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CANADA  
MEDICAL & SURGICAL JOURNAL

SEPTEMBER, 1878.

Original Communications.

TWO CASES OF URETHRAL FEVER,

BY JAMES BELL, M. D.

Assistant House Surgeon Montreal General Hospital.

(Read before the Medico-Chirurgical Society, June 21st, 1878.)

The subject of my paper, 'Urethral Fever,' is well illustrated by two cases which occurred in the Hospital last winter. They were both in Dr. Roddick's wards. The first is that of a sailor, George Ives, who was admitted for stricture of the Urethra on the 23rd of October, '77. He was a large, well-built, muscular young Englishman, 24 years of age. His family history was obscure. The only reliable fact that could be ascertained was that his mother died of some wasting disease—probably Phthisis. He had been at sea since he was 12 years of age and had always been healthy. He had gonorrhœa 6 years ago and was treated by his Captain with injections, and recovered in a month without having any of the ordinary complications or sequels of gonorrhœa, as orchitis, bubo, or stricture. He had no difficulty in micturition after this attack. About 2 years ago he contracted gonorrhœa again. It lasted six months, and when his ship arrived in New York he consulted a doctor, under whose treatment he rapidly recovered. The treatment consisted in injections and the administration of capsules—probably of copaiba. About nine months ago he noticed that in micturition the stream was very small and often irregular and twisted at the meatus, and he had sometimes to strain a good

deal to evacuate his bladder. These difficulties gradually increased, and once at sea he had complete retention for three days, and was ultimately relieved by a comrade by means of a gum elastic catheter. On his last voyage he had complete retention again; this was about three weeks before admission. He was relieved and enabled to evacuate his bladder on this occasion by means of a hot hip bath. On examining his penis, he was found to have a bridge of tissue extending across the meatus near its upper part. On the 27th October, this band was divided and the urethra was explored with *Lister's Metallic Sound*, and a firm tight stricture was discovered in the usual situation—about the junction of the spongy and membranous portions of the urethra. An instrument was not passed through the stricture,—in fact, this feat was scarcely attempted. This was about half-past three in the afternoon. A small piece of gum-elastic catheter was tied into the meatus where the small band had been severed. About two o'clock next morning he had a severe rigor. His temperature, unfortunately, was not taken until seven in the morning. It was then 103° F. He was ordered tr. aconiti, m. v liq. ammon. acet, ʒ ss. 4 q. h. He had also some diarrhoea which was easily checked by the use of bismuth. His temperature reached 104.8 in the evening, and he was given twenty grains of quinine. His urine was not measured, but he passed a fair quantity which was very high-colored and deposited a large amount of lithates. It contained no albumen. He was very dull and drowsy and complained of head-ache and a feeling of restlessness and anxiety. He was now thoroughly examined, but no organic disease could be discovered.

Oct. 30th.—Still flushed and feverish, great head-ache and restlessness. Is somewhat delirious at night and can with difficulty be kept in bed. Tongue coated and dry. He was ordered chloral and bromide of potash at night, which, in moderate doses, had little effect upon him.

Oct 31st.—Has difficulty in micturition; has to stand up to evacuate his bladder. He passed 70 oz. of urine in twenty-four hours. The urine now contains two or three per cent. of

albumen and deposits a small quantity of pus; it deposits a large quantity of lithates on standing. Diarrhœa set in again but was easily checked.

Nov. 9th.—Fever continues; little change in symptoms, except that prostration is greater. He is restless and delirious at night. He was ordered a chloral draught at night again, but it had no effect on him; he has now considerable tenderness on the right side of the abdomen and in the right loin. Up to this time we had considered this a case of urethral fever, but the continued high temperature, which so far had been pretty regular; the increasing prostration and delirium at night; the tenderness on the right side of the abdomen and the diarrhœa, and the general severity of the case, began to make us suspect that it was typhoid fever, in spite of its mode of onset and several other circumstances which were opposed to that diagnosis. He was accordingly transferred to the medical wards in charge of Dr. Ross, who examined him carefully, and gave it as his opinion that he had not typhoid fever, but from the position of the tenderness in the abdomen, which was over the right kidney and along the right ureter, and the presence of the slight amount of pus in the urine which persisted without any appreciable variation from day to day, he thought that he had probably some organic disease of the right kidney; he found all his other organs healthy. He remained in the medical wards under Dr. Ross's care until the 30th of November. For about two weeks there was but little change in his symptoms, but his temperature was very erratic—the difference between the morning and evening temperatures being sometimes as much as 8° F. He then began to improve, and on the 30th November he was re-transferred to the surgical wards, but nothing more was done for his stricture, and on the 10th of December he was discharged.

The second case was from the country—a married man, 30 years of age, of Irish descent, large and well-built. He was admitted on the 5th of November, '77, for stricture of the urethra. He has no history of constitutional disease; was always very healthy; never had rheumatism or any disease

that he can remember. He attributes his stricture, which he says he has had all his life, to riding bare-backed when a boy, having received several slight injuries in that way. He had gonorrhoea sixteen years ago, which aggravated his stricture a good deal. His stricture began to trouble him seriously about seven years ago, when he consulted a doctor, who passed a catheter for him. He believes that it never entered his bladder. He then consulted another doctor, who passed a No. 3, and he felt "all right" for twelve months afterwards. He was then obliged to consult another medical man, who passed bougies, which gave only temporary relief. He has had trouble ever since in micturition, especially in spring and fall. Two years ago he was in the hospital under the care of Drs. Reddy and Wilkins, who ruptured his stricture with *Thompson's Divulsor*. He left the hospital soon after, and had no difficulty for a year and a-half afterwards. He had no instruments passed after leaving the hospital. During the last six months he has frequently been unable to evacuate his bladder, and on these occasions was relieved by the late Dr. Cline, who passed a No. 3 silver instrument. He never had complete retention until six months ago, when he first consulted Dr. Cline; he never suffered from chills or fever in any of these manipulations—nor at any other time. He was admitted about 10 o'clock in the morning of the 5th of November, '78; at 2 p.m., four hours afterwards, Dr. Roddick explored the urethra and discovered a tight cartilaginous and somewhat elastic stricture at the junction of the spongy and membranous portions of the urethra. He made two or three unsuccessful but not at all forcible attempts to pass a catheter into the bladder; no blood was drawn, and there was no reason to suppose that even an abrasion of the mucous membrane had been produced. About half-past four, two hours after the operation, he had a severe rigor, and his temperature ran up to 103° F; he perspired profusely and was very restless. During the night he had two slight chills; he complained of severe head-ache, and could not sleep. Next morning at 11 a.m. he had another severe rigor, followed by a temperature of 106° F; he was then given

fifteen grains of quinine. At 4 p.m. he had another chill, and a temperature of 101° F. At 2 o'clock next morning he had another chill less severe, and his temperature rose to 103° F.; he had still another slight chill in the afternoon. His urine, unfortunately, was not measured during the first twenty-four hours after the operation. He passed some urine, however—I don't know how much; but it was dense, high-colored, and contained no albumen. He was very restless, complained of severe head-ache, and slept none at all for three days during this attack. His tongue was coated and he had no appetite. He had no pain, except the head-ache. All this time he was confined to bed and on milk diet; there was no vomiting nor diarrhoea. He was now thoroughly examined, and all his organs found to be healthy except his heart. He had both mitral and aortic disease, with great hypertrophy of the left ventricle. He was ordered spts. ether, nit. ʒss., tr. digitalis, mv. liq. ammon. acet. ʒii t. i. d. He had no more chills after the 7th, and by the 10th his temperature was normal and he felt quite well. On the 14th, a No. 5 gum-elastic catheter was passed, and left in the urethra for two hours; no bad results followed. This was done daily for the next three days without any chill or rise of temperature. On the 20th, at his urgent solicitation, he was put under the influence of chloroform and an attempt was made to pass *Thompson's divulsor*, but without success. A No. 5 gum-elastic catheter was however passed and immediately withdrawn; this was about 2 o'clock in the afternoon. Next morning at 11 o'clock, twenty-one hours after the operation, he had a chill and his temperature rose to 103 3-5. He was given quinine, grs. xx, and by evening his temperature was 101 2/3; next morning it was normal, but he felt impatient and discouraged. He was ordered to remain in bed and have a hot hip-bath night and morning. Two days later, business difficulties compelled him to leave hospital and return to the country, and I have not heard from him since.

Now, it is an established fact in pathology that operations of any magnitude on any part of the body, are followed by febrile reaction, and as a rule this reaction is in direct propor-

tion to the magnitude of the operation—or, in other words, to the amount of injury done, due allowance being made of course for the patient's surroundings, &c. This rule does not hold good in operations about the urethra and bladder, where the most trifling operation may produce alarming or even fatal results; while severe operations, such as lithotomy and lithotrixy, external urethrotomy and rupture of structure by divulsion, are seldom followed by bad symptoms and hardly ever by the group of symptoms constituting the disease called "*Urethral fever*." This disease seems to follow as a rule the simpler operations on the urethra, as the passage of a catheter or the gradual dilatation of a stricture, and though it may occur in any patient, those who have diseased kidneys are thought to be specially liable to it; while the use of anæsthetics seems to afford protection against it. It generally sets in a few hours after the operation, and it varies greatly in degree, the simplest consisting of a chill, or perhaps two, followed by slight fever and head-ache, which continues for twenty-four or thirty-six hours, and then leaves the patient as well as before. This slight form is no doubt constantly overlooked, as the patient is frequently quite well by the time of the surgeon's next visit.

Secondly. There may be a severe rigor, followed by high fever, great restlessness or delirium, and in a few hours by profuse perspiration. These chills with fever and sweating may be repeated at intervals of a few hours for several days, and the patient recover in a week or two without the supervention of other more alarming symptoms; or, there may follow a number of days of general febrile excitement, delirium and prostration, with scanty high-colored urine, perhaps containing albumen, diarrhœa, and frequently copious perspirations. There may be remissions from time to time. To this class both the cases which I have reported belong,—the second case having a series of chills with high fever, lasting over three or four days; the patient in the first case suffering from continued fever for weeks, with many of the symptoms enumerated above, and also some pus in his urine, which I believe to have originated in the bladder.

There are still other cases in which the operation is followed by a violent rigor, high fever, prostration, alarm, anxiety and excitement, violent vomiting, profuse diarrhoea, suppression of urine, and death from uræmia.

