have the

drains inspected by a sanitary engineer, as he certainly would do should he have a similar experience.

DR. WILKINS thought many of these cases were due to changes in temperature. All practitioners about that time had a number of such cases.

DR. ROSS pointed out that in the early stages scarlatina was very difficult to diagnose. A rash accompanied or preceded by sore-throat, such as Dr. Blackader described, should always be treated as scarlet fever.

DR. MILLS had no doubt but that sore throat is frequently caused by open drains.

DR. PROUDFOOT thought that the question of contagion is often lost sight of in these cases.

DR. SPENDLOVE said he was able to trace six cases of tonsillitis with rash to a broken soil-pipe. A separation of two inches was found at one of the joints.

MR. FLEMING, Sanitary Engineer, was introduced by the President, and said he had numerous experiences of cases of sore throat clearly traceable to defective drainage. In one family no fewer than eleven were ill. Here he found sewage gas blowing into all the rooms, and the worst case was the one most exposed to the gas. Wherever the ventilating shaft of the drain passes through the house, any opening will cause a draught from the pipe into the rooms. He found upwards of 75 per cent. of the best houses in Montreal had defective house drains.

DR. CAMERON, in reply, made a strong appeal on behalf of the Montreal Sanitary Protection Association, of which Mr. Fleming is the engineer.

The Late R. P. Howard, M.D.—The following resolution of regret was proposed by Dr. W. Hingston, seconded by Dr. G. Fenwick, and as a mark of respect was passed by a silent standing vote :—

Resolved,—That this Society record its profound regret at the death of Dr. R. P. Howard, one of its most distinguished members and more than once its president, whose brilliant professional career was fairly earned by his untiring application to study, by his unflagging zeal in the discharge of his duties, and by the most delicate observance of the amenities of social and professional life.

Stated Meeting, April 19th, 1889.

WM. GARDNER, M.D., PRESIDENT, IN THE CHAIR.

Angina Pectoris: Occlusion of Coronary Artery.—DR. LAFLEUR presented the heart of a patient who had suffered from angina pectoris. The left ventricle was much dilated, and there was extensive fatty and fibroid degeneration of the myocardium. The coronary arteries were much thickened from atheromatous changes, and the interventricular branch of the left artery was completely occluded, near its origin, by a firm, calcified thrombus. Fine anastomoses with branches of the other vessels were traced out. The degenerative changes of the myocardium were most marked in the neighborhood of the occluded vessel.

DR. BELL stated that he had amputated the leg of this patient, and during convalescence he had been attacked by gangrene of the stump, severe pain coming on suddenly at night, and death occurring from exhaustion.

DR. ROSS, who had seen the patient for his thoracic symptoms, described his first attack of angina as coming on in bed, with excessive pain, anxiety and distress. The only physical signs were those of enfeeblement of the heart sounds. He regarded cases in which the attacks took place when at rest as much more serious than the more common ones, in which pain occurred during exertion.

DR. F. W. CAMPBELL referred to a case of angina and sudden death, with advanced disease of coronary arteries.

Cancer of Liver; Metastasis involving Fifth Cranial Nerve.—DR. LAFLEUR exhibited a liver affected with encephaloid cancer. The organ was enormously enlarged, weighing over ten pounds. The cancerous nodules were scattered through the organ, the largest being about an inch and a half in diameter, were soft, fluctuating, and not umbilicated. The centres of the larger ones were softened and broken down to a fluid detritus. There was no primary growth in the stomach or elsewhere. A small secondary tumor was present involving the fifth cranial nerve of the left side. Microscopic examination showed a typical encephaloid cancer.

DR. WILKINS stated that in addition to the emaciation, enlargement of the liver, and jaundice, the patient had suffered from severe shooting pains in the course of the trigeminus, which was explained by the growth involving the nerve. Briefly, the history of the case is as follows: Patient, a soldier, aged 48, who drank freely, was jaundiced for twelve months some years ago. Admitted to the hospital, March 25th, with great pain in epigastrium and general weakness; face of an earthy, cachetic appearance. The epigastric region was full and tender; dullness over all the upper abdominal region and in right nipple line for eight inches from the fifth rib, and in the axillary line it reached the crest of the ilium. A hard, rounded, tender mass with nodules could be felt across the abdomen two and a half inches below the navel. The patient could not sleep without morphia, the abdomen became distended and tympanitic, failed rapidly, and died April 12th.

