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CONTENTS.

Original Communications.

CASE OF SEVERE PROCIDENTIA UTERI CURED BY VAGINAL HYSTERECTOMY AND PLASTIC OPERATIONS ON THE VAGINA.*

By A. LAPTHORN SMITH, B.A., M.D., M.R.C.S. Eng., Surgeon to the Woman's Hospital. Gynecologist to the Montreal Dispensary.

Mrs. C., aged 46, mother of 8 children, consulted me about a year ago at the Montreal Dispensary. Her condition was a pitiable one. The uterus, which had been badly lacerated at her first confinement, was enormously enlarged and at the site of the laceration the everted mucous membrane of the cervical canal was ulcerated and discharging a thick, tenacious secretion. The vagina was also very much thickened. The sound measured a uterine depth of nearly six inches. This poor woman had to work hard and stand on her feet for fourteen hours a day, and when she did sit down, her womb would stick to her clothing, and sometimes bleed freely when it was detached. The womb could be replaced after some little effort at taxis, but it came out again the moment she assumed the erect position. She had suffered so much and so long that she readily accepted my proposition of an operation, provided that it could be performed at her own house, as she had a great dread of a hospital. I visited her home, and found it very small, and with an outlook upon a yard full of privies. Nevertheless, it was decided to make the best of the situation, and accordingly on the 15th May, 1893, assisted by two of my post-graduate pupils, the operation of vaginal hysterectomy was performed. It was somewhat annoying on our arrival to find that the minute instructions to remain in bed for at least one day before the operation had been disregarded, and that the patient was just finishing the scrubbing of the floor of her bedroom, and we had to wait a few minutes till this was finished and she could get into bed.

The external genitals were shaved and scrubbed with soap and water, and afterwards bi-chloride 1 in 1000, as was also the prolapsed uterus and vagina. The cervix, which was badly lacerated, was firmly

* Read before the Medico-Chirurgical Society, Montreal.

grasped in the vulsellum, and firmly held. A circular incision was then rapidly made around the cervix, and the vagina was easily peeled back with the finger all around. Douglas' cul de sac was then opened with the scissors, and torn laterally with the fingers until the broad ligaments were reached on either side, and the peritoneum was sewed to the vagina with catgut sutures, which also completely arrested the bleeding from the cut edges of the vagina. The bladder was then separated from the uterus with the finger of the right hand, until it had reached the finger of the left hand, which had been introduced from the posterior opening and hooked over the broad ligament. The peritoneum was then opened with the scissors in front and torn laterally, as was done with the posterior layer. A few stitches were then made to bring together the anterior edge of the vagina and the peritoneum. This left the uterus held only by the broad ligament on each side, which was then transfixed with Cleveland's ligature carrier ; and stout catgut, which had been rendered thoroughly aseptic by soaking, was passed through and tied with three knots. A considerable number of sutures were used in each side, so as not to take too much tissue in each one, and the broad ligament was cut free from the uterus, as the sutures advanced farther and farther up. When the middle of the broad ligament was reached, the fundus was brought out through the anterior opening, which enabled me to tie the upper half of the broad ligament without the slightest difficulty. The uterus was then removed. It was found afterwards to measure nearly six inches in length, the sound entering over five and a-half inches. The stumps of the broad ligament were then brought together with catgut stitches from top to bottom, and Douglas' cul de sac having been first carefully cleaned, the vaginal opening was accurately closed with a running catgut suture, and the wound was dressed with dry boracic acid and a light piece of boracic gauze. As there was a great redundancy of the vaginal mucous membrane, which was enormously thickened, Hegar's operation, which consists in denuding the triangular surface on the posterior vaginal wall, was then performed. The apex of the triangle extended fully half way up the vagina, and the extremities of the base were located about one inch and a-half below the meatus, so that quite a large area was denuded. This was brought together with three rows of running catgut sutures, care being taken with the last row to bring the cut edges of the vagina accurately together, as also the edges of the vulva. This made a very solid perineal body, and had the advantage of requiring no after-treatment, the catgut being left in until it was absorbed or melted off.

A small hypodermic was allowed that afternoon ; the patient's water was drawn with the catheter that evening ; the gauze was removed next day, after which the patient received no treatment whatever. She suffered no pain, and it was with the greatest difficulty that she was kept in bed seven whole days, at the end of which time she got up and went about her household duties as if nothing had happened. She did not seem to realize the severity of the operation, thinking it was a matter of course that she would recover, for she constantly begrudged the week she had to stay in bed.

The brilliant success in this case has impressed me with the advantage and safety of thus treating all cases of procidentia, accompanied by enlargement of the uterus. If the uterus were not enlarged I would certainly give the preference to ventro fixation ; but where the sound enters over three and a-half inches, the uterus is too heavy for suspending operations, either Alexander's or ventro fixation

to give satisfactory results. I am also particularly in favor of combining repair of the perineum with any operation for displacement of the uterus.

THE PROFESSION, THE PUBLIC AND THE CODE.

An address delivered by invitation before the Third General Meeting of the Pan-American Medical Congress, Washington, Sept. 7, 1893, by ERNEST HART, D.C.L., *Hon. Causa, Editor of the British Medical Journal, London, formerly Dean and Ophthalmic Surgeon, St. Mary's Hospital, London.*

Sir Astley Cooper, one of the greatest surgeons and most accomplished gentlemen of the last generation, was in the habit of addressing every candidate for membership of the Royal College of Surgeons of England, of which he was president, somewhat in the following words: "Gentlemen, you are about to enter on a noble and difficult profession; your success in it depends on three things: first, on a good and thorough knowledge of your profession; second, on an industrious discharge of its duties, and third, on the preservation of your moral character. Without the first,—knowledge,—no one can wish you to succeed; without the second,—industry,—you cannot succeed; and without the third, even if you do succeed, success can bring you no happiness." Those words might form a very adequate summary text for guidance of the conduct of all medical men. And it might conceivably be asked whether there is any necessity for a more detailed and elaborate code. Indeed, it practically has been asked, and there are large questions involved in the decision. On the other hand, it has, from time to time, lately, in our country been found necessary to reinforce and strengthen our code by additional declarations, and I think to some extent in yours; the need for a stringent upholding and development of the code has also become a question of the day. I think it is clear that if ever there were such necessity, at no time could it be stronger than at the present moment. For under the stress of the modern social development, under pressure of the modern temptation for advertising and the severity of competition, in view of the arts of those who make advertisement a business and a profit; in presence of the temptations held out to draw medical men from the ancient paths of modesty and self-effacement, there is now stronger reason than ever to fortify ourselves against those growing and innumerable seductions by a code so exact, so far reaching, that the physican need never be in doubt as to what is his duty in any complication, or in the face of any doubtful case in which he may be inclined to give himself the benefit of the doubt.

But, first of all, I want to elaborate the view that our rules of medical etiquette stand upon a logical and strong basis, and that their strict enforcement is for the benefit of the public, at least as much, if not even more, than for the benefit of the profession. Medical etiquette has been sneered at by shallow cynicism as mere trades unionism. It is, on the contrary, a self-denying code which is made in the interests of pure morality, and for the benefit of the public far more than for the interests of the profession. This allegation of trades unionism is the converse of that of inutility, which those who are prone to call themselves of the younger school allege; but not even the youngest of us, as you know, are infallible, and in this matter it is the youngest who are most likely to go wrong. They proclaim themselves liberals. Is it, however, in some cases, the liberalism of Gallio? Let us look at this matter from the largest and most liberal standpoint. Let us begin by comparing our code with the standards of the legal profession.

My distinguished friend, Sir Edward Clark, lately the Solicitor General of England, in writing to me on the subject recently, said the essence of the matter might be summed up in a very few words: "Every lawyer ought to be a gentleman, and ought to do only what is right and honest; if he does not, other men ought to have nothing to do with him." Notice that "if he does not, other men should have nothing to do with him." That position of the bar is strengthened by this, that the etiquette of the bar is absolutely in the hands of the bar circuits and attorney general, and that of the solicitors in the hands of the Incorporated Law Society, so that any solicitor who is guilty of an offence, whether as a lawyer or as a gentleman, can be, and

from time to time, is not only temporarily suspended, but deprived of the right to practice at all. In a case tried last July in England, a solicitor in a certain town had been the proprietor of a house used for an immoral purpose, of which he received the rent. That was considered a stain upon his character as a gentleman, and for that he was suspended from the roll and excluded from practice. So that we have at least the example of the legal profession, who have a code even stricter than ours, in insisting upon a high standard of honorable conduct in the profession.

Legal etiquette prescribes certain technical acts which a lawyer must not do. An eminent American lawyer, whom I had the pleasure of meeting, mentioned to me for example that he may not conduct a "speculative suit;" that is, he may not conduct a suit in which his pay is to depend on the success of the suit,—a palpable restriction on his liberty. Liberty is a blessed word, but compulsion is, under certain circumstances, often a more blessed word. The reason for this rule is that if a lawyer undertakes such a suit he becomes personally and financially interested in the result, and may be tempted not to give the court all the aid which is his duty, or may in the end lose the relations of harmony and respect which are indispensable between the Court and the lawyers, who are officers of the Court and are bound to help Justice to duly balance its scale.

In the same way "champerty" is a legal offence. So, too, no respectable lawyer will give separate advice upon a case which is already in the hands of a colleague. As between advocate and advocate, harmony, courtesy, and the forms of friendship must prevail; and at any time they must in the interest of the client be able to come together and to seize the earliest opportunity of avoiding litigation by compromise or mutual settlement, where it is possible and right. The etiquette of the bar is very strict, and is closely observed.

Legal etiquette is, like medical etiquette, a code of honor and of duty by which the public benefit; and those who depart from it or deride it,—"legal shysters" I think they are called in the United States,—are not, any more than medical quacks, those of whom their country or their profession have most reason to be proud.

I will pass at once to the consideration of our code of medical etiquette. I will ask you to consider whether you are of the opinion that it is safe or wise to cast aside the precedents of past experience and to substitute individual judgment for settled rules. If man were a purely abstract and perfectly moral intelligence, no doubt few words would suffice to legislate for his daily needs. Enough to say, "Do unto others as ye would they should do unto you."

But medical men are not pure creatures of perfect and abstract morality any more than other men. They have, indeed, certain advantages from the outset. From the very beginning of their professional life it is impressed upon them by their teachers that their profession is *a mission and not a trade;* a mission involving frequent self-sacrifice and a steadfast regard for interests other than their own. In this they are greatly helped by the force of precedent, by the example of those around them, and of the leaders whom they most respect. But even these are inadequate. Without the aid of the written as of the unwritten law, even the best of men are apt to decide *wrongly in their own favor*, on a doubtful question of ethics, and often in matters and cases where there are settled instructions in the code which would guide them rightly.

Let me read to you a few of the rules of our College of Physicians, which command with us a universal adhesion and respect. I do so only as an example of the conclusions to which many years of observation of the impingement of the forces of modern life on professional duty have led some of our wisest heads. I will refer only to a few as follows:—

"No candidate shall be admitted to examination who refuses to make known, when so required by the president and censors, the nature and composition of any remedy he uses."

"That the practice of medical authors frequently advertising their own works in the non-medical journals, and especially with the addition of laudatory extracts from reviews, is not only derogatory to the authors themselves, but is also injurious to the higher interests of the profession."

Again, "No fellow, member, or licentiate of the college shall officiously, or under color of a benevolent purpose, offer medical aid to, or prescribe for, any patient whom

he knows to be under the care of another doctor."