Finally, true pyæmia and septicæmia may follow operations on the urethra and bladder, as they follow operations elsewhere, and then they are frequently mistaken for urethral fever, which is not to be wondered at when we consider the similarity of the symptoms in these diseases. Pyæmic abscesses are found post-mortem in the prostate, the liver, kidneys, joints, &c., and then these cases seem to support the view that urethral fever is essentially a form of pyæmia. Without going into the discussion of this subject, I believe that urethral fever is due to nervous shock, and that clinically it is not always discriminated from septicæmia and pyæmia. In support of this view I would simply ask, in what other way can we explain its rapid onset and different degrees of severity from such different degrees of causative irritation, or how can we call those symptoms pyæmic which set in two or three hours after the passage of a gum-elastic catheter which can scarcely have abraded the urethra, and before the passage of urine over the possibly abraded surface can have left anything for absorption by it? And, again, how seldom do these symptoms occur in the course of the different suppurative diseases of the genito-urinary tract? With reference to treatment, the great object of course is prevention, for when once established medication seems to have little, if any, effect. Knowing as we do that patients with kidney disease are specially liable to it, and that in them it is particularly dangerous, every case ought to be carefully examined before operation and the patient placed in the most favorable conditions. Some surgeons recommend the use of five-grain doses of quinine, two or three times a day, for several days before the operation. Any operation about the urethra, or even the dilatation of a stricture, generally causes so much pain that anæsthetics are called for, and it is a satisfaction to feel that in using them you are not only sparing the patient the pain of the operation but lessening its risks. *Tr. ferri perchlor*, in ten minim doses, three



times daily, has been used as a prophylactic, and Fleming's tr. of aconite in two minim doses immediately after the operation, has been very highly spoken of, and especially by Mr. Harrison, of Liverpool, who, in a recent clinical lecture (which was published in the *Lancet* last winter) said that he invariably used it and that he had found it almost unfailing.

Quinine in large doses may be said to be the standard remedy when the disease has been established. Diarrhoea, vomiting and suppression of urine, &c., and other special symptoms, must of course receive appropriate treatment.

### CASE OF PARTIAL PLACENTA PRÆVIA.

By J. A. HUTCHINSON, M. D., C. M.

On the 20th of August last, I was called in haste to attend H. S. æt 33, a woman living on Bonaventure street, who was said to be bleeding from the womb. On my arrival at the house, I found a rugged French woman, seated on a chair in a weak condition. On enquiry she told me that she had had eight children and one abortion at the third month of pregnancy; that she was now in the seventh month of gestation; that her general health had always been good; that she had never any previous hæmorrhages, or felt anything unusual during her present pregnancy; that she had been engaged running a sewing-machine during the day, and had felt slight pains in the abdominal region; and that about two hours previous to my arrival, she experienced a severe pain, and felt that blood was escaping from the vagina. She then sent for her husband to come and bring a doctor, and, as previously stated, it was two hours before I was in attendance. She had remained in the chair all the time, being afraid to move, as she felt that the hæmorrhage was still continuing, and imagined that if she attempted to lie down, the child would be immediately expelled. This she wished to avert until a doctor was present. I at once caused her to lie down, and found that her clothes were saturated and the blood had coagulated in large clots. Fortunately, the hæmorrhage was easily controlled, and on a vaginal examination

being made, the os was found to be dilated to the size of a penny-piece. I could also feel the boggy and unresisting mass of the placenta, which was at first mistaken for a coagulum of blood. At this time I did not push the examination further, and finding the hemorrhage had subsided, allowed the patient to rest for a time. She had still a strong, regular pulse, and did not exhibit much evidence of exhaustion. The labor pains occurred at intervals, but were not at all severe. The child was still alive, as the foetal heart could be heard, and with greatest distinctness on the right side. Made another examination, and diagnosed placenta prævia, as what I had previously mistaken for blood clots could not be detached, and on auscultation the uterine souffle was heard with greatest distinctness over the site of the os. Under the circumstances, I deemed it advisable not to temporize, but to aid nature in the expulsion of the child, as it was then of a viable age, and, at any rate, this occurrence seemed inevitable. With this end in view, a moderate dose of ergot was administered, which was hoped to serve a double purpose, viz: to increase the contraction of the uterus, and by pressing the head of the child against the placenta, would check the escape of blood; and, also, to assist in the expulsion of the child. The necessity of puncturing the membranes was happily avoided, as at this time the liquor amnii began to escape. It did not seem to flow away readily, being, I think, impeded by the pressure of the placenta. At every pain an additional amount would be evacuated, and would be accompanied with clots of blood. When the os became largely dilated, I could pass my fingers up at one margin of the placenta, and feel the head of the foetus. The hemorrhage continued, though not to an alarming extent, in the intervals between the pains. At the next examination, found a hand down below the head and at the margin of the os not covered by the placenta. This I pushed up, and, at the same time, separated the attachment of the placenta from around the margin of the os. A strong pain following, the head came down, engaging in the os, and the child was soon after born in the second position. Unfortunately, the child showed no signs of life and could not be resuscitated.

Hæmorrhage did not follow to any alarming extent, nor any other unfavorable symptoms. Her pulse continued almost normal, neither did she exhibit signs of exhaustion. The uterus contracted to the cricket ball shape and feel, having expelled into the vagina the placenta, which had to be removed manually. The ordinary treatment followed, and the patient soon after resumed her usual health.

The above case must be considered as resulting unusually fortunately to the mother, when we consider the great mortality attending such a complication of pregnancy as placenta prævia. The death of the foetus I take to be due to the loss of the maternal blood, and by respiration having been carried on during labor by a placenta which was only partially attached. Its death would also be hastened by its being premature.

It may be interesting here to add a few remarks with respect to the *cause* of this abnormal placental site. The older writers believed that the placenta had originally been situated at the fundus, from which it had accidentally fallen to the lower part of the uterus. It was supposed by Tyler Smith to depend on the ovule not having been impregnated until it had reached the lower part of the uterine cavity. Others think that an abnormal size or unusual shape of the uterine cavity may favor the descent of the impregnated ovule. This opinion is supported by the fact that placenta prævia generally occurs in women who have borne several children. The cause of this abnormality, however, is still an open question, and many eminent authorities consider it purely accidental.

The *source* of the hæmorrhage is now generally admitted by authorities to be from the lacerated utero-placental vessels. In Playfair's system of midwifery, the following anent this matter occurs: "Only a few years ago, Sir James Simpson advocated, with his usual energy, the theory sustained by his predecessor, Dr. Hamilton, that the chief, if not the only source of hæmorrhage, was the detached portion of the placenta itself. He argued that the blood flowed from the portion of the placenta which was still adherent to that which was separated, and escaped from the surface of the latter; and on this supposition

he based his practice of entirely separating the placenta, having observed that, in many cases in which the after-birth had been expelled before the child, the hæmorrhage had ceased. The fact of the cessation of the hæmorrhage, when this occurs, is not doubted; but Simpson's explanation is contested by most modern writers, prominent among whom is Dr. Barnes, who has devoted much study to the elucidation of the subject. He points out that the stoppage of the hæmorrhage is not due to the separation of the placenta, but to the preceding or accompanying contraction of the uterus, which seals up the bleeding vessels, just as it does in other forms of hæmorrhage. The site of the loss was actually demonstrated by the late Dr. Mackenzie in a series of experiments, in which he "partially detached the placenta in pregnant bitches, and found that the blood flowed from the walls of the uterus, and not from the detached surface of the placenta. The arrangement of the large venous sinuses, opening, as they do, on the uterine mucous membrane, favors the escape of blood when they are torn across; and it is from them, possibly to some extent also from the uterine arteries, that the blood comes, just as in post-partum hæmorrhage, when the whole, instead of a part, of a placental site is bared."

The *cause* of the hæmorrhage is viewed differently by different authorities. It is contended by some that it is due to a loss of proper relation between the placenta and the uterus where it is attached. Dr. Mathews Duncan, however, maintains that the hæmorrhages are accidental, being due to similar causes to those which give rise to hæmorrhages when the placenta is normally placed; the abnormal situation of the placenta rendering the causes more apt to operate.

MONTREAL, August, 1878.

[The Editor of this Journal does not hold himself responsible for the opinions expressed by contributors.]

## Hospital Reports.

MEDICAL AND SURGICAL CASES OCCURRING IN THE PRACTICE OF THE MONTREAL GENERAL HOSPITAL.

*Case of Acute Tuberculosis.*—Under care of Dr. REDDY:—  
Reported by JAMES BELL, M.D., Asst. House Surgeon.

J. F., aged 40, a large, well-built Englishman, was admitted on the 13th of May, complaining of cough and pain in the chest. He was also delirious and unable to give any reliable account of himself. From his friends it was learned that he was a very hard drinker, had had *delirium tremens* several times, and had also had several attacks of acute illness, with lung symptoms. The nature of these attacks could not be determined. He was a machinist, and, when sober, a hard-working man. About four weeks prior to his admission to hospital, he had been drinking very hard, and was obliged to give up work. He became somewhat delirious, especially at night. This was looked upon as the natural result of his spree, and little attention paid to it for some days. He had nothing more to drink, but remained delirious at times, and was very despondent.

About four or five days before his admission he became much worse, was feverish and complained of cough and pain in his chest. On admission his temp. was 103° F.; pulse, 108; resp., 30. He complained of a good deal of pain in the chest, but could not localize it. His expectoration was viscid and rusty. He was given chloral grs. xx, pot. bromid. ʒi, as he was delirious and could not be kept in bed. He was quieter after the draught, but did not sleep.

On examination, there was found to be dulness on percussion over upper lobe of right lung—slight in front, but more marked behind.

There were dry bronchial râles and fine, moist râles to be heard all over both lungs. In the right infra-clavicular and scapular regions (the dull area) there was fine crepitation, and the breathing almost tubular over the rest of the lung. Fine crepitation was also heard over a limited area at the base of the

left lung, in the infra-axillary region. Heart normal. Ordered a mixture of ammon. carb. and liq. ammon. acet., and poultices to the chest.

Next morning his temperature was  $101^{\circ}$  F.; pulse, 104; resp., 40; physical signs unchanged. Ordered quinine, grs. xx, in the afternoon.