Subdiaphragmatic Abscess; Gangrene of the Extremities.—DR. FINLEY exhibited the organs. A large abscess cavity, bounded below by the liver, above by the lung, and communicating freely by an opening in the diaphragm. The liver, which was pushed down three and a half inches below costal border, presented a shallow, saucer-shaped excavation surface, three inches in diameter, and lined by pyogenic membrane. The lung bounding the abscess was firm and carnified, and showed early interstitial changes microscopically. Old adhesions closed the pleural sac over its lower two-thirds. A large bronchus opened directly into the cavity. The spleen was large, soft and pulpy; the other organs normal. Moist gangrene was present in right leg almost as high as knee, also in both upper extremities. Dissection of the vessels of the lower limb showed the arteries, as far as the bifurcation of the popliteal, to be normal, but the popliteal vein was blocked by a partially organized thrombus. The origin of the abscess was probably subdiaphragmatic. Abscess of the liver could be excluded by the anatomical conditions in addition to its rarity. Localized basal empyema usually presents greater pleural thickening and often small pockets of pus, and very seldom caused perforation of the diaphragm.

DR. STEWART gave the following history of the case :—

L. R., aged 39, carter, was admitted into hospital Jan. 30th, 1889, complaining of an incessant and distressing cough with copious and occasionally blood-stained expectoration, also pain in right side in taking a long breath, and dyspnoea, which occasionally amounted to orthopnoea. Patient has been irregular in his habits and often severely exposed himself during periods of intemperance. No history of syphilis. Family history negative. Present illness began four weeks ago by pains in right shoulder and chest; had a chill followed by severe catching pain in right side, with hacking cough and a sense of oppression across chest. During last ten days expectoration has become muco-purulent, copious, and occasionally blood-stained; has lost strength rapidly and dyspnoea has increased; pulse 80, full and compressible; temperature $100\frac{1}{2}^{\circ}$; respirations 24, shallow, restrained, and catching in character; constant cough and anxious expression.

Physical Examination.—Slight deficiency of expansion of right side; vocal and respiratory fremitus slightly diminished; dullness in front, on right side, from second rib to base and throughout axilla, and from eighth rib to base behind; breath sounds over dull area diminished and proceeding towards the base, almost extinct at apex; breathing harsh; sputum copious, purulent and blood-tinged. Examination of sputum showed red blood-cells, small amount of elastic tissue, no tubercle bacilli.

Feb. 4th.—Is spitting up large amount of frothy red blood, sometimes one pint per diem. Severe pain below right nipple. Sputum contains large amount of elastic tissue. *10th*—Still copious hemorrhage, which is becoming more profuse. *20th*—Some moist sounds heard at base of right lung; breath sounds more distinct. *23rd*—Sputum less copious, but chiefly composed of bright red blood; dullness diminished to third rib in front; orthopnoea marked. *27th*—Patient becoming weaker constantly.

March 3rd.—Sputum lessened and not so much blood; signs of cavity near right nipple. *15th*—Complains of great pain in left hand, which came on suddenly this morning, also in right foot; hand and foot very tender at different parts; temperature

105.2°; pulse imperceptible at wrists; brachial artery felt feebly beating; neither tibial arteries can be felt; pain on pressure in popliteal space on right side. 16th—Complains of coldness and numbness of hand and leg mentioned; temperature 100°; sputa less copious; great pain in leg and arm. 18th—Parts are becoming livid and cold, and this condition is extending up leg and arm, as also is seat of pain; sensation in fingers and toes nearly gone; no pulse in radial or tibial arteries; perspires profusely at times; complains of pain in right wrist coming on suddenly; left hand livid and cold. 20th—Complains of severe pain in left foot (instep); gangrene extending in other parts. 23rd—Complete stasis of blood in both hands and feet; is failing rapidly and suffering great pain. 28th—Gangrene still extending, is half-way up right leg and above right wrist-joint; blebs appearing; suffering great pain; very weak and delirious at times.

