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# THE CANADA MEDICAL RECORD.

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### *Original Communications.*

#### OBSTETRICAL MEMORANDA.

##### CASE OF INTERSTITIAL FŒTATION.

By Carr Holstok Roberts, L.R.C.P.L., M.R.C.S. Eng., L.S.A., M.B., M.A.

The rarity of these cases induces me to ask you to give me a niche in your columns for a short description of this one :

On Sunday evening, the 1st inst., at half-past ten, I was requested by the husband of the patient to come and see his wife ; he stated that they had gone to bed as usual and had been to sleep, when his wife woke him, and said that she had been woken by " pains in the stomach, and could not get rid of them, nor go to sleep again." He had given her some brandy, but without any good effect.

I found her in bed ; a tall, stout woman, aged 32, complaining of pain in the abdomen (which, however, was not swollen or tender, nor was the pain aggravated by pressure), of sickness, and slight diarrhoea, which she attributed to her having taken Pil. Cochia pills. The vomit looked only like semi-digested food, and the diarrhoea was only like the loose motion that would be produced by a purgative ; her skin was cool and moist, her pulse good, and her respiration and temperature both normal. She was perfectly conscious, quite calm and collected, and there was nothing what-

ever to indicate such a sudden and fatal termination as took place. I elicited that she had missed two periods. She had had two (only) children, both born at the full period, and both living. The youngest, being fourteen months old, had been weaned about two months. She had never had a miscarriage, but thinking it most probable that such was the nature of this illness, I gave her opium, ammonia, and chloric ether, and ordered hot fomentations, and linseed poultices to the abdomen, with a little brandy at intervals, and left instructions to be sent for if necessary. I was not, however, called again until 8 a.m. the following morning, as she had suddenly become much worse. I then found her in a state of collapse, and evidently dying, but perfectly conscious, and complaining of a great desire to pass water. She had, however, done so during the night, and the bowels had been once relieved, but she was not purged. I passed a catheter, but the bladder was empty. She became rapidly worse (there had been no more vomiting), but remained perfectly conscious until half-past ten, when she expired. I should have said that her previous health history was very good.

*Autopsy.*—There were no external marks of violence: the body was, for a woman of her age, very fat, the abdominal cavity was full of clots and bloody liquid—the clots weighed very nearly six pounds, and the fluid measured five pints. Floating amongst this was a fetus (apparently

about two months) enveloped in its membranes, and with the placenta attached. At the upper part of the uterus there was a rupture, close by the right Fallopian tube, large enough to contain three fingers, looking like a sac the walls of which were extremely thin.

There was no communication between it and the interior of the uterus, which weighed exactly eight ounces. The heart was fatty and somewhat flabby, and was perfectly empty, as were also all the large bloodvessels. The other organs of the body appeared perfectly healthy. The head was not examined. The uterus, etc., etc., has been sent through Mr. Dorian to the Museum of the Royal College of Surgeons. I have no remarks to make on the case, except as to the absence of the graver symptoms, until within so short a time of the death. The blood had evidently continued oozing out, until there was no more to come; the apparent desire to pass water was evidently caused by the pressure of the clots, etc.

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## *Society Proceedings.*

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### MEDICO-CHIRURGICAL SOCIETY OF MONTREAL.

*Stated Meeting, Sept. 22nd, 1882.*

GEORGE ROSS, M.D., PRESIDENT, IN THE CHAIR.

*Pathological Specimens.*—Dr. Shepherd exhibited a specimen of ossification of the sacro-iliac synchondrosis. On separation of the bones, the articular surfaces appeared quite healthy, but those of the lumbo-sacral articulations were somewhat diseased. This condition is sometimes found to be congenital, but in the case under notice Dr. Shepherd thought it was of rheumatic origin.

*Subject of Paper.*—Dr. Alloway narrated the following case: The patient, a woman, aged 24, was attended by himself and Dr. Rodger in her confinement. She had been in labour about 12 hours. Occipito-posterior position. Ether was administered, and Simpson's long forceps applied. During traction the head suddenly slipped from under the pubic arch and carried away the perineal body, sphincter ani and the recto-vaginal septum for fully two and a half inches in its extent upwards (length of index finger). The immediate operation was done, which was a combination of Simon's and Emmet's. The rent in the bowel

was first united by interrupted sutures of strong grey thread, the only material obtained at the time. The perineum was united in the ordinary way, care being taken that the lower or Emmet's suture was entered low down on a level with the lower margin of the anus, on the left side, passing upwards and inwards over to the opposite side, and downwards to the point corresponding to its entrance on the left side. The vagina was well washed out with carbolized warm water, the parts anointed with vaseline, and the patient's knees tied together. The carbolized injections were continued every two hours by a very faithful nurse in attendance. On the fourth day diarrhoea set in, which could not be arrested until several days had elapsed, it being due to the milk the patient was taking. The fluid fæces passed between the sutures into the vagina. Patient became very despondent, thinking she was ruined for life. On the 10th day carbolized injections reduced to twice only. On the 15th day removed all the perineal sutures, except Emmet's. This was left until the 18th day, when it and all the internal sutures were removed through the bowel. There was still a small fistulous opening in front of the sphincter. This, however, had completely closed by the 22nd day. From this out the patient made a perfect recovery. Was examined some months afterwards, and exhibited no laceration of the cervix, unless it had completely healed, and had a perfect perineum. Uterus normal depth. Dr. Alloway drew attention to the fortunate accident of diarrhoea having set in shortly after the operation, and alluded to a paper just then published in the *New York Medical Record* (July) by Dr. H. T. Hank, of the Woman's Hospital, New York, upon the advisability of intentionally keeping the bowels loose during the whole period of treatment, from the second day after operation. Dr. Alloway attributed much of the successful issue to this circumstance.

*Discussion on Paper.*—Dr. Kennedy spoke of the great frequency of laceration of the perineum, especially in occipito-posterior positions of the head, in spite of the most skillful precautions on the part of the accoucheur. In such cases he favored the method recommended by Dr. White, of Buffalo, of making lateral incisions on both sides as soon as the perineum becomes distended, thus preventing laceration through the perineal body, which is always more slow to heal. His experience was limited to laceration through the sphincter, which he always treats by immediate operation,

and with success in the majority of cases. He mentioned having seen one case in which the septum was destroyed and the patient had recovered to her own perfect satisfaction, without operation. No opportunity offered for a subsequent examination in this case. He favored keeping the bowels loose during the convalescence, and was inclined to ascribe much of the good result in Dr. Alloway's case to this condition. In conclusion, he asked why ether was used in preference to chloroform. He personally favored the use of chloroform, as the voluntary muscles are more relaxed by its use, and lying-in women appeared to enjoy immunity from its poisonous action. If pushed to its full action it tends to favor flooding, but he thought this action was due more to its lessening reflex irritability than from any other cause.

In reply, Dr. Alloway said he invariably uses ether, feeling much safer with it, and has never met with that relaxation of the uterus which he has frequently noticed after using chloroform. Dr. Cameron also favored immediate operation in these cases, as the difficulties are increased the longer it is put off; he thought sutures of silver wire were preferable to those of silk in the rectal tear, and these were easily applied by means of Pean's needles. Dr. Roddick thought sutures of catgut were specially advisable in the rectal tear, as they required no further attention; he also recommended the use of intermediate sutures of catgut in the perineum as being preferable to all wire. Accidents with chloroform are rare in midwifery practice owing to the minor degree of anæsthesia induced, and the eagerness with which it is taken as a rule, whereas in general surgery the patients frequently resist, and thus, possibly, the danger is increased. Dr. Ross complimented the reader of the paper on the readiness with which he had made use of the means at his disposal in the emergency, but thought he was singular in the use of ether in preference to chloroform, and that he had shown no special reason why the latter should not be used. The fact that flooding had followed its use was merely a *post hoc* argument, and it might also occur with ether; at the same time, he recognized the great danger of using chloroform in ordinary surgical practice. The great inflammability of ether, its bulk, and the offensiveness of its odor, all argue strongly against its use in midwifery practice.

Drs. Macdonnell and Mills also took part in the discussion, after which the meeting adjourned.

*Stated Meeting, October 6th, 1882.*

GEORGE ROSS, M.D., PRESIDENT, IN THE CHAIR.

This being the first meeting in October, was also the annual meeting.

*President's Address.*—The President, in delivering his address, gave a short *resumé* of the work of the Society during the past year, but, before proceeding to do so, made allusion to the removal by death of Dr. George W. Campbell, one of the Society's oldest and most respected members. He had always taken an active interest in the work of the Society, until failing health compelled him, unwillingly, however, to absent himself from its meetings. The Society has had to mourn his loss, but by his example should be stimulated to further exertion in its work. The question of public health was next referred to. During the past year a draft of a bill was prepared by the City Health Officer and the advising attorney for the purpose of seeking for the incorporation of a complete system of supervision of public health; this was submitted to a joint committee from the Board of Health and from the Medical Societies. This bill has not yet become law, but there is a prospect of its soon passing the Legislature. In August last the city was honored by the presence of the members of the American Association for the Advancement of Science, among whom were many medical men from the United States and Europe. The meetings have been regularly held, the attendance has always been good, and the amount of work done has been very satisfactory. A number of interesting papers have been read by members, the topics of which have been extremely varied, and in most instances have given rise to animated and profitable discussions. The pathological specimens and anatomical preparations exhibited during the year have also been numerous and interesting.

At this stage of the proceedings, Dr. Osler announced that Dr. Workman of Toronto, who had been on a recent visit to this city, was about leaving, and before allowing him to do so, thought the Society should in some way express to him its sense of his many excellent qualities and its high appreciation of the services rendered by him to the medical profession. He then moved the following resolution, seconded by Dr. F. W. Campbell:—"Resolved,—That the members of

the Medico-Chirurgical Society of Montreal, in session this evening, cannot allow the opportunity to pass of expressing to you the pleasure your visit to this city has been to them. They feel that to you the medical societies of Canada owe much, your zeal and ability having always been liberally expended in promoting their welfare; and desire to express the hope that you may still be spared for many years to give them the benefit of your wisdom and counsel."

*Subject of Paper.*—Dr. F. W. Campbell then read to the Society the paper by Dr. A. H. David (who from severe illness was prevented from being present), entitled "Reminiscences connected with the Medical History of Montreal during the last fifty years." Dr. David's paper was published in the October number.

*Stated Meeting October 20th, 1882.*

DR. R. A. KENNEDY, THE PRESIDENT, IN THE CHAIR.

*Pathological Specimens.*—Dr. Osler exhibited the following specimens:

(a) A specimen from a case of fatty diarrhoea, sent by Dr. Wolverton, of Hamilton. A woman *æt.* 30 had suffered for some weeks with gastro-intestinal disturbance, and for the past two weeks the dejections contained a remarkable amount of fat. Dr. Wolverton has promised a full report of the case.

(b) A portion of the paunch of a cow presenting numerous examples of "Amphistoma Conicum," a fluke not uncommon in this region in "Ruminants." It would appear to be particularly abundant in the animals in Pictou County, N.S.

(c) Specimens of obliterated superior vena cava from a patient of Dr. Wilkins, who had been in the hospital some twelve weeks with symptoms of venous obstruction in the thorax, lividity and swelling of face and upper extremities, with attacks of intense dyspnoea. Constantly accumulating effusions occurred into the left plural cavity, necessitating frequent tapplings. The superior cava was obliterated in its entire length and converted into a firm fibrous cord, about the thickness of the thumb. The internal jugulars and innominate contained fine thrombi undergoing fibroid transformation. Between the ascending aorta and the right lung there was a good deal of cicatricial tissue covering over and surrounding the ob-

literated vein. No heart disease or other lesion found.

(d) Specimen of a case of pneumonia terminating in abscess of the lung. The patient was under care of Dr. Molson in the hospital, a very intemperate woman aged 35, brought to hospital on the 4th day from onset of a severe pneumonia of the left lung, following a heavy drinking bout. On the 10th day she spat up large quantities of stinking purulent matter, and at the same time the temperature, which had remained about 104°, fell to 99°. She died on the following day.