*May 15th.*—Had a very bad night. There is now constant low muttering delirium. Surface is very livid. Ordered spts. ether co. mxx 3 q. h. and brandy. Little change in physical signs, except that there is a small circumscribed area of dulness at base of left lung, near axillary margin; pulse, 140, very feeble; resp., 40; temp.  $104^{\circ}$ . Ordered quinine, grs. xx (per anum., as he refused to swallow it.) Urine high-colored, deposits lithates and phosphates on standing; no sugar nor albumen.

*May 16th.*—Condition scarcely changed since yesterday; still delirious; pupils contracted to the size of pin-heads. Ordered another dose of quinine (grs. xx).

*May 17th.*—Had a very restless night, and is evidently sinking; surface is very livid, and urine and fæces are passed involuntarily. He remained in this condition during the day, and died at five o'clock next morning. The temperature throughout ranged from  $102^{\circ}$  to  $104^{\circ}$  F., and did not seem to be affected by the large doses of quinine.

*Post mortem.*—Eight hours after death. Body fairly well-nourished. No rigidity. On opening the abdomen extensive adhesions are found between the visceral and parietal layers of the peritoneum, chiefly connecting the omentum transverse colon and surface of the liver. The coils of the small intestines are glued together by soft flaky adhesions. The mesentery and peritoneal covering of the small bowel and caecum are covered with numerous small firm tubercles varying in size from a pin's head to that of a small shot.

*Thorax.*—Both lungs are intimately adherent to the chest wall.

*Right Lung.*—Numerous small evident tubercles in the lung tissue just beneath the pleura; lower lobe is covered with a thi

layer of old pleuritic membrane. From apex to base the lung is stuffed with small grey miliary granulations. At the apex they are not so abundant, and there are one or two firm nodules the size of peas. The lung is more or less crepitant throughout, but in the upper lobe there is a good deal of exudation into the air cells and the lung barely floats in water. There is a very small cavity in apex.

*Left Lung.*—Crepitant throughout, though the lower lobe is firm, heavy, and dark red in color; it is also stuffed with tubercles from apex to base. There are no nodules nor cavities. The tubercles are disseminated, not arranged in groups, and present a greyish, semi-translucent appearance.

*Heart.*—About two ounces of clear amber-colored fluid is found in the pericardium. Right auricle is filled with a dark clot; right ventricle also contains dark grumous clots.

*Left Auricle* contains a dark jelly-like coagulum.

*Left Ventricle* contains a small black clot; valves and chambers normal.

*Spleen.*—355 grammes. Capsule presents a spot of localized thickening. On section, Spleen pulp is of good consistence and studded with innumerable small tubercles the size of pin-points. They are of uniform size and resemble grains of sand they are so excessively small.

*Kidneys.*—Left, 230 grammes. Capsule detaches readily. Cortex coarse looking on section. Malphigian bodies very distinct. Scattered throughout the substance are numerous small tubercles. A small brownish calculus found in one calyx.

*Right Kidney.*—180 grammes; appearance similar to that of left kidney. It contains tubercles also.

*Liver.*—Firmly adherent to diaphragm. Numerous tubercles in adhesions. Organ soft; no tubercles in substance.

*Stomach.*—Normal.

*Small Intestines.*—Peritoneal surface studded with tubercles. Mucous membrane also infected; no ulceration.

*Brain and Membranes.*—Normal. No tubercles discovered anywhere.

*Case of Aneurism of the Thoracic Aorta.*—Under the care of  
DR. REDDY. Reported by W. R. SUTHERLAND.

P. P., aged 48, of Irish descent, unmarried man, of medium height, strong and muscular, was admitted into the Montreal General Hospital on the 19th April, 1878, complaining of short breath and constant cough (which has a peculiar ring), with pain in right shoulder, side of neck and crown of the head. Pain is much aggravated on attempting to lie down, and a sense of choking comes on so that he has to be propped up in bed.

He expectorates large quantities of thin, frothy mucous, with purulent patches through it. Dyspnœa is not worse after exertion; appetite good; voice somewhat hoarse.

Family history obscure; but, as far as can be made out, it is good.

He has never had syphilis, nor any other disease of any consequence. Was a soldier for twelve (12) years, during which time he saw active service and endured severe hardships. Since his discharge from the army, has been a policeman, porter, and, for the past ten (10) years, caretaker of the armory. Has been a man of regular habits, and enjoyed good health up to January, 1877, when he was first troubled with more or less pain in the right shoulder and side of the head. Cough and hoarseness were not noticed until July, 1877.

On examination, the superficial veins of the front of the chest are seen to be moderately distended, one markedly so, running from left axilla across chest to sterno-clavicular articulation. Breathing is almost entirely abdominal. Visible pulsations in both super-clavicular regions and in superficial arteries.

Pupils are equal.

*Mensuration*—During inspiration left side measures 18 $\frac{1}{4}$ ".  
 " expiration " " " 18.  
 " inspiration right " " 18 $\frac{1}{2}$ ".  
 " expiration " " " 18 $\frac{1}{4}$ ".

*Palpation*—Appreciable impulse over first bone of sternum. Percussion gives no decided dullness along upper part of the chest, except a shade over the first bone of the sternum, more



marked on the right side. Left lung hyper-resonant in front and behind.

*Auscultation.*—Find respiration feeble all over the chest. Vocal resonance somewhat increased over upper part of chest. Loud sonorous râles over front of the chest, and stridulous-breathing over both back and front of the chest. Double murmur in first space of both sides, much louder on the right.

*Heart.*—Point of maximum pulsation is at 1st space, to the right of the sternum, and at this spot there is a double sound, also a double murmur, transmitted all through the arch. Systolic, short, soft and flowing. Diastolic, very short and very soft. Both sounds and murmurs are less distinct at 2nd space, audible but less distinct at 3rd, also audible at ensiform cartilage. Inside left nipple is a systolic murmur, followed by a clear second sound without a murmur.

*Urine*—Contains no sugar nor albumen; sp. gr. 1.014.

*April 21.*—Condition is unchanged. Is taking liq. morphia, ℥ii; vin ipecac, ℥i; syr. pruni virg., ℥iii; aq. ad ℥vi;—dose, a table-spoonful three times a day.

*May 2.*—Passed a bad night; cough was very distressing, being hard and without much expectoration. The pain in his head, neck and shoulders is much worse on damp days.

*May 7.*—Is much weaker, and not as well as usual, though his condition is apparently unchanged. Has been ordered a tonic of quinine and iron.

*May 29.*—Up to this time there was no change to be noticed, except that the veins are more distended; visible pulsation very marked over right sterno-clavic articulation. In addition to the marked impulse over the upper part of the sternum, a thrill can be distinctly felt. Pain is less severe on the right side of the head and neck, but he cannot raise his right arm higher than on a level with his shoulder without experiencing very great pain of a lancinating character just over the coracoid process. Cough is much worse and sputamuco purulent.

*June 4.*—For the past few days he has been troubled with rheumatic pains in his ankles. Yesterday afternoon, had a

very severe attack of dyspnoea, which lasted about half an hour. Pulse was 120; temp. 100°.

He continued to suffer from dyspnoea and pain in the chest, which he could not localize, until June 12th, when he died after a prolonged attack of orthopnoea.

*Autopsy*, 30 hours after death:

Body that of a medium-sized man; rather emaciated.

On opening the abdomen, intestines appear normal.

*Thorax*. — Lower lobe of right lung adherent at lower part by soft recent adhesions. Further up there is a plastic lymph, non-adherent, and beyond this, intense congestion of the pleura; the surface of the upper half of the upper lobe alone is healthy. The upper part of the lung is compressed by about one pint of turbid serous effusion. The lower part of right lung, especially at the margins, and for a space of three or four inches, is in a state of pneumonic consolidation—red hepatisation; a small part of it has advanced to the stage of grey hepatisation. On the anterior surface there is an abscess about the size of a filbert, apparently arising from a previous bronchopneumonia. Upper part of lung fairly healthy.

*Left Lung*—Non-adherent; anterior surface healthy; posteriorly hypostatic congestion; apex on section appears acutely congested—crepitant; on pressure, exudes a large amount of frothy serum.

*Heart*—Weighs 330 grammes; substance apparently healthy, also valves, except aortic, which appears to be slightly incompetent. The arch of the aorta is dilated and lengthened so as to form a large fusiform aneurism, involving, chiefly, the transverse portion of the arch.

The innominate artery is dilated throughout its whole length so as to form an independent aneurism which sits upon that formed by the arch. The right subclavian and carotid are given off from this sac, but are of normal size and appearance from their origin. The recurrent laryngeal nerves were not observed in the dissection, but it seems probable that the right was in some way interfered with by the innominate portion of the aneurism.

## Correspondence.

PARIS, 12th August, 1878.

*To the Editor of the CANADA MEDICAL AND SURGICAL JOURNAL:*

DEAR SIR,—The annual meeting of the British Medical Association, you are aware, has taken place this year at Bath, between the 6th and 9th days of this month. Bath is one of the quietest but pleasantest of towns and seems admirably suited for meetings of that kind. It is not so small but that ample and good accommodation can be afforded for a very considerable number of visitors, and yet not so large but that all shall be conveniently situated towards the rooms and places of meeting. In itself, too, the good old city has much to interest a visitor, medical or otherwise—Its famous hot springs, in which old Romans bathed and forgot their ills, are still seen boiling and steaming as they rise above the ground—its really beautiful buildings which surround those springs and afford the invalid every desirable luxury in the way of bathing—its noble cathedral, where the Bishop of Bath and Wells opened the meeting by an eloquent sermon to the Association, and queer old houses of almost all possible dates, carrying you back to the time when Dr. Johnson and his faithful boy came to the baths for the good of their constitutions and to enjoy the society of the many beauties of that day who found it “the thing” to go there. Bath is famous for its antiquities, and chief amongst those of great interest are a large number of Roman altars and other remains in wonderful preservation, which have been found here in all directions, and have been preserved in the local Antiquarian Museum. Members of the Association and Medical visitors were made free of all the baths during the meeting, and I assure you the swimming baths, the cutidaria, and the draughts of the aerated water were fully appreciated by a great many.