April 10th.—Patient died to-day, gangrene having extended over two-thirds of left arm, nearly to knee of right leg, and over other foot and hand.

DR. ROSS had seen the patient in the earlier part of his illness. Hæmoptysis had then been the most prominent symptom.

DR. LAFLEUR suggested that the gangrene was due to capillary thrombi of micro-organisms.

Old Encysted Trichinæ.—DR. FINLEY exhibited the larynx of a woman aged 45, in the muscles of which trichinæ were imbedded. The trichinæ were found in moderate numbers in the muscles of the tongue and larynx, but were not observed elsewhere. They were distinctly visible to the naked eye as fine yellowish particles. There was fatty degeneration of the heart and cirrhosis of liver and kidneys, attributed to chronic alcoholism.

DR. WILKINS stated that the woman had been brought to the hospital a couple of days before death with convulsions, and died of uræmia, a noticeable feature of the case being the slow pulse, which was only 40 per minute. Albumen and tube casts were present. Trichinosis had, of course, not been suspected.

Chronic Alcoholism—Cirrhosis of Liver and Kidneys ; Gastric Ulcer ; Death from Hæmatemesis.—DR. FINLEY exhibited for Dr. Wilkins the stomach of a patient who had died of hæmatemesis. The organ presented a small ulcer, with sharply-cut edges, one-third of an inch in diameter, on the posterior wall, near the middle of the lesser curvature. A small, open-mouthed artery is present in the centre of the ulcer, into which a small probe is readily passed. The stomach contained a small amount of blood, and there was a large quantity of more or less altered blood in the small and large intestines. The liver, was fatty and cirrhotic, about normal in size. The kidneys were small and cirrhotic. The spleen was atrophied, and the heart showed fatty infiltration and degeneration.

DR. WILKINS stated that the patient, a female aged 40, had been brought to hospital the day before her death. She was too ill to give an account of herself. Severe hæmatemesis began forty-eight hours before death, and was looked upon as probably due to ulcer. The patient was known to have been a hard drinker, and to this the changes in the kidneys, liver and heart were probably due.

Selections.

Some Observations on Œdema, WITH TWO CASES OF IRREGULAR ŒDEMA COMPLICATING MALARIA.—Different names are applied to œdemas of different location and extent, but for all practical purposes I may say that the following list embraces substantially all the different varieties of œdema: 1. Œdema due to portal obstruction, or liver œdema. 2. Œdema due to cardiac disease, heart œdema. 3. Œdema due to renal disease, or kidney œdema. 4. Essential œdema of Wagner.

Œdemas from other causes worthy of mention, though their causative relation is disputed, are, those from exposure to cold and damp, the sudden suppression of an habitual discharge, the rapid cure of a cutaneous disease and extreme anæmia and debility. The four last named are considered to induce œdema by exciting congestion in internal organs from the afflux of blood to them, on its being driven from the

surface, and in this way disturbing the renal as well as other functions; or in consequence of abnormal states of the blood and tissues. It is doubtful, however, if either of them can of itself actually occasion œdema. It is very likely indeed that many or all of them exist at the same time and contribute each its part to the production of the undesired result. After some remarks on the first three varieties, Dr. Keefe continues: I would now draw your attention to the essential œdema of Wagner. This is more frequently found in children than adults, and generally occupies the entire surface of the body. Although we do not know its etiology it is thought that cutaneous, vascular and blood changes and cardiac asthenia are among the most frequent causes. Heredity also seems to be a factor in its production, the father or mother having been rachitic, while in other cases a brother or sister has been subject to general œdema. "Neither autopsies nor experiments on animals have served to explain the genesis of this disease. It is considered doubtful if the vaso-motor or trophic nerves have any part whatever in its production." The generalized œdema accompanying febrile disease is also a kind as to the cause of which we are entirely ignorant, though there are many speculations in this regard. I will relate briefly two cases of irregular œdema occurring in my practice as a complication of malarial disease.