A further rule prescribes that no physician shall himself assume any special designation of therapeutic method, such as homœopath, electropath, hydropath, or countenance those who do so.

Again, "A physican shall have no interest in a secret medicine, and that he shall always, when called upon by the college, disclose every part of the composition of his medicines."

"If it shall at any time hereafter appear or be made known to the president or censors that any fellow or member of the college has obtained admission into the college, or that any licentiate of the college has obtained the license of the college by fraud, false statement, or imposition, or that any fellow, member or licentiate has been guilty of any great crime or public immorality, *or has acted in any respect in a dishonorable or unprofessional manner*, or has violated any statute, by-law, or regulation of the college, relating to fellows, members or licentiates as the case may be, the president and censors may call the fellow, member, or licentiate so offending before them, and having investigated the case, may admonish or reprimand, or inflict a fine; or if they deem the case of sufficient importance, may report the case to the college, and thereupon a majority of two-thirds may declare such fellow or member or licentiate to be no longer a fellow, member, or licentiate, as the case may be, and his name shall be expunged."

Let us consider now those restrictions which operate to forbid a medical practitioner to consult with "homœopaths," and of which the wisdom has been by some disputed. We do not believe, and we cannot appreciate the medical capacity or fitness to undertake the treatment of disease of those who hold that drugs which given internally will produce certain symptoms of disease are the appropriate remedies for those maladies. For instance, medicines which produce skin reddening for erysipelas, leucorrhine for leucorrhœa; syphiline for syphilis. We do not agree that all chronic maladies arise from syphilis, sycosis or itch, and that medicines act with an intensity proportionate to the infinite diminution of the dose; or that there is any utility in prescribing, in accordance with these principles, say a decillionth of a grain, when we all know that a dose so small, if taken by every being on the globe once a minute would not finish the grain in a thousand years. Nor again, do we believe that the activity of medicine increases in the ratio of the number of shakes given to the vessel containing it. We hold that we have nothing in common with those who assume to base their practice and theory on this kind of therapeutics. Being well assured that these methods and this theory are absolutely delusive, the negation of reason and the acme of folly, it would be useless, deceptive, and contrary to good faith and the public interest that we should pretend to consult with those who profess them and who take a designation derived from them, and to cover with the respectability of logical science what they are pleased to term their system of treatment. Faith curing, it may be, but in that too we can take no part under false pretences.

But then it is said, What if the physician or surgeon of good standing is only called in by the homœopath to assist in diagnosing the nature, the stage, the complications, or name of the disease? Ought he not to give this help for the patient's sake? The answer is, the physician is a healer; not a reader of riddles nor a conner of conundrums. He is there not to give a name to symptoms or pathological conditions, but to heal the patient; and if he knows that his solution of the riddle is not to be followed by a method of treatment which he considers capable of attaining that result, he would be infamously wrong, and he is always wrong when he gives the cover of his accepted position, of his recognized ability, and of his professional sanction, to what becomes under such circumstances a dangerous farce or a deliberate fraud. The riddle is read, but the patient is none the better.

But it is said, May a regular medical practitioner not be called in to perform a difficult surgical operation? If a surgical operation meant only cutting, sawing, and sewing, it would be a plausible excuse for the surgeon accepting the responsibility of acting as sawbones to a quack. But there is no surgical operation which does not in its preliminary stages, and may not in its various phases and sequels, require concomitant medical consideration and treat-

ment, or in which septic, constitutional, or accidental complications may not arise. The surgeon cannot honorably, in the interest of his client, divest himself of the responsibility for the wise and faithful treatment of these as an essential part of his operative interference.

I have used the word quack. It is a word often used now in too restricted a sense. This is Dr. Johnson's definition of a quack: "A boasted pretender to arts which he does not understand; a vain, boasting pretender to physic, one who proclaims his own medical abilities in public places; an artful, tricking practitioner in physics." This strikes at the root of the matter, now as then. Observe, here is no distinction between those who have degrees and those who have not. The great lexicographer makes no distinction; neither do I.

The essential note of the quack is love of advertisement. The public "places" of Dr. Johnson's time were the coffee-houses; they are now the newspapers. Now what are the ways in which the diplomaed quacks adopt the methods and become the imitator, the rival, the accomplice of the undiplomaed? You may know them by their works. They are the gentlemen who put themselves forward to be interviewed, and are the sham Jupiters and willing Mercuries of the newspaper world. They confide to the ubiquitous reporter what is their opinion of the last new bacillus, the last new anti-toxine, or invite reporters to their amphitheatre and hospital ward. All this is only an outcome of the venal desire for advertisement. They are the gentlemen who, if they have the good fortune to attend a prize fighter or a ballet girl or the ruler of a State, are not slow to disclose the secrets of the sick-room, and all for the public good.

Now, in the venerated Oath of Hippocrates, which is the foundation of our code of to-day, the disciple swears to impart the knowledge of his art to others according to the law of medicine, and to share with his colleagues by precept and every other mode of instruction all that he knows. He further binds himself that he will have *no medical secret*, that he will practise his art and pass his life with purity and holiness, that he will abstain from every voluntary act of mischief and corruption, and that *whatever in connection with his professional practice* he sees or hears in the life of men which ought not to be spoken of abroad he will not divulge. "While I continue to keep this oath unviolated, may it be granted to me to enjoy life and the practice of the art respected by all men and in all times. But should I violate this oath may the reverse be my lot."

This is the spirit of the modern British code, and I know well it is yours also.

We have dwelt as long as time will allow on the considerations of public utility and professional duty which oppose consultations with homœopaths and their congeners, nor can I stay long to discuss the prohibition of open advertisement. The advertisement in the lay press of medical books intended for the profession, the submitting of technical books to review, the public criticism of the treatment of any disease or person, the thousand and one acts in fact by which the advertising surgeon physician seeks to gain the ear and favor of the public by means of notoriety or self-proclamation, in place of hard honest work, real professional worth, and the judgment of those whose knowledge makes them alone competent to judge. Self-advertisement is the note of the quack. It is as dangerous to the public as hateful to the profession, for it misleads the masses by substituting easily purchased notoriety for merit, and covering by loud talk and bombast and plausible pretences the emptiness of the shallow pretender. It covers also with a pseudo respectability the venal corruption by which whole columns and pages of reading matter of the newspaper are very frequently devoted to quack nostrums and "treatments"—save the mark—often of the most fantastic, false and dangerous character. It destroys the landmarks of honor and reticence, when in successive numbers of the daily and weekly papers are found the lucubrations of these pests of society, and, alongside of them, the interviews, the explanations, and the descriptive narratives put forth for the public good by reputable physicians, *à propos des bottes*, but hardly-veiled self-advertisement.

It is, however, only fair that the physician should have notice of the offence or its penalties, and that this salve which he puts to his conscience should be rubbed off.

Hence the value of "a code." We have seen that the medical man is prohibited from deriving any profit directly or indirectly from any medicine which he uses or recommends, and from tampering, however remotely, with secret medicines. If this were merely an abitrary rule, if it were not at least as much for the benefit of the public as well as for the practitioner, there might be ground for calling it in question. But it is a rule of the highest public import.

That a healer, whose judgment in prescribing should be clear and unbiased, should possess and profit by a secret remedy is as obvious a source of public peril as it is a heinous offence against professional morality. Every physician has a traditional and immemorial right to expect from, and he is bound to give to, his fellow-practitioners every possible aid and assistance in the treatment of disease and in the healing of the sick. He has received such knowledge from his predecessors; he daily and continually receives it from his colleagues and contemporaries, to whose knowledge and experience, and from the results of whose investigations (openly stated and submitted to critical discussion) he owes the great bulk of his knowledge and of his ability to practise at all.

A new method of treatment, a new drug or a new dogma in medicine is like a new doctrine or a dogma in theology. The one is as much a means of physical salvation as the other is of spiritual salvation. The man who keeps either of them to himself as a profitable secret for his own mean gain is a traitor to his profession; he is also a traitor to humanity, and he is false to his mission. It is fitting that the code should provide for such cases, and that the penal clause should not remain a dead letter.

But it is sometimes suggested that the usefulness of the "secret" drug may be so great as to overpower and outweigh morality, and call for its prescription. I put it to you all: is there any foundation for such an assumption in the whole history of medicine? In the whole history of the past can we recall any example of a secret medicine which had aught but the most insignificant value, or could not easily be replaced? We may take even the most famous, such as the famous remedy of Mr. Stephen, for dissolving stone in the bladder, for the divulging of which eminent men petitioned Parliament for a grant of £5,000. It was granted; and what do we read of the remedy when divulged? That it consisted of calcined egg-shells or of lime obtained by a filthy and obscene process. Naturally, and like all secret remedies when divulged, it ceased to cure. Hartley—the famous Dr. Hartley—one of those strenuous supporters of the grant, died of stone in the bladder after taking two hundred pounds of the remedy. In our day there is no such thing as a secret remedy in the true, or in any other than the trade meaning of the word. We doctors know the composition of all of them. They are secret only to the gullible public to whom they are to be sold. Pain annihilators, blood-purifiers, vegetable and animal extracts, botanical nostrums, invigorators, electric belts, amulets and chains, Asiatic, African electrical pills and phials, "green, blue and yellow electricity'—there is nothing secret about them. When examined in our private or public laboratories, they are all found to be commonplace in composition; or if they have anything not well worn in use, it is merely the name of some indifferent or trivial matter,—Indian grass or African leaf added, most often, and chiefly for the sake of novelty. These secrets are trade devices, with which we are not concerned. Let us visit those physicians who dabble in them with the severity of the code. I don't think that is asking more than is due to the honor of the professional body and the welfare of the public.

In respect then of secret medicines, at least, the world has up to this date lost nothing by the stern and scornful disapproval with which the medical profession regards these tricky nostrums, and by the punishment with which they visit, and always ought to visit, those who sell the honor of their calling and the free communication of medical knowledge, which is the birthright of mankind, for some mess of commercial pottage.

Finally, I will say a word or two of what is known as the etiquette of consultation. The patient, it is said, and is said cogently, has the right to determine whom he shall consult, and to change his medical adviser if he desires so to do. No one will dispute that. But, like other rights, it is limited

by the legitimate claims of others; and a medical practitioner may justly object if he shall be, without explanation or courtesy, superseded in attending on a case. In such event, moreover, the superseding practitioner is morally and ethically bound to take due care that the same courtesy and respect which he individually would expect to receive be paid to his discarded colleague, not only by himself, but by those who have professionally consulted him.

Every day cases of this kind occur; few days pass without bringing to me some complicated question arising out of them. The pages of our *British Medical Journal* are full of such questions. Very often all I have to do is to say, see Code, page so and so, section so and so, and that decides both the practice and the principle. Probably if that is the case with us, it might occur here also, and not less frequently. Of one case I became cognizant here only the other day. An eminent doctor in a capital city of the United States of America was called in, came and saw a patient severely ill, said he would return; when the family physician returned in the evening, he was told, "But you are not any longer in charge; Dr. So-and-so has charge of the case." He said, "But I don't understand. I was here this morning." "Well, it was the particular wish of—that the consulting physician whom you called shall take charge, and you are not wanted." Exit family doctor.