The first evening was chiefly occupied by the President's address—Unfortunately, this year that official was a Dr. Fal-

coner, a local practitioner, and he had devoted nearly the whole of his paper to extolling the virtues of the healing spring in which it is incumbent upon every true Lathite to believe—it contained, however, nothing new or of any general interest. This was followed on the succeeding day by the address in Medicine, by Dr. Goodridge, Senior Physician of the Royal United Hospital, Bath. It will, I daresay, appear better in print than when read—the delivery having been painfully defective. It was, however, of excellent quality, and was listened to with much attention. The subject selected was that of the natural production and regulation of heat in the human body, and the pyrexial state. After a survey of the various theories of heat production, it was readily shown how little is really yet known of the true physiology of this subject, and a portion how much less of the various complex processes which result in the production of the pyrexial state. All physicians and workers in practical medicine were exhorted to give this subject all the attention its great importance deserves. Dr. Goodridge would look hopefully forward to the time when, possessed of a true fundamental knowledge of the laws governing heat production and discharge, we shall be able on true scientific grounds to remedy with a degree of certainty hitherto undreamt of, those pyrexial abnormalities which now constitute an often serious part of a great many of the very commonest maladies we are called upon to treat.

The same afternoon the sections opened and the medical one was the centre of attraction. It was presided over by Prof. Grainger Stewart, the popular Professor of Medicine of the Edinburgh University. His opening address was devoted to a discussion of certain recent observations by himself and others upon the pathology and relationships of certain of the forms of Bright's disease which have caused him to alter or modify many of his pre-conceived views as expressed in his work on that subject.

The daily programme had announced that a discussion upon obstruction of the bowels would be held and would be opened by Mr. Jonathan Hutchinson—It was this which had attracted

so many, and the room was crowded to excess—nor were we disappointed.

His paper was a most able and exhaustive, and at the same time, concise exposition of his views on most of the many very important questions which so often arise in connection with this serious trouble—it will well repay perusal. As regards diagnosis, he especially remarked upon the importance of bearing in mind the great similarity between an acute obstruction and a paralysis of the bowel caused by acute peritonitis, generally from perforation. Several instances of the mistake were alluded to. Of course, the practical importance of this point cannot be overrated. Then, with reference to operation in cases of impermeable obstruction where all other means have failed, Mr. Hutchinson, with characteristic caution, tells us that as in even apparently desperate cases he has seen spontaneous recovery take place, he would never consent to operate, except where the diagnosis could really be satisfactorily made out and where a constricting band was believed to be the cause. In cases of intus-susception he prefers trusting to nature. He strongly condemned the practice now followed by many of puncturing the abdomen to relieve from flatus, as he has seen severe peritonitis from the fœcal gaseous exudations from the little holes. In this he was opposed by Dr. Clifford Allbutt and others, as they claim that sometimes it really may help to cure, and that puncture is not dangerous except after the abdomen has been opened in gastrotomy. One member, whose practice lies in a lead-working district, stated that he had quite frequently met with forms of lead colic strongly resembling obstruction, and advocated the importance of excluding this possible origin of the symptoms. Dr. Broadbent urged the value of forming a diagnosis as early as possible of the exact seat of the obstruction, as then, from the patient's age and the other circumstances of the attack, a very certain opinion might often be formed of the real nature of the trouble. He also would examine every such case by the rectum, observing that, although no tumor may be felt, yet sometimes other information may be got, as, for instance, that the rectum is held open by a

tumor and not allowed naturally to collapse. Several other papers on the same subject and illustrating various points, were read by Drs. Kerr, J. Kerrit, and others, and the discussion was sustained and animated.

The Surgical section was presided over by Mr. Callender, of St. Bartholomew's, who, in his introductory remarks, dwelt chiefly upon the necessity of relief to pain in encouraging the healing of wounds. All that this eminent surgeon says on that point and every other with the same end in view is worth bearing in mind, because it is notorious that his results are said to be every way equal to those of Lister, and still he is the great unbeliever in antiseptics. The jealousy of the London surgeons towards Lister crops out every now and then. Callender was showing a splint with some modifications—"We, of London," he said, "have seen fit to import a surgeon from Edinburgh, whilst they of Edinburgh have actually imported this splint. We thought they considered that no good thing could come out of London." This was followed by the reading of papers on subjects connected with stone in the bladder—but not having attended, I am not able to give you any further particulars, but I did not learn that anything very novel concerning the operations for stone had been developed.

The following day, however, Surgery came to the front. The address had been entrusted to Mr. Wheelhouse, of Leeds, and he certainly did not fail to do full justice to the subject he had in hand. It was a lively and interesting review of the progress of Surgery during the 50 years of the writer's own experience. It was admirably delivered, and at times the reader's enthusiasm even carried him into eloquence. Its interest was greatly enhanced by the numerous examples introduced, in which he had himself been led by reasoning upon the now established principles of Surgery, to some of the most remarkable and satisfactory results. I may not take up much more of your space, but would refer your readers to the address itself. One or two instances, however, may be mentioned of the unusual procedures to which Mr. Wheelhouse has occasionally had resort. For example, he has recently had under his care a man

who, through a fall upon a scythe, had received a great gash in the back of the thigh, injuring also the sciatic nerve. The subsequent cicatrization had completed the destruction of the nerve's function by pressure, and complete paralysis was the result. This paralysis had lasted several months, and the man came to the hospital for the purpose of having the limb amputated, so cumbersome had it become. This surgeon, however, determined to try the effect of exposing the ends of the divided nerve and joining them together. This was done, and the result was a perfectly good limb, with (after some months) free motion and sensation.

Antiseptic Surgery, of course came in for a full share of attention. Without entering into any theoretical discussion, Mr. Wheelhouse contented himself simply with stating his belief that by this means results could be attained which he had always failed to procure before its introduction, and which, indeed, he believed to be still impossible without it. Reference was also made to the great advantages which surgery has reaped from Dieulafoy's method of aspiration. After enumerating many of the maladies to which this improved means of removing fluid is applicable the writer made some further suggestions with reference to the extension of its use—especially to the emptying of large and putrid cavities in lungs and washing them out with some disinfectant fluid. (I have since been informed that this has already been done by some German surgeons.)—G. R.

### Reviews and Notices of Books.

*Transactions of the Medical Association of Georgia.* Twenty-ninth Annual Session, held at Atlanta, April 17th, 18th and 19th, 1878. 8vo, pp. 279. Atlanta, Georgia: JAMES P. HARRISON & Co., 1878.

This is simply what its title indicates, and contains much matter of interest. The order of arrangement is in the usual style; the body of the book, which consists of exactly thirty-two pages, being taken up with table of contents, index to authors, list of officers, special committees and sections, after

which a daily record of the minutes of the meetings appears. The papers which have been selected for publication are next given in the appendix. As an introduction we have the President's address—this is followed by an oration in which the author, Dr. Burgess, touches upon the subject of unwise medical literature, of which there certainly appears to be a superabundance. Dr. Dostor next reports a case of amputation of the leg for necrosis of the tibia; the patient recovers, and, as the Dr. naively observes, he was made "apparently a happy man," after thirty-four years of suffering. This is succeeded by a report of cases from Dr. Walker, and also a paper on tubercular meningitis, by Dr. Grimes.

The next paper is on Yellow Fever, its history, causes, nature, pathology and treatment, by Dr. J. C. Le Hardy, of Savannah. This is a very important paper, and one that will attract much interest at the present time, as yellow fever is said to be epidemic in the South just now. The paper is based on the experience gained by the author during the epidemic of 1876, through which the city of Savannah passed during the latter part of the summer of that year. In the history of the epidemic, the author gives a description of the sanitary condition of many parts of the city, and points to the condition of over-crowding of buildings and defective drainage to which he attributes the aggravation of the disease when once developed. He says:—"The sections of the city principally inhabited by the working classes, (white and black) and extending on the eastern and western slopes of our bluff, were in their usual wretched sanitary condition. The streets narrow, running east and west; the houses wooden, small, decaying, built in tenements, with miserable ventilation; the yards small, with high plank fences, and filled up with offal of all sorts; their privy vaults badly closed; stables, pigeon and poultry houses, &c., all huddled together—Here was a picture to meet the eye on every side,—such a combination was quite sufficient to produce filth diseases; but it had existed for years, and although it was not in my judgment, an efficient cause for yellow fever, yet during an epidemic it could aggravate its ravages." It has been



said that cleanliness is next to Godliness, for in verity it consists in our duty towards our neighbour and ourselves. We fear that Savannah is not the only city on this continent afflicted with squalor and neglect of sanitary precautions in the construction of buildings and their appurtenances. We have often in our own city viewed with anxiety and regret the system of over-crowding of buildings, and we may observe that during the two past epidemics of cholera that afflicted our city, although the disease was very generally distributed, yet it proved most fatal in localities where sanitary precautions had been neglected. Such, we imagine, is the experience of all observers not only in reference to yellow fever, but also of every plague with which the human family has been afflicted since the time of Moses. Dr. Woodhull, U. S. Army, who wrote an official account of the causes of the epidemic of yellow fever at Savannah in 1876, and which is published in the number for July, 1877, American Journal of the Medical Sciences, remarks:—"From the data which I have been able to collect, I think it is clear: First, that there is no evidence of importation of the yellow fever poison in this epidemic; Second, that if it was imported, no system of quarantine could have guarded against it; Third, that the spread and virulence of the epidemic were closely connected with air and soil pollution, whether this pollution be considered as a sufficient explanation of the origin of the disease or not." \*

Le Hardy, in his paper, is inclined to the belief that so far as Savannah is concerned, the yellow fever germ can originate without importation. Although this question is still debatable, as professional opinion is by no means pronounced on the subject, we observe that the author, while admitting that a lack of sanitary precautions will aggravate the disease, and tend to its spread, he does not regard it as a factor of the disease. On this point, he remarks: "Had filth, and its resulting gases and pollution been capable of producing yellow fever once—its presence being ever acting and increasing, its effects should be

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\* Am. Journal of Med. Sciences, vol. 74, p. 53.

constant, and we would have yellow fever recurring here every summer, under the influence of our solar heat, which varies very little from year to year." Such not being the case however, the author infers that some other cause must be looked for. Such cause he regards as miasmatic, due to a mild winter succeeded by long-continued oppressive heat, with much rainfall, and consequently a large area of stagnant water, wet soil, which would give rise to noxious emanations or miasms, called more recently *contagium vivum*. This paper throughout is most interesting, as in it the various destructive epidemics which occurred in 1817, 1820, 1854 and 1876 are compared. The author concludes this part of his essay with a clinical table which shows, as he observes, "as naught but figures can, the variations of the pulse, temperature, relapses, and influence of quinine treatment, all of which sustain me in classifying yellow fever as a malarial disease."

