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BY GEORGE ROSS, A.M., M.D., MONTREAL.

Gentlemen:—My first duty is to thank the members of the Canadian Medical Association for the great, and I may add, entirely unsought, honor of being called upon to serve as its President. Having been absent from last year's meeting, my election to this important position at that time was still more a source of surprise, but, nevertheless, of much gratification. If a simple loyalty to this Association as one of the rank and file, and humble efforts to sustain it by regular attendance and an occasional contribution, entitle one to any recognition, I may fairly claim that much. To more than that I lay no claim, and I know it is only the indulgent goodwill of my friends and fellow-members which has procured for me this great honor, one which I can assure them I duly appreciate, and I shall always endeavor to give them no reason to consider their kind confidence misplaced.

He whose duty it is to address officially an important meeting of this kind may well claim to be overwhelmed by an *embarras de richesses*. No restriction is placed upon his choice of a subject, and the field is practically limitless. To select is indeed difficult, and even when that difficulty has been overcome, there

remains the still greater one of so presenting it as to be deserving of your attention. Following after so many eminent predecessors, it is, I can assure you, no false modesty, but a sense of genuine incapacity for the task which has been constantly present with me.

It may not be amiss, on an occasion like the present, to take a hasty survey of the general standing and prospects of the profession in the Dominion, and to consider whether it be progressing as it should. In a young country like this, progress is exceedingly rapid in almost every department of life—in trade and commerce and agriculture—in the building of cities and the opening of great lines of railway, extensive systems of telegraphy, and other public works on a commensurate scale—in the establishment of public schools and the foundation of universities—in the consolidation of the professions and giving them their proper status—and a comparatively few years works changes which are rapid indeed in comparison with the more steady ways of older and more settled parts of the world. When we think that the Confederation, just like this Association of ours, is only even now of age,—that, up to that time, we were but a few weak provinces, with diverse interests, and without any common bond —and that to-day, only twenty-one years later, we are a vigorous and lusty young nation with territories extending across a whole continent and touching on either side the two great oceans of the world, territories with a climate of the most varied and salubrious character, containing vast riches and unbounded possibilities for the present and for future generations—territorries which are rapidly increasing in population by natural increment and by the yearly addition of many thousands of settlers from other lands—when we consider all this, it well concerns us to ask, What has been the record of the medical profession during this time? It has been a time of wonderful activity in all the centres of learning. A time during which an almost entire revolution has been wrought in the science of medicine and in the methods adopted for the teaching of the same. A time during which the keenest minds have been directed to the elucidation of innumerable problems in those sciences

which form the basis of medical doctrine and practice—Anatomy, Physiology, Biology and Chemistry. A time in which the whole practice of surgery has been changed—been based upon principles entirely new, but proved by the severest tests of experience to be founded upon unalterable laws—a change so great that the accomplished student of twenty years ago would find himself to-day committing the most egregious enormities and sinning perpetually against the first elements as now understood. A time in which a generous rivalry has been kept up between the two great departments of Medicine and Surgery, and, great and startling as has been the progress in the latter, it is doubtful if the advances in the former have not been fully equal or even greater. For, whilst Lister and his followers have abundantly shown to the world the enormous importance of what we now call "surgical cleanliness" (a truth till now never properly appreciated), Pasteur, Koch and others have been searching for the true cause and prevention of cholera, hydrophobia, and the other great scourges of mankind. Animalcular life, and its bearing upon the diseases of man and animals, has assumed an importance heretofore undreamt of: and the science of Bacteriology has sprung at once into the forefront as an absorbing pursuit, already fruitful of wonderful results which have opened up a boundless field for investigation, and afford endless scope for observation, thought, and research! A time in which Preventive Medicine has begun to occupy the place to which its importance justly entitles it. Before this period, sanitary science was but in its infancy, sanitary laws were but little understood, and sanitary regulations seldom enforced. Now, the questions of sanitary legislation attract the attention and occupy the minds of the highest statesmanship. The more civilized the country, the more widely is knowledge of public health matters disseminated, the more carefully are statistics collected, the greater the skill and talent exhibited to cope with the difficulties surrounding the sanitary legislator. In fact, there is now no better test of the intelligence and real civilization of a community than an estimation of the attention given to the enforcement of sanitary laws and the degree of diffusion of sound