Once more our College of Physicians explicitly directs that the physician called in to consultation by a brother practitioner shall not express directly to the patient his individual views and the conclusions at which he arrives, but that whatever he has to say shall be said after consultation with the practitioner, and through his mouth; that he shall behave with the utmost courtesy and forbearance to such practitioner, to whom shall be left all explanations and statements of the conclusion resulting from the consultation. Were it otherwise, were consultants authorized to supersede or to snub the family doctor, the public client would be the first to suffer. For anything which creates ill-will or unnecessary friction between consultant and family practitioner tends to limit the range and frequency of consultations. Therefore is it forbidden to the consultant called in subsequently to assume the sole charge of that patient, however he may be entreated to do so, or under whatever inducement. Were it otherwise, the attending or family physician could not call in a consultant without the fear being before his eyes of losing the charge of his patient. There would arise at once the temptation to limit and restrict consultations, and this would be an impediment in the way of ascertaining the best means of cure by consultation. The strict observance of such rules and of the whole code as to consultations may sometimes be something of a personal trial to the patient, something of a personal loss to the consultant; but it is a rule which is of infinite importance to the public welfare.

The maintenance of a high standard of professional honor, the acceptance, adoption and enforcement of a detailed code of professional etiquette, the agreement by all and the observance by every individual of the whole range of limitations and restrictions, which are set up by that code and by the logical deductions from it, —these things are, I contend, demonstrably as valuable to public welfare as for any professional interests concerned or supposed to be concerned.

I infer from the repeated and enthusiastic plaudits with which you have honored me, that the opinions and conclusions which I have ventured to bring before you have agreed with your sentiments, and are accepted by you sympathetically, and that you consider them opportune and proudly useful.

I have been encouraged by your continuous signs of general and warm approval to speak at greater length than I had intended. But there is yet much more to say. In thanking you now for this most gratifying ratification by the unbroken plaudits of this representative general meeting of the argument which I have ventured to state, it seems to me of great importance to such progress or fair ethical development. I will only add that I shall be most happy to hear privately from anyone who has doubts to solve or arguments to suggest either for or against or in supplement of those which I have developed before you.

Society Proceedings.

AMERICAN GYNÆCOLOGICAL SOCIETY.

NEW YORK, February 1, 1894.

DEAR DOCTOR:

The next meeting of the Society will be held in Washington, on Tuesday, May 29th. According to the resolution adopted at the last meeting, the morning sessions of the first two days will be devoted to the discussion of the following subjects:

1. Extirpation of the Uterus in Disease of the Adnexa.
2. The Management of Face Presentations.
3. Rupture of the Uterus; Surgical *vs.* Expectant Treatment.

The afternoon of the third day will be devoted to a special discussion before the Congress, under the direction of the American Gynæcological Society. The following topic has been assigned:

The Conservative Surgery of the Female Pelvic Organs. Referee, Dr. Wm. M. Polk; co-referee, Dr. Wm. Goodell.

Since there will be time for only twelve or fifteen papers in addition to the above discussions, those gentlemen who desire to contribute are requested to send the titles of their papers to the Secretary on or before April 1st, as he will be compelled to limit the number to the first fifteen which he receives.

The Fellows are reminded of the By-Law: "All papers that may be read before the Society, and accepted for publication, shall become the property of the Society, and their publication shall be under the control of the Council. Such papers may be published in full in medical journals, provided that they are also printed in the Transactions."

There are eleven vacancies in the list of Fellows.

Very truly yours,

HENRY C. COE,
Secretary.

THE MONTREAL MEDICO-CHIRURGICAL SOCIETY.

Stated Meeting, May 26, 1893.

DR. JAMES BELL, 2ND VICE-PRESIDENT IN THE CHAIR.

Abdominal section after Confinement.—Dr. ARMSTRONG read a paper on this subject as follows:

Mr. President and Gentlemen—I have recently had to do with three or four cases which in my experience are not common, and my friend Dr. Perrigo has had to do with one of a somewhat similar character. We think that a brief rehearsal of the principal points will be of interest to the Society, and hope that the discussion will be mutually helpful and instructive.

On the 3rd of March last Dr. W. G. Stewart asked me to see with him a lady whom I had myself previously confined three or four times. Her confinements had always been normal, but her recoveries had not always been as satisfactory as could have been desired. She had generally recovered slowly, had usually had a little temperature, and some soreness and tenderness over the uterus and adnexa, but nothing of a serious character.

Dr. Stewart told me that her last confinement had been a normal one in every respect. She did well afterwards, and got up on the tenth day. In brief, she soon afterwards became feverish, complained of some abdominal pain and soreness, and went to bed. During the next four weeks she had a very fluctuating temperature, an occasional chill, frequent sweats, and sufficient abdominal pain to require poultices and opium to relieve. When I saw her six weeks after confinement she had a temperature of 101.5, pulse of 130, small and weak, and an anxious expression. The abdomen was rounded, and for the most part tympanitic. In the left lower abdominal region a distinct but ill-defined mass was easily felt, which was tender on pressure. I advised an exploratory incision, which was consented to. Before opening the abdomen I curetted the uterus, swabbed it out with a solution of permanganate of potassium and packed with iodoform gauze. On opening the abdomen the omentum was found adherent to the uterus and tube of the left side. On carefully detaching the adherent margin, a pus sac was found, the walls being formed anteriorly by the omentum, below by the left tube and ovary, and above by knuckles of intestine. The pus was carefully removed, the tube and ovary tied off, as well as fully one-third of the omentum, which was infiltrated and thickened. The patient made an excellent recovery.

The tube in this case was brightly injected, swollen to probably twice its normal size, but there was not evident any constriction, and it contained no pus.

CASE II.—This case occurred in the practice of Dr. J. Perrigo, and I am indebted to him for the report of it. Mrs. S., referred to me by Dr. Tatley, March 11, 1893. Chief points of history obtainable were: Confined five weeks previously of her second child; attended by a midwife; labor normal. On seventh day developed severe rigor, with temperature of 104° and quick pulse. From this date rigors frequent and temperature continuously high. Great pelvic pain on left side, moderate abdominal distension; occasional vomiting and diarrhœa; prostration extreme. Examination disclosed a tender abdomen with a large mass in left side of pelvis, a soft patulous "os," with uterus adherent to mass. No fluctuation could be

detected. Patient could bear very little pressure on the mass, and any attempt to move the uterus caused intense pain. Patient removed to private ward of Western Hospital on March 12th, and abdominal section performed that day. All aseptic precautions taken on the part of operator, assistants, nurses and instruments. The field of operation also made aseptic.

Before doing the section, the uterus was curetted and some decomposed placental tissue removed. This was done very gently, but notwithstanding the care taken, the fundus close to the left groin was perforated, so soft were the uterine walls. This was discovered when doing the section. It was quite small, and there was no hæmorrhage from it. The uterus was irrigated and packed with iodoform gauze. Upon section the right side of pelvis was found healthy. The contents of the left side formed one mass of inflammatory exudation, all the structures being agglutinated together, adherent to the uterus and to the wall of the pelvis. The lower half of the omentum showed patches of gangrene, and in two small points were attached to coils of intestines, and its left and lower border was adherent to the abdominal wall and to the mass in the pelvis. The omentum was first detached and all diseased portions removed. Great care was required in separating the adhesions from the intestines. No injury to intestines. The tube was enlarged to the size of an average adult's wrist and contained small pockets of pus. The tubal canal was obliterated. Ovary of normal size and gangrenous.

The tissues were so friable and softened that it was with difficulty ligatures could be applied without cutting. The thermo-cautery was freely used, but there was not much hæmorrhage. Abdomen flushed and drainage tube used. Before operation, patient's temperature was 103 2-5 and pulse 130. Operation was at 4 p.m., and was an hour and a half in duration. Temperature at 7 o'clock same evening was 99 3-5, pulse 110. Iodoform gauze removed from uterus day after operation.

From this date up to the evening of the seventh day the temperature ranged from 99° to 100°, respiration 18 to 24, pulse 96 to 104. Tube removed on second day. no discharge from it, and incision appeared clean and healthy. On evening of seventh day temperature went up to 102°, pulse 120, respiration 26, and had a restless night, although passing flatus freely. On the morning of the eighth day temperature was normal and pulse 88, but in the evening the temperature went up to 103 1-5, pulse 120, respiration 28. The incision was examined, and appeared healthy, but the evidence of pus being present was so strong that two of the central sutures were removed and about half a pint of pus evacuated, The opening in the incision caused by the removal of the two sutures was sufficiently large to pass the finger in. A large pus-cavity was discovered, which had followed in the tract of the glass drainage tube. The cavity was well irrigated and a large tube inserted, which was cleansed every two hours. From this date the patient convalesced steadily, interrupted at times by her own misconduct.

CASE III.—Presents a history which in some respects is unique. She was attended during her second confinement by Dr. F. R. England. Her confinement was a normal one in every respect, not unduly prolonged, and the child was born alive and well. Dr. England saw her each of the immediately succeeding nine days. Her recovery was all that could be wished. Her temperature and pulse were normal every day. The lochia was present in sufficient quantity and at all times free from odor. Her breasts were always full and the child nursed well. The lacteal secretion was always sufficient for the child. At 4 p.m. on the ninth day after confinement Dr. England paid what he intended to be his last visit. Her temperature and pulse were normal, breasts full, lochia getting scanty and odorless. No abdominal pain or tenderness; it was soft, and bore palpation without the slightest discomfort. She lay in bed with her babe upon her arm, well and happy and hopeful. At 10 o'clock that evening the nurse decided that her patient's bowels needed moving. As the baby had a little looseness the nurse thought that an enema was the proper thing to give. The patient objected strongly to this, on the ground that after her first confinement she had had an enema, and that she suffered very great pain for 48 hours afterwards. Her objection, however, was overcome, and the enema was given. She was almost immediately seized with intense abdominal pain, with great general tenderness, and vomiting. She had a small stool almost immediately, and her bowels did not move afterwards. The vomiting persisted and soon became bilious. Hypodermics of opium were given to relieve the pain. The abdomen became tympanitic, the temperature rose, the pulse became rapid and shabby, the face became drawn and anxious, and it was evident that the patient was suffering from some severe lesion, sufficient to cause a condition of collapse. I saw her with Dr. England during the afternoon of the next day. I thought the history and symptoms pointed to some acute obstruction of the bowels, possibly a volvulus. Her condition was an extremely grave one, and it was easily seen that if anything was to be done more than had already been done, it was of a surgical nature. An exploratory incision was advised, and with that object in view she was removed to a private ward in the Montreal General Hospital.

There, with the assistance of Dr. Shepherd, I opened the abdomen by a median incision.

The peritoneal covering of the intestines was congested. I think I am within the limits when I say that two pints of thin, pale yellow, odorless pus flowed out. After thorough irrigation the uterine appendages and appendix vermiformis were examined without finding any condition that was thought to bear a causitive relation to the peritonitis. The tube and ovaries were tied off and sent to Dr. Adami, whose report upon them I will read. This woman was moribund when the operation was begun, and died ten minutes after being removed from the table, or just 24 hours from the giving of the enema and onset of symptoms.

The following is Dr. Adami's report:

PATHOLOGICAL LABORATORY, McGILL UNIVERSITY,

May 17th, 1893.

The Fallopian tubes are rather more capacious than normal; their epithelium is healthy; the peritoneal surface layers are congested and thickened.

The ovaries present no suppurative foci; all that can be said of them is that they are more fibroid than they ought to be—possess large tortuous vessels and thickened capsules. Evidently, therefore, the peritonitis has not started from the tubes or ovaries in this case.