Dr. James B. Baird gives an excellent paper on neuralgia, and its modern therapeutics. The author's conclusions as to cause of these affections is that, while admitting the possibility of their being variable, that in this country at least, the most frequent cause is malaria. The malarial origin of some cases of neuralgia would seem to be undeniable, but the most severe, constant, and unrelievable cases of neuralgia which we have ever witnessed, were due to pressure directly on the nerves by cancerous growths. The next paper is a report of one hundred and thirty operations for strabismus, from the pen of Dr. A. W. Calhoun.

Dr. V. H. Taliaferro, professor of obstetrics in the Atlanta Medical College, gives a paper on "the application of pressure in diseases of the uterus,"—this is followed by a paper on the use of uterine tents; the author, Dr. Goldsmith, proposes the pith of the dried corn stalk as a uterine tent. There are two reports on Surgery, the one by Dr. A. A. Smith, for the third congressional district—the other for the fifth congressional district, by Dr. J. T. Johnson. These are followed by a paper on the soft palate, from the pen of Dr. W. A. Love. Dr. Leitner suggests tar as a means of rendering solid bandages,

and as a substitute for starch, glue, dextrine, &c. The work is concluded with a report of an obstinate case of hiccough, a report on necrology, the constitution and by-laws of the association and the roll of members. Altogether, this is a very creditable production, and the Secretary, Dr. Baird; to whom we presume we are indebted for its publication, is to be congratulated for its respectable appearance.

*The Throat and its Diseases.* With one hundred typical illustrations in colour and fifty wood engravings designed and executed by the author. By LENNOX BROWNE, F. R. C. S., Edin.; Senior Surgeon to the Central London Throat and Ear Hospital. 8vo, pp. 351. London: BALLIERE, TINDELL & COX, 1878.

The author in his preface states that this book, the result of eleven years of work devoted to diseases of the throat, is offered as a practical guide to the diagnosis and treatment of those affections. He does not enter into pathological questions, but confines his remarks to whatever can aid the busy practitioner in carrying through, with the hope of success, the treatment of affections of the throat. So that questions of "purely pathological interest" are not discussed in these pages.

The attention of the reader is in the main directed to diseases of the throat which have been brought out more prominently since the introduction of the use of the laryngeal mirror. By the use of the Laryngoscope the observer has the means of making out with accuracy many special conditions of the larynx and trachea, by actually seeing with his eye these parts, which otherwise would be invisible during life. Thus with this powerful auxiliary he has these cavities laid open to his view, and it alone requires careful observation, with an intelligence equal to knowing what is observed, to enable the physician to form an accurate diagnosis and to predict results, which will surely follow, although no indications of such events may be present. Thus, for instance, a man may be the subject of thoracic aneurism encroaching on

the trachea, or probably almost completely blocking up one of the bifurcations of the trachea; the symptoms may be obscure—not sufficient at least to enable the practitioner to positively pronounce the presence of such a fatal malady, but the laryngoscope would in all likelihood aid him in making out the pressure or obstruction, and its most probable cause.

The text of this work is divided into seventeen chapters; the first three are taken up with a description of the laryngoscope and how to use it; the anatomy of the larynx is next dealt with, after which the laryngoscopic and rhinoscopic images are described—these are accompanied by several excellent outline engravings on wood. Chapters four and five are devoted to the semeiology and therapeutics of throat diseases, after which the diseases of the pharynx and fauces, the uvula and tonsils are discussed in chapters six and seven. Catarrh, naso-pharyngeal and posterior nasal, has a chapter devoted to itself. Diphtheria is the next subject taken up in chapter nine. On the question of general treatment, the author is not very pronounced. He remarks that, “Many general remedies have been suggested, and some have been vaunted as specifics, but the most rational and satisfactory method seems to be that of treating symptoms as they arise.” The author believes that, “locally very much may be done”; as long as the disease is confined to the pharynx he believes that the spray or brush may be of great service. The author does not enter into the question of tracheotomy, although he remarks that if it does not save the life of the patient, it certainly lessens the agony of death. We certainly think, that in view of the marked success of the operation in this very fatal malady, where the larynx is implicated, that the neglect to perform the operation is to be condemned, and we are disappointed to find in a work ostensibly devoted to the practical consideration of this subject, that it is dismissed in a paragraph of some six lines. This work is offered as a practical guide to the diagnosis and treatment of diseases of the throat, but it would appear that the author has not fully made up his mind, at least on this most important point of treatment, and the sooner he does so the better. We

do not believe in half measures in surgery. In surgery, as in war, action to be successful must be prompt, decisive and energetic, with a full knowledge of the topography of the country, and a careful attention to the rules of strategy. It must not be supposed, however, that, because there is this want of decision in recommending the operation of tracheotomy in diphtheritic laryngitis, that there is the same lack of practical instruction throughout the volume. There are a few points in which a decided opinion might be advantageously given, but we presume the author has not acquired such an amount of experience as to give him that necessary self-reliance which alone is looked for in the practical man. We shall hope to see a decided improvement in this and many other respects in a second edition of this work. Meanwhile, we may remark that there is much instruction to be gained from these pages, and the coloured lithographs are very beautifully executed and very truthful.

*Anatomy—Descriptive and Surgical.* By HENRY GRAY, F. R. S., with five hundred and twenty-two engravings on wood, with an introduction on general anatomy and development. By T. HOLMES, M. A., Cantab. A new American from the eighth and enlarged English edition, to which is added Landmarks, Medical and Surgical. By LUTHER HOLDEN, F.R.C.S. Imp. 8vo, pp. 983. Philadelphia: HENRY C. LEA, 1878.

It is scarcely necessary to draw attention to this well-known work, except to announce a new American from the eighth and enlarged English edition. This edition has been passed through the press by Dr. Richard J. Dunglison, and from the fact that the work had received three revisions at the hands of the English editor, Mr. Timothy Holmes, since the issue of the previous American re-print, no further additions were deemed necessary. The publisher has enhanced the value of this book by adding to it at the end of the volume Holden's Landmarks, Medical and Surgical; this has been an addition of some 45

pages of reading matter. Gray's Anatomy has been a favourite with students and practitioners for many years, and this edition has lost none of its attractiveness. It is the same valuable and reliable guide brought down to the anatomical knowledge of the day.

### Extracts from British and Foreign Journals.

Unless otherwise stated the translations are made specially for this Journal.

#### **The Treatment of Phagedænic Ulcers—**

By Dr. G. E. WEISFOLG, *Virch. Archives*, Vol. LXVI, page 311.—Among the many therapeutical problems presented by the various manifestations of syphilis, the treatment of phagedænic ulcers is, perhaps, the most difficult.

No plan of treatment hitherto recommended by the best authorities suffices to alleviate, much less to arrest, the pain which these ulcers give rise to.

The desire to afford relief in this terrible disease, has led to the use of an infinite variety of local remedies. One author has even extolled the use of the actual cautery.\* As an offset to this truly barbarous surgical practice, I venture to publish the result of treatment in nine cases. The method to be described was so successful, that I think it deserves to take precedence of all others.

No matter how intense the pain occasioned by a phagedænic ulcer may be, it ceases immediately when the ulcer is exposed to the action of an electro-magnetic bath.

If the sore is not so situated that it can be immersed in the water, the faradization may be applied to the nerves supplying this part; the effect, though not so strikingly beneficial, still suffices to render the condition of the patient comparatively comfortable.

The faradaic bath may usually be applied as follows: The sore is to be immersed in a basin of warm water, to the bottom

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\* Morrison. Fiset "On the local treatment of Venereal Ulcers," in the *New York Recorder*, Oct. 15, 1874.

of which one electrode is connected. The battery being so arranged as to give a very weak current, the patient applies one finger to the sponge of the other electrode; two or more fingers may be placed upon the sponge, if the patient does not find the application too strong to be borne with comfort.

Faradization of the nerves leading to the wound may be conducted in a similar manner; the parts in the vicinity of the sore being stroked with the sponge of one electrode, whilst one or more fingers are placed upon the other.

Patients very soon learn to manipulate in such a way as to avoid painful muscular contractions in the neighbourhood of the ulcer, and can then be trusted to make subsequent applications for themselves; in the intervals the sore may be dressed with oiled lint. The pain at first soon recurs after each faradization, and for a few days the patient will frequently have recourse to the use of the battery; [but the period of relief gradually becomes longer after each application, and at the end of eight or ten days the sore is not more painful than an ordinary non-specific ulcer.

In the meantime the appearance of the ulcer has not undergone any corresponding improvement, its base still being covered with adherent sloughs, its margins raised and occupied by a brawny infiltration, although the excessive sensibility has entirely disappeared. At this stage there are many remedies which will act beneficially, but of these the nitrate of mercury deserves the preference. It may be used in the form of an ointment, eight grains to the ounce. At first this application causes a slight smarting, but under its influence the ulcer soon cleans rapidly, its raised edges sink, and the healing process makes rapid progress, so that in from fifteen to twenty days the cure is completed. Treated in this way a phagedænic ulcer as large as a twenty-dollar gold-piece will heal in about a month. A phagedænic ulcer is more difficult to treat when a patient is at the same time suffering from periosteal pains, for in these cases the relief afforded by the faradaic current is not so complete. Under these circumstances injections of the nitrate of mercury are extremely

serviceable. They are less harmful than injections of the perchloride of mercury, do not cause abscesses, and supply the system with a much larger quantity of soluble mercury, without causing salivation, than can be done in any other way. For the relief of periosteal pains the subcutaneous injections of nitrate of mercury do not require to be made more often than once in fourteen days. They will usually effect a cure in about two months.

The formula for injection is as follows :

R Hydrarg: oxid: nit: crystall . . . . gr. viii.  
 Aq: destill: . . . . . fl ʒ iiii.  
 Dispens solutio limpida.