sanitary knowledge. A time in which the public have begun to appreciate the importance to themselves of having a constant supply of thoroughly educated young medical men—men learned in all the learning of the day—who, scattered throughout the land, may be ready to apply to them in their need all the resources of modern medicine. Wealthy laymen, acting upon this belief, have endowed hospitals and schools of medicine with funds sufficient to enable them to teach medicine as medicine should be taught. Bright examples of this are found in the great gifts to the Johns-Hopkins Hospital and University in Baltimore and the munificent donations to the College of Physicians and Surgeons of New York. The same sentiment doubtless animated the generous donors of the endowment fund to McGill University and the gentleman who has so much enhanced the teaching capability of the University of Toronto. Let us hope that these instances of far-seeing public-spirited and open-handed men giving of their abundance for an object designed to be of service to the whole country will not fail to direct many others towards one way of doing much good in their generation.

It has been a time when the system of medical education has been undergoing a gradual change. The period opens with the old-fashioned medical school—a few professors, a large number of didactic lectures upon a few subjects—practical anatomy being the only branch taught in a truly demonstrative manner—"walking the hospitals" beginning to be supplanted by some clinical teaching. The transition stage is now—the professors are numerous, the didactic lectures are fewer, the subjects taught have multiplied many times, practical anatomy is thoroughly worked up, and the student is obliged to pass through several other laboratories and acquire a practical and personal acquaintance with the other branches of the curriculum. Old-fashioned "walking the hospitals" is a thing of the past, and, instead, the greatest attention is paid to organizing systematic attendance upon the wards, systematic case-taking, and systematic lecturing upon the cases by a special staff. A time during which we have witnessed the development within the profession of a number of specialties. Specialism is an accomplished fact, and on the whole

the profession has been the gainer by its establishment. The advantages of division of work and devotion to one branch of practice are great and obvious, and, I believe, counterbalance to a great extent the objections that are urged against specialism. Like many other systems good in themselves, it is open to abuse, may readily be overdone, or may be cultivated by unworthy members.

Such are a few of the more striking changes which have been accomplished during the time that this Association has been slowly coming of age. At the time of its inauguration, there was much enthusiasm, and all minds were full of the great possibilities for the future from the confederation of the provinces. No narrow or provincial ideas were to be entertained, and all regulations concerning medical education and the practice of medicine, it was expected, would be assimilated for the whole Dominion. This Association started bravely forward on this basis, imbued with the idea that it had a great mission to fulfil. Committees were appointed, and elaborate reports prepared upon "The best means for General Education," upon "A Uniform System of Licenses," upon "Registration and Vital Statistics for the entire Dominion," and upon "A Code of Ethics for the whole Profession." During several years much labor was bestowed upon these subjects, and the greater share of time at the meetings was given to their discussion. It then, however, became apparent to the members that, in devoting their energies to working out schemes for medical legislation, much valuable time was being absorbed, and the results produced were by no means commensurate therewith. The Act of Confederation, by taking away from the Federal authorities the governance of educational matters, left each province free to look after these in its own way. Thus, at the present time, we find a curious complexity of medical legislation in Canada—there being no uniformity amongst the provinces in regard to matriculation, to curriculum, or to qualification for practice.

It is to be hoped that, before long, some arrangement may be come to by which, at least, a Dominion Medical Register may be established at Ottawa, so that, on entry therein, it will be

possible to practice medicine throughout the Dominion. It is, perhaps, possible that this can be effected without prejudice to the functions of the separate official bodies which now govern the medical affairs of the different provinces. In some such way alone can the existing anomalies be remedied, and the present undesirable confusion be removed.