Dr. Osler then exhibited some eighteen ounces of bile, obtained by aspirating the gall bladder of a patient, having the following history:

C. M. S., *æt.* 58, farmer, of fairly good health, with phthisical history on mother's side. In the month of April last first felt pain in back and shoulders and across the kidneys, did his spring work and did not consult any doctor. Early in June he noticed his water was dark, and his face became jaundiced and deeper than at present. Never had any paroxysmal pain, but pain was of a dull heavy character; no vomiting, lost much flesh in last two months, clay-colored stools, great itchiness, sleepless, appetite good. Present condition: Well-preserved man, not very grey, skin jaundiced, walks bent because of pain, conjunctivæ stained, tongue clean, breath not bad, abdomen flat, a little prominent in right hypochondriac region; liver dullness greatly increased, and a rounded mass is felt on right side of abdomen, corresponding to upper half of area of increased dullness, movable, elastic and evidently connected with the liver; surface of liver below costal border not roughened, a little tender below xiphoid cartilage. The distended gall bladder was aspirated, and about 18 oz. bile removed, but without much benefit; nature of obstruction not quite clear; no history of gall stone.

Dr. Bell exhibited a bladder in a state of phlegmonous inflammation from a patient who died in the hospital from the effects of fracture of the spine.

Dr. Shepherd exhibited two femurs which belonged to an old woman *æt.* between 80 and 90 years, the subject of general "Fragilitas Osium," or senile atrophy of bones. The left femur had the characteristic deformity of osteoarthritis, the neck being shortened and the head enlarged; the acetabulum of that side was much enlarged also. In this femur there was an old

united fracture just above the condyles. In the right femur there was an ununited intracapsular fracture. Dr. Shepherd remarked that all the bones presented the atrophic condition, the skull cap in particular, being only of parchment thickness. The astragalus could be easily broken down between the finger and thumb; very slight accidents in these cases are liable to produce fracture.

*Cancer of Œsophagus.*—The next specimen was exhibited by Dr. Ross, who also made a few remarks on the history of the case. The patient from whom the specimen was taken, J. M., æt. 54, was admitted into the General Hospital Oct. 10th, 1882, complaining of cough, pain in epigastric region and weakness. In May had pain in mid-sternum and to the left side. In June had frequent vomiting; after a time solids seemed to be stopped on the way down, to roll about in his- and then would be at once brought up. Has lived on soft toast, tea, and milk for a long time. Has been intemperate. Began to cough three weeks ago, and soon noticed a very foul smell coming up his throat with the cough.

*Status Prævus*—Anæmic and emaciated pulse weak; sharp bubbling sounds heard at base of right lung to spine of scapula and into the axilla. Expectoration serous with purulent masses, faint, fetid odor. Liver felt greatly enlarged, smooth and very little tender. A large-sized bougie was passed readily into the stomach, no obstruction; was made to swallow dry bread, which he did well. In spite of the negative signs given by the passage of the bougie the case was considered to be one of cancer of œsophagus with secondary affection of lung, and possibly fatty or cancerous liver.

*Post Mortem.*—The œsophagus presented an enormous cancerous ulcer situated in its lower half, extending for about four inches and involving nearly the whole circumference of the tube with the exception of a narrow tube-like portion on the posterior wall. The edges were swollen and infiltrated, and the base presented a deep excavation which at the right margin had perforated the lung, and formed near the root a series of sloughy abscesses in an area about size of an orange; there were extensive secondary masses in the liver, particularly in the left lobe.

#### *Remarks on Specimens Exhibited.*

Dr. Mills, in cases of cancer of œsophagus, thought the passage of the bougie might be explained by a peculiar turn of the instrument; he thought it would

have been a good case for auscultation of the œsophagus.

Dr. Ross, on the other hand, thought auscultation would have also failed, inasmuch as there was no obstruction; he thought œsophagoscopy would have been more desirable.

Dr. Mills then explained the mechanism of Morrell Mackenzie's apparatus for œsophagoscopy. He did not agree with Dr. Ross in regard to auscultation, the œsophagus being a closed tube. Although no obstructions were present its walls were so diseased that they could not act muscularly, and thus, in swallowing, the sounds would be delayed sufficiently to be appreciated by means of the stethoscope.

Dr. Osler also agreed with the last speaker; he had had some experience in œsophageal auscultation in the Vienna Clinique, and the difference in the sounds was very marked.

Dr. Henry Howard, speaking in regard to the bonis exhibited by Dr. Shepherd, remarked that such a condition was frequently found in aged persons of unsound mind, and accidents were frequently occurring in lunatic asylums from very slight causes, owing to this fact.

Dr. Roddick reported a case of laceration of the left kidney, followed by death on the fourth day. The case occurred in the practice of Dr. Simpson, with whom he had seen the patient in consultation. The patient, a woman of sixty years, but remarkably healthy and vigorous, fell accidentally from the top to the bottom of a long stairway, and was picked up in an insensible condition. There was no wound to be found, but she complained from the first of great pain in the right loin. Vomiting soon began, and, in spite of all treatment, continued to the end. The bowels became tympanitic, and refused to act. The most marked symptom, however, was the passage of pure blood from the bladder. This formed a large clot in the vessel, and urine was for some hours almost absent. The urine after the first twenty-four hours became more and more smoky, until, on the fourth day, it was almost bloodless. Rupture of the kidney was diagnosed, and, on account of the obstinate condition of the bowels, ileus was suspected, although no tumor could be felt. The long O'Berne's tube was passed, and a large injection thrown into the bowel, but with no effect.

At the autopsy a large clot of blood was found surrounding the right kidney, and a rent through the border of the organ, communicating with the

pelvis, whence the blood evidently came. The kidneys were slightly granular. The bowels were found unobstructed, although it was thought that the blood clot might have pressed unduly on the ascending colon, and interfered with its functions.

CLINICAL NOTES ON HÆMATEMESIS IN CHRONIC SPLENIC TUMORS, BY DR. OSLER.

Dr. Osler commenced his paper by alluding to the frequency with which hæmorrhages are associated with all forms of splenic tumors, especially in that accompanying leucocythemia, a depraved condition of the blood seeming to be the chief factor in their production, they being also met with in profound anemias, not of splenic origin. Epistaxes are the most frequent, and next hæmorrhages from the bowels, but hæmatemesis, hæmoptysis and hæmaturia are also occasionally met with. Of 150 cases of leucocythemia collected by Gowers, hæmorrhages occurred in eighty, and eight of these were from the stomach. The point to which attention was chiefly called was the possible occurrence in some instances of severe, perhaps fatal, hæmatemesis, even before the constitutional symptoms are marked, and indeed may be the first symptom complained of; and hence the great importance of directing the attention to the spleen as well as to the liver as a possible cause in an attack of vomiting of blood. In illustration of this fact, the following cases were referred to:

Case 1. J. H., æt. 36, admitted to hospital, September, 1879, with anemia. Has been healthy and temperate, had intermitting fever in India. In January, 1877, had an attack of vomiting of blood, preceded by slight indisposition, weight in abdomen and nausea; had three attacks that week, each time losing a large amount of blood, and was much reduced. Strength returned slowly, and he resumed work. In July had another single large hæmorrhage with a severe diarrhoea, and shortly after another hæmorrhage. During July and August the abdomen, which had been noticed somewhat prominent at beginning of trouble in January, now increased considerably. On admission there was marked anemia, abdominal distension and œdema of ankles. Spleen greatly enlarged. The blood was thin and watery, and microscopically presented characters of anemia. Red corpuscles reduced below two millions to cubic millimetre and hæmaglonia correspondingly diminished. No leukœmia. Heart's action was always a little excited; pulse about 100; hæmic murmur present;

sweats were troublesome. He took iron with benefit, œdema of ankles disappeared, and belly diminished in size; left hospital in a month, during which time he had no hæmorrhage. He died subsequently at home from effects of a severe hæmorrhage.

Case 2, August 13th, 1882. A little girl, æt. 11, brought from Kingston, Ont., for examination; of good family history and of previous good health, excepting four years ago, when she was not very well, and the mother thinks she vomited a quantity of blood-tinged matter, but this is doubtful. Two years ago, during a slight indisposition, with some pain in abdomen, which also appeared swollen, she had a severe hæmatemesis, lasting over twelve hours vomiting a basinful of blood. Recovered from this and seemed to thrive, although pale. In July last, one month ago, a brother died, and the excitement brought on another attack, lasting thirty-six hours, and she lost nearly three quarts of blood, and since then has picked up rapidly. She was well nourished and stout, but face pale, and puffy look about eyes. Complained of uneasy fulness about stomach, swelling of feet in evenings, and shortness of breath when walking fast or going up stairs, and lately her appetite has failed. Heart and lungs appeared normal; sounds clear; no murmur. Abdomen a little distended, panculus adiposus thick, splenic tumor extends three inches below costal border and to within an inch of navel, edge clearly felt and not painful. Liver not enlarged. Abdominal veins not distended, no signs of ascites. Blood thin, corpuscles normal in size and general appearance, no increase of the colorless elements. Red corpuscles  $2\frac{1}{4}$  millions per cubic millimetre; ratio of white to red 1 to 316.

Dr. Osler then referred to two cases occurring in the practice of Dr. R. P. Howard, which also illustrated the same point.

Case (a). A plump, well-nourished lad, æt. 13, four years ago was unwell and passed blood from the bowels, and was pale. On the 12th April last had an attack of vomiting of blood, and shortly after a large bloody stool. On the day before had played "Lacrosse" and seemed in fair health; he died four days after from the effects of repeated vomitings, having lost about four pints of blood. The spleen was enlarged and the blood leukæmic. At the autopsy the spleen was found much enlarged, weighing 480 grains. No erosions or ulceration of stomach; mucous membrane pale.

Case (b). Young American lady at school in this city was suddenly attacked with violent hæmatemesis, which rapidly proved fatal. She had been in apparently good health, was well nourished, and neither she nor her parents suspected any disease. At the autopsy the spleen was found enlarged and firm, and the blood in the portal vein was markedly leukæmic. A peculiar malformation was met with in this case, the portal vein presenting a double trunk.

*Discussion on Paper.*—Dr. Buller asked for information as to the supposed possible cause of hæmorrhage in these cases, if mechanical or due to condition of blood.

Dr. Osler replied that in some cases it would seem to be due perhaps to a feeble condition of the vessels as in leucocythemia and pernicious anæmia.

In the cases under notice it might be explained by mechanical causes, considering that three fourths of the blood from the stomach is discharged into the splenic vein, and in engorgement of the latter a sweating or diapedesis might be conceived as occurring from the vessels of the stomach.

Dr. Ross spoke of the obscurity connected with such accidents occurring under such peculiar circumstances, and the exact conditions giving rise to them. In the early stages of cirrhosis we also have profuse hæmorrhages, and possibly the cases are of a parallel nature; probably other conditions have something to do with it. The great depression in mind spoken of in connection with one of the cases might have influenced the nerve supply of the blood vessels, allowing more or less dilatation of the splenic vein and damming back the blood into the gastric veins.

In reply to a question by the President, Dr. Osler said that he had used injections of ergotine, but could not say with much benefit.

Dr. Stephen remarked that in a recent number of the *Lancet* injections into the substance of the spleen had been condemned as being dangerous and inadvisable.

Dr. F. W. Campbell thought that something would be required to act more quickly than ergotine, and suggested that the application of the ice-bag to the pit of the stomach would be specially good.

*Stated Meeting, November 3, 1882.*

THE PRESIDENT, DR. R. A. KENNEDY, IN THE CHAIR.

Dr. Major then read a paper on papillomatous growths of the larynx, reporting two cases of simple papilloma, one of warty growth, in a case of rapid tuberculosis, and one of warty growths of the velus valati.

Dr. Major considered that papillomata did not present themselves so commonly on this continent as in Europe, if he might judge from the number of cases that had occurred in his private and hospital practice. In expressing this opinion he did not include the fringe-like growths so often observed in laryngeal phthisis.

During the past five years in his clinic at the Montreal General Hospital, where he had extended opportunities for investigating laryngeal disease, come six (6) only had been met with.