Case 1. Single female, domestic, aged 24, extremely restless, chill, nausea and vomiting; left hand and wrist greatly swollen, pitting on pressure, as were both ankles also; temperature $104\frac{1}{2}^{\circ}$, pulse 110, pain in head, back and limbs; had been told she had dropsy, which greatly frightened her. Urinary examination proved negative, as did physical examination of chest and abdomen. I accordingly gave quinine in anti-periodic doses, and was pleased to find a ready response. There was no return of the paroxysm and she returned to her work in a few days. In about six weeks I was again called and found her in a similar condition. Quinine gave, a second time, a prompt cure.

Case 2. Married female, Swede, aged 38, had lived in a malarious district, and had several tertian attacks. Called to see her for œdema under eyes, and in right wrist and arm; later, painful chilly feelings in back, headache and weakness in limbs. Quinine with iron and arsenic removed all symptoms.

While I do not pretend to be able to explain how malarial

poison acts on the organism to produce such exudations, I would suggest that it is due to the poison of the disease acting on the nerve centres, just as I have explained regarding urea in kidney diseases, and through the sympathetic ganglia paralyzing the vaso-motor nerves, thereby dilating the arterioles and thus causing an afflux of blood to one part. In other words it causes an inco-ordination on the part of the vaso-motor nervous system. This superabundance of blood, the veins of the part find it more than usually difficult to return to the circulatory centre, in consequence of the congestion existing in nearly all the important viscera and consequent pressure on and narrowing of the lumen of the veins and lymphatics passing into and through them. For these reasons stasis and transudation are encouraged and produced. The points of interest, as it seems to me, in these cases are: the importance of keeping in mind the possibility of malarial disease as a causative factor in irregular œdema; its speedy yielding to anti-malarial treatment; and the advisability of resorting to such treatment in doubtful cases.—*Dr. D. E. Keefe, in Bost. Med. and Surg. Jour., May 16.*

Diseases of the Circulatory Organs—

PROGNOSIS IN HEART AFFECTIONS.—At the meeting of the Verein für innere Medicin on April 1st, 1889, Dr. Leyden discussed the prognosis of diseases of the heart. After some preliminary observations on the general importance of prognosis, the speaker went on to say that the advance in our present knowledge was due to the emancipation of observers from purely physical methods which were assuredly not undervalued, but on which formerly reliance had been too exclusively placed. The clinical method now in vogue took into account, in addition to physical diagnostic measures, all other local and general symptoms, and had thus acquired a broader standpoint. Until a short time ago the prognosis of heart disease had been extremely bad. A more hopeful outlook had for the first time been taken quite recently. Experience had shown that many sufferers from heart disease lived in fairly comfortable ease. A gloomy prognosis appeared to be confirmed by the fact that persons with diseased heart often died suddenly. Closer examination, however—especially by English physicians—had shown that in the majority of chronic heart affections, sudden death was rare, except in the case of inadequacy of aortic valves, and true angina pectoris (of Heberden). In both of these, although the patient is not safe any day, his life may be prolonged for years. In relation to aortic insufficiency, Dr. Leyden had