Compare the general condition of the medical profession in Canada with that prior to the time we are speaking of, and, in so doing, look just for a moment at the condition then and now of the leading medical schools of this country. The number of students in attendance was often sufficiently large, perhaps sometimes nearly as large as even in some recent years. The curriculum was by no means short, for it covered four full years, but it was composed almost entirely of didactic lectures and some clinics upon general medicine and surgery. The course was not distinctly graded, but divided only into a primary and a final department. Now, the staff of teachers presents a long array—the subjects are divided up so as to allow each one to devote his attention exclusively to a particular department. Many special departments have been added, and skilled teachers placed in charge. Above all, the importance of laboratory work is fully recognized, and in every year a full share of time and attention is exacted for practical work on the part of every student. Hospitals have been enlarged and extended and the work divided and specialized. Carefully-conducted cliniques are the order of the day, and the material, both interne and externe, is fully utilized for teaching purposes. Summer sessions—some voluntary, some compulsory—have been established at nearly all the schools, and several months of the best kind of teaching is thus placed at the disposal of the student of to-day. The standard of examinations is high, as shown by the percentage of rejections and by the excellent standing so generally attained by Canadian students both at the examinations of our local provincial boards and also abroad. Is it not certain that, with such marked advance in the facilities for sound medical education, the graduates of recent years must be correspondingly more competent and more thoroughly fitted for their important duties than those who preceded them?

In the general profession there have been many evidences of a better condition of things than formerly prevailed—of a greater interest in the scientific side of medicine and a desire not to practice our Art from a purely perfunctory or purely financial point of view. The best evidence of this is the formation of medical societies. These have sprung up on every side—provincial, county and local societies,—and it is most encouraging to observe how actively and energetically many of these are maintained,—good papers read, good discussions held, and a spirit of emulation evinced in correct observation, the thoughtful care of cases, and their systematic and accurate recording. The difficulties encountered in keeping up such societies are often great. Our population is still a mostly scattered one, and members have often to go long distances and sacrifice much time in order to attend: but the gain is worth it all. The best men of every town and every country side will always be found the keenest supporters of their own medical society. Our Canadian physicians, too, are beginning to write more than formerly—not, perhaps, even yet as much or as often as they should—but they maintain medical journals which are alive and active and are a credit to their country and to their contributors. There are now in Canada no less than four English and two French monthly journals, all apparently prosperous. Nor are the contributions of Canadian writers confined to this country. Many of our prominent men are frequent and valued contributors to, and correspondents of, the best of the American journals.

It may be said that, in drawing this comparison between the condition of the profession now and that when this Association began, I have presented an optimistic view and one not altogether warranted by the facts, but I think not so. I believe that, great as has been the progress of science in these years, great as has been the progress of the country in material prosperity, the medical profession may fairly claim that it has not lagged behind: that it has always had such leaders to frame its policy and such earnest and devoted and able men in its schools as have kept it fully abreast of the busy and stirring times in which we live. Has this Association done its share in securing such

a state af things? The programme it laid out for itself at the outset, as I have already shown, was very extensive; it was too extensive for any society to carry out. This was soon perceived, and from the time that the Association got away from the business of framing bills which were never to be enacted, and discussing schemes which came to naught, and settled down to its legitimate work of fostering a scientific spirit in its members, encouraging them to produce good literary work, urging them to original observation, helping them to good understanding amongst themselves, assisting in the maintenance of a high standard of ethics, promoting sociability and good-fellowship—then it succeeded, its meetings were instructive, useful in many ways, and thoroughly enjoyable. It has no feeling of rivalry towards any other society, and I trust none is felt by them towards it. Each has its own sphere of usefulness, and can accomplish its own good ends, without detracting in any way from the necessity for a general reunion of this kind. This Province of Ontario has successfully organized an active and thoroughly admirable society; other of the Provinces have done the same, and it is only a source of regret to many of us from the old Province of Quebec that circumstances have not favored our following their excellent example. This Association, I am convinced, has done much good, and will, I hope, continue to do much more in the years to come. For instance, though failing to carry through such comprehensive measures as were at first contemplated both in educational matters and in matters of State medicine, yet this Association has been again and again occupied in considering the important subject of general hygiene; and, at many of its meetings, the discussions which have taken place and the resolutions passed have aided very materially in promoting such legislation as has been secured bearing upon the public health. Indeed, it must needs be that expressions of opinion from a meeting of the profession representing all sections of the country should command the attention of those who control these matters. The need still existing for further exertions in this direction is emphasized by the lamentable apathy exhibited in so many cases where the public health is in ques-