### **On the abortive treatment of Syphilis**

—By Dr. GUSTAVE E. WEISFOLG, from Virchow's Archives, Vol. LXIX, 1, p. 143.—The author, who appears to think the abortive treatment of syphilis is quite within the bounds of possibility, says that whoever believes at all in the efficacy of medicines must also admit that we have only to find a suitable remedy or method of treatment in order to prevent the first local manifestation from passing on to a general or constitutional affection. In support of this proposition, he points to the fact that there is always a considerable interval between the appearance of the local disease and the symptoms denoting general infection, and maintains that during the interval it should be possible to anticipate and prevent the process of general infection. One of the chief difficulties to be overcome is to form a correct estimate of the actual value of any course of treatment pursued with this object in view, since several years must necessarily elapse before any decisive results can be attained.

Certain it is, however, that those remedies which are known to have a curative effect when given internally for constitutional syphilis, do *not*, when given in the same way, possess the power of preventing general infection. This indicates at least one direction in which there is nothing to hope for from the abortive plan of treating syphilis. The author adheres to the generally



accepted doctrine that infection takes place through the medium of the lymphatics—though doubts as to the correctness of this view have recently been raised—and lays great stress on the experiments of Broca. The latter attempted to prevent general infection when there was a syphilitic sore on the penis and swellings of the inguinal glands, by incising and injecting them with iodine, thus setting up an acute inflammation of the glands in question.

He was led to this from the common observation that sores followed by suppurating bubo seldom give rise to constitutional infection, and he hoped to attain the same result by imitating nature. Although the author finds this plan of treatment useless as an abortive measure, he maintains that the principle upon which it is founded is correct, only it is essential to be beforehand with the syphilitic poison and grapple with it before the general lymphatic system is impregnated by it. He, in fact, attains the object which Broca had in view, but by a different method of treatment. The author directs attention to the curious fact, that the watery solution of nitrate of mercury mentioned in the previous article, may be injected under the skin of a healthy part without even setting up purulent inflammation, but that if the part be already inflamed, such an injection invariably produces an abscess, and he has utilized this peculiarity of action in such a way as to prevent the spread of venereal poison from a primary sore through the inguinal glands to the system. In any doubtful case he injects some of the solution subcutaneously, between the sore and first convolution of inguinal glands likely to be infected by it. If these glands, or the lymphatics leading to them, are not already in an inflamed condition, no abscess is formed, and if the injection is repeated every ten or twelve days till the primary sore is healed and the induration has disappeared, constitutional syphilis never ensues.

In those cases in which, on account of already existing inflammation, abscesses formed, the patients still remain free from syphilis. The author has practised this abortive treatment, during the last five years, in thirty-two cases of indurated and

mixed chancres. Of these, abscesses formed on both sides in fourteen cases, on only one side in six cases. The final result was followed up in twenty-eight of these cases, all of which remained free from syphilis, as did also their children.

This method of treatment is based, according to the author, upon the law that "mercury exercises its specific action as an antisiphilitic most effectually when it comes in direct contact with the chancre poison in the tissues primarily affected:" and this occurs when those tissues are impregnated with mercury, which contain the lymph vessels connecting the chancre with the general lymphatic system. The author concludes the articles by earnestly inviting the profession to give the proposed method a fair trial.

### **Paracentesis Abdominis by gradual drainage with a single fine Cannula.—**

By Reginald Southey, M.D. Oxon., F.R.C.P.—The unusual relief of the distressing symptom of anasarca which I found follow the employment of fine drainage-cannulas encouraged me to employ nearly the same apparatus in the treatment of ascites; and now that my experience has extended over a fair number of cases, enough to satisfy me that this mode of proceeding is attended by no extra risks, I venture to lay it as briefly as I can before the profession.

*Apparatus.*—The trocar and bulb-headed cannula required for the purpose of gradually drawing off ascitic fluid, by the help of a capillary tube, differs very little from that employed by me for anasarcaous limbs. Both instruments are equally fine. The calibre is the No. 1 exploring trocar of the surgeon. One long needle-trocar, measuring an inch and three quarters in length from hilt to point, has appeared long enough for all the cases hitherto tapped by me. Three or four cannulas of different lengths, adapted to the thickness from fat and œdema of different abdominal walls, are required. The cannulas may be perforated with as many as six or eight side holes—the more the better, so that their strength is not interfered with. The mouth end of each cannula should be armed with a small silver

plate or shield, to obviate any risk of the cannula head sinking beneath the surface of the skin when this is highly œdematous; and, simple as it may seem to contrive an armature which may thus secure and help to maintain the cannula in position, I may say that I have not yet quite mastered the matter. As to the length of the shield or cross-beam, one inch appears ample—i.e., half an inch each side of the cannula. The shield may be round or square with rounded edges, or, as I have had mine made, as elongated plates, one inch long by a quarter of an inch broad, and about a thirty-second of an inch thick. Whether the cannula was best fixed immovably to the shield or otherwise, was the next point to decide. It was found that the immovably fixed shield, held fast by two strips of plaster, by dint of the movements of the abdominal muscles in respiration either worked away from its plaster moorings or tended to work out the cannula end from the peritoneal cavity. Messrs. Ferguson therefore contrived a shield for me which held, but allowed the cannula a limited play in every direction, and in practice this has worked admirably. One instrument I had made for those particular cases in which, although the ascites has been considerable, and its relief urgent, the presence either of cancerous tumours in the abdominal cavity or an enlarged liver has rendered a hard and pointed body, like the cannula end, abutting on the peritoneal aspect of the abdominal parietes, undesirable; for as the fluid drains away the abdomen collapses and the parietes sink, and large, soft-surfaced masses, moved up and down by the descent of the diaphragm, might be torn and fretted against the cannula, and made to bleed. To meet this emergency a cannula which merely traversed a shield-plate, and was not fixed at all, appeared best adapted. If anything pushed it from within, out it could come.

*Mode of operation.*—Trivial as this is, it appears to me from experience that there is a right and a wrong way of introducing the cannula. Instead of driving the trocar in quite perpendicularly, it is best to slope the point downwards somewhat towards the pubes, and to avoid making the cannula point upwards towards the sternum. The wound made is so slight

that one can afford to make it almost anywhere, but from prejudice I should select the raphe or mesial line below the umbilicus, and about midway between this and the pubes. Before operating, I always insist upon my house-physician ascertaining that the bladder is empty.

I append one case of ascites from cirrhosis thus treated, but for the last year I have had every case of ascites—hepatic, carcinomatous, cardiac, renal—which has fallen under my care at St. Bartholomew's, and required tapping, tapped in this way; and the results have proved sufficiently satisfactory for me to recommend it highly. I have had no instance of peritonitis thus provoked. The paracentesis, instead of being a formidable operation, is nothing more than the prick of a needle. The ascitic fluid is quite sufficiently evacuated; it is also removed gradually, the near average rate of its removal being from ten to twenty ounces per hour. The pressure upon the diaphragm, the intestines, the intra-abdominal vessels, and the walls of the abdomen, is slowly but steadily relieved. There is no syncope provoked and no necessity for swathing the patient with bandages, a circumstance in the old method of performing paracentesis by large trocars which in hot weather added greatly to the patient's distress. Both by doctors and patients this mode of performing paracentesis will, I think, be hailed as an advance in clinical medicine.

William H——, aged fifty-eight, shoemaker, was admitted into Luke ward on March 12th, 1878, for extensive ascites and anasarca of his legs. The abdomen was very tense; dyspnoea considerable; some cyanosis. Urine scanty, high coloured, of high specific gravity, containing no albumen. Heart's apex beat two inches outside left nipple line; systolic murmur loudest at apex and over ventricle. Pulse very irregular. Breathing shallow; some œdema of both bases posteriorly, with bronchial râles. Limit of liver and spleen not to be ascertained by reason of the ascites. Up to ten years ago he had had good health; then had first attack of rheumatic gout. Was admitted into the hospital in June, 1876, for dropsy of legs and abdomen, and

was discharged well, and again for a recurrence of dropsy about Christmas, 1876.

The man's physiognomy, his habits of life, and the manner in which his present dropsy had commenced, the abdomen swelling before the legs, led me, notwithstanding the cardiac murmur, manifest dilatation of both ventricles, and irregular heart's action, to attribute his dropsy principally to cirrhosis of the liver and an obstructed portal circulation.

Paracentesis abdominis with my fine trocar and fixed shield was performed at 6 p.m. on March 13th. In twenty-one hours, 11,400 cc. of clear, straw-coloured serum had been evacuated by the capillary tube. The specific gravity of the ascitic fluid was 1020; reaction alkaline. The amount of fibrin as well as of albumen in it very considerable; the former manifesting its presence by spontaneous formation of a slight coagulum in the fluid. The tube was removed during the night of the 14th-15th, the fluid having ceased to flow, and the abdomen being quite flaccid.

March 18th.—Condition singularly improved: appetite good; functions normal; urine flow abundant, clear, amber-coloured, alkaline, sp. gr. 1024, no albumen; breathing quite tranquil; sleeps well; heart's apex still beats two inches outside left nipple perpendicular between fourth and fifth ribs; action still irregular; first sound loud and ringing, but attended by no murmur; liver manifestly contracted, small, and cirrhotic.

Towards end of April the abdomen had again filled considerably, and the legs began to be œdematous once more, but his appetite and general health were otherwise fairly good.

May 5th.—The distension of abdomen and interference with the descent of the diaphragm again threatened death by dyspnoea. Breathing shallow and hurried. The auscultatory signs rendered presence of some fluid in right pleura probable, as also œdema of lower part of left lung. Paracentesis again performed as before. The tube remained in thirty-three hours, during which time twenty-one pints of clear fluid were drawn off; it ceased flowing on the morning of the 7th of May.

On May 9th he was so perfectly comfortable and feeling so

well that there was no object in keeping him longer in bed. On May 11th he was discharged at his own request.