Few cases of vocal disability either in the wards or out-patient department were left unexamined, and he believed that if any morbid growths were present in those examined he would undoubtedly have discovered them. It was in private practice that we would naturally look for the more frequent occurrence of these growths, and for obvious reasons.

In private he had seen but three cases of simple papilloma; he suggested that possibly the dry atmosphere of the climate might account for their apparent rarity.

Two of the cases reported had occurred within a few weeks of each other, but it would not do to argue that because two had been seen within so short an interval, that, therefore, the condition was common.

In the Spring of 1881, E. M., aged 4 years, was referred to him for examination. The breathing was difficult, and the child presented a miserable appearance. The laryngoscope showed the existence of extensive sessile, warty growths, covering the surface of both vocal bands and entering the ventricles, and general hyperæmia of the surrounding parts. Two years previously the child was the subject of an attack of acute laryngitis, recovery was slow, hoarseness of varying intensity, ending in complete aphonia and accompanied with embarrassed respiration.

The usual nocturnal aggravations were observed, he performed tracheotomy, from which date more or less improvement, local and general, was obtained.



He observed, however, the tendency of these growths to increased development on the removal of the tube.

In August last these growths had so far disappeared, that the vocal and respiratory power were almost normal. An acute cold, however, ushered in with fever, so far aggravated matters, that recourse to the tube was again necessary. The tendency to recurrence of these growths was probably due to some constitutional peculiarity aided by a local hyperæmia favoring their development.

In June of the same year a lady aged 45, who had suffered from aphonia for six years, and who gave the history of a laryngitis the result of cold, sought his advice. On listening to her breathing the inspiratory current was not interfered with, while obstruction to respiratory breathing was noticeable; this difficulty was increased on phonation.

Laryngoscopic examination showed on phonation a growth about the size of a wild raspberry, attached to the under surface of the right vocal band, and extending beyond the anterior commissure. The patient objected to an intralaryngeal operation. On the following day he attempted to remove the growth by an operation through the crico-thyroid membrane, but found it necessary to divide the cricoid cartilage in addition.

The growth was removed piece by piece, the origin scraped and a probe armed with lunar caustic applied.

Fearing more or less swelling, a tracheotomy tube was introduced, chloroform was badly borne, and it was with difficulty the patient was carried through the narcosis with safety.

Either as the result of the caustic application or of the forcible distention of the cricoid cartilage, perichondrial inflammation set in; this in a few weeks subsided, and a satisfactory result obtained. On the 26th June, 1882, no recurrence had taken place, and the patient was in the enjoyment of good voice and health.

On Sept. 30th, 1880, J. T. H. was referred to him for aphonia and an irritating cough, had suffered from pneumonia the year before. On examination minute feathery growths were observed on posterior walls of larynx. Pear-shaped swelling of the aryternoids, laryngeal surface pale and bathed with moisture. The growths were removed with forceps, affording relief to the cough.

Two weeks later, high temperature ushered

general tuberculosis, marked head symptoms and fatal result within four (4) weeks. Post-mortem examination confirmed the diagnosis.

A great variety of opinion exists as to whether these growths may be looked upon as a special indication of phthisis, or merely as an accidental occurrence, the result of the continued presence of moisture. The writer attached some importance to their presence as an aid to diagnosis. Whatever might be their immediate cause, in his experience he could not call to mind a single instance where these fine thread-like developments had existed on the posterior wall of the larynx or interaryternoid space in which grave fears of tuberculosis did not exist.

He did not mean to say that they were met within every case of tubercular disease of the larynx, but where he found general pallor of surrounding parts, great moisture, and these growths, he at least regarded them with suspicion.

He remarked the great tendency of papillomatous growths to recur, and also referred to the opinion held by some that continued irritation of them by forceps would lead to malignancy. In this opinion he did not share, as he thought it more than likely that cases afterward discovered to be malignant were of that character from the first.

Warts in the larynx were of the same pathological nature as warts elsewhere, subject to the same changes, making all due allowance for locality. They were subject to spontaneous and unaccountable disappearance, and before operating all due allowance must be made for this tendency.

He referred to the different means of removing them, and laid great stress on the necessity for after-treatment.

He suggested that in all cases where it became necessary to divide the cricoid cartilage (a procedure that should never be resorted to unless in cases of necessity, for the reason that the cricoid forms the immovable base of the larynx, and any change in its position must materially affect the movements of the superimposed parts, to say nothing of the very low vitality of this cartilage, and the great tendency of its posterior plate, to undergo necrosis), more especially where a tube was required to be worn for any time; it would be well to remove a small section from each side of the cut surface, and thus lessen the pressure exerted by the tube, and the strain on the posterior plate. By this means he thought an operation, that

otherwise was unscientific might, occasionally at least, be tolerated.

*Discussion on Paper.*—Dr. Osler, in reply to Dr. Major in regard to the pathology of papilloma of the vocal cords, said he did not think it differed from ordinary papilloma of other regions; those of the larynx seemed to be abnormal growths of the epithelial layers. He asked Dr. Major if it were possible to distinguish this growth from an epithelioma, and whether it ever passed into an epithelioma.

Dr. Roddick in speaking of the operation referred to by Dr. Major, at which he assisted, expressed his pleasure at the skillful manner in which the tumor was removed, although not unattended with difficulty, the tumor being he thought larger than it appeared by the laryngoscope, and at one time the patient being in a very alarming condition. He asked Dr. Major why he did not remove the growth by opening the thyroid cartilages, and if it would not be preferable to have permanent aphonia than necessitating the continual carrying of a tube.

Dr. Mills said growths of this kind and their removal was a very debatable subject. Morrell McKenzie prefers their removal, and by evulsion, while Lennox Brown says that benign growths often become malignant even when well removed, whereas McKenzie does not think so. He thought from his experience that they are of more frequent occurrence than Dr. Major had shown. Malignant disease cannot be diagnosed if you rely on ordinary signs, as the glands, cachexia and pain. He thought it a mistake after the removal of such growths to allow the patient to return home, as subsequent cauterizations are always advisable. Evulsion he considered as not being always practicable. He also spoke of the advisability of educating the throat not only by the physician but also by the patient to render skillful examination practicable. In all cases of aphonia careful examination of the throat should be made early. He would object to thyrotomy unless to save life.

Dr. Major in reply said it was exceedingly difficult to diagnose between the epithelioma and papilloma, as a rule time and history alone will decide. In this case thyrotomy was thought of, but the hope that the growths would ultimately disappear led him to put it off. And as a rule the tracheotomy tube is well borne.

PAPER BY DR. BESSEY. SUBJECT—A PROPOSED VACCINE INSTITUTE.

Dr. B. commenced by referring to the history of animal vaccination in Canada, the first attempt towards which was in the year 1875 in this city, but which for some reason or other was in a short time abandoned, and about the same time in a town in Ontario an attempt was made to furnish animal virus to the profession, but it also was soon discontinued. In 1877 a spontaneous epidemic of cow-pox having occurred at Longue Pointe, Dr. Bessey was afforded opportunity of procuring abundance of lymph, which he continued to furnish to the Montreal Board of Health for two years. In 1880 an allowance of twenty dollars per month was voted by the Board as a permanent subsidy to defray the expenses incurred in keeping the animals required, Dr. Bessey agreeing to furnish the Board (for the use of the public vaccinators) from time to time with such an amount of lymph as experience showed was necessary, each vaccinator being charged to collect the lymph from his first vaccinations to continue the service until the distribution of the next supply. An estimate given of the numbers vaccinated during the years 1878, '79, '80 and '81, compared with the average birth rate and allowing 25 per cent. to be deducted for death rate, showed that there must remain a large number still unprotected.

In the year 1872 there were 872 deaths from small-pox, and in the four following years 728, 647, 590 and 704 respectively. Prior to 1877, when animal vaccination was introduced, public opinion in certain quarters had been very strong against general vaccination, till the people becoming convinced of its safety began to submit very generally to the operation, after which the prevalence of small-pox began to decline, and has finally disappeared altogether.

The deaths in 1877 amounted to 506 and in 1878, 728; in 1879, 472; in 1880, 140; in 1881 only 5 deaths occurred, and this year there have been no deaths so far.

It had been found by experience that lymph one or two removes from the animal gave the most perfect results; and while animal vaccine guarantees against the transmission of syphilis (which has been shewn by well-authenticated cases to occur with the use of humanized lymph, however rarely), and while it is believed to afford perfect immunity from attacks of small-pox, yet it is the experience of many that frequently there is difficulty in making

preserved vaccine "take" on the human subject, the average number of successes being about 80 per cent., whereas those of the 1st human remove average 98 per cent. This difficulty the reader of the paper thought could be removed by: 1st. An ample and constant daily supply; 2d. Its careful preservation or immediate use; and, 3rd. The establishment of a national vaccine institute. Dr. Bessey stated that in the United States lately serious consequences had followed the use of so-called vaccine lymph furnished from some 14 vaccine farms, which fact, on investigation, was found to be due to the want of skill on the part of those employed in its collection. For some time past Dr. Bessey has been striving for the establishment of such an institution as the one proposed, and many petitions have been sent to the Government, but without receiving much more than a bare recognition, until, lately, the Joly Government offered ten acres of the Government farm at the Tanneries in perpetuity, but they had no money to put buildings thereon. More recently the Chapeau Government signified its willingness to vote a small annual subsidy, and also continue Mr. Joly's offer, provided the Dominion Government would build, or aid in putting up the necessary buildings. This was the subject of a letter to the Hon. J. H. Pope, the Minister of Agriculture, who replied that, while recognising the advantage of such an institution, there was no vote from which the sum of money could be furnished. In the meantime a new Premier and a new Government have come into power, to whom application would have to be made to ratify the offers of the two former Premiers; and while awaiting the action of the Government Dr. Bessey thought the Society, by concerted action, might do much, whereby a suitable building might be erected, and thus have the grant of land secured at any rate. Dr. Bessey submitted to the Society a plan of such an establishment as he thought would be desirable, which would call for an outlay of about five thousand dollars, to build, equip, and put in running condition.

*Discussion on Paper.*—Dr. Hingston stated that to the efforts of Dr. Bessey was very much due the removing of the strong opposition on the part of the French, by using animal virus in vaccinations; he, however, took exception to the view of Dr. Bessey in regard to the transmission of syphilis by vaccine lymph, which was believed to be impossible by some of the ablest men in Europe;

but, when such infection did occur, it was through the blood of the crust and not from the lymph.

Dr. Osler asked Dr. Bessey for definite figures as to the proportion of children vaccinated direct from the heifer and those from humanized vaccine. In regard to the absolute immunity of pure lymph he took it that Dr. Hingston meant that the syphilis is conveyed in the formed matter of the blood, and, if conveyed in the red blood corpuscles, why can it not be also carried in the white cells? Now it is a fact that you cannot get lymph without colorless corpuscles; if you take it ever so pure and clear it will be found to contain a few colorless cells, and as it gets older these multiply by taking nourishment from the lymph.

Dr. F. W. Campbell said that the Local Government should be conferred with to have an Order-in-council passed donating the land, and then the Dominion Government should be asked for a grant towards putting up the buildings. He thought it very important that a large stock of animal virus should be always obtainable, and he thought the Society should act with Dr. Bessey in this matter.

In reply, Dr. Bessey, said in the absence of positive records, he should judge that 50 per cent. of the cases were vaccinated from heifer lymph, and the remainder with early removes from healthy children. In reply to Dr. Hingston he held that the serosity of vaccine was quite capable of being the medium for conveying the syphilitic germs, as readily as a pus granule or blood corpuscle; it was as much a secretion of the body as was the saliva, the perspiration, or the seminal fluid, either of which, as has been frequently demonstrated, are capable of transmitting the syphilitic poison.

It was then moved by Dr. Hingston, and seconded by Dr. Campbell, and resolved: "That this Society desires to express its deep appreciation of the necessity that exists for a sufficient supply of reliable bovine vaccine lymph, and expresses its confidence in the purity of the supply afforded by Dr. Bessey during the past few years, and will hail with satisfaction any assistance the Local and General Governments may be pleased to afford in order to secure an efficient supply for the Dominion of Canada.

The matter was then referred to the Council to take action.