had a very large experience, both in hospital and private practice. In other kinds of valvular inadequacy sudden death was comparatively rare; in mitral incompetence it occurred in about two per cent. of the cases, that is to say, so seldom that the practitioner might leave this unfortunate termination out of account. Further observations on prognosis might be grouped under three heads: (1) with reference to general disposition and circumstances of life; (2) with special groups of cardiac affections; (3) with reference to particular physical and physiologico-pathological symptoms. In connection with the first of these, the age must first be considered. Young children bear heart disease very badly. In adolescence and early adult life the prognosis is better. This depends on the fact that at that age those forms of cardiac affection chiefly occur in which the prognosis is relatively favorable. At more advanced periods of life, heart diseases are for the most part associated with arterio-sclerosis. This often became developed at a very early stage. Arterio-sclerosis had always a progressive tendency; this progressive character might, however, be very gradual. Compensative changes were easily brought about in more mature years. But precisely because of this progressive tendency, those forms of valvular insufficiency presented an unfavorable prognosis. The second general etiological factor was the sex. The prognosis was on the whole better in the female than in the male sex. If this was less clearly the case in hospital than in private practice, that was due to the fact that women of the lower classes led a life exposed to the same hard work, the same mental disturbances, and partly the same excesses as men. In women of the upper classes these etiological factors were wanting. Arterio-sclerosis was, moreover, less frequent in the female sex, and even in families in which it was hereditary it affected the female members to a less extent. The female character was better adapted to bear troubles. Finally, experience proved that in women mitral incompetence, in which the prognosis was good, was more frequent than aortic insufficiency. A third factor was to be found in the patient's circumstances and manner of life. Hard bodily labour was the most dangerous enemy to sufferers from cardiac disease. Even mental emotion often aggravated the condition. The less disturbed by worry the patient's life was, the more care he took of himself, the better was the prognosis; therefore patients in better and easier circumstances bore heart affections better than persons less fortunately situated. A further point was connected with the possibility of treatment and the re-action of the constitution to medicines, of which digitalis was the most important. The right use of that drug was one of the most difficult problems in medicine.

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DIABETES MELLITUS FOLLOWING EXTIRPATION OF THE PANCREAS.

Mering and Minkowski (*Centralblatt f. Klin. Med.*) have found that extirpation of the pancreas in the dog is invariably followed by diabetes mellitus. Sugar appears in the urine shortly after the operation and is constantly to be found till the death of the animal, which usually occurs some weeks after. In addition to the sugar in the urine, the other well known symptoms of the disease also make their appearance; polyuria, excessive thirst and emaciation in spite of abundant nourishment. The urine was also found to contain acetone, the blood sugar was also found to be increased in quantity. The normal glycogen of the liver and muscles was found absent in a dog that had been operated on four weeks previously and after being fed with a rich nitrogenous diet. As care was taken not to wound the solar ganglion during the operations, the authors conclude that the diabetes was due to the extirpation of the pancreas.

LEPROSY IN ENGLAND.

Within the last few months great alarm has been expressed lest leprosy should secure a footing in England and become a prevailing disease. There is no doubt that it is spreading in India and those of our colonies which are situated in tropical climates. But in spite of the alarmists it is not present in England to any extent, especially when we take into consideration the fact that so much oriental traffic centres in that country. Altogether there are supposed to be not more than twenty lepers in England, and two of them were exhibited lately at the Epidemiological Society. A dis-

cussion ensued on the increase of the malady in India, and the necessity for strict segregation. Several speakers pointed to the danger of leprosy becoming common in this country unless precautions were taken to limit the risk of contagion. They all agreed that there was no curative treatment. Legislation to compel lepers to enter asylums was demanded by some medical men present, whilst others, including the chairman, Dr. Thorne Thorne, advocated a Government enquiry upon the subject.

HOSPITAL FOR THE TREATMENT OF THE DISEASES OF THE GREAT TOE.

In the course of a very able address given at the Mansion House, London, on the 20th ult., in aid of the Hospital Sunday Fund, Sir Andrew Clark alluded to the growth of special hospitals as one of the causes of the falling off in the revenues of the general hospitals and dealt heavy blows at the founders of special institutions and those who had been induced to contribute to their support. To use his own words "Then there is another reason, and that is the foundation and maintenance of improper hospitals which divert funds in a direction in which they ought not to be employed and rob the great hospitals of the support which they ought to receive. A doctor who cannot get on in the ordinary way takes to studying the great toe, and he discovers something about it that has never been discovered before. In the course of his studies he ascertains that the diseases of the organ are not only supremely important in themselves but that they have the most intimate relation to all the other serious diseases of the body. He also invents a wonderful instrument whereby he can look into the great toe and see what is threatening and prevent all those terrible things which happen in the organ and affect the whole system. He goes to his friends, shows them his instrument and tells them of his discoveries. They then club together and establish a hospital for the treatment of the diseases of the great toe. The hospital is manned by his friends who, having joined in the venture, must make it a success. They soon get patients who are convinced of the vast importance of the great toe; marvellous cures are expected and all sorts of frightful diseases are prevented.