With kind regards, yours sincerely,

J. GEORGE ADAMI.

Careful search was made for volvulus and hernia, but nothing which could be taken for a cause was found. Thinking that perhaps a small perforation existed along the sigmoid or colon, I asked one of the house physicians to inject water into the rectum. It entered freely, filled the colon, and passed through into the ilium, but none escaped through into the peritoneal cavity. I was obliged to close the abdomen without determining the cause of the pathological condition present. No autopsy could be obtained. From the symptoms of obstruction which were present, and the history of severe pains following the administration of an enema after a previous confinement, I am inclined to think that in some way a volvulus of the sigmoid was produced by the enema which had untwisted, but not before some pyogenic micro-organisms had escaped into the peritoneal cavity. What it was—whether the bacillus coli or one of the proteus group, described by Hauser in 1885, or some other, I cannot say, as unfortunately none of the pus was saved for bacteriological examination.

Dr. Flexner, Associate in Pathology in the Johns Hopkins Hospital, describes in the April number of the *Johns Hopkins Bulletin* a case of peritonitis occurring in a patient, the subject of chronic disease, thought to be due to the action of the proteus vulgaris. In the same paper Dr. Flexner says that "Foa and Bonome found in the blood and organs of a man dead of supposed hæmorrhagic infarction of the intestine and mesentery and thrombosis of the mesenteric vein, a bacillus which they identified as the proteus vulgaris."

CASE IV.—A patient of my own was attended for me in my absence by Dr. Spendlove in June, 1892. It was her third confinement; labor easy and rapid; child living and healthy; recovery apparently perfect; no history of any tubal or ovarian trouble. Two months after confinement, while in apparent health and nursing the child, she was suddenly seized with a severe rigor, rapid pulse, and a temperature of 104, followed by pain and tenderness in the lower abdominal region. She recovered in a week, so far that the pain and tenderness disappeared and pulse and temperature became normal. The lacteal secretion was sufficient for the child, and she resumed her household duties. In fifteen days she had a similar attack, followed in ten days by another; apparently good recovery, only to suffer another recurrence ten days afterwards. The third attack was the most severe of all. In addition to the rigor, high temperature and pain and tenderness, there developed a large, soft, tender mass on each side of the uterus, easily felt by bi-manual palpation. I now decided to open the abdomen. On doing so I found a large tubo-ovarian abscess on each side. It was treated in the usual way, and a rapid and perfect recovery followed. This patient is now in better health than she has been for years.

I might add a fifth case operated on in the General Hospital some two years ago, followed by recovery.

Case III must be considered separately from the rest. The symptoms were those of obstruction. Dr. Adami, in his report upon the tubes and ovaries, says they cannot be called diseased, and that we must look elsewhere for a cause of the peritonitis. The cause was apparently a temporary condition, which had ceased to exist at the time of operation. Remembering the symptoms that followed the administration of an enema after the first confinement, and the apparently causative relation of enema and symptoms at the onset of her last illness, I think that probably, as I said before, a volvulus was produced which untwisted before we inspected that region, or perhaps it was untwisted while we were looking at the condition of the uterine appendages on the left side.

The two lessons to be learned from the other four cases are, first, the necessity for greater caution against sepsis when attending confinements or miscarriages. The technique

of a case of midwifery should more closely resemble that for a modern surgical operation. The greatest care should be taken to render the hands of the accoucheur aseptic. His coat and underwear should be above suspicion. The patient's person and clothing and bed should be made as clean as circumstances will permit. A napkin or towel wrung out of a hot solution of corrosive sublimate 1 in 2000 should be used, instead of the old dry napkin, to support the perinæum. The parts should afterwards be frequently washed by the nurse, who should be impressed with the necessity of having clean hands herself.

Secondly, these cases teach us that when septic infection occurs, great care should be taken to discriminate between infection from the vagina, torn perinæum, uterine cavity, or torn cervix, and infection extending up and involving the Fallopian tubes. The treatment should aim to meet efficiently the pathological condition present. The experience gained from these five cases demonstrates the utility of proper surgical treatment in properly selected cases. No amount of vaginal douching or curetting and irrigating of a septic uterus will save a woman suffering from ruptured pus tubes, with intra-peritoneal inflammation and abscess.

But the history of these cases does show that surgical treatment may not only save their lives, but restore them to perfect health. Thoroughly cleanse and render aseptic the vagina and uterine cavity, and then if there is pus in the abdomen, open that cavity, remove the pus and diseased tubes and infected omentum, and make it also as aseptic as possible.

Dr. ENGLAND, referring to Case No. 3 of the series just reported, had nothing more to add to what Dr. Armstrong had so well expressed. The woman had a very satisfactory puerperal period. The giving of the enema was, or seemed to be, the beginning of her pain, which persisted till death. He saw her the same night as the enema had been given, and even a hypodermic of morphia could not relieve pain.

Dr. LAPTHORN SMITH dwelt upon the necessity of greater care being exercised by the accoucheur in cleansing the hands, and for this purpose he knew of nothing better than permanganate of potash and oxalic acid.

Relative to Case No. 3, he did not agree with Dr. Armstrong in thinking that a volvulus or obstruction was the cause of the trouble. Two pints of pus in the peritoneal cavity is more than could be manufactured in such a short time, and in his opinion it must have been locked up somewhere in the form of an abscess, and during the administration of the enema it suddenly burst and flooded the cavity.

Dr. J. C. CAMERON said that Dr. Armstrong's series of cases seem to confirm the belief that abdominal section is sometimes useful in local peritonitis, and that it is always hopeless in general septic peritonitis.

With reference to curetting, he said that this should be done before the peritonitis was set up. Where there is a suspicion of any portion of the placental tissue being left in the uterus, we should not treat a rise of temperature with douching. Douching is not sufficient to remove any adherent membranes or placenta; nothing but the curette is sufficient in such cases. Here in Case 2, if the curette had been early used, the necessity for an abdominal section would have been spared. Interfere early and interfere thoroughly was his advice in all such cases.

He was not in accord with Dr. Smith in his absolute faith in permanganate of potash and oxalic acid as disinfectants. He thought it a dangerous doctrine to set forth that the thorough use of those agents on the hands does away with the necessity of any or all other precautions. In the abstract it may be correct to say that thorough disinfection makes previous occupation of no importance; but, in practice, it will be found unjust and unwise to counsel men that they may leave the post-mortem room and confine a woman with impunity, provided they wash their hands in permanganate and oxalic acid. It will be found that disinfection comprises much more than the cleansing of the fingers.

Dr. JAMES BELL thoroughly agreed with Dr. Cameron's remarks regarding the insufficiency of manual disinfection. The truth of this is well seen in the hospital, where students, ever apt to seize upon the most prominent part of the technique, often confine their disinfection to washing the hands, etc., and neglecting other and very essential precautions.

Dr. ARMSTRONG, in reply, said that relative to the Dr. Smith belief, that the hands are the only source of infection in midwifery, it has lately fallen to his lot to see three cases, two of them fatal, occurring in the practice of accomplished, faithful, truthful men, who asserted that the children were born before they reached the house; that they never touched the vulva, never made a vaginal examination. Granting that the hands are the most important part, if you have a dirty field of operation, dirty vulva, if you have fecal matter coming down, no matter how clean your hands are, you carry over the germs that are on that surface; you must have everything clean.

In regard to Case 3, and Dr. Smith's remarks about the two pints of pus, he said that he had no knowledge of any kind of peritonitis that could be present for nine days and give no symptoms; that, at the operation, puzzled with the obscurity of the case, the incision was enlarged, and a most thorough examination of the cavity and its contents made, with a view to find an abscess or some such explanation for

the quantity of the pus, but without success. In the face of these facts, unlikely as it appeared, the conclusion expressed was the only one left them.

In regard to operating in peritonitis, he agreed with Dr. Cameron; still, there is no other hope for these patients; and while there is even the shadow of a chance by operating, he felt it is hard to refuse to undertake such a step.

Stated Meeting, 20th Oct., 1893.

JAMES BELL, M.D., PRESIDENT, IN THE CHAIR.

Drs. H. B. Carmichael, C. F. Martin, P. J. Hayes and T. P. Shaw were elected as ordinary members.

Enucleation of Tumor of the Thyroid Gland.—Dr. SHEPHERD related two cases of this operation.

The first was performed on 5th July, 1893, by cutting through the capsule after ligating the thyroid arteries. The tumor was readily shelled out, and the hæmorrhage was trifling. The growth had been rapid and had caused increasing difficulty of breathing. In the second case, operated on 29th September, 1893, the growth was larger, and extended below the clavicle, but was easily shelled out. Attached to it were a number of vessels spreading out like the branches of a tree, but none of them required tying. In the dissecting room he had recently seen a similar tumor, which he had been able easily to shell out. After this operation there was no danger of any œdema, and enucleation was likely to be the operation of the future.

The PRESIDENT remarked that in both Dr. Shepherd's cases the growths were cystic. He had seen Kraské enucleate an adenoid goitre extending below the clavicle. It had shelled out quite easily.

Fibroid Tumor of the Uterus.—Dr. LAPTHORN SMITH showed a specimen which he had removed from an unmarried lady aged 34 years. The bowels had always been regular—an exceptional circumstance in such cases. A few weeks ago her legs became swollen. On examination, a diffuse fibroid tumor was found occupying the posterior wall of the uterus. The transverse diameter of uterine cavity was increased. Patient was anæmic. Abdominal hysterectomy was performed on 2nd October, 1893, the uterus being transfixed at the level of the internal os. No complications. Highest temperature was 100½° in mouth. The stump was dressed with boracic acid and was free from all unpleasant odor. Peritoneum, linea alba and skin were sutured separately. Convalescence was good.

Small Fibroid Tumors of the Uterus and Broad Ligaments.—Dr. WM. GARDNER exhibited this specimen removed from Mrs. L., aged 42, married 13 years, sent to him by Dr. W. Grant Stewart. The operation was exceptionally difficult, owing to adhesion of the entire omentum to the anterior abdominal wall. Two nodular myomata were enucleated from the right broad ligament, the ovaries and tubes removed, and the uterus amputated by the flap method after ligating the uterine arteries. There was considerable oozing. A glass drain was introduced. Four hours later hæmorrhage commenced, but was checked by pouring a sterile solution of perchloride of iron into the tube. The tube was removed in 48 hours, and recovery was steady. The growths in the broad ligament appeared to be distinct from the uterus.

Grape Tuberculosis of the Peritoneum.—Dr. ADAMI exhibited a specimen received from Dr. Gardner.

Dr. Gardner had recently performed an exploratory laparotomy upon a young woman, where, upon opening the abdomen, the intestines, omentum and the parietal peritoneum were found to be studded with nodules varying in size from a small pea to that of a grape. There must have been more than a thousand of these new growths, which were white, firm and gobular. No large conglomerate growth could be found in connection with the ovaries, uterus, intestines or other organs. In removing a few of the growths from the mesentery they were easily separated from the surrounding tissue, and upon microscopic examination exhibited the characteristics of tubercles. The masses were subserous, and were composed of tubercles of a peculiarly chronic type, many showing central necrosis, although the caseating masses did not coalesce, while all were surrounded with well formed layers of fibrous tissues. There were numerous giant cells, and further study demonstrated the presence of numerous tubercle bacilli. Dr. Adami described this as "grape tuberculosis" from its similarity to the "disease," or tuberculosis, of cattle. This is a chronic form of tuberculosis. He exhibited the liver of a calf just received by him, which upon its surface showed similar grape-like masses of tubercles.

Dr. GARDNER stated that the patient had been sent to him by Dr. Ewing of Hawkesbury. The nodular masses and thickened omentum could be made out by palpation. After watching the case for three weeks tuberculosis was suspected, there being physical signs in the lungs and a rise of one degree or more in the evening temperature. Operation was performed, as experience had taught that peritoneal tuberculosis was a remediable condition.