Dr. Hingston laid before the Society several "proofs" of a pamphlet now being printed for him, as a note-book on ovarian and other abdominal tumors. He said that those of Spencer Wells and

Hodges were more than complete in the matter of history, but incomplete in what related to diagnosis. While many diseases with which ovarian tumors might be confounded were to be found in the pamphlets of those writers, much had been omitted, and to supply these omissions was the purpose of the pamphlet. Dr. Hingston stated he had followed the arrangement by Hodges, had restored much of what had been omitted from Wells, and had supplemented, chiefly under the head of diagnosis, what was not to be found in the note-books of either.

## Progress of Medical Science.

### IMPROVED METHOD OF TREATING UTERINE DISPLACEMENTS.

By ROBERT BELL, M.D.

The peculiar posing of the uterus in the body, the elasticity, or rather yielding nature of its supports, and its dependence upon the health of the neighboring viscera for this support being uniformly maintained, renders it peculiarly liable to displacement. Anything which interferes with circulation in the pelvis will naturally interfere with the health of the womb, and will thus render it more susceptible of disease, and will predispose to malposition. If constipation exists, then the weight of the feces in the sigmoid flexure and the higher reaches of the colon will not only interfere with the free circulation in the pelvis, but will also, by mechanical pressure on the organ, crowd it out of position. If we have an irritable bladder, and in consequence of this the viscus being unable to retain more than a few drams of urine, the straining which accompanies micturition will force the uterus forwards. Another pregnant cause of displacement is dyspepsia, which, causing distention of the intestinal canal, brings undue pressure to bear from above upon the fundus. One more powerful factor has recently been pointed out, viz., the endeavor to obtain greater compass and volume in singing by powerful action of the abdominal muscles, and so forcing downwards all the viscera. It is obvious that any causes such as those enumerated must be removed before local remedies can have the desired effect. It will also be necessary to attend to the health of the canal of the neck and body of the organ at the time the displacement is being tackled, or we will be most certainly disappointed.

I have had this remedy as it now stands in use about two years, and have treated over 200 cases by means of it alone. I have not used a pessary during the past 18 months. Every form and gradation of displacement has come under observation, and in every case great relief was obtained, and in the majority of cases a complete cure was

the result. The patient requires to be under careful and patient observation for weeks in every case, and in many instances for months at a time; but surely these are trifling objections. I had used, for years previously, the ordinary glycerine of tannin of the pharmacopœia; but though I found it a most efficacious astringent, yet its expense and the disadvantage of staining the underclothing told very much against it. Had recourse to the following:—Glycerine, 80 oz.; alum, 10 oz.; carbolic acid,  $1\frac{1}{4}$  oz. If a displacement continues for any length of time, hypertrophy of some portion or of the whole organ is the result. We have thus a greater strain thrown upon the uterine supports, so that what at one time was a result becomes a factor in aggravating the disease. Our first duty, then, is to endeavor to reduce the overgrowth, and at the same time prevent its recurrence by rectifying the position of the organ and retaining it *in situ*. When we have a hypertrophied condition of the walls of the uterus, in the majority of instances there is softening of the texture, so that a flabby condition results. In these cases it is a matter of little difficulty to restore the position of the organ, but as soon as the support is removed it falls back into its abnormal position. Moreover, if there exists (which frequently does) any amount of inflammatory action, the presence of a pessary is a most serious source of danger; and besides, supposing there is no danger of an attack of acute metritis, there yet remains the disadvantage that the relief is entirely due to the fact of a mechanical support being retained in the vagina, and which every little while requires to be removed to make way for one of larger size, till in the course of a short time the walls of the vagina become as capacious as the pelvis will admit of; moreover, the woman always retains the disagreeable consciousness that she is wearing an instrument, and there is ever present the danger of the hard pessary injuring the soft parts upon which it is constantly resting. A pessary to be of service must fit accurately, and only long experience and patient care will ensure this result. If it does not apply itself with precision to the parts, it certainly will result in serious mischief. One advantage of my treatment is, that it is rarely necessary to employ either probe or elevator when there is a flexion. This is another prolific source of danger removed.

Prolapse of the uterus: This may vary from a slight lowering of the position of the womb to complete procidentia. It is due either to (1) an increase in weight of the organ; (2) to faulty action of the supports; (3) it may arise from pressure from above, or from all these factors combined.

A lacerated perinæum must of course be rectified before treatment. From whatever cause prolapse occurs, there is always, as a result, hypertrophy of the organ and relaxation of the vaginal walls and uterine ligaments. If the uterus, then, is elevated to its normal position, and retained there by a suitable appliance, the hypertrophy will disappear,

and if at the same time we can stimulate the capillary circulation of the parts, and also cause a steady drain to take place of the watery constituents of the blood in the uterus and its neighborhood, we will do much to remove the tendency to the displacement by reducing the size of the organ and simultaneously strengthening its supports. This end is attained most satisfactorily by replacing the prolapsed uterus in its normal position, and retaining it there by a tampon of cotton saturated with the glycerine of alum and carbolic acid, and allowing this to remain in the vagina from 3 to 4 days. The tampon excites an abundant water discharge from the vagina, necessitating the patient constantly to wear a napkin. Glycerine excites this discharge, but when combined with an astringent, the effect is an even more profuse drainage of the watery components of the blood; the effect on the capillary circulation is also intensified, and the astringent effect on the vaginal wall is most beneficial. By this means alone I have completely cured procidentia which existed 3 to 8 years, after above treatment had been persevered in for from 2 to 7 months, and in a few cases where the disease existed for a much greater time very great relief has been experienced after more protracted treatment. If the tampon is merely saturated with glycerine it becomes very offensive after a few hours; when, however, the carbolic acid is added, there is no foetor at the end of four days, when the tampon may be replaced. We can keep the organ *in situ* for months, and likewise act on it and the neighboring tissues to restore them to a healthy condition, the woman's general condition indicating a marked improvement. I claim for this method of treatment equal advantages with any plastic operation that may be performed upon the vaginal walls; and there is this, that the uterus itself also probably partakes of benefits which an operation on the vaginal walls cannot confer.

Versions and flexions of the uterus: I have treated quite a number of cases which had been subjected to the general routine of pessaries and stems without deriving any benefit whatever, and which have, after a few applications of the tampon, expressed themselves as feeling great relief. It may perhaps be interesting to give one case. This lady had been suffering from retroflexion of the uterus for six years, which was aggravated very much by obstinate constipation, but this symptom had been quite overlooked. She was a most miserable-looking object, with an ashy complexion, which, however, was partly attributable to the absorption of foetid matter from faecal accumulations in the rectum and colon, as when these masses were removed and kept from accumulating, her complexion improved, and she felt somewhat relieved in every way. Yet the least exertion completely prostrated her, and the dysmenorrhœa was most intense. For six years she had been under treatment by means of pessaries and stems of all descriptions, from solid silver stems down to pessaries made of gutta-percha covering copper

wire, and with no benefit; in fact, she was daily getting worse. In this case I used *two* tampons saturated with the solution, one much smaller than the other, so that it would occupy a position supporting the fundus, well up in Douglas's pouch, while the other and larger tampon was placed behind the cervix, and acted as a support to the smaller. After three months she was able to endure considerable fatigue, and eat and digest satisfactorily, and sleep well, feats she could not perform before; and at this moment I know she enjoys life thoroughly.

I think it often a good plan to employ two tampons in retroflexion and also in anteflexion, but, as a rule, one answers all the purpose. It is gratifying to observe the speedy effect of this treatment on the bladder symptoms in anteversion and anteflexion. I think I need hardly enter into further details as to the method of treating other varieties of displacements.—*Edinburgh Med. Jour.*

#### THE TREATMENT OF STRAINS AND SPRAINS BY COLLODION.

By A. N. BLODGETT, M.D.

Physicians are called upon to treat a great number of injuries to the joints in which there is no discoverable fracture or dislocation, but which are considered to be partial dislocations of the less mobile articulations, accompanied by more or less extensive rupture or laceration of the ligaments about the articulating surfaces, with some degree of effusion into the cavity of the joint, and often a very considerable amount of hemorrhage and suggillation in the neighboring soft tissues. The nature of the injury makes its recovery a gradual process, the tissues involved are often those in which reparative operations are carried on slowly; the external swelling and the effusion into the articulating cavities are both mechanical hindrances to recovery, so that healing of the lesion can hardly be looked for until they have subsided. Added to this is the fact that the most frequent seat of this class of injuries is some joint in the articulations of the ankle or foot, and we have in the location of the accident, perhaps, the most important obstacle to a speedy recovery from the injury. There are but few persons who so completely follow advice as to grant the injured limb freedom from use, for most people will persist in a certain amount of walking with the injured foot under any circumstances. It is often impossible to convince the patient that it is necessary to favor a *strained* joint for the same reason that it is necessary in a dislocated one. Oftentimes the difference between a strain and a dislocation is simply one of degree.

In the winter of 1878 I sprained my own ankle, and within the usual time found the parts all about much swollen, the pain considerable, and disability nearly complete. I tried to adjust a bandage, but

succeeded only indifferently well, for at the best it would not do what was necessary, and was not easy to retain in place. Treatment by evaporating lotions was so troublesome to me that I soon discontinued all measures of that sort.

I was resigning myself to let the sprain take care of itself, when it occurred to me that the application of collodion, so prepared that it would contract in drying, might be of some service. I made the trial, and was surprised and pleased at the result. For a few minutes no appreciable effect seem to follow, but after several coatings there commenced a contraction of the whole layer of collodion from all directions at once, to a much greater degree and in a much more efficient manner than any bandage could possibly effect. The contractile power of the collodion was so great that it seemed as if it would divide the skin at the border of the film. Some of the hairs around the ankle were accidentally included in the collodion film, and were so violently pulled upon that several of them were actually drawn out of the skin. The discomfort attending the contraction of the collodion subsided in a short time, and gave way to a feeling of coolness in the ankle and relief from the pain. The skin became drawn into wrinkles in all possible directions, with a positive and marked diminution in the measurements of the ankle, due to the decrease in the effusion in and about the injured part. After some hours the collodion film cracked in many directions, thus becoming divided into small scales, which I picked off. The skin was not in the least irritated or inflamed by the application. Another fresh coating consisting of several layers of collodion was at once applied before putting the foot to the floor, and the same powerful contraction and a similar diminution of the swelling was effected as at first. In the short space of three days the ankle was restored to its original size, and there was a total absence of pain and tenderness in the joint. I was able to walk without pain, unless the foot was set upon some inequality in the ground, when the strained place of course became painful. In a week I found myself quite well, and have never had a relapse, which I consider the more remarkable as I am not particularly careful, and am upon my feet a great deal.

[Here Dr. Blodgett cites eight cases successfully treated by collodion.]

The uniform result which followed the use of contractile collodion in these few cases seems to me a sufficient reason for desiring to call the attention of the profession to this method of treating strains and sprains, particularly in and about the ankle. These cases may be supposed to represent the majority of such injuries as they present themselves in daily practice, and I consider them without doubt to be such as would otherwise have been a source of trouble for weeks, as is usual under ordinary conditions. The treatment by contractile collodion greatly accelerated the recovery, besides restoring to the injured parts an

almost perfect immunity from relapse, which is the exception in the healing of strains and sprains.

I do not remember ever to have heard of the use of contractile collodion in the treatment of sprains, and I have never known of its being employed by any person for this purpose previous to the injury which I sustained in my own ankle. This was my first experience in its use, and the result was so satisfactory that I have employed it in all appropriate cases occurring in my practice since that time. In each case its action has caused great surprise to the patient, and the treatment thus far is perfectly satisfactory. I do not know any objection to its use, either from its composition or from its retracting power. It seldom causes any irritation of the skin, it does not interfere with the circulation, it never endangers sloughing. The fact seemed to me quite remarkable that, although the contraction was very powerful around the ankle, there was never any puffiness or swelling about the toes or any part beyond the ankle. I do not think a bandage could possibly be applied so as to exercise a similar compression upon the parts beneath without occasioning swelling of the parts beyond the bandage.