Then they have an annual meeting; they have a chairman who sets forth bashfully, in the presence of the great physician, the diseases of the great toe, the wonderful things that had been done, the great service which has been rendered by the hospital, the terrible prejudice it has had to encounter, the determination that this great institution shall be liberally supported notwithstanding the prejudices of the medical profession and of those who herd along with them."

CHANGES IN THE CURRICULUM OF THE ONTARIO MEDICAL COUNCIL.

We are pleased to hear that the Ontario Medical Council have determined to make one summer session compulsory. This is a much needed change in the interests of the student. Another change instituted is the attendance on a course of fifty demonstrations on medical and surgical anatomy during the final year. Such a course will no doubt be an aid to many students in working for their examinations in the final subjects, but on the other hand it will seriously interfere with what should be the real work of the year—clinical work. We have also noticed that the Council in future will require two six months' courses on medical jurisprudence. This is the only change made in the requirements of attendance on didactic lectures. It is a most unfortunate change in many ways. The previous requirements of two three months' courses on this subject were, in the opinion of many, well able to judge entirely too much. There can, we think, be no two opinions on the unadvisability of doubling what was previously a burden. The Council as yet do not require any attendance on lectures on general pathology, a subject of very much greater importance than jurisprudence.

THE ONTARIO MEDICAL ASSOCIATION.

The recent meeting of the Ontario Medical Association in Toronto was the most successful that this body has as yet held. The attendance was good, and many excellent papers were read. The discussions were keen and interesting. The address of the president, Dr. Henderson of Kingston, dealt in a very able manner with many of the questions that are specially attracting the attention of the pro-

profession in this Canada of ours. The following officers were appointed for the ensuing year: President, Dr. J. Algernon Temple; first vice-president, Dr. Landy, of Preston; second vice-president, Dr. G. Shaw, of Hamilton; third vice-president, K. N. Fenwick, Kingston; fourth vice-president, Dr. Hanley, Waubaushene; general secretary, Dr. D. G. Wishart, Toronto; treasurer, Dr. Barrick, Toronto; assistant secretary, Dr. W. P. Caven, Toronto.

AMERICAN MEDICAL ASSOCIATION.

The fortieth annual meeting of the American Medical Association, recently held in Newport, was, especially in a scientific aspect, one of the most successful meetings that this important body has ever held. The address of the President, Dr. Dawson, of Cincinnati, dealt mainly with questions affecting medical education. The address on Medicine, delivered by Provost Pepper, of the University of Pennsylvania, was mainly a sketch of the life work of Benjamin Rush. Prof. W. H. Welch, of Baltimore, delivered an exceedingly able address on State Medicine. We hope in an early issue to publish this address. Our distinguished countryman, Sir Jas. Grant, of Ottawa, ably represented the profession in Canada.

COLLEGE OF PHYSICIANS AND SURGEONS OF THE PROVINCE OF QUEBEC.

At the triennial meeting of the College of Physicians and Surgeons of the Province of Quebec held at Laval University, Quebec, on July 10th, the President, Dr. Hingston, presiding. The Treasurer, Dr. Lachapelle, submitted his financial statement, showing that the total receipts of the College from 1st July, 1886, to 1st July, 1889, had been \$16,013.03 and that, after paying all expenses, there remained a balance on hand of \$4,672.64, together with five shares of the Bank of Montreal.

The thanks of the College were unanimously voted to the Treasurer for the able manner in which he had discharged his duties during the last nine years, and the meeting then proceeded to the election of forty new governors for the next three years, with the following result:

City of Quebec.—R. F. Rinfret, L. Larue, C. T. Parke, A. G. Belleau, A. A. Watters and E. A. de St. George.