Dr. SHEPHERD referred to a man under his care three or four years ago, where the temperature reached 101° daily for several weeks, and hardness could be felt through the abdominal walls. On operation he had found a condition almost identical with the specimen shown. Some of the masses were examined

microscopically, and pronounced tuberculous. From the day of operation, he commenced to improve. The temperature soon fell, and a year later he had gained twenty pounds in weight.

Dr. MILLS thought the benefit was explainable through the effect of the operation upon the nervous system, thus indirectly changing the metabolism of the whole organism.

Dr. SMITH thought the improvement might be due to the irritation caused by the entrance of air.

Dr. LAFLEUR was surprised to find this subject regarded as new. Dr. Osler in his monograph on tuberculous peritonitis states that though miliary tuberculosis does not get well, chronic forms always improve. Ordinary puncture does not have the same effect as incision. He considered that spontaneous healing of peritoneal tuberculosis also took place.

Dr. ADAMI considered that the "shock" which follows upon abdominal incision suffices. to explain the retrogression of the tubercled It is well known that exposure of the peritoneum leads to an inflammatory condition of the same, to dilatation of the vessels and increased blood supply As Professor Roy had recently shown in "shock" produced by various means, the specific gravity of the blood rises rapidly, and is accompanied by increased exudation into the peritoneal cavity and dilatation of the mesentery and intestinal vessels. He held that with this inflammatory or sub-inflammatory condition there was increased nutrition of the tubercular areas, improved state of the cells, and thereby arrested advance of the tubercular process, and cicatricial tissue developed so as to encapsule the tubercles. In the chronic cases such as that exhibited by him, there was already a tendency to this, so that slightly increased vascularity and improved nutrition would turn the scale in favor of the organism and against the micro-organism.

Dr. F. W. CAMPBELL thought that the system could be permanently influenced by shock, and gave illustrations in support of this view.

Ovarian Dermoid.—Dr. ADAMI exhibited a large dermoid which had been sent to him by Dr. W. Gardner. The tumor measured six inches in diameter; the walls outside showed membranous adhesions. Upon opening, the cyst was found to be filled with thick fluid with fatty particles floating in it; and when this had escaped, the cavity was seen to contain a large amount of fatty material and debris, and a relatively very large quantity of loose hair tending to be arranged in balls. The walls were irregularly thickened, and in them was a large bone of irregular shape, consisting of a main portion 2¼ in. in length and ½ in. in thickness. From this at one extremity projected two wings, of which the larger was 3 in. long, while the smaller bore a clump of three well developed teeth projecting into the cyst. At the other extremity was given off a line of three small flattened bony plates united together by fibrous tissue, in all 2⅛ in. long. The main mass of bone was hollow, containing towards its outer surface a subsidiary cyst also bearing hair. Into it projected from the bony floor a cystic glandular mass. This large bony mass could easily be felt upon abdominal palpation before the operation. While small bony developments in ovarian dermoids are not uncommon, it is extremely rare to obtain so large a mass as the one here described.

Dr. WM. GARDNER stated that clinically the only point of interest was that the portion of the pedicle was not extreme enough to interfere with the circulation.

Fibroid Tumor from the sheath of the Femoral Artery, with secondary growth within the Femur—Dr. ADAMI. This tumor had been removed by Dr. Roddick, who, finding upon his first attempt at simple removal that it was intimately connected with the sheath of the lower end of the femoral artery, determined to amputate the leg of the patient, an elderly lady, and cut across the femur at the junction of the upper and middle thirds of the bone. The tumor reached Dr. Adami in bad condition, having accidentally been laid aside. Its structure was that of a slow growing spindle-celled sarcoma, which in parts was more truly fibromatous, and which throughout showed a tendency to a fasciate arrangement of the constituent cells. No secondary growth had been made out anywhere, but upon making a longitudinal section of the removed femur there was discovered a white mass, the size of a Barcelona nut, lying somewhat loosely in the medulla of what corresponded to the lower part of the middle third of the bone, and this upon microscopic examination was seen to be of sarcomatous nature, being formed of spindle cells, of typical form towards the periphery, but more internally possessing nuclei which might at first sight be mistaken for those of a myoma, their length being remarkable.

Perforation of the femoral artery and vein in Hunter's canal by a bullet wound.—Dr. BELL. On Sept. 16th, 1893, the patient, a boy, was shot in the thigh by a 16-calibre ball. On bandaging, the bleeding ceased, but the pain in the thigh prevented walking. A few days later he entered hospital, when a fusiform swelling in the region of Hunter's canal was observed. There was no diffuse pulsation, but a very loud bruit on auscultation. One and a half inches of both vessels were removed. On the fifth day pulsation could be felt in the posterior tibial artery.

Appendicitis.—Dr. JAMES BELL exhibited specimens from the following seven cases:

1. Recurrent case. Operation three weeks

after the second attack. Perforation with local abscess.

2. Operation 18 hours after the onset. Appendix greatly dilated and quite gangrenous.

3. Operation 48 hours after onset. Widespread abdominal pain. The appendix looked normal externally, but was full of grumous bloody fluid.

The adjoining lymph glands were enlarged and soft, and the peritoneum œdematous. It appeared to be a case of early catarrhal appendicitis with severe lymphangitis.

4. Operation 50 hours after onset. Appendix gangrenous.

5. Operation 41 hours after onset. Appendix perforated and gangrenous.

6. Operation one week after onset. Appendix perforated. The patient was in a septic condition, and subsequently died.

7. Operation two weeks after onset. Appendix perforated with local abscess. The patient died apparently from toxæmia rather than septicæmia.

Of the gangrenous cases none had died, and of the catarrhal cases, two died; so that the milder forms appeared to be by no means so far from danger as is generally thought. The marked symptoms in gangrenous cases lead to early operation while the milder forms are neglected.

Dr. SHEPHERD referred to a case where the appendix was apparently only a little thickened. Dr. Johnston had found it filled with pus and blood. He had been unfortunate with his gangrenous cases three having died unrelieved by the operation. Operation may be performed too early, before there is a line of demarcation formed.

Enlarged Glands pressing upon the trachea from a case of Hodgkin's disease.—Dr. FINLEY exhibited the specimens obtained at an autopsy upon a man aged 27, and gave an account of the case. (The patient had been previously brought before the Society in Oct., 1890, by the late Dr. R. L. MacDonnell, and the case had been published in the *International Clinics* for Oct., 1891.)

The disease had lasted 7 years. The earliest symptom was the occurrence of urgent attacks of dyspnœa. After an interval of two years these attacks recurred, and enlargement of the cervical lymph glands was noted. The spleen was then enlarged. The removal of some glands from behind the sternum by Dr. Shepherd gave relief. In 1891 there was stridor and dyspnœa, with enlargement of the cervical and axillary lymph glands, the size of which varied considerably from time to time. In Dec., 1892, the inguinal glands enlarged. Six months before death the man became very weak and anæmic, though temporary improvement followed the administration of Fowler's solution. In June, 1892, the blood count gave 3,317,000 red cells, with white cells 1.50, mostly polynuclear. In Dec., 1892, the red cells were 2,571,000, no leucocytosis. In June, 1893, there was effusion into left pleura, and the patient died in orthopnœa. At the autopsy, body was emaciated, and showed (arsenical?) pigmentation of skin. The trachea surrounded by a cluster of enlarged glands as big as a fœtal head. Lumen of trachea compressed to a mere chink, and mucosa eroded. Some of the glands presented softened centres. Retro-peritoneal and pelvic glands enlarged to masses of considerable size. Spleen three times normal size. Growth infiltrated lower lobe of left lung. Six secondary nodules in right lung. Bone marrow of ribs and sternum grayish red. The seven years duration of the case was remarkable. In 50 cases tabulated by Gowers, only one exceeded 5 years. Osler gives the duration as from 3 to 4 months to as many years. Possibly the continued use of arsenic had lengthened life.

Stated Meeting Nov. 3rd, 1893.

JAMES BELL, M.D., PRESIDENT, IN THE CHAIR.

Drs. G. A. Berwick and J. T. Reid were elected members of the Society.

Removal of Gasserian Ganglion for Facial Neuralgia—Dr. JAMES BELL exhibited a woman upon whom he had performed this operation for intractable facial neuralgia. Krause's operation was performed, an incision being made from the external angular process to point in front of the tragus of the ear. The zygoma was removed with bone forceps. In trephining the skull, the middle meningeal artery was seized. It ran in a foramen, and therefore some bone had to be chipped away. The dura was separated from the bone down to the petrous region, the brain being held away with the finger. The second and third branches of the fifth nerve were divided at the foramina, and reflected backward with the Gasserian ganglion till the trunk of the nerve could be cut and the ganglion and attached nerves dragged away with the forceps. To familiarize himself with the operation he had practised it on the cadaver. The risks of operation were: (1) wounding the adjacent vessels, and (2) trophic changes in the eye-ball. To avoid the latter the eyelids were sutured for a few days. Except for loss of power of the temporal muscle, paralysis of one side of the face and slight giddiness lasting a few weeks, there were no bad symptoms, and she had been free of pain since the operation. Previously the nerve had been stretched without any relief being obtained. In the operation known as "Rose's," the foramen ovale is approached from the base of the skull by an incision over the parotid region. This operation is more difficult. Five

cases are reported by Mr. Rose and six are reported of Krause's operation—which should really be called Hartley's operation, Hartley of New York being the first to perform it. It was too early to judge fully of the results, but cases were reported free of pain after 22 months where stretching and external neurotomy had failed.

Discussion—Dr. STEWART had seen the patient, and regarded medical treatment as useless. The pain was intense, and had been worse since the stretching. It was hard to say whether the cure would be permanent.

Dr. MILLS thought that from the important nerves involved the dizziness noted might be owing to the operation.

Dr. LAPTHORN SMITH had found benefit result from constitutional treatment by iron and tonics in cases of tic.

Dr. BELL, in reply to Dr. Mills, said that dizziness is common in persons confined to bed after any operation.

Sub-diaphragmatic Abscess—Dr. ADAMI related a case of this nature due to suppuration around a cancer of the lower part of the œsophagus, as follows :

It is not a little noticeable how silent are even the best and most modern text-books upon the subject of sub-diaphragmatic abscess, with a silence that is out of proportion to its diagnostic and clinical interest, and, it maybe added, to its relative frequency. Doubtless the fact that the subject cannot be treated under the heading of any one special organ leads to its being neglected in well-ordered text-books, so that information has still to be gathered from scattered papers. Thus it happens that although I am acquainted with a fair number of cases in which the original disturbance has originated in connection with the liver, kidney, spleen or stomach, I have been able to find none presenting the anatomical features of the case here recorded, though such must exist.*

The patient, L. F., sixty-five years old, was received into the General Hospital, under Dr. Molson, upon October 3rd, in a state of semi-collapse. All that could be ascertained as to his previous history was that for the past four or five days he had been suffering from pain in the epigastrium, thirst, restlessness and pains in the joints. He died within twenty-fours hours, before time had been allowed for a full diagnosis. The pulse was almost imperceptible, there was a large area of cardiac dullness, the heart sounds could scarcely be heard, while no murmur could be detected. Over the region of the liver in front there was acute pain upon pressure. The respiratory sounds were tubular. A provisional diagnosis was made of pericarditis.