The adaptability of this mode of treatment to cases requiring the application of cooling or evaporating lotions is also of great advantage. The refrigerant is applied directly to the points where such an action is most desirable, and exercises its full force in the way of reducing the temperature of the part, and yet it does not absolutely touch the skin. The result of the protection to the skin is, that the effect of a *dry* cold is obtained instead of a *wet, chilling* cold. The skin does not become macerated and soggy from the action of the cold application, and the sensation of the patient is much more comfortable, not to say agreeable, than from the *contact* of a refrigerating application. Indeed, the film of collodion is so admirable a conductor of heat that I have seen the temperature in a sprained ankle become reduced from this alone, when I am convinced that without the collodion film an evaporating lotion would have been indispensable in the local treatment of the injury. The skin is not thickly covered as by a bandage, but a thin transparent film is spread evenly over its surface, through which every symptom in the injured part can be distinctly and clearly recognized and every shade of color in the skin be plainly discerned. After some hours the film already applied becomes cracked in the lines of its wrinkles, when it may be easily peeled off and a new film immediately applied to the same spot, by which all the benefit of a new, fresh compression of the parts is at once obtained.

The treatment may be continued indefinitely. Before applying the collodion it is advisable to gently wash the part to be treated with soap, in order to remove any oily or greasy matter from the skin. These substances might decompose beneath the film and irritate the skin, and they might also prevent the collodion from adhering perfectly in

every part. It is desirable to avoid both these contingencies, and for these reasons I always wash the ankle and dry it carefully by pressing a towel upon it *without rubbing*, by which the moisture can be completely removed, when the collodion may be at once applied. Each additional coat of collodion strengthens the layers already applied, thus acting with a cumulative power in compressing the part and reducing effusion about the seat of injury.

Among the advantages of this mode of treatment are, briefly, prolonged elastic compression in parts notoriously difficult to bandage properly; waterproof protection to the skin from external irritants or applications; hermetical sealing up of wounds in the region of the strain or sprain; constant access to the part without the removal of dressings; an uninterrupted view of every part of the injured limb; reduction of heat in the tissues; great acceleration of the process of healing with perfect restoration of function; a great degree of immunity from relapse; and absolute simplicity in application.

So far as my limited experience warrants an opinion of collodion in the treatment of strains and sprains, I am inclined to consider it by far the best, simplest, and most satisfactory method I have ever known, and I am confident that others will obtain equally pleasurable results in similar cases. I think it more than probable that collodion may prove valuable in the treatment of certain other diseased conditions, upon which I trust to be able to communicate some observations at a future time. The degree of contraction depends much upon the quality of collodion employed. There is a *flexible* collodion which contains castor oil; this does not contract at all, or but very slightly, and will not do the work. The so-called "*contractile* collodion" must be employed for this purpose. It yields uniform and satisfactory results, and is quite durable. It is very volatile, and should be kept stoppered, and when being used the finger should be tightly applied to the mouth of the bottle. It is also liable to explode, from the ether it contains, if brought too near a flame, but is fully as safe as ether, and we all use this agent by day or by night without accident.

To obtain the contractile effect of collodion it is necessary to apply several coats successively, one upon the other. I think I have never applied less than six layers, which is easily accomplished, as the collodion dries very quickly, and a second coat can be applied almost as soon as the first is finished. If for any reason it should become desirable to remove that which has been applied, this can readily be done by means of a small quantity of ether, which dissolves the collodion with great readiness. This will hardly be necessary, as the collodion, even if applied to a part where it were not required, causes at most only a slight inconvenience, but no great pain, and is not productive of dangerous results.—*Boston Medical and Surgical Journal*.

## CAPILLARY BRONCHITIS.

By JOHN G. SKELTON, M.D.,

late Lecturer on Obstetrics and Diseases of Women and  
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Richmond, Va.

I propose to confine our attention to the acute form of bronchitis, as it prevails through the period between earliest infancy and the fifth year of age. In this form and during this period of life, whether we regard the frequency of occurrence, the important structures involved, or the intensity of suffering and the degree of danger which it may attain, acute bronchitis claims an importance second to no other disease of childhood, and its earliest symptoms should be watched with great care. The most common termination of cold thus contracted is favorable, and the conservative powers of the system may prove adequate to carry the little invalid safely through, notwithstanding neglect, and without the aid of medicine; but the wiser course is to watch these milder symptoms, lest they become more serious, and we have to apprehend those results which sometimes follow the extension of inflammation from its most common situation in the larger bronchial tubes to their capillary extremities, and thus involve the lobules and air vesicles of the lungs.

Acute bronchitis may be primary or idiopathic, or secondary, such as occurs in the exanthemata and certain blood diseases. Mechanical, as by minerals, etc.; and epidemic, as in influenza and catarrhal fevers, etc.

The *rational symptoms* are sometimes preceded by irritation or inflammation of the lining membrane of the nose, larynx, pharynx, trachea, successively, the bronchial tubes sooner or later taking on inflammatory action; or these tubes may become at once inflamed without such continuity with the surfaces above. Symptoms of invasion may be observed, such as languor and general debility, morbid sensitiveness to temperature, muscular pains about the head, back, and limbs.

The *local symptoms*, after the period of invasion has passed over, become more or less intense, as sensations of burning or soreness on inspiration behind the sternum and along the sides, headache—general or frontal—becomes more acute, etc. The dyspnoea, not always distressing at first, becomes more oppressive later in the attack—this symptom being more grave in the child at the breast, because of the difficulty in receiving food, and is aggravated when there is coincident irritation of the nostrils with free secretion. Cough is not painful, but always a prominent symptom. This, at first, is dry and hoarse, until the second or third day, when the mucous secretion is established, which is at first thin, transparent, and more or less frothy, but soon becomes somewhat viscid and tenacious, assuming changes in color—yellowish or greenish. This becomes in a few days of an opaque, muco-purulent character, mixed with epithelial cells, ciliated cells, and sometimes with blood. These changes in secretion are difficult to

observe in children under five years old, who do not expectorate; but the matter may be caught or noticed if ejected from the stomach by vomiting. In mild cases the temperature is but little higher than normal, and in quite severe attacks does not rise so high as in pneumonia— $102^{\circ}$  F. being quite high for bronchitis. This feature of temperature is important in making out the diagnosis between bronchitis and pneumonia, and also some of the exanthemata before those are well developed. The attending fever is remittent, the paroxysms being higher in the evening and early night. The functions of digestion are generally effected, the secretions being suppressed, the appetite impaired and the bowels constipated. The skin is easily kept moist by warmth and diaphoretics. The tongue is moist in the milder cases, with moderate coating of white fur. Thirst is generally well marked. Nausea not often occurs. The secretion of urine is diminished in quantity somewhat, in accordance with the severity of attack, and in a varying degree is colored by the urates. The respiration is, in moderate cases, always more frequent, reaching thirty-five per minute, but varies with the degree of violence and character of the tubes involved, until, in the capillary form, it is attended with alarming anxiety, and is only accomplished with great labor.

This capillary form may come on at once, but generally succeeds the ordinary acute form. Besides the difficulty of respiration, this is recognized by signs of obstructed circulation—the imperfect decarbonization of blood causing darkness and lividity of complexion. In the onset of inflammation of the capillary vessels, we have pyrexia, but a very high temperature is not reached, perhaps  $102^{\circ}$  F. The rapidity of circulation and respiration is very great. The pulsations are as rapid as 150 a minute, while the respirations are 50 or 60 or 70 or even 100 in the same period. The warmth of surface becomes abated; and, if the condition proves progressive, coldness of the extremities and face with increasing cyanosis, is soon accompanied by a change in the child's manner—restlessness giving way to indifference, and sleeplessness to drowsiness; this running into stupor, with still shorter respirations and more rapid, feeble pulsations, with convulsions to close the scene.

*Broncho-pneumonia.*—Lobular pneumonia may occur in the course of acute bronchitis, and particularly if it assumes the capillary form—the clusters of collapsed lobules, with their connective tissue, becoming involved in inflammation. The condition is better expressed by the term *broncho-pneumonia*, as it includes a variable condition of bronchitis and vesicular pneumonia. The pneumonic consolidation exists in nodules the size of a pea and larger, scattered about through tracks of air containing tissue, which coalesce to form larger tracks. It will be found to prevail simultaneously in both lungs. It is more likely to be developed

in that kind of capillary bronchitis which attends influenza, measles, whooping-cough, etc.

When inflammation in this way extends to the parenchyma of the lungs, the most prominent symptom, perhaps, is the increase of temperature, as in lobar pneumonia, reaching very soon  $104^{\circ}$  or  $105^{\circ}$  F. There is observed also less regularity and remission in the paroxysms of fever. The rapidity of respiration is increased, and becomes as frequent as 100 and more per minute, the action of accessory muscles in respiration being violent, raising up the superior chest, while the diaphragm draws in the lower portion. The action of the *alæ nasi* is conspicuous. The cough becomes more painful.

The secretion from the bronchial tubes is diminished, and, if it can be examined, will be found to be more tenacious and rusty-colored, or containing streaks of blood. The power necessary for inspiration and expiration is comparatively less in the child than in the adult, in consequence of the soft and yielding character of the bony structure of the chest. It follows that in broncho-pneumonia, as in capillary bronchitis with collapse, the muscular strength is sooner exhausted, when mechanical obstacles impede respiration.

*Physical signs and diagnosis.*—The *anatomical changes* which are of most importance in acute bronchitis, in respect to the physical signs are thickening and swelling of the walls of the bronchial tubes, the liquids contained in these tubes, the quantity of liquid present, and the obstruction afforded to the removal of such liquids.

As a general rule, resonance on percussion is little affected in cases of ordinary degree of extent. Auscultation reveals at first only dry sounds, the sibilant and sonorous râles being heard singly or simultaneously over the chest, according to the extent and portions of the tubes involved, the tenacity and quantity of the liquid adhering to the tubes, and the thickening and diminished calibre of the same. These dry râles cannot be too much relied upon in diagnosis, as they may arise from spasm of the same tubes, as occurs in asthma. When, in a few days, the secretion from the mucous coat is well established, these dry sounds in bronchitis are mixed up or superseded by other râles, which are moist or bubbling. These moist râles also vary, according to the size of the tubes, the density of liquids and amount contained, being coarser in the larger tubes and finer in the smaller bronchial branches. The finest of these moist râles concerned in bronchitis is that called the *subcrepitant*, which has its origin in the smaller ramifications of the tubes before entering the lobules. This subcrepitant râle is the nearest approach to the *crepitant* râle, which takes place in the vesicles themselves, and is caused by the separation of their walls on inspiration.

The moist sounds, like the dry, may fail in differential diagnosis, as they may originate in other liquids than mucus, as from *blood*, serum, etc. The subcrepitant râle indicates the presence



of liquid in the finer bronchial tubes, but is not confined to bronchitis, occurring also in pneumonia, in œdema of the lungs, in phthisis and pulmonary apoplexy. In bronchitis the liquid which causes the subcrepitan sound is mucus; and, like all the other râles, dry and moist, is heard, in bronchitis, on both sides of the chest, when it is primary or idiopathic. Importance is due to the location in which these several sounds are heard. If confined to the middle third of the lung, it may be inferred that the larger tubes are involved; if to the upper and lower third, that the smaller tubes are also engaged. The respiratory murmur may be occasionally obscured, and renewed, after coughing, by the removal of obstructing mucus. Resonance, on percussion, enables us to distinguish *bronchitis* from *pneumonia* and *pleurisy*, as flatness attends both of the latter on one or both sides. In pneumonia we have the crepitan râle and dull pain in the affected side. In pleurisy, we have sharp pain, and also the friction sounds. Between pneumonia and the capillary form, we may distinguish the crepitan râle of the former, on inspiration, from the subcrepitan, which is common to the expiring and the inspiring act.

Pneumonia is ushered in by a severe chill; the temperature, after reaction, is much higher; the cough is not so sharp and frequent; expectorated matter is rusty-colored; redness of the cheek is characteristic, and there is not the cyanotic hue. In pneumonia, on physical examination, besides dullness, we find increased vocal resonance and fremitus and bronchial or tubular respiration. Bronchitis may so resemble whooping-cough, that, for the first three weeks, it may be hard to make out a differential diagnosis. The means which may avail consist in the sudden paroxysms of cough, with readiness to vomit; flushing and swelling of face during the paroxysms of cough, until the characteristic whoop will decide. Diagnosis is the more difficult between these two, because bronchitis is so constantly attendant upon whooping-cough, to some degree, in the beginning.