*Remarks.*—This patient's case was doubtless a highly favourable one for relief by tapping. The best prognostic feature in any case of hepatic dropsy is a stomach that still maintains digestive powers. In treatment, however, this mode of performing paracentesis leaves nothing to be desired; the *tuto, cito, et jucunde* are sufficiently fulfilled by it.—*The Lancet.*

**Causes and Cure of Insomnia.**—Dr. Sawyer observes that insomnia is one of the commonest complications and consequences of a vast variety of morbid states. Pyrexia, physical pain, coughing, dyspnoea are all conditions which prevent or shorten sleep. Such insomnia may, for the most part, be controlled either by the exhibition of remedies which directly promote sleep (hypnotics), or by the adoption of measures which combat the cause of the insomnia, by reducing fever, by palliating pain, by checking cough, or by relieving cardiac disturbance. But there is another form of sleeplessness, which may be called *insomnia per se*, or simple inability to sleep, for which it is difficult to find an adequate cause, but which seems to depend upon inability on the part of the brain and nervous system generally to adapt themselves to the conditions that are requisite for sleep. It is more common in the upper middle class than amongst others, and especially in those of a high mental endowment. There are, he thinks, three varieties of this form, psychic, toxic and senile. In natural sleep the brain is anæmic and inactive, hence any cause that prevents due repose of a sufficient number of the cerebral cells, or sustains cerebral hyperæmia, will prevent sleep. Examples of psychic insomnia may be found where severe and sudden emotional shocks, or prolonged mental strain affect men of nervous temperament. The patient is dull and listless, the eyes wanting in vivacity, complexion sallow, head-ache is present with occasional giddiness and disturbance of the senses, twitching of the muscles. In toxic anæmia the cause of the sleeplessness acts primarily upon the vessels of the brain, giving rise to some degree of ar-

terial hyperæmia. The external poisons thus acting are tobacco, alcohol, tea and coffee, the internal are certain effete products of tissue metamorphosis which accumulate in the bodies of gouty patients or of those whose kidneys act deficiently. The insomnia of these cases he believes to be due to the maintenance of a state of high tension in the cerebral arteries. In the senile form of insomnia the sleeplessness is due to senile degeneration of the smaller cerebral arteries, which are physically unable to adapt themselves to the condition of relative arterial anæmia, which is requisite for healthy sleep. In the treatment of insomnia, soporifics must often be used. Of these, the chief are chloral, opium, morphia, the bromides, Indian hemp, alcohol, and affusion with cold water. In psychic insomnia, Dr. Sawyer prefers chloral. Change of air and scene and rest are essential. In the well nourished, bromide of potassium is the best hypnotic, in 30-60 grain doses, combined with tincture of ergot, or of digitalis. Over-worked men are often anæmic, and require iron, with a little alcohol, at night. Exercise may generally be enjoined. In gouty lithiasis, with a pulse of high tension, he has confidence in the curative effects of colchicum, supplemented by the use of dilute saline purgatives, such as Pullna, Friedrichshall, Hunyadi Janos, or Rakozy waters. Senile insomnia is very obstinate, but perhaps in the bromides, with full doses of hops or henbane, we have the best and least harmful means for its relief.—*Lancet and Hospital Gazette, N. Y.*

**New method of compression of the iliac artery in amputation at the hip-joint.**—Mr. Richard Davy, of the Westminster Hospital, remarks that in all severe operations, one of the first considerations of the surgeon is to anticipate shock, and to prevent the loss of blood. He accordingly permits a patient to have a glass of wine or brandy and water about an hour before the operation, with a result that partakes more of a sedative than of a stimulant character; apprehension is assured; cardiac tone is gained; fitness for the ordeal is exhibited. The American sur-

geons devised pressure on the aorta for hæmostatic ends during amputations high up towards the pelvis. Lister arranged a horse-shoe clamp and screw-pad for compressing the aorta above the umbilicus. Dr. Davy saw this mechanism employed in Syme's operation on gluteal aneurism in 1860, and in 1874 he drew Mr. Holmes' attention, who was then lecturing in the College of Surgeons, to the possibility of controlling the aorta, common iliacs, and internal iliacs, by pressure through the rectal wall, which he considers a less serious procedure than compression of the aorta through the abdominal wall. Last January a favorable case presented itself for testing the value of the suggestion in a boy suffering from morbus coxæ, and requiring amputation at the hip-joint. In the performance of the operation the right leg and thigh were emptied partially of blood by Esmarch's bandage, chloroform was administered, and about one ounce of sweet oil was injected into the empty rectum. A straight lever of wood (run smooth and round out of a lathe) was introduced *per rectum*; the small end was applied over the right common iliac artery between the bodies of the lumbar vertebræ and psoas magnus muscle; the projecting part of the lever ran nearly parallel to the left thigh. Mr. Bond readily compressed the common iliac artery by elevating the projecting arm of the lever, the perineal tissues acting as a fulcrum. As the lever was raised or depressed, so did the right femoral artery cease or continue to pulsate. The left femoral was undisturbed, beating with regularity throughout. A long square anterior flap was made by transfixion over the joint, the muscles and capsule were divided, and a short posterior cut severed the limb. The arteries were tied, sutures inserted, and the boy placed in bed. About a wine-glassfull of blood was lost. The boy recovered, with the exception of one or two small sinuses. —*Brit. Med. Jour. & Hospital Gazette, N. Y.*

**Enterotomy.**—Dr. Von Langenbeck, at the late Congress of the Society of German Surgeons, showed a patient on whom he had performed enterotomy last May, and who wore an India-rubber bladder as an obturator to the artificial anus. He



called attention to the importance of providing a sufficient closure for the new opening. In a case of colotomy, performed on a child for absence of rectum, and which was in other respects successful, death had occurred from prolapse of the intestine, in consequence of the want of a proper obturator.

Dr. Trendelenburg (Rostock) had performed enterotomy three times, and considered it much less dangerous than colotomy. in consequence of the injury to the soft parts being less. For the closure of the fistula, remaining after gastrotomy, he recommended a drainage-tube provided with a stop-cock, which could be fixed securely in a perpendicular direction by means of a ring of cork.

Dr. Czerny (Heidelberg) thought that, independently of the connection in size between the prolapsed portion of bowel and the opening, the prolapse was always absent, or very small, when there was adhesion of the serous membrane above the opening.

Dr. Von Langenbeck said, in order to prevent misunderstanding, that in the case of the child to which he had referred he had not performed Amussat's operation, but had opened the flexure of the colon. He had made the opening very small, and he believed that the prolapse was the result of invagination. A means of preventing prolapse, not attended with danger, but certain in action, was the use of a plug to be inserted in the intestine. One of his patients had for some years used this plan with success.—*Lond. Med. Record & Hosp. Gazette, N. Y.*

**Treatment of Ulcers of the Leg.**—Dr. Becker advises a new method of treating ulcers of the leg. First, the patient must remain in bed twenty-four hours, so that the usual œdema which accompanies ulceration may be got rid of. During this period the limb should be wrapped in lint soaked in a solution of carbolic acid. The leg should then be well dried and the bandage applied—this bandage must be of the thinnest possible linen and put on a hot plate and spread with heated emplastrum adhæs. (Emp. Resinæ). This plaster goes easily through the thin linen bandage, so that both sides

are equally covered with the mass. The bandage is then applied to the leg from below up, in strips, which must go completely round the leg, and the upper strip overlap the under by a third of its breadth. It is important that the strips be evenly applied so that there may be no interference with the circulation. After the application of the bandage, the patient must remain some hours in bed. The bandage is taken off after four weeks, and during the night succeeding, the limb must be enveloped in lint soaked in a solution of carbolic acid, and the next morning the bandage should be re-applied in the same way. If there is a foetid discharge which escapes from under the bandage, Dr. Becker advises over the emp. adhæs. should be applied one of Lister's gauze bandages impregnated with carbolic acid, and an ordinary linen roller applied over all—this last bandage should be moistened every two or three days with a solution of carbolic acid in spirits of wine (20-100). Dr. Becker claims that this method of treating ulcers is superior to Lister's or Reverdin's.—(*Berlin, Klin, Wochschr.* xiv, 1877), quoted in *Schmidt's Jahrbucher*, 1878.

[This method of strapping is very similar to that advised by Mr. Baynton, years ago. Dr. Becker, however, evidently is unacquainted with Baynton's strapping.]

**Treatment of Psoriasis.**—Prof. Thiry (*Presse Méd.*, xxiv, 1877), employed jaborandi in the treatment of two cases of inveterate psoriasis in young persons. In one case of general psoriasis the result was very favorable,—in the other, psoriasis guttata, the cure was not complete. The first case was cured in eight weeks. He gave the jaborandi in the form of infusion, in doses of  $\bar{\text{v}}$ — $\bar{\text{vii}}$  daily. (Quoted in *Schmidt's Jahrbucher*, 1878.)

**Psoriasis.**—WUTZDORFF, of Berlin, holds the opinion that psoriasis is never acquired except in those in whom the tendency is congenital, and whose skin is irritated from various mechanical, chemical and thermic causes. In those that have the tendency, the psoriasis always appears in some part of the

skin that is irritated, as the buttocks in riders, in shoemakers on inner side of the left knee, and the gluteal region in tailors.—(Quoted in *Schmidt's Jahrbucher*, No. 5, 1878.)

**Psoriasis Vulgaris.**—Dr. E. Poor (*Prager Vierteljahrsschr*) declares that psoriasis vulgaris is a constitutional affection and is the manifestation in the skin of malarial fever. He calls it “malarial psoriasis,” and treats it with quinine, arsenic, carbolic acid, &c., internally. In 68 per cent. of the cases the parents suffered from ague, and 31 per cent. from lichenous eruptions. In most of the cases examined (327) he found enlargement of the spleen.—(Quoted in *Centrallblatt f. Med. Wissensch*, 1878.)

**Erythema Nodosum (Œhme.)**—Among 18 patients examined suffering from e. nodosum, 17 were women and 1 was a male; their ages varied from 16 to 27 years, except one, who was 54. In 16 cases the eruption was distinctly accompanied by fever. The prodromal fever usually lasts from two to eight days, and seems disproportionate to the local eruption. As complications we find pain and swelling in the joints, as in rheumatism ac., but endocarditis is never seen.  
\* \* \* \* While e. nodosum is harmless in healthy persons with no hereditary taint, it must always be a subject of alarm in those whose families are phthisical and who themselves are badly nourished and anæmic individuals.—[*Dresdener jahr. f. Nat. Heil.*, 1877. Quoted in *Centrallblatt f. Med. Wissensch.*]

DR. SVETLIN (*Centrallblatt f. Med. Wissensch*, April, '78), has been experimenting with guinea pigs on the efficacy of atropine in epilepsy. He found that he could control the reflex spasm of epilepsy (which had been induced in guinea pigs after the usual manner) by small doses of atropine with the greatest ease; the dose he used was 0,001,—0,902. He has also had good results with his own patients suffering from epilepsy; he uses it in very small and not increasing doses 0,001 gramme, in the form of pill.