District of Quebec.—P. M. Guay, Come Rinfret, R. Fiset, L. H. Labrecque, L. T. Rousseau, P. E. Grandbois and A. Moiresset.

District of Three Rivers.—Hon. J. J. Ross, E. C. P. Chevrefils and F. Trudel.

City of Montreal.—T. A. Rodger and J. M. Beausoleil.

District of Montreal.—Hon. Dr. Paquet, P. Laberge, J. O. Mousseau, J. H. L. St. Germain, J. Lippe, H. A. Mignault, Hon. Dr. Marcell, Jules Prevost and J. B. Gibson.

District of St. Francis.—Drs. J. F. Austin, F. Pare and T. Larue.

The new Board met immediately, when the President, Dr. Hingston, presented his report, which was unanimously adopted. The representatives of the universities were then named as follows:

McGill.—Drs. Craik and Geo. Ross.

Montreal School of Medicine, etc.—Drs. Hingston and Desjardins.

Laval, Quebec.—Drs. Lomieux and Simard.

Bishops.—Drs. Campbell and Perrigo.

Laval, Montreal.—Drs. Rottot and Dagenais.

The election of officers resulted as follows:

President, Hon. Dr. J. J. Ross; Vice-Presidents, Drs. R. F. Rinfret and Gibson; Treasurer, Dr. Dagenais; Secretaries, Drs. Campbell and Belleau; Registrar, Dr. L. Larue.

Professors Laflamme, Verrault, Howe and Petry were chosen as preliminary examiners.

The following were named assessors:—

Laval, Quebec.—Drs. Sewell and Gameau.

Laval, Montreal.—Drs. Marcell and Gibson.

McGill.—Drs. Austin and P. E. Mignault.

Victoria.—Drs. Angus Macdonnell and O. Raymond.

Bishops.—Drs. H. A. Mignault and Rodger.

Thanks were then voted to the retiring President, Dr. Hingston, and the other outgoing officers, and the meeting adjourned to the 25th of September next.

—THE fifteenth annual meeting of the Bathurst and Rideau Medical Association was held in Arnprior on July 3rd last, Dr. Cranston, of Arnprior, president, in the chair. The following officers were appointed for the ensuing year: President, J. G. Cranston, of Arnprior; vice-presidents, Dr. R. W. Powell, of Ottawa, and Dr. Burns, of Almonte; secretary,

H. B. Small, of Ottawa; treasurer, Dr. Hill, of Ottawa; executive committee, Dr. Horsey, Rogers and Sir James Grant for the City of Ottawa; and Drs. Dickson, Lynch, Armstrong, Mann, Allan and Grant for the rural districts. It was decided to hold the next meeting in the City of Ottawa in January, 1890.

Obituary.

DR. JAS. B. HUNTER OF NEW YORK.

Death has again cut into the ranks of the leaders of medical thought of this city. This time the victim was James Bracebridge Hunter, who, although a native of New York State, in which he had lived the major part of his life, always felt a warm filial feeling for Canada—the scene of the happy days of his boyhood. His family continued residing in Toronto and there his remains were taken for burial. Dr. Hunter died on June 10th, at the age of fifty-two years, after an illness of twenty-six weeks, having suffered from acute rheumatism complicated with endo- and pericarditis.

He was a medical student in Cincinnati at the time that the civil war broke out in 1861, when he entered the army as a volunteer and was soon promoted to the rank of first lieutenant and adjutant. Later on he passed the Army Medical Board Examination and was assigned to the 60th Indiana Regiment as assistant surgeon. In this capacity he saw active service under Grant at Vicksburg and at other points. On the termination of the war he came to this city and continued the study of medicine at the College of Physicians and Surgeons, where he was graduated in 1866. He then went to London and attended Moorfields Hospital with a view of becoming an oculist. On his return here he became associated with Dr. T. G. Thomas in hospital and college work and this circumstance determined his efforts and energies into the paths of gynæcology. He was appointed house surgeon to the Woman's Hospital in this city in 1867, assistant surgeon in 1871. In 1878 he was elected attending surgeon—a post which he occupied until his death. He was one of the early members of the New York Polyclinic, holding the chair of Gynæcology, and was visiting surgeon to the Cancer Hospital, of which he was one of the founders.