*Morbid anatomy.* A variable degree of redness, according to the degree of severity and extension of the attack, is observed over the mucous membrane. This is not so often seen in the smaller tubes as in those of larger and medium size. Thickening and softening of the walls of the tubes is found with a deposit of muco-purulent secretion. After severe and protracted attacks, the tubes are dilated somewhat irregularly, representing cavities or sacs of various dimensions.

If broncho-pneumonia has been developed, we find hard patches of lung of red or gray color, corresponding with the lobules and terminating branches of particular bronchial tubes, these patches having so coalesced as to make spaces so large as to resemble lobar-pneumonia. They contain *pus*, distributed through the affected parts in soft and yellow spots. When pulmonary collapse has only occurred, the condition is different. In pulmonary collapse the vesicles have been cut

off from access of the air by contraction of the thickening bronchial tubes, and by fluids in excessive quantity, or by adhesive lumps of partly inspissated matter in the smaller branches, until the residual air, being entirely exhausted in them, their walls have fallen together. The lobules containing the air vesicles are found shrunken in dimensions, violet colored, and heavy; so that, when detached from the healthy tissue, they sink in water. The pleura covering these is healthy. If air is forced into the bronchial tubes leading to such lobular mass, they become promptly distended, and resume their dimensions and relations to the adjoining tissue. The posterior surfaces of the lobes and their margins, being the most remote from the centre of the lungs, are found to be the situation in which most collapse has taken place.

*Prognosis.* Primary, simple bronchitis is comparatively free from danger, if not neglected, even in very young infants. In this form, and in the secondary forms, the mildest case may resist all treatment; and the patient may become embarrassed with apneumotosis, and the dangers which result from capillary inflammation, collapse of lobules, or from broncho-pneumonia. Delicacy of constitution and epidemic influences may contribute to this result. The irritability of system, during the period of dentition, may also lend unfavorable influences. The character of primary diseases, which become complicated with bronchitis, will also help to determine the extent and severity of its effects. Every symptom diagnostic of collapse or lobular pneumonia is unfavorable.

*Treatment.* In the milder forms of bronchitis a strict adherence to suitable hygienic measures will most frequently comprise all the treatment necessary to avert danger, but a compliance with such course cannot often be obtained. Strict confinement to the cradle or the bed should be the rule. The air and temperature of the apartment is of great importance. The purity of air should be carefully regarded and proper ventilation secured. Dryness of air, where stoves are used, can be avoided by means of the evaporation of water. A temperature ranging from 65° to 70° should be maintained. The cradle or bed and bed-clothes should be made to correspond with the object of perfect comfort, and as much uniformity of temperature as possible. The diet should be simple and digestible, the mother's milk, in such as are at the breast, being the standard. When active treatment becomes necessary this should be subordinate to the degree of inflammation, the febrile action, the strength of constitution, the idiosyncracies of the patient, and the relations which the attack may bear to those disorders which it may accompany. When ushered in by symptoms resembling croup an emetic of ipecac is always proper. After the action of this the relaxing expectorants are to be carefully adapted to the establishment of secretion along the bronchial tubes.

The warm bath will promote diaphoresis, reduce

febrile heat, compose the nervous system, and equalize the circulation. The warm foot-bath, throughout every stage, is valuable, and may be improved sometimes by the addition of mustard. As expectorants in the early stages, ipecac and squills, in the form of syrups, are often found suitable. Senega, in syrup or by infusion with liquorice, may be chosen in some cases. Along with these demulcent infusions, as those of flaxseed, slippery elm, the bene leaf, etc., will be good adjuvants and serve to allay thirst, which is always more or less urgent. Small doses of the syrups mentioned, either alone or combined, may be given at intervals of two hours, according to the urgency of symptoms and the tolerance of the child. In the very young and delicate infant it is best to avoid making undue impression with even such mild agents, when the administration is left to anxious friends or unskillful nurses. We think tartar emetic unsafe, except in cases of great inflammatory action, and with the expectation of its use for only a limited time, and under the sanction of the physician. This precaution in the use of depressing agents is necessary throughout the course of this disease, but more particularly in the infant and in the advanced stages. In following out plain indications which may be present at the time of our visit, to subdue excessive arterial action, we may overlook one principal feature in the character of bronchitis in children—that unfavorable terminations are most apt to occur in connection with debility. With the mild expectorants and diaphoretics, early in this affection, opium in some form may be proper. If feverish condition is obstinately kept up, with evidence of progress in the extent of inflammation, within the first few days, we have a more safe antiphlogistic remedy than tartar emetic in the combination of calomel with ipecac or Dover's powder. We prefer these when the paroxysms of fever are strong, the tongue furred, the skin unusually warm, the cough dry and attended with pain, and when the milder remedies have failed. The condition of the bowels, the degree of pain and of restlessness will govern us in deciding between the ipecac and Dover's powder. To a child two years old, half a grain of calomel may be given, in combination with one of the other medicines in corresponding dose, every two hours until the amount of a purgative dose has been taken. After satisfactory action on the secretions by the calomel, if feverish symptoms continue, the expectorants before mentioned may be used, with the addition of bicarbonate of potash. For example, for a child two years old:

℞. Potass. bicarbonat..... ℥ij.  
 Syr. scillæ simp.....  
 Syr. ipecac.....aa f ʒ j.  
 Spirit. ether nitroc..... f ʒ ss.  
 Syr. acaciæ..... f ʒ ss.  
 Aq. distillat. q. s. ad..... f ʒ iij.

*M. S.*—One teaspoonful every two hours.

We attach much importance to the use of bicarbonate of potash during the feverish stages. If the state of the skin, the temperature, the pulse and respiration show no abatement of symptoms, there may be added to each dose of the above mixture one drop of tincture of veratrum viride until its influence has been observed on the frequency of the pulse. We have found the veratrum viride to be the most safe and sure sedative to diminish the action of the heart in bronchitis and pneumonia. The attending fever is remittent, and paroxysms are periodical, being more so when malarial influences abound and when catarrhal fevers prevail.

This circumstance is suggestive of quinine. But, although we do regard this therapeutical application of quinine, we do not limit its influence to that of a simple antiperiodic, nor to that of an antipyretic. We think, through its action on the vasomotor nerves, it lessens the tendency to congestion, which inclines to the development of capillary bronchitis and broncho-pneumonia. Quinine proves antagonistic to malarial influences, which keep up fever and add to the general debility. It may be given to the amount of several grains each day, in broken doses, along with the other remedies—diaphoretics and expectorants—the latter being withdrawn when contra-indicated. The quinine may be either continued alone to favor convalescence, or we conjoin it under other circumstances with carbonate of ammonia or senega to promote expectoration of secretion too freely established. Bronchitis may require care such as we have detailed for one week or for a fortnight without dangerous symptoms threatening, and, in secondary cases, longer, according to prior affection.

We have had care in regard to the liability, at any time, to the occurrence of the capillary form, and to lobular pneumonia. As soon as treatment is first indicated, we advise mild rubefacients to the surface of the chest, and continue them, in varied forms, according to indications, using "camphor liniment" with flannel, and this with variable proportions of spirits turpentine or the aqua ammonia. As soon, in the progress of the complaint, as we see symptoms suggestive of unsafe degree of congestion or collapse, we prefer fermentations to the chest. Flaxseed or other poultices, or flannels wrung out of warm water, spongio piline, etc., all covered with oiled silk, and kept in position carefully with a bandage. Our favorite mode is in the corn-meal mush, made of proper consistence by boiling, and spread on and enveloped in linen, and bound in the bandage carefully around the chest. To the mush thus applied is added red pepper or mustard in small proportions, say one teaspoonful of either one to a four-ounce cupful of the poultice, this being intended to gently stimulate the exhalants to increased action, and maintain capillary circulation on the surface. We do not approve of blisters, except under peculiar circumstances, and then only to rouse up reaction when other means have failed.

When collapse of the air vessels has taken place, and the circulation is feeble, the skin pale and cool, the difficulty of breathing extreme and asphyxia threatened, and the case is desperate, without quick aid from new resources, we would look to oxygen gas with great hope. It has been suggested that an increase of oxygen in the air might be affected by burning chlorate of potash on live coals in the room with the patient, but a more satisfactory mode would be to manufacture the pure gas, and administer by means of a gas bag. The imperfect decarbonization of the blood may thus be corrected until other means can be brought to bear favorably on the chances of the patient's life. In more ordinary cases of bronchitis the inhalation of atomized fluids has been found convenient and useful. The vapor of water alone is often beneficial. This may be practised by means of a tin tube extending from the boiling kettle to the cradle of the patient.

Water, holding in solution those medicines which promote expectoration, or which render the vapor more agreeable, may be used by means of an atomizer. Camphor, carbolic acid, tolu, vinegar, muriate of ammonia, etc., have been used to great advantage.—*Virginia Medical Monthly.*

#### INTESTINAL OBSTRUCTION OF TWENTY-ONE DAYS' STANDING RELIEVED BY CARBONIC-ACID-GAS INJECTIONS.

Dr. Heustis, of Mobile, reports this remarkable case in the *Medical News* of June 3d. It is of great practical interest.

After a tedious labour, attended by an extensive perineal laceration, and followed by puerperal fever lasting three weeks, a severe colic attacked the patient. Anodynes relieved the pain, and after this various cathartics were ineffectually given; likewise enemata. Obstinate emesis came on, and on the second day stercoraceous vomiting occurred. Dr. Heustis continues as follows:

Seeing that it was a case of ileus, calomel and opium were given regularly (calomel, two and a half grains; opium, one grain) every two hours; but the opium had to be increased to two and a half grains, and sometimes given every hour when the distress was great. Warm poultices were kept on the belly, and large injections of soap and water, or ox-gall and water were used every day. The opium appearing to be too slow in its effect, a grain of morphia was substituted, and a quarter of a grain of extract of belladonna, with the *two and a half grains of calomel*, which was kept up every two hours while awake. She would generally get a little sleep at night, but was hardly ever free from pain, and almost every day a large quantity of stercoraceous matter was vomited. Notwithstanding this, the expression of countenance remained good and the belly soft. Before the coming on of an attack of stercoraceous vomiting there would be a

rumbling of the bowels; but instead of causing a desire to go to stool, there would be a reversed action and then the horrible vomiting.

No spot could be located as the seat of the obstruction; and though the same train of symptoms continued from day to day, the last resort of making an exploratory opening of the abdomen was postponed. Her dozen pills (of *thirty grains of calomel*, twelve of morphia, and three of belladonna extract) would last two or three days, sometimes not so long; but there was no appearance whatever of salivation.

On the seventeenth day it was determined to make an exploratory incision into the abdomen, but the gentlemen to assist could not be got together, and it was deferred until next day. Next morning her pulse and countenance were good, belly soft, free from any swelling; and the operation was deferred. Large injections containing ox-gall were forced through an india-rubber tube, eighteen inches up the rectum and colon, with a stomach pump, but nothing but the injection would come away. Quantities of melted lard were tried in the same manner, with the same result.

Having read of carbonic acid gas succeeding in such cases, I had the husband get one of the large siphon bottles, sold as seltzer water, fasten the India-rubber tube tightly on the spout, and after oiling it well and passing it far up into the bowel, turn on the seltzer. He did so in my absence, and when I saw her in the morning she declared that the gas came out of her mouth; she was sure of it for she tasted it distinctly. Still her bowels did not act, and she had another attack of stercoraceous vomiting next morning.

Her husband having got another quart bottle of seltzer I attended to the administration of it, passing the tube about eighteen inches up the bowel before turning on the gas. It made an noise like escaping steam as it passed into the bowels, and before the bottle was half empty the feces began to flow out; and when the flow stopped, the gas was turned on again, to be interrupted by more feces; and so it was kept up until the bottle was empty, and the bowels too, apparently, from the quantity passed.