tion. The etiology of typhoid fever may be said to be pretty thoroughly understood: but, even in the face of violent outbreaks of that disease in some of our Canadian cities, what want of intelligence, and what unwillingness to be governed by competent medical opinion! What incapacity to realize the extent of injury done to the community, the cruel, unnecessary loss of life, with all the suffering attendant thereon! A town near Montreal was recently thus affected to a most alarming extent, diarrhœa was almost universal, typhoid fever was very prevalent and deaths were numerous. The visitation became notorious, and was much commented upon in the press. The facts were amply sufficient to show two things: 1st, That the water supply was contaminated with sewage. 2nd, The manner in which the contamination was effected. Local health board there was none, and the disease for months continued its ravages to such an extent that the locality was shunned by every intelligent traveller, while the poor inhabitants suffered and died. It is a reflection upon the intelligence of the age that such a thing could be, and it is a reflection upon some of our sanitary organizations that no sufficient pressure was exerted to remedy the evil as soon as its cause was fairly determined. It is the duty of every member of this noble profession to render all the assistance in his power towards the furtherance of good and effective legislation bearing upon local and general sanitation, and to aid in the dissemination of sound literature upon hygienic subjects. Many examples similar to the above might be quoted to show that we are yet very far from the position in which we should be, in accordance with the advanced teachings of the present day.

One subject which, it will be observed, from the very foundation of the Association, commanded its attention, and upon which much time and labor has been bestowed by individual members at different times, is that of a Dominion Registration Act. It would be futile at the present day to offer arguments to show the importance of accurate and reliable vital statistics. A good deal has been accomplished in this direction, here and there by local efforts, and in some instances by provincial action, but we are very far indeed from the attainment of that comprehensive

system which this Association decided at its early meetings to endeavor earnestly to obtain. It is, indeed, active members of this Association who have been largely instrumental in educating public opinion on the subject, and in pushing forward such measures of reform as have been reached; and it is to be hoped that the same members, with many others to assist them, will continue their laudable efforts until much better results are obtained.

The Association adopted a Code of Ethics, and a very good code it is. There is only one point to which I would allude in connection with the attitude of medical men towards each other, and that is with reference to cases of alleged malpractice. Nothing is more injurious to the best interests of the profession than the wretched lawsuits of this kind which are so lamentably common in certain sections of this country—only in certain sections, for I am happy to say that elsewhere they are of very occurrence, and in some favored localities are practically unknown. There can be only one explanation of this striking difference, viz., that such contentions are originated and fomented by unworthy physicians who adopt this means of harassing and and injuring a competitor. Everyone knows that, if medical men were true to each other, these unhappy disputes would hardly ever be begun—that, if rancor and ill-feeling were jealously guarded against and only fair and reasonable opinions expressed, we should not be called upon to witness those painful exhibitions of a house divided against itself. This is a sore blot upon the boasted claims of the medical profession to engender feelings of mutual charity and goodwill. The main remedy for this consists in the cultivation of the true scientific spirit, in keeping up connections with our medical societies, in indulging our natural social tendencies and preserving that natural pride which produces the desire to stand well with our fellows, especially those whose good opinion is worth having. I am sure it is the earnest wish of every member here present that the scandal of these malpractice suits may yearly become fewer in this Canada of ours, to the great advantage of the whole profession.

Again. Has this Association advanced in membership and in influence as it should during the course of these years? As regards the first of these questions, it is not possible to give an answer in figures, for the reason that the method of recording our membership has been very loose; but, on looking at the minutes of the early meetings, it is seen that the attendance was large, and that the distant provinces were extremely well represented. As much cannot be said for the later meetings, at which, though the actual number present has been good, yet the attendance from the maritime provinces is noticed as having greatly fallen off. It is also matter for regret, that our French-Canadian *confrères*, many of whom were amongst the founders, and who came in large numbers to the early gatherings, have gradually ceased attending till, now, a very few only of the more literary-minded and enthusiastic of them unite with us in keeping up our national Association. It may be that the difficulty of using two languages has had something to do with this. I should like to see this difficulty overcome, and the Association strengthened by the hearty support of our brethren from the old Province of Quebec. It should be remembered that, at the International Congress, three languages—French, German and English—were recognized, and a speaker could address the meeting in any of these.