At the autopsy performed upon October 5th, the following were the more important conditions observed. The skin of the whole body had a slight yellowish tinge. The pleural cavities contained about eight ounces of clear serum. The lungs were very œdematous, showed some slight signs of anthracosis, and in either apex were found evidences of an old and cicatrized tuberculous condition. The pericardial cavity was enormously distended, the fluid was milky with numerous flocculi floating therein. The heart was covered over with a layer of inflammatory lymph ; and its cavities were filled with well-formed clots, firm and rather pale, together with some fluid blood. The lower and inner half of the parietal pericardium was thickened, and upon cutting into it, down upon the diaphragm an abscess cavity was exposed lying between diaphragm and pericardium. This was of irregular shape, and contained a quantity of thick, creamy pus. Upon inspecting the abdomen, a large abscess was found beneath the diaphragm, having in its centre the abdominal end of the œsophagus and the cardiac end of the stomach. This extended to the left edge and under the surface of the left lobe of the liver on the one side ; on the other it almost touched the splenic flexure of the colon and the surface of the spleen. It was filled with a thinner greyish pus, and communicated through the diaphragm with the supra-diaphragmatic abscess. The cardiac orifice of the stomach was discovered to be greatly stenosed and ulcerated. Further inspection revealed that there was a ring of cancerous growth implicating the gastric mucous membrane, and forming a ring varying in breadth from 2 to 3 cm. around the cardiac orifice; the growth extended a short distance up the œsophagus. Microscopical examination showed the cancer to be primarily gastric — that it is to say, it was of the nature of a columnar-celled carcinoma. It infiltrated all the coats of the stomach.

No actual perforation of the stomach or œsophagus was to be discovered.

It would seem evident that the history of the case was one primarily of cancer of the cardiac orifice of the stomach leading to stenosis ; ulceration of the cancer, and extension of the septic process through to the serous surface of the organ—or, it may have been, perforation above the stenosed area by a fish bone or other fine spicule, the passage closing behind the foreign body ; suppuration around the termination of the œsophagus leading to a sub-diaphragmatic abscess ; extension of the process through the diaphragm ; inflammation of some little standing of the outer layers of the parietal pericardium ; extension through the pericardium ; purulent pericarditis ; death.

Judging from the condition of the sub-dia-

* Petit, Dissertation, Berlin, 1868, quotes a case of sub-diaphragmatic perforation of the œsophagus following upon cancer, but of the extent of the succeeding inflammation I cannot clearly learn, not having the original by me.

phragmatic abscess, and the want of the well defined boundary, this had of late been extending rapidly.

There is a possible alternative that the supradiaphragmatic abscess with its more creamy pus was of the earlier origin, but this I think is improbable. The presence of the gastro-œsophageal carcinoma in such characteristic relationship to the surrounding sub-diaphragmatic abscess renders the former the more likely course of events.

Papillomatous Cyst of the Ovary—Ovario Hysterectomy—Dr. LAPTHORN SMITH showed this specimen which he had removed from Mrs. E., aged 30. Enlargement of the abdomen was first noticed by her husband on their wedding day, and wrongly attributed to pregnancy. Examination showed that the uterus was not enlarged, but that the whole of the pelvis was occupied by a large cystic tumor. After a few weeks preparatory treatment, laparotomy was performed on 4th Oct., 1893. The lower part of the cyst was adherent to the Douglas fossa. The uterus was removed with the tumor at the level of the internal os. The abdomen was flushed with water at 100° F., and drainage tube inserted. The patient made an excellent recovery. The tumor is a multilocular cyst of the left ovary, the inner surface covered with warty growths. Both ovaries and uterus closely adherent and the line of separation is difficult to determine. Fallopian tubes were free.

Dr. WYATT JOHNSTON showed the inferior maxilla of a drowned woman pronounced by coroner's jury to be a girl of 18, missing for some months, and was claimed as identified by an article of jewellery. The wisdom teeth in this case were fully developed, and corresponded with those of persons thirty years of age; a malformation of the bicuspids described in the missing girl was also present in the specimen, but it was in all probability a case of mistaken identity in spite of the coincidence of the jewellery and malformation of the teeth.

Saline enemata in post-partum hemorrhage—Dr. JOHN A. HUTCHINSON related the case as follows:

I wish here to refer to a case of severe post partum hæmorrhage occurring in practice a short time ago, which illustrates the beneficial effects of saline enemata:

I was called late one night to see Mrs. S., who had an abortion at the second month, and had bled profusely for several hours. On examination she was found to be much collapsed, and presented the appearance of one near death from loss of blood. She was very blanched and anæmic, with a pulse of 140, weak and thready, sighing respiration and partially unconscious. The bleeding had stopped, but there was danger of death unless something was done to aid the circulation.

It seemed a favorable case for transfusion, and I spoke to Dr. Roddick with a view to having this done. He advised, before doing this, to try saline enemata. This I did, and used the same solution as is now used for transfusion into a vein or artery, that is,

Sodium chloride grs. xcii.
Liquor soda mxx
Aqua O ii

Half of this solution was injected and well retained, and in two hours after the other pint was given and retained.

The temperature of the solution was 98°F.

The hips were raised to allow the fluid to gravitate up the bowels.

A marked improvement resulted, both in pulse and respiration. A slight rigor ensued, followed by rise of temperature. Since that time the patient has made a good recovery.

The advantage of this treatment over transfusion is very apparent, in the fact that it can be done at once, as the solution is easily obtained, and also easily administered, while there is some danger in transfusion, particularly as air may get into the vein or artery. Again, it requires some training in manipulation that the every day practitioner may not have, and the necessary instruments are not always at hand when wanted.

Since this case occurred, I find in the *British Med. Journal* of the 14th of October, that Warman reports the treating of 28 cases of post-partum hæmorrhage in this way. In his cases he only uses a teaspoonful of salt to a quart of water, and at the temperature of the room, which he thinks causes it to have a more rapid effect than at a higher temperature.

He also states that the saline solution has marked hæmostatic properties, and recommends its use in all hæmorrhages except those from intestines.

I have reported this case because I think that in emergencies of this kind, this treatment has not received the attention its importance demands. Most cases are treated by stimulants and nourishment, if transfusion is not done; but by the absorption of this saline in the bowel, the blood vessels are quickly supplied with a solution that certainly takes the place of the lost blood at a critical time for the patient.

Hibernation and allied states in Animals and Man—Dr. MILLS read a paper on the subject, published in the transactions of the Royal Society of Canada, 1892, Section IV, page 49.

Besides studying cold-blooded animals and bats, Dr. Mills had made observations extending over a period of five years on woodchucks, one of which presented a drowsy or torpid condition from November to April, independently of conditions of food and warmth. Another woodchuck did not hibernate at all, even when kept in the cold. Three remarkable in-

stances of profound lethargy in the human subject were also studied under the direction of Dr. Mills. One of these, known as Sleepy Joe, aged 60, would sleep for weeks at a time, waking only to take food and void his excretions. Another case, that of John T., of a neurotic family, had been the subject of melancholia. For the past twenty years he remained in a somnolent condition from September to June in each year. His temperature was observed to be 96° on one occasion. Once he was aroused by application of an electric battery, but subsequently this failed to disturb him. The third case was studied with Dr. Clark, of Kingston Asylum. The patient, a woman of over 60, was lethargic for nearly 20 years. Appetite was usually good. The urine contained one-third the normal amount of phosphates. An autopsy was obtained, the brain being found healthy. The lungs contained tubercles.

The discussion upon this paper was postponed till the next meeting.

Stated Meeting, 17th Nov., 1893.

JAMES BELL, M.D., PRESIDENT, IN THE CHAIR.

Dr. George Villeneuve and Dr. R. Tait Mackenzie were elected members.

Pyloroplasty—Dr. SHEPHERD exhibited a patient from the Montreal General Hospital, upon whom he had performed pyloroplasty in July last. A diagnosis of dilatation of the stomach with stenosis of the pylorus had been made by Dr. Wilkins. There was a history of stomach trouble for 15 years, consisting in recurrent attacks of gastritis lasting from two weeks to two months, with occasional vomiting of blood; between these attacks he enjoyed fair health. Three months before entering hospital he had an attack of gastritis, which was not recovered from as usual, the stomach having apparently lost the power of passing solid food on to the duodenum, so that liquid food only could be employed; after a time this was also rejected, vomiting occurring in enormous quantities at intervals of two to three days. On entering hospital he weighed only 119 pounds. Dr. Shepherd performed the Heinicke-Mikulicz operation of resecting the scar tissue about the duodenum and bringing together the healthy tissues of the duodenum and stomach, rather than the Italian or Loretti operation of forcibly dilating the pyloric orifice. At the operation the pylorus was involved in a huge fibrous mass, looking like scirrhus, the orifice being too much constricted to admit the point of the little finger. For six days after the operation the man was fed by the bowel; afterwards, fluid nourishment was allowed by the mouth, and a few days later he was allowed ordinary diet, but cautioned against excess. His weight was now 179 lbs., or a gain of 60 lbs. from the time of entering hospital. The pylorus appeared to be acting normally. No vomiting had occurred since the operation. The highest temperature observed was 99 3-5. Before operation the stomach was repeatedly washed out with boracic lotion, as salicylic lotion was considered dangerous.

Discussion—Dr. WILKINS said that while under his care the patient had not improved on a peptonized diet. He had satisfied himself that the disease was non-malignant and was due simply to the cicatrization of an ulcer. This diagnosis has been confirmed by the increase in weight since the operation. He congratulated Dr. Shepherd on the result.

Dr. WESLEY MILLS said the persistence of vomiting showed that anti-peristalsis of the stomach took place. The history did not clearly show whether the increase in weight was due to increased ingestion of food or improved powers of absorption.

Carcinoma of the sudoriparous glands—Dr. C. F. MARTIN showed this specimen:

The patient from whom the above growth was removed was a contractor, 45 years of age, having a history of previous good health, with the exception of occasional attacks of dyspepsia. No history of syphilis, nor was there any family history of cancer or other tumor.

Early in 1890, the patient observed, for the first time, a small lump in the left groin, in size equal to a bean, perfectly painless, which he attributed to a blow received in this region some months previously.

The growth was regarded as some affection of the sebaceous glands, and no treatment other than the application of iodine was adopted for over a year, there being no appreciable alteration in the character of the tumor during that time.

Towards the end of 1892 it gradually increased in size, and was now for the first time painful, the patient at times suffering intensely. The skin too showed signs of irritation, and became adherent to the growth. This condition became progressively worse, and removal was recommended, and performed November, 1893, by Dr. Roddick, who forthwith sent the tumor to the McGill Pathological Laboratory.

On examination the growth was found irregularly spherical in shape, 1½ inches in diameter. On section it offered considerable resistance to the knife, while on the cut surface were seen numerous small points from which a greyish turbid fluid escaped. This fluid, examined under the microscope, presented masses of irregularly rounded or oval cells, slightly larger than pus cells, and many undergoing fatty and granular degeneration.

Stained sections of the tumor, cut so as to include the adherent skin, showed the epidermis to be only slightly affected, there being

but a slight proliferation of the epithelium, while beneath it was increased fibrous tissue, a condition of chronic inflammation. Beneath this, in the subcutaneous tissue, was seen the tumor proper, presenting the usual appearance of a simple carcinoma; masses of large irregular cells amid extensive areas of fibrous tissue, in an alveolar arrangement.

On closer inspection of the parts, it was found that the growth took its origin from the epithelial lining of the sudoriparous glands, in whose ducts could be seen the various stages of proliferation of cells, while in the neighboring regions were the appearances of an alveolar cancer. The sebaceous glands presented no abnormal appearance, nor was there any evidence to point to the origin of the tumor, other than that suggested.