After that her bowels acted every day, and she had no further trouble with them.

As the exact seat of the obstruction could not be ascertained, its cause remained doubtful. Possibly a band of adhesive lymph resulting from the recent attack of peritonitis might have pinched the bowel; but in such a case there would probably have been swelling and tension of the abdomen. In the absence of positive signs, it will be reasonable to assign a spasmodic contraction of the bowel as the cause; but why it should have continued so long, and not be relieved by such large quantities of morphia, is a mystery.

The elastic and pervading force of carbonic acid gas thrown far up into the colon would appear to be the readiest and best means of overcoming such obstructions.

## AN OBSTETRICAL PHENOMENON.—CRYING OF THE FETUS IN UTERO.

By A. HARLOW, M.D., Detroit, Mich.

The following case is sufficiently striking, I think, to warrant its publication, even at the risk of having my veracity called in question by doubting Thomases.

The lady to whom I was called moved in the humbler walks of life, and was about forty years of age and in her fifth confinement, eleven years having intervened since giving birth to her fourth child. I would state for reasons that may be apparent to the reader before closing this note, that another physician, one of high respectability and standing, had been previously called, but prior engagements preventing his attendance in time, I was summoned in his stead. Soon after my arrival, finding her pains rapidly increasing in severity and frequency, in absence of all female assistance, I helped my patient upon her seat, and from digital examination found the waters just gathering, and after one or two additional pains the membrane broke and the amniotic fluid quite flooded the bed. I had no difficulty in satisfactorily diagnosing the position, which I found to be a vertex presentation of the sixth variety, according to Baudelocque. Immediately after I had thus satisfied myself as to the nature and character of the presentation and before the labor had further progressed, and while the head was yet engaged in the superior strait, the child made two distinct audible screams that could be plainly heard in any part of the room. When this cry was first heard I was alone with the sick woman, and being greatly surprised at what I heard, gently passed my hand up the vagina and found the head still in the superior strait. Immediately following this cry of the foetus there was another free discharge of amniotic fluid. During the space of an hour or more before the arrival of female help to assist me, I made several ineffectual attempts to disengage from its fixed position, that it might be forced down the passage by the same uterine contractions that were regularly taking place, but with all my efforts and the assistance of nature, did not succeed in getting any descent of the head, and during this time the child had several spells of crying, the same as was heard at first, the tone and voice being unmistakably that of a child. Two or three elderly women coming in to sympathize and assist, as is usual on such occasions, I made little or no further attempts for one or two hours of hurrying on the labor. Satisfied there was no danger in the case, I did little but watch and wait for a time, to see what rest and nature would do where art and officiousness had apparently failed. During this apparent lull the pains did not entirely cease; and generally following each one the child would cry as before. At the first cry after the arrival of female help one old lady exclaimed in her joy:

"La me! the child is born."

"No, madam, the child is not born."

"You don't say, Doctor, that the child is not born, and crying, too?"

"Yes, madam, it has had spells ever since my arrival the same as you have just heard."

"Dear me!" was the exclamation of the good woman, and as soon as she could take a long breath, said, "and is not that strange?" and as a mark of veneration settled the matter by declaring that "with God there is nothing impossible."

Waiting as long as I thought it justifiable for the ineffectual contractions to disengage the head from its impacted position, I applied the forceps, and with suitable traction, accompanied with one or two good pains, delivered the woman of a large female child.

I saw my patient next day, and found her very comfortable and apparently doing well; her pulse was normal, no unusual heat or tenderness across abdomen, and was free from all pain. Finding her alone on this my second visit, and in a mood and condition for conversation, I took occasion to investigate her more fully relative to this curious phenomenon. She told me "the child first commenced crying four weeks before it was born, and kept it up at intervals till its birth, since which time it has not cried at all." This lady declared and persisted that she went four weeks over her regular time; that at the proper period for the birth of the child it commenced crying and kicking, as though, to use her own language, "it would come right through her ribs." At first, she said, she was greatly surprised and alarmed, but as this peculiar freak of nature continued without producing any particularly alarming symptoms, she became so accustomed to its frequent repetition that her alarm vanished. After many thanks from my patient for bringing her so safely through her perilous condition, I left after prescribing her favorite opening medicine, which she informed me on such occasions was castor oil, a little to be taken that evening at 9 o'clock, and if need be repeated next morning.

The following day I called according to promise, expecting to dismiss my patient from further medical attendance as intimated the day before; but to my surprise on calling according to appointment, found another doctor present, an occurrence, whether agreeable or otherwise, not altogether unknown to the medical profession. I learned that the woman had taken the oil as I directed the night before. About 1 o'clock a.m. she was taken with a pain in her stomach, and claiming that there was no messenger at hand who knew where I could be found in the night, sent for the gentleman I found present at his second visit. I was told that the woman had not only had no operation from the oil, but that medicine had been given to prevent any movement of the bowels. Without expressing myself pleased or displeased at the course taken, I left the patient in the hands of the physician first called, who could not attend in time to render relief. And

now, having no criticisms to make or animosity to gratify, I will only add that the lady died the next day. The child is living and doing well.

Deeming the above case an anomaly in obstetrical practice, having been an accoucheur for forty-six years without ever having met with one like it before, I have thought best to make a brief but truthful statement of the leading facts and circumstances.

To any doubting the facts stated, I can only say that I have reported my case accurately and truthfully in every particular, which I know to be so from personal knowledge.

[We have only to add by way of comment on the above that Dr. Harlow is well known to the profession of this city, and unless he was himself greatly deceived, which he assures was impossible under the circumstances, we here have a case which is, we believe, usually regarded as an impossible occurrence. Those who know Dr. Harlow will certainly not call his veracity into question.—*Ed. Mich. Med. News.*]

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## THE CANADA MEDICAL RECORD,

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### OBITUARY.

THE LATE AARON HART DAVID, M.D., EDIN.,  
L.R.C.S.E., D.C.L.

It is with deep sorrow that we have to announce the death of Aaron Hart David, M.D. Edin. L.R.C.S.E., D.C.L., Emeritus Professor of the Practice of Medicine and Dean of the Faculty of Medicine of the University of Bishop's College, which took place on the 5th of November, after a painful illness, extending over two years. In the summer of 1880 Dr. David, owing to failing health, resigned his chair of Practice of Medicine, and was elected Emeritus Professor, Dr. F. W. Campbell being appointed to the vacant chair. Owing to Dr. Campbell's having to visit Europe, Dr. David undertook to lecture the first half of the session of 1880-81, but he had hardly commenced his course, when it became evident that he was not equal to the task. With a determination and pluck

thoroughly characteristic of the man he stuck manfully to his work until Dr. Campbell's return, and on the 15th of November, 1880, gave his last lecture, Dr. Campbell entering upon his duties the following day. A few days subsequently a consultation of his medical friends was held, and the melancholy duty devolved upon them of informing him that he was suffering from cancer of the bowel about the sigmoid flexure, which diagnosis was confirmed by *Post Mortem*. The prognosis was guarded—but few thought to see his life extended full two years. During most of the time he was confined to the house, and was assiduously watched over by his professional friends, whose frequent calls made the tedium of his illness at least shorn of some of its trials. Several of his most intimate medical friends never, during all his illness, missed spending an hour or more with him every Sunday afternoon; and upon those occasions, from the abundant store-house of his knowledge, he gave out much that was interesting and important of the Medical history of Montreal since 1830. These meetings will, we believe, remain green in the memory of those who took part in them, so long as their life lasts. In August last he was obliged to take to bed, to which he was all but constantly confined till death closed his sufferings. Dr. David was born in Montreal on the 9th of October, 1812, and was the son of the late Samuel David, a retired merchant, who was Major in the 42nd Batt. Canadian Militia, and served with it during the war of 1812 with the United States—receiving the war medal. After getting a liberal education he was, in January, 1829, indentured, as was then required by law, to Dr. William Caldwell; and in the fall of the year he entered as a student of Medicine in the Medical Faculty of McGill College—then opening its first session. But four gentlemen of the class of that year still survive. In 1833 Dr. David proceeded to Edinburgh, and in 1835 he graduated at the University of Edinburgh, being 24th in honors in a class of 117 graduates. His Thesis was on "The Medico-Legal Proof of Infanticide."

After travelling a short time on the continent, Dr. David returned to his native city, and commenced the practice of his profession, marrying in the following year (1836). During the years 1837-9, Dr. David was assistant-surgeon of the "Montreal Rifles," and with it he served during the whole of the rebellion, being present with his regiment at the battle of St. Eustache.

In the year 1841 he removed with his family to the town of Three Rivers, where he soon got into a large and lucrative practice. It was while an honored resident of that town that Dr. David was several times requested to run for the constituency, but invariably declined the proffered honor, preferring to adhere to his chosen profession than to enter the political arena. In 1844 he returned to Montreal, and recommenced practice, which he continued up till two years ago, when his illness compelled him to give it up.

In 1852, in conjunction with the late Drs. R. L. Macdonnell, F. C. T. Arnold, and Drs. G. E. Fenwick and R. P. Howard, he assisted in organizing the St. Lawrence School of Medicine, and acted as its Secretary. This school only delivered one course of lectures, when some seventeen students attended. It was closed simply because, being a school, its students could not receive a degree, and would have had to go elsewhere for that honor, while those who might have been satisfied with a simple license to practice medicine would have had to present themselves for examination before the College of Physicians and Surgeons, on which Board their opponents held powerful sway.

In the same year (1852), in conjunction with the late Dr. R. L. Macdonnell, he started and edited *The Canada Medical Journal*, which, for want of support, was discontinued after one volume had appeared. During the building of the Victoria Bridge Dr. David was one of the physicians to the contractors; he was, from 1847 to its being done away with by Government, Secretary to the Central Board of Health, and a physician from May, 1849, to December, 1851, to the Montreal General Hospital; and from December, same year (1851), until it was merged into the present Hotel Dieu Hospital, physician and clinical lecturer in medicine to the St. Patrick's Hospital. In 1870 he, with the late respected Dr. Smallwood and Drs. Hingston, F. W. Campbell, Trenholme, Leprohon, Godfrey, Kennedy, Gardner and Kollmyer, started a new school of medicine, which became the present flourishing Medical Faculty of Bishop's College. He became Dean in 1870, and from the first session filled the chair of Theory and Practice of Medicine, which post he retained up to two years ago, when he was elected Emeritus Professor. In 1871 he received the degrees of M.D. (*ad eundem*) and D.C.L. *honoris causa* from his University, and in 1881 the Faculty of which he was the head founded in his honor the "David

Scholarship," which is given "to the student who obtains the highest number of marks in the primary examinations, and consists of one full course of the final branches delivered at the college," thereby perpetuating his name with the college he worked so hard for in his later years.

Dr. David was one of the original members of the Canadian Medical Association, and in 1869 was elected its General Secretary. He filled the duties of that office till 1881, when failing health compelled him to resign. His urbanity and general business knowledge were of great use to the Association, and there were but few who did not miss his amiable face, when in 1881 the Association met for the first time without him—Years ago he was a Governor and Secretary of the College of Physicians and Surgeons, and since 1878 he was one of the representatives on this Board from his own Faculty.

In 1867 he joined the 6th Battalion of active militia in this city—now that splendid corps the 6th Fusiliers—as surgeon, which post he resigned in July, 1878. During his tenure of this post he served on the frontier during the Fenian Raid of 1870, and was principal medical officer of the Brigade during the march from St. Johns to Pigeon Hill and return, on 26th May, in that year, and during the time it did duty at St. Johns. Again, in 1871, he held the same position whilst with his regiment at Laprairie Camp, and in 1872, at the camp at St. Andrew's. He also served with his regiment in this city at various times in aid of civil power, notably the burial of Guibord, and the Orange troubles at the time of Hackett's death and resigning his rank of surgeon he was granted the honorary rank of lieutenant-colonel in the militia for long and faithful services of forty-six years.

Dr. David contributed at various times to the Medical Journals of this city, and his articles were thoughtful compositions, for he was an earnest student of his profession. Our October number contained his last contribution, and as a record of past events, which no other pen could give, it is very valuable. Written during a period of much suffering, its preparation during his last moments was but another illustration of that indomitable pluck which was so characteristic of the man.