From 1872 to 1880 he was connected with the *New York Medical Journal*, first as assistant then as chief editor, and exhibited the same thoroughness, earnestness and good common sense in this position as in all that he filled. Dr. Hunter's career in this city is a forcible illustration of what patience, industry and perseverance will accomplish even in the face of great odds. Naturally reserved, modest, unostentatious, with no family connections, with a face and manner which repelled rather than attracted at first sight, he was the last person of whom one would predict a brilliant career in this vast metropolis where the competition is so keen and great. And yet for at least the past decade he was reckoned among the leading gynecologists of the day and had a very large and profitable *clientile*. There were a few more brilliant operators, but there were none more cool, more neat and more skillful than he. As a diagnostician there were few his equal. As a teacher he was conscientious, clear and practical. Those who have reason to know him best speak very highly of the goodness of his heart, of his loyal friendships and of his almost morbid sensitiveness lest his acts of charity should become known to the world. Of him it might be truly said "he gave with the right hand and the left hand did not know it." His heart beat warmly for all in distress and in physical suffering. To those of his colleagues who served with him he was kindness in itself and full of consideration. It is deplorable that such an active and useful life should be cut off just in its prime, at a time when the thorny paths that beset it were beginning to be left behind, when the summit of the mountain was about to be reached, and when the vision was gaining in width and in height, for there can be no doubt that had he lived for another decade he would have enriched medical science to a considerable degree. Even in this immense aggregation of human beings, where one soul is like a drop in the ocean, his loss will be felt by the profession and by the community for some time to come.

H. N. V.

New York, 1 July, 1889.

THE LATE DR. WOOLDRIDGE OF GUY'S HOSPITAL.—Guy's Hospital has been singularly unfortunate within the last few years in that it has suffered the loss of so many of the members of the medical staff. Moxon, Fagge, Carrington and

Mahomed, all men of mark, all in their prime, and in the very thick of professional life, followed each other very rapidly to the grave. The last English mail brings news of the death of another assistant physician of Guy's, Dr. Leonard Charles Wooldridge. The nature of the fatal illness seems to have been obscure. The onset was acute and death unexpectedly sudden. The autopsy showed congestion and ecchymosis of the stomach and duodenum, with follicular ulceration of the colon. There was slight but undoubted dilatation of both ventricles of the heart. It would appear that the morbid state of the stomach and colon produced in his exhausted condition a cardiac dilatation, which proved fatal from syncope. Dr. Wooldridge was the son-in-law of Sir Edward Sieveking.

Medical Items.

—THE following is the list of officers of the Ontario Medical Council for the current year: President, Dr. Cranston, Arnprior; vice-president, Dr. Crawford; treasurer, Dr. W. T. Aikins; solicitor, B. B. Osler; registrar, R. A. Pyno.

—We beg to draw attention to Dr. Holford Walker's change of advertisement in this issue, announcing that his new hospital in Toronto is now open for the reception of patients. The doctor has taken a wise course to confine himself to the speciality of Diseases of Women and Abdominal Surgery, and as such is the pioneer specialist in that department of the profession in Toronto or in fact in Ontario. We understand his Hospital is a model one in every respect, and worthy of the support of the profession throughout Ontario.

TREATMENT FOR CATARRHAL AFFECTIONS OF THE THROAT.—Dr. G. B. Hope of New York, attending surgeon Metropolitan Throat Hospital, and Professor Diseases of the Throat, University of Vermont, says: "For a long time I have been employing Horsford's Acid Phosphate as a constitutional treatment for catarrhal affections of the throat. I consider it to be among the very best tonic excitants of the vocal organs, and particularly applicable in relieving the fatigue and huskiness of voice incident to those who pursue a professional career of actor or vocalist, and far preferable to the various forms of wines now so generally recommended for this purpose. I have seen no other allusion to its employment in this direction, which I believe you are perfectly safe in recommending both from a theoretical and practical point of view.