Although many cases of adenoma of the sweat glands are said to have been falsely regarded as carcinomatous, there is, however, in the present instance so typical an appearance of an alveolar carcinoma that such an error is quite impossible, and the tumor cannot be regarded other than as a cancer arising from the sudoriparous glands.

Dr. ADAMI stated that the tumor had at first been regarded by Dr. Roddick as an enlarged sebaceous gland. Subsequently a diagnosis of epithelioma was made. He had recently shown an analogous case, when what looked like an epithelioma of the tongue proved to be a scirrhus arising from some of the muciparous glands of that organ.

Chronic abscess of bone—Dr. ADAMI showed a knee joint resected by Dr. Armstrong at the Montreal General Hospital during the past summer. The patient apparently recovered, but sinuses formed, and kept on discharging in increasing quantities. The man became emaciated. Amputation was performed by Dr. Sutherland two weeks ago. Union was pretty well advanced, but was entirely fibrous in nature. There was still a slight movement between the bones. On making a section, a number of small abscesses connecting with one another were found situated in the lower extremity of the femur, and connected with the region between the two bones from whence they discharged. No tubercle bacilli were found. The condition appeared to be one of chronic suppuration. The question was whether these abscesses were the result of old foci of disease not detected at the time of operation.

Dr. ARMSTRONG stated that the patient, a lumberman about 35 years of age, had sustained some slight injury of the joint, but was able to continue work for about six months. The joint was then found swollen and painful, and evidently extensively diseased. Immobilization of the limb was tried without benefit, and so Dr. Fenwick's excision operation was performed. Some sinuses which persisted were scraped under ether two or three times, without benefit. He was surprised to learn that no tubercle was found, as at the time of excision the joint had all the naked eye appearances of tuberculous disease.

Dr. BELL suggested the possibility of the condition being originally tuberculous, the bacilli having subsequently become destroyed. He was of opinion that the abscesses were there at the time of operation, but did not communicate with the joint. All surgeons know that when a thin slice is sawn off the end of a bone, little foci of disease are noticed in the new surface exposed. Had always thought it strange that more of these little pockets did not lie higher up in the bone; in this case it looked as if they had.

Dr. SHEPHERD thought that the abscesses were present at the time of operation. The pain, at the time, was much more severe than seemed called for by the extent of the joint disease.

Tuberculosis of the Liver and Oviduct of a Pigeon—Dr. WESLEY MILLS exhibited the specimen, showing what extensive disease could exist in domestic animals in apparent good health. The bird seemed quite well till a few days before its death.

The discussion was postponed pending a report from the pathologist.

Pyosalpinx and Gonorrhœal Arthritis—Dr. LAPTHORN SMITH exhibited a specimen of double pyosalpinx in a woman aged 42, suffering from gonorrhœal rheumatism of the right knee joint. The patient had been ill ever since her marriage, 10 years before. Examination showed the uterine appendages filling Douglas pouch and forming a tender fluctuating mass the size of an orange. While in hospital, preparatory to operation in June, 1893, she suddenly developed high fever, swelling of the first joint of the right fore-finger and scalding in micturition. Next day the right knee became swollen and painful. There was a yellow purulent discharge from the urethra and vulva vaginal glands. Exploratory puncture of the knee-joint yielded an opalescent serum. This was not examined for gonococci. After seven weeks the joint was still stiff and painful. Temperature then normal. In October, 1893, cœliotomy was done and the appendages removed. The tubes were found distended with pus and closely adherent. Recovery was good. The operation was followed by marked improvement of the knee joint, and the patient made a rapid recovery. The husband admitted having recurrent attacks of gonorrhœa, the last occurring shortly before the wife developed the above-mentioned arthritic attack. The gonorrhœal infection probably affectedthe parenchyma of the uterus, which should really have been extirpated.

Dr. ALLOWAY said he differed from Dr. Smith as regards the interpretation of the metastasis. He thought the disease of the knee-joint not gonorrhœal, but pyæmic, and that the subsequent occurrence of inflammation in the finger joints confirmed this view. He had seen several times metastasis of this nature following pelvic disease. In one case seen with Dr. Shepherd, where there was suppuration of both knee joints, the remains of a necrotic placenta were found in the uterus. On scraping the uterus the patient recovered. He did not think the joint disease in Dr. Smith's case was due to the gonococcus.

Dr. SMITH in reply stated that if his case had been pyæmic, pus would have been found in the joint, instead of only an opalescent fluid. He had himself thought of pyæmia, but the fact of the pus tubes having been there for ten years without any metastasis, and the knee affection appearing after an attack of gonorrhœa made him change his opinion.

Discussion on Dr. Mills' paper on Hibernation—Dr. F. W. CAMPBELL mentioned a case of duodenal ulcer where the subjective symptoms had disappeared under the mental condition induced by a favorable (though wrong) diagnosis being given, and had returned again only when the correctness of the diagnosis was insisted upon. The diagnosis was confirmed by autopsy. The mental condition seemed to determine whether pain, etc., was felt or not.

Dr. GIRDWOOD told of the doings of two woodchucks formerly in his possession. These animals did not hibernate.

Dr. ADAMI asked if Dr. Mills had tried the experiment of feeding the animals abundantly.

Dr. MILLS, in reply, stated that he had not been able to prevent hibernation by good feeding. He referred to some interesting work by Carlier on the histology of the hedge-hog, showing that the tissues during hibernation differed from these in the normal state in the following particulars:—(1) They were less readily acted on by nuclear stains. (2) The cells were smaller. (3) The leucocytes of the blood were diminished in number. This latter point would, theoretically, make the animal more susceptible to infection than when not hibernating. His object in making these studies was to see if a general law of relation could be established between hibernation and sleep. It was possible that primæval animals lived in a state analagous to hibernation.

Statistics of Homicide in American cities—Dr. WYATT JOHNSTON, who read a paper on this subject, had found the annual number of homicides (including manslaughter and infanticide) per 10,000 living to be approximately as follows: Central District of London, .15; Vienna .18; Paris, .19; Philadelphia and Liverpool, .22; Montreal, .24; Buffalo, .33; New York, .35; Boston, .43; Toronto, .50; Pittsburg, .51; Chicago, .65; Cleveland, .66; Birmingham, .89; St. Louis, 1.38; Louisville, 1.58; Charleston, 2.00. These estimates were based on the findings of inquests, not of trials. The greater proportion of homicides occurred in the Southern States, where a large and lawless negro element existed and where concealed weapons were habitually carried. The apparent low homicide rate in great European cities was a matter of surprise. The low rate in Montreal might be due to the peaceable character of the people and the absence of concealed weapons rather than to cases being overlooked, as in other cities the majority of homicides were from such easily recognized causes as cuts, blows and stabs. Abortion and poisoning were forms likely to be overlooked, and a proper system of death certification would be a great check upon homicides of this kind. In Boston a system of investigation of all deaths from peritonitis in all women of the child-bearing age had led to the detection of many cases of abortion previously unnoticed.

Mr. QUINN, Q.C., Crown Prosecutor, who was present, said he thought the composition of coroners' juries in various places would tend to affect the statistics. A low status of jury would lessen the number of homicide verdicts. Montreal juries rarely gave a verdict in accordance with the evidence. In the case of large cities like London, many homicides probably occurred when the bodies were never found, and this might partly explain the apparently low proportion. The means of concealing crime increased with the population. He had reason to believe that abortion is more common in Montreal than was supposed. The criminal death rate reported in Montreal was not the true one. All deaths should be reported to the health office, and, unless properly accounted for, the matter should be placed in the hands of a medical officer, for thorough medico-legal investigation.

Dr. GIRDWOOD agreed with Mr. Quinn, as to death certification. In the Hooper case, a certificate was obtained from a physician who knew nothing about the woman or the death. No man should give a certificate unless he had seen the person during life or had made some diagnosis.

Dr. SHEPHERD believed that many cases reported as stillbirth were really cases of infanticide.

Death Certification.—The Secretary read a communication from Dr. LABERGE, city health officer, asking for the co-operation of the Society in securing an amendment to the city charter in the matter of certification.

Dr. LABERGE'S letter pointed out that a death certificate could be given by any relative or friend of the deceased, practically by anyone at all. It was essential that these certificates

should only be signed by properly qualified medical men, and that the matter of deciding whether the qualifications of the signer were satisfactory and the certificate properly made out, as regards nosology, should be left to competent persons, instead of, as at present, to superintendents of cemeteries, whose education hardly fitted them for these important duties.

Upon motion of Dr. F. W. CAMPBELL, it was resolved to refer the matter to the council of the Society, and such other persons as the council might select, with power to give Dr. Laberge such advice and assistance as seemed necessary.

Progress of Science.

HERNIA IN CHILDREN.

Wirt (*International Medical Magazine*, February, 1894), in an excellent contribution on hernia, gives the following table of the relative frequency of the different forms of hernia as found in 19,756 cases treated in the Hospital for Ruptured and Crippled, New York City:

	No Cases.	Male.	Female.	Under 14.	Right.	Left.	Double.
Inguinal..	16,864	14,994	1870	4 348	7806	4375	4686
Umbilical.	1,488	569	919	789	....	....	....
Femoral..	1,135	418	717	26	700	379	56
Ventral...	269	95	174	13	....	....	....
Total.	19,756	16,076	3680	5176	8506	4754	....

He classifies treatment under three heads: 1. General treatment; 2. Mechanical support; 3. Operative measures.

General treatment is directed toward the relief of the conditions causing the hernia, as vomiting, coughing, calculus, a rectal polypus, or chronic diarrhœa, or, when necessary, to tonic treatment, out-door exercise, etc.

Mechanical treatment as given in the Hospital for Ruptured and Crippled, consists in using a steel spring truss for all reducible cases except umbilical and ventral. The Knight truss is used most, and is efficient and cheap. In cases difficult to hold, the Hood truss is employed, and in the worst cases a combination of the Knight and Hood.

Umbilical herniæ are treated by means of a wooden button held in place by rubber adhesive plaster.

Operation for hernia requires strict antiseptic precautions, great care in dissecting out the sac and handling of the supermatic cord. The sac should be tied off well down in the wound, the external portion removed, and the stump returned into the abdominal cavity. The wound should be closed and dressed antiseptically, and over all a plaster-of-Paris spica should be applied from ankle to umbilicus. The casing should be removed in eight days, and the wound then dressed.

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MONTREAL, APRIL, 1894.

THE PHYSICIAN'S WIFE.

We thought we knew something about the doctor's wife; but after having read a charming little book entitled "The Physician's Wife and the Things that pertain to her Life," by Ellen W. Firebaugh,* we must confess that we had only a very faint idea of all the beauties of her character. The author in the most natural and modest manner tells her own feelings, which are probably the feelings of a majority of her sisters, amidst all the vicissitudes of pleasure and sorrow which go to make up the daily life of the country doctor. No doctor or doctor's wife can read this book without exclaiming at almost every page: "How true to life the description is." Whether it is her efforts to keep the doctor's dinner hot without spoiling it; or talking care of the doctor when he is sick,—one of the most difficult tasks she has to perform; or whether she is describing a sick-bed scene among the poor; or her fear and trembling at being left alone in the house while the doctor is answering a midnight sick call, her descriptions are always graphic and interesting. Many of them are illustrated with sketches which bring them still more home to ourselves. One picture shows the doctor's first meeting the little girl who is to be his future wife; another, the doctor and his wife in their easy chairs drawn close to the grate fire, and enjoy-

*Published by F. A. Davis & Co., Philadelphia.

ing an all too brief rest after the labors of the day have been concluded, and, we might add, before the labors of the night begin. Then we see the doctor at the dinner table with a couple of medical friends beside him, while the doctor's wife has to listen patiently while they are talking "shop." In the latter, however, she soon becomes very proficient, so that in her husband's absence she is often able to tell an anxious patient what to do until the doctor comes. The country doctor will especially appreciate her descriptions of the difficulties of collecting a little ready cash, and of being so often paid with a load of pumpkins or turnips; and will sympathize with her when she tries in vain to obtain the assistance of some recalcitrant debtor who when ill expects to receive the best of care and medicine, but when well begrudges the doctor a day's work on his potato patch or flower garden. The doctor's wife sees human nature very often from behind the scenes, and she has in the volume before us described what she has seen with an amusing but not unkindly pen. While it will be most enjoyed by those for whom it was written, the doctors' wives, it will not be without value to the doctor himself, who, after reading it, will be ready to admit, if he has not done so before, that much of what he is or hopes to be he owes to the tender care and companionship of his better half. Many a young doctor will be induced to risk the unknown troubles of a country doctor's life when he learns that they are so much lightened by the assistance of a country doctor's wife.