Dr. David had been President of the Natural History Society of this city, besides holding other offices in the same Society, and at the time of his death was a life member thereof, elected September,

1859; also a trustee or warden of the Portuguese Congregation of Jews Synagogue in this city, in which congregation he has one time or another held every office it were possible for a layman to hold.

Among others he held the following degrees and offices:—Life member Natural History Society; member by diploma, 1833, Medical Society of Montreal; licentiate Royal College Surgeons, Edinburgh, Scotland; extraordinary member Medical Society of Edinburgh; graduate University Lying-in-Hospital of James VI. College, Edinburgh (diploma); Doctor of Medicine (M.D.) James VI. College of University of Edinburgh, Scotland; *commissioned* to practice as a physician, surgeon and *man-midwife*, signed by Earl of Gosford, Governor-General of Canada, 4th January, 1836; corresponding member Literary and Historical Society of Quebec; licentiate College Physicians and Surgeons of Lower Canada; member Canadian Medical Association, 1868, and General Secretary thereof from 1869 to 1881; corresponding member Gynæcological Society of Boston, Mass.; Governor of the College of Physicians and Surgeons, Lower Canada; honorary member American Medical Association of the United States, 1880.

Among the entire profession he was much beloved and looked up to as a man of the most sterling honor. It was a common saying, no one ever knew David to do a mean and disreputable act towards a brother practitioner. To the young men of the profession he was ever exceedingly kind, and although a fiery medico-politician, those he fought most bitterly loved him the best. As our contemporary the *Canada Medical and Surgical Journal* says: "He lived a busy and useful life, and he died at a good old age respected and honored by all."

His funeral took place on 8th inst., and was one of the largest Montreal has seen. The pall-bearers were Dr. R. P. Howard, Dean of McGill Medical Faculty; Dr. Rottot, Dean of Laval Medical Faculty; Dr. Dorsonnens, Dean of Victoria Medical Faculty; Dr. F. W. Campbell, Acting Dean Bishop's College Medical Faculty; Dr. Robillard representing the College of Physicians and Surgeons of the Province of Quebec; and Dr. Henry Howard, representing the general Medical profession.

At a meeting of the Medico-Chirurgical Society of Montreal, held on Friday evening, the 17th inst., the following resolution was passed unanimously

—"Resolved, That the Medico-Chirurgical Society of Montreal deeply regret the death of A. H. David, M.A., M.D., Dean of the Faculty of Medicine of Bishop's College, and formerly a member of this Society. Always highly esteemed and respected by his brother practitioners for his many sterling qualities and honest bearing towards them, being especially kind and considerate to the younger members of the profession, his loss will be felt, and his place can with difficulty be filled. That this Society tenders its sincere sympathy to the members of the bereaved family, and assures them that the profession sympathizes with them in their great affliction.

We add the following resolution:

That in the death of Dr. A. H. David the Medical Faculty of the University of Bishop's College have to deplore the loss of their respected Dean, who from the first inception of the Faculty until his last moments took the deepest interest in the welfare of the College, and contributed largely to its success. The Faculty desire to convey to his bereaved family their sincere sympathy in the loss thus sustained by them, by the Faculty and by the Medical Profession at large.

#### CORRECTION.

In our last number we published among our selected articles one from the pen of Dr. Godell of Philadelphia "On 113 Cases of Operation for Laceration of the Cervix Uteri," and credited it to the *Medical Gazette*, that being the journal credited with the article in the source from which we copied it. We now learn that the article first appeared in the January, 1882, number of the *American Journal of Obstetrics* published at New York. We gladly make this correction, and in so doing desire to say that the *American Journal of Obstetrics* is one of the best magazines published, and that it should be in the hands of all those members of the profession who are interested in obstetrical literature.

#### COLLEGE OF PHYSICIANS AND SURGEONS, PROVINCE OF QUEBEC.

A charlatan named Jean Jacques, *alias* Johnny, LeBland, of the Parish of St. Pierre les Becquets, District of Three Rivers, against whom the College had obtained a conviction, has been imprisoned in the common gaol of Three Rivers for the term of imprisonment according to the Medical Act, being unable to pay the fine and costs.

## REVIEWS.

*Manual of Diseases of the Skin.* By L. Duncan Bulkley, A.M., M.D., Attending Physician for Skin and Venereal Diseases, at the New York Hospital, &c., &c. Second Edition. New York: G. P. Putnam's Sons; Montreal: Dawson Bros.

This little work presents in a practical and concise form the subject of skin diseases; and the author's great experience as a specialist is a sufficient guarantee that it contains all that is essential for a guide book. He has based his classification upon that of Hebra's, arranging the groups according to pathological changes. The relative frequency of the different affections is estimated by an analysis of over 8,000 cases. A few general rules are laid down as aids in forming a diagnosis, while the diagnosis of each affection is given in connection with the individual disease. The chapters on Diet, Hygiene and Therapeutics will be found of great practical importance, as heretofore insufficient attention has been given to this portion of the subject. Appended is a formulary containing 108 selected and well attested prescriptions. We commend this manual to the student whose time does not permit him to carefully read the larger treatises on the skin, as it will enable him to recognise the different affections usually seen at Hospital clinics. The general practitioner will also find it a useful work to refer to in his office practice.

*The International Encyclopedia of Surgery: A Systematic Treatise on the Theory and Practice of surgery, by Authors of Various Nations.* Edited by John Ashurst, jr., M.D., Professor of Clinical Surgery in the University of Pennsylvania, in six volumes. Vol. I. New York: William Wood & Co., 1881.

Judging by the size of the volume before us, this Encyclopedia, when completed, will comprise a very respectable surgical library. The comprehensive nature of the undertaking may be surmised when it is stated that herein there is contained over 700 pages of reading matter; numerous woodcuts and beautifully executed chromo-lithographs illustrate its pages, while the correctness of the text exhibits the careful supervision of its able Editor. This volume embraces such subjects as are usually included under the heading of General Surgery. The contents are as follows:—Disturbances of Nutrition; the Patho-

logy of Inflammation, by S. Stricker, M.D., Vienna; Inflammation, by William H. Van Buren, M.D.; Erysipelas by Alfred Stillé, M.D., LL.D.; Pyæmia and Allied Conditions, by Francis Delafield, M.D.; Hydrophobia and Rabies, Glanders, Malignant Pustule, by W. S. Forbes, M.D.; Scrofula and Tubercle, by H. T. Butlin, F.R.C.S., London, Eng.; Rachitis by J. Lewis Smith, M.D.; Scurvy, by Phillip S. Wales, M.D., Surgeon General U.S.N.; The Reciprocal Effects of Constitutional Injuries, by A. Verneuil, M.D., Paris; General Principles of Surgical Diagnosis, by D. Hayes Agnew, M.D., LL.D.; Shock, by C. W. Mansell-Moulin, M.A., M.D. Oxon., F.R.C.S. London, Eng.; Traumatic Delirium and Delirium Tremens, by Wm. Hunt, M.D.; Anæsthetics and Anæsthesia, by Henry Lyman, A.M., M.D.; Operative Surgery in General, by John H. Brinton, M.D.; Minor Surgery, by C. T. Hunter, M.D.; Plastic Surgery, by C. Johnston, M.D.; Amputations by John Ashurst, jr., M.D. These various subjects are elucidated in a most exhaustive manner, and each may be regarded as a complete essay. The remarkable changes in the views held by pathologists during the past decade, especially in regard to the origin of pus cells, is shown in the article on the Pathology of Inflammation, much new light being thrown on this subject; while that on inflammation is a very practical and valuable contribution to our literature. All the subjects enumerated will be found equally of value, and the Surgeon who devotes a portion of his time to their careful perusal will find himself amply repaid for so doing.

*Transactions of the American Gynecological Society.* Vol. VI., for 1881. Philadelphia: Henry C. Lea, Sons & Co.

The issue of the volumes containing this Society's transactions should be welcomed by every gynecologist and general practitioner. In every volume papers of the greatest importance will be found, written by specialists eminent in the practice of Gynecology. The writers have devoted considerable time and labor in their production, as evidenced by the manner in which they are presented. In the discussion which follows each paper we obtain the criticisms and opinions of the ablest men of our time, each adding his quota of experience, and thus we have recorded a great deal of useful knowledge which otherwise might be altogether lost to the profession. The delay in the



issue of these volumes is to be regretted, as they are seldom published until some months have elapsed since the Society has last met. In the volume before us we have the table of contents, list of fellows, and report of meetings placed at the beginning, and at the end of the volume the usual Gynecological Index is inserted, forming a very important guide to the literature of these subjects, and is evidence that a great deal of patient labor is given to make it a complete reference of all that is written during the past year relating to diseases of women. Twenty-one papers were read and discussed. All the papers are of interest, and some of considerable practical value.

Dr. Garrigue's paper on Exploratory Puncture of the Abdomen will interest ovariologists, his conclusions being that tapping gives valuable information in forming a diagnosis of cystic tumors; that all tumors should be tapped before operation, and that carefully performed this is a safe procedure. In the discussion which followed, the majority of the speakers expressed their disapproval of so doing as being unnecessary, and not without dangerous consequences.

A paper on Pelvic Effusion resulting in abscess is important, considering the relation of uterine disease to pelvic inflammations. The necessity of an early recognition of these inflammations is pointed out, and also the fact that they are often overlooked and improperly treated; this is seen by the adhesions so often met with.

Forcible Elongation of Pelvic Adhesions was the subject of a paper by Dr. Van de Warker, and his method of doing this explained. Dr. Goodell's paper on Bursting Cysts of the Abdomen gave cases of these rare tumors which the author considers to arise from the parovarium, or broad ligament.

Axis Traction with the Obstetric Forceps, by Albert Smith, of Philadelphia, elicited a valuable discussion. The writer objects to the Tarnier Forceps as being too complicated, disinfected with difficulty, the compressing screw being dangerous, and, lastly, he believes that *it cannot do what it professes to do, make axis traction at all*. He believes that axis traction can be better effected by the ordinary forceps, by pressure on the lock backwards and downwards with one hand while the other lifts the handle upwards. He also favors the "Davis" forceps as being the best, Drs. Lusk, Fordyce Barker, Thomas, Wilson, Taylor and others taking part in the dis-

ussion. Dr. Lusk said the application of Tarnier Forceps was limited to a certain class of cases where immediate delivery was required in a moderately contracted pelvis with the head at the brim, removing the instrument before the head passes the vulva. Dr. Barker expressed the same views, the operator allowing nature to accomplish the mechanism, while he follows nature by the guide to the tractors.

Can laceration of the cervix be prevented? Dr. Polk ably presented this question of so much interest owing to the prominence given to the lesion of late years by the writings of Dr. Emmet. His conclusions are that most of the lacerations of the cervix are avoidable. Necessarily only a few of the papers are mentioned, sufficient, however, to show the value of this Society's work.

*Suppression of Urine: Clinical Descriptions and Analysis of Symptoms.* By E. P. FOWLER, M.D. New York: Wm. Wood & Co., 1881.

The substance of this small volume was presented in a paper to the New York Medico-Chirurgical Society, December 14th, 1880. The author gives an analysis of the symptoms present in 93 cases, with illustrations, tables and diagrams. The special significance of each symptom is considered, as well as the influence of sex and age. The duration of anuria is also noticed. The value of this work is in the statistics, which are included.

*An Index of Surgery: Being a Concise Classification of the Main Facts and Theories of Surgery, for the Use of Senior Students and others.* By C. B. KEETLEY, F.R.C.S., London, Eng. New York: Wm. Wood & Co., 1882.

The author states in his preface that it is intended for the senior student prior to his final examination, after having carefully studied a complete text-book. From this standpoint this index will be found very useful, otherwise we fear but little useful knowledge can be gained by a study of it. Its value consists in presenting the chief points of Surgery in a brief and accurate manner and in supplying notes to the student whose pen is unable to follow a lecturer. To obtain a correct knowledge of the subject it is essential that a complete text-book should be studied by the student, and then he will find this little work of value as a review of the work already accomplished. The practitioner, in like manner, may find it useful to refer to.