**Jaborandi.**—Dr. O. KAHLER (*Prager Med. Wtssechr.* 1877) recommends jaborandi in cases of diabetes, where the digestion is in good condition. It rapidly reduces the amount of urine. In acute bronchitis and chronic dry catarrh he has found it of service, and also in parotitis accompanying severe infectious diseases. He advises its use in mumps, rheumatic affections, neuralgia, nephritis, urœmia, &c., and in chronic metallic poisoning. Kahler uses jaborandi in the shape of infusion, and says its use is contra indicated by a weak heart.

**Athetosis.**—Dr. OULMONT (*Etude clinique sur l'Athétose* par le Dr. P. Oulmont, Paris, 1878), during his residence in the Salpêtrière under M. Charcot, had the opportunity of studying several patients afflicted with athetosis, an affection little known as yet, and of which the name even was until lately almost ignored in France. The history of athetosis is of very recent date it was first named in 1871 by Hammond of New York, who devoted a chapter to it in his treatise *On Diseases of the Nervous System*. Some years before Charcot (1853) and Heisse (1860) had described phenomena analogous to those defined by Hammond; and, since the labours of the latter, several other observers have spoken of athetosis, chiefly in America and in England.

Athetosis (*athetos*, without fixed position) is characterized, according to Hammond, by “the impossibility which the patients find of keeping their fingers and toes in any desired position, and by the continual movement of the same.”

The name of athetosis, like that of chorea, says M. Oulmont, is a general appellation, comprising varieties which are very different in point of progress and symptomatology. Athetosis may be unilateral (hemi-athetosis) or double. M. Oulmont has studied both forms in a series of thirty-seven clinical observations, from which he has drawn the following conclusions:—

1. There are, in what is described under the name of athetosis, two entirely distinct forms which must be completely separated; unilateral or hemiathetosis, and double or general athetosis.
2. Hemiathetosis consists of slow, exaggerated, involuntary movements, limited to the foot and hand of one

side of the body, and now and then occupying the corresponding half of the face and neck. 3. To these movements are generally added transitory contractions or intermittent spasms, which are simple modifications of athetotic movements, a sort of intermediate stage between the mobility of athetosis and the rigidity of post hemiplegic contraction. They may attack all parts of the upper extremity, but in the lower extremity they rarely pass the instep. 4. The movements are involuntary, little modified by the will, and often exaggerated by it. They persist during rest, often even during sleep, at least to the degree of fixing the limb in an abnormal position. 5. Hemiathetosis appears nearly always on the paralyzed side during the course of motor hemiplegia. 6. It coincides, in the great majority of cases, with more or less complete hemianæsthesia of the same side. 7. The other symptoms which may accompany it, namely permanent contraction, rigidity, and atrophy, with laxity of the articular ligaments, do not depend on the athetosis, but on the hemiplegia itself. Articular relaxation in particular is specially marked. 8. Hemiathetosis resembles hemichorea; like it, it is the symptom of a cerebral lesion of some sort, without doubt in the neighbourhood of the lesion which produces hemichorea, that is to say, the fibres in front and outside of the sensory bundles at the lower part of the corona radiata (of Reil). In cases where motor or sensory hemiplegia, or both, are absent, it may be admitted that there is such a tendency to concentration, that it attacks the athetotic fasciculi at a place where the sensory and motor bundles, united at the lower part of the internal capsule, are already dissociated. 9. Hemiathetosis and hemichorea, very distinct varieties of posthemiplegic disorders, may be united by various forms of actual tremblings, transitional states in which the characters of both are blended. 10. Double athetosis presents the same clinical aspects as hemiathetosis, except that the movements exist on both sides of the body. The face seems to be attacked more constantly and more severely than in the unilateral form. 11. It is not accompanied by any disorder of movement or of sensibility. 12. Its nature is unknown; still it may be admitted that there is between it and hemiathetosis the same relation as there is between chorea and hemichorea.

—*London Med. Record.*

## CANADA

# Medical and Surgical Journal.

MONTREAL, SEPTEMBER, 1878.

### YELLOW FEVER.

This scourge still continues to infest southern cities, and it is surmised that it will continue until the frosts of winter have set in. It has apparently extended farther north on this occasion than during any previous epidemic. This is accounted for from the continued rain with an unusual hot term, and the disease appears to have been aggravated by the neglect of sanitary precautions such as efficient drainage and cleanliness. Dirt and neglect of sanitary means is not held to be sufficient to generate the fever, but there can be little doubt that during the prevalence of an epidemic it will greatly add to its virulence and fatality. We read of whole families being swept away in Grenada. This probably is somewhat exaggerated, as there appears to be a panic amongst the people and it is the fashion now a days, at least with some people, to deal with inflation even in our miseries. That the fever is bad enough and fatal enough is sufficiently evident by the report of Dr. Woodworth, of Washington, Surgeon-General to the U. S. Marine Hospital Service. The following abstract of that report we take from the *Boston Medical and Surgical Journal* :—

*New Orleans*—During the week ending 30th August, 1878, there were 1,204 cases of yellow fever in that city, of whom 333 died. Since the outbreak of the epidemic there have been 2,877 cases with 867 deaths. This gives an average of a little over 30 per cent.

*Vicksburg*.—It is estimated that there have been from the outbreak of the epidemic in this place 800 cases of yellow fever

with 185 deaths. This gives a percentage of over 23.

In Memphis the death rate has been high; during the week ending 30th August there were 721 cases of yellow fever, with a mortality of 241, yielding a percentage of 33.42.

The disease appears to be confined to the line of the Mississippi, although cases are reported in Cincinnati and Philadelphia. These were all imported cases from infected places south.

No reliable information or official reports obtained from Granada, Canton, Port Gibson, and Port Eads, La.

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### MARKS OF MURDEROUS VIOLENCE.

We observe by a recent telegram from Quebec that at the inquest held on the body of Joseph Guenette, found decapitated on the railway track at St Henry, a verdict of wilful murder has been rendered against some party or parties unknown. The circumstances are somewhat peculiar. Guenette was a perfectly sober man and was seen late in the evening of the night of the supposed accident. He had evidently been killed by a stab in the chest which had implicated the heart. The medical gentlemen who examined the body *post mortem* gave it as their opinion that life was extinct some time before his head was severed from his body by the wheels of the passing train, and that death was the result of a stab in the chest wall near the heart inflicted by some sharp instrument. The body subsequently had been placed on the track with the neck on one of the rails. This evidence was substantiated by the conductor, who examined the body as soon as the train was stopped. It was almost cold, somewhat rigid, and there was very little blood on the track. The matter is in the hands of the police.

A very similar case is reported in an English periodical where the body of a man supposed to be drowned was recovered from the Serpentine. The surgeon who gave evidence at the inquest testified that he found a bullet-wound on the left side of the chest which involved the heart and which he believed would have caused speedy death. It is not stated however

whether the signs of death by drowning were absent. Other evidence went to show that the deceased had shot himself while on the bridge and that his body fell into the river. These cases are instructive as they point to the necessity of careful and patient investigation, and by the exercise of reason the actual nature of the case can generally be arrived at with certainty. Murder, when perpetrated, can very rarely be so covered up as to obliterate all trace of the crime. And it is as well the public should be aware that the profession possesses sure and certain signs, unmistakeable, reasonable, and convincing, which will bring to light a hideous crime of this nature even though there may be no corroborative evidence, which, however, in the instances above referred to was not wanting.

### THE BONES IN PERNICIOUS ANÆMIA.

We notice that reference is made in the London *Lancet* of August 2nd, to some observations published last autumn in the "Transactions of the Canada Medical Association," by Professor William Osler, M.D., of McGill University, in reference to the condition of the bones and marrow in Pernicious Anæmia, as well as to other remarks on the same subject, more recently published. The latter we have not seen, but the *Lancet* does not accredit the source from whence it has obtained the information. This is to be regretted, as it is due to the author, as well as to the readers of the *Lancet*, to give them the opportunity of seeing the entire article, and not a mere abstract of observations which are of practical importance, and which are attracting very general attention. Dr. Osler has devoted a large amount of time to these inquiries, and so far as he has gone his deductions are highly interesting and instructive, and reflect credit on his persevering industry.

### IMPORTANT ANNOUNCEMENT.

The enterprising book publishing house of William Wood & Co., 27 Great Jones Street, New York, have undertaken a scheme of reproducing books of foreign authors at prices far below anything of the kind heretofore attempted. We can



illustrate the reproduction of Ziemssen's Cyclopaedia of the Practice of Medicine, now near its completion, and we must state without hesitation that in our opinion the reading professional public owe a debt of gratitude to Messrs. Wood & Co. for having carried out so successfully this great enterprise.

A somewhat similar attempt on their part is about to be inaugurated, and we trust their laudable efforts will receive that recognition and support which they deserve. Indeed the profession is offered a library of books, which will be sold to subscribers only, at an annual subscription of twelve dollars.

The proposal for the year 1879 is to issue twelve volumes. "Rest and pain," a course of lectures by John Hilton, F.R.S., and which, at the time of their delivery, attracted much attention. This valuable work is profusely illustrated with engravings on wood. "Diseases of the Intestines and Peritoneum," being articles published by Wardell, Bristowe, Begbie, Thos. B. Curling and Ransom. These papers are taken from Reynolds' System of Medicine, and will form a volume with numerous illustrations. A third edition of Ellis' "Practical Manual of the Diseases of Children," with formulary. Lawson Tait's work on diseases of women. "A Clinical treatise of Diseases of the Liver," by Dr. Fried. Theod. Frerichs, translated by Dr. Murchison. This work is worth all the money asked for the 12 volumes, it is the most valuable treatise ever written on this subject, and will be published, in this series, in three volumes. "Infant Feeding and its influence on life," by C. H. F. Routh, M.D., third edition. The remaining four volumes are not announced as Messrs. Wood desire to avail themselves of whatever may appear in the announcements of books to be published in 1879, which are usually made in October. We trust our readers will entertain the offer of the publishers and respond freely and promptly, as it is very important that all who intend to subscribe should do so without delay, so as to give the publishers some idea of how large an edition will be required.