BOOK NOTICES.

ANNUAL OF THE UNIVERSAL MEDICAL SCIENCES, a yearly report of the progress of the general sanitary sciences throughout the world. Edited by Charles E. Sajous, M.D., and seventy associate editors, assisted by over two hundred corresponding editors, collaborators, and correspondents. Illustrated with chromo-lithographs, engravings, and maps. In five volumes. Philadelphia, 1893. The F. A. Davis Company, Publishers. Annual Subscription, $15.

We hope our readers are fully acquainted with the excellencies of this most excellent Annual. It is a store house of medical progress, a time saver when hunting information, and, in the highest and best sense, practical. The volumes of the sixth series only serve to emphasize our previous opinion of the value of the Annual to every reading physician. The editor's residence in Paris, in the interests of the Annual, has enabled him to secure the assistance of some of our more distinguished associates in Europe on the editorial staff, and in various ways to strengthen and improve the work.

With the appearance of each new series our admiration increases. As we have said before, we hardly know which to admire most, the financial courage of the publishers or the unremitting toil of the editors. These thousands of pages come direct from the pen of the leading men in Europe and America, each in his speciality; how they manage to find the time to do it has puzzled us more than once. Those of our readers who have purchased this work have told us that they were more than satisfied with it; for those who have not seen it we may mention that it contains the gist of the thousands of articles which have appeared in the medical journals throughout the world during the past year, so that there is hardly a subject one can think of that has not been fully noticed in the volume before us. We hope that it will receive such strong support from the profession as to justify the publishers in undertaking such a marvelious work.

HOW TO USE THE FORCEPS, with an introductory account of the female pelvis and of the mechanism of delivery. By Henry G. Landers, A.M., M.D., Professor of Obstetrics and Diseases of Women and Children in Starling Medical College, Columbus, Ohio. Revised and enlarged by Charles Buchong, M.D., Assistant Gynecologist and Pathologist to Demilt Dispensary, New York. Illustrated. New York: G. B. Treat, publisher, 5 Cooper Union, 1894. Price, $1.75.

In our experience the forceps are used much too often; only in exceptional cases is the other extreme met with in which they are not used when they clearly should be. The work endeavors to show when and how they should be used so as to do the least damage.

VENEREAL MEMORANDA. A Manual for the Student and Practitioner. By P. A. Morrow, A.M., M.D., Clinical Professor of Venereal Diseases in the University of the City of New York. New York: William Wood & Company, 1894.

It must be the experience of most practitioners that a great deal of time is lost while driving along the country roads in summer days, or while waiting at a confinement case during the night. That time might be well employed if one

only had something in his pocket to read. To fill this very want the publishers have provided this series of pocket manuals, of which the above is one of the most interesting. It measures less than 3 by 5 inches, but contains over 300 pages, and it is surprising how much profit one may derive from the study of it during one's spare moments. We are unable to state the price, but it is probably very moderate, and it can be obtained through any bookseller.

SYLLABUS OF LECTURES ON THE PRACTICE OF SURGERY, arranged in conformity with the American Text-Book of Surgery. By N. Senn, M.D., PH.D, LL.D., Chicago, Professor of the Practice of Surgery and Clinical Surgery in Rush Medical College; Professor of Surgery in the Chicago Policlinic; Attending Surgeon to Presbyterian Hospital; Surgeon-in-chief St. Joseph's Hospital. Philadelphia: W. B. Saunders, 925 Walnut Street, 1894. Price $2.00.

Every teacher of surgery must have felt the need of some short guide to aid him in the lecture room in presenting the various subjects in a systematic, clear, succinct and practical manner. The student of surgery during his early college experiences is often bewildered by what he hears and reads, and keenly experiences that want of something which should enable him to separate the chaff from the wheat, and to memorize facts which he is expected to retain and apply at the bedside during his future professional career. This little book has been written to meet these requirements. Its contents have been arranged in conformity with the *American Text-Book of Surgery*, which in less than a year has achieved an unparalleled popularity, both among teachers and students. Wherever the text was found defective facts have been added names of authors and operations, while in other places subjects not belonging within the limits of the practice of surgery have been excluded. Recitations are gradually displacing didactic lectures, and it is the author's hope that the Syllabus will prove of special value for this method of instruction, as well as in the preparation of the student for the final examinations.

NINTH AND TENTH ANNUAL REPORTS of the Bureau of Statistics of Labor of the State of New York for the year 1891, in 2 volumes.

We have to acknowledge the receipt of the above 4 interesting volumes from the commissioner, Mr. Thos. J. Dowling.

A PRACTICAL TREATISE on the office and duties of Coroners in Ontario, and the other Provinces, and the Territories of Canada, and in the Colony of Newfoundland, with schedules of fees, and an appendix of forms. Third edition. By William Fuller Alves Boys, LL.B., Junior County Court Judge County of Simcoe, Ontario. Price $3.50 cloth or $4 in half calf. Toronto: The Carswell Co. (Limited), law publishers, etc., 1893.

This work is specially interesting just now when we are trying to improve our Coroner's laws in this province.

A PRACTICAL TREATISE ON NERVOUS EXHAUSTION (Neurasthenia); its symptoms, nature, sequences, treatment. By George M. Beard, A.M., M.D., Fellow of the New York Academy of Medicine; of the New York Academy of Sciences; Vice-President of the American Academy of Medicine; Member of the American Neurological Association; of the American Medical Association; the New York Neurological Society, etc. Edited, with notes and additions, by A. D. Rockwell, A.M., M.D., Professor of Electro Therapeutics in the New York Post-Graduate Medical School and Hospital; Fellow of the New York Academy; Member of the American Neurological Association; of the New York Neurological Society, etc. Third edition, enlarged. New York: E. B Treat, 5 Cooper Union. 1894. Price $2.75.

Neurasthenia is now almost a household word, and, equally with the term malaria, affords to the profession a convenient refuge when perplexed at the recital of a multitude of symptoms seemingly without logical connection or adequate cause. The diagnosis of neurasthenia, moreover, is often as satisfactory to the patient as it is easy to the physician, and by no means helps to reduce the number who have been duly certified to as neurasthenic, and who ever after, with an air too conscious to be concealed, allude to themselves as the victims of nervous exhaustion. The doctrine to be taught and strongly enforced is that many of these patients are not neurasthenic, and under hardly any conceivable circumstance could they become neurasthenic. They do not belong to the type out of which neurasthenia is born, either mentally or physically.

Many of them are unintellectual, phlegmatic, and intolerably indolent, and are pleased at a diagnosis which touches the nerves rather than the stomach, bowels and liver. Instead, therefore, of rest, quiet, and soothing draughts, they need mental and physical activity, less rather than more food, depletion rather than repletion.

These patients are lithæmic and not neurasthenic. The nervous system is strong enough, and would give no trouble were it not poisoned by the abnormal products of digestion that en-

ter the blood and circulate freely through every tissue of the body.

Nevertheless, there are many cases of genuine nervous exhaustion occurring equally among merchants and society ladies, whose education and mode of life have given too great a preponderance to the functions of the nervous systems to the neglect of the digestion and muscular system. These cases are generally exceedingly difficult to manage for obvious reasons. The book will therefore be of great value, coming as it does from one who has had such a large experience with this class of cases.

A TREATISE ON HEADACHE AND NEURALGIA, including Spinal Irritation and a Disquisition on Normal and Morbid Sleep. By J. Leonard Corning, M. A., M.D., Consultant in Nervous Diseases to St. Francis Hospital; Fellow of the New York Academy of Medicine; Member of the New York Neurological Society, etc. Author of "A Treatise on Hysteria and Epilepsy," "Local Anæsthesia," "Brain Rest," etc. With an Appendix. Eye Strain a cause of Headache, by David Webster, M.D., Prof. of Ophthalmology in the New York Polyclinic; Surgeon to the Manhattan Eye and Ear Hospital, etc. Illustrated. Third edition. New York: E. B. Treat, 5 Cooper Union; London: H. K. Lewis, 136 Grower Street. 1894. Price $2.75.

The affections treated of in the following pages have ever shown a decided predilection for the neurotic portion of our population. For the great towns of the Atlantic seaboard, headaches and neuralgias exhibit a special preference. To the nervous exhaustion and strain incident to the irregular mode of life and competition of the great cities are due, in no small degree, these head pains so often the precursors of impending nervous bankruptcy. The same causes, in conjunction with one of the most trying climates to be found in the whole world, serve also to give rise to a thousand aches and pains, the most excruciating of which are those neuralgias of the face that not infrequently drive the victim to suicide or the madhouse.

For several years past the author has devoted much time to the careful study of these prolific sources of human misery. He has not done this in a spirit of mere pathological analysis; but his endeavors have been of a practical kind, every thought being directed to the relief and cure of these distressing affections.

He has also added chapters on insomnia; relation of eye strain to headaches; and the localization of the action of remedies on the brain.

A PRACTICAL TREATISE ON THE DISEASES OF THE HAIR AND SCALP. By George Thomas Jackson, M D., Professor of Dermatology, Women's Medical College, N.Y. Infirmary; Chief of Clinic and Instructor in Dermatology, College of Physicians and Surgeons, &c. New, edition revised and enlarged. New York: E. B. Treat, 5 Cooper Union, 1894. Price $2.75.

In this edition of this book the reader will find all the knowledge about the hair that has been gained during the years that have gone since the appearance of the first edition of this book in March, 1887. During this time alopecia areata, the parasitic diseases, and seborrhœa have been studied with great care by many investigators.

Every page of the old edition has been revised and corrected; new articles upon folliculitis decalvans, leptothrix, and aplasia pilorum propria, and many new sections to the old chapters, have been added. The bibliography has been brought down to January, 1893, and nine new illustrations have been inserted in the text.

TRANSACTIONS OF THE COLLEGE OF PHYSICIANS OF PHILADELPHIA. Third series, volume the fifteenth. Edited by G. G. Davis, M.D. Philadelphia: Printed for the College, 1893.

This volume, which does great credit even to this distinguished body, contains twenty-four articles from the pens of such men as C. K. Mills, Shoemaker, Tyson, Sinkler, Noble, Wood, Hare, Cohen and Hirch.

The president's address by Weir Mitchell and the memoirs of Hayes Agnew by J. William White are also very interesting. Any young man who has the good fortune to read this life of Agnew cannot fail to be benefited by its perusal. The secret of his success is easy to find. The book is printed for the College, but we trust for our readers' sake that it has been placed on sale at a reasonable price, for it contains many medical gems.

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