A suggestion made in the presidential address of last year deserves, I think, to be repeated, as no action was taken upon it, and it seems feasible and promises to be useful. It was proposed that a committee might be named to take into consideration a scheme arranging for a closer connection of some kind being brought about between this Association and the various provincial and local societies already in existence. Any suggestion which will add to our membership and increase the interest taken in our work, is worthy of being carefully considered. Without having looked into the question, I am not prepared to say just how this can be accomplished, but, if the meeting think with me in the matter, it will be competent for it to take action in that direction.

Another task which it has been thought suitable for this Asso-

ciation to undertake, and which was fully laid before the meeting last held in this city, was, to bring before the proper authorities the question of medical experts at coroner's inquests. I am not aware that anything was done, though the importance of it was strongly dwelt upon by the reader of the address. The value of such expert evidence would probably be admitted by any educated layman; but we medical men appreciate much more fully the difference between the opinion of the average practitioner and that of a thorough pathologist who is constantly making autopsies and conducting pathological investigations of various kinds: and when we think of the enormous interests so often hanging upon such opinions, we might well consider it a duty to seek some means for skilled evidence being furnished when the object is, to determine the cause of death in a doubtful case.

My predecessor in this chair offered, in his address, some timely advice to his *confrères* upon the necessity for allowing themselves a due amount of recreation at reasonable intervals, and he draws a disheartening, but perfectly true, picture of the results of neglecting this important matter. In accordance with such sound doctrine, I last month rested from my labors and spent twenty days in our Great North-West. There is something particularly attractive to the Eastern city-man in seeing something of the open and free life of our great plains, ranches, mountains and Western coast. Having myself derived much pleasure, profit, and renewed health from this short tour in the Western Provinces, I would say to any of my medical friends who feel jaded or overworked, try the tonic effect of a combination of fresh lake breezes, balmy prairie winds, keen mountain air, and soft ozone draughts from the Pacific Ocean. The variety is charming, and whilst the body is being refreshed and renovated, the mind is being delighted with some of the finest scenery in the world. Upon the route, one spot in particular engages the attention and excites the interest of all medical visitors. I refer to the hot sulphur springs at Banff, which are only now becoming known, and are not nearly as well known as their merits entitle them to be. The springs, as every one is aware, are situated in the heart of the Rocky Mountains,

and in one of the most picturesque parts of that wonderful region. The steaming water, clear as crystal, bursts forth in unlimited quantities high up on a grand mountain side, some four thousand feet above the sea-level. It is strongly sulphurous and its medicinal properties are of a high grade. Such springs are sufficiently rare, there being but two or three of any note even in the whole of the United States, and, most assuredly, none of these possesses the additional attractions of this choice locality—exquisite lofty mountains, affording a surrounding panorama of truly alpine character, and a lovely valley containing a broad blue river which has well been compared to the great Rhone of European fame. The natural attractions of Banff would alone suffice to draw multitudes of pleasure-seekers there, and, as the value of these natural waters becomes more appreciated, it is certain that more and more of our patients will be sent there every year. Apart even from those who would go to drink the waters, there is another class of invalids that I believe could be sent to this high region with the happiest results. The Davos-Platz in Switzerland has been gaining greatly in favor in England and elsewhere as a winter-resort for cases of phthisis in an early stage, and for those who may be looked upon as disposed to tubercular disease on account of family tendencies or defective physique. This resort is high in the Alps, and the winter is rather severe, with an abundance of snow, but there is plenty of sunlight. Necessarily, our information concerning the meteorlogy of Banff is yet extremely deficient, but, from all I could learn, the conditions are very similar to those which have been found to operate so beneficially in the case of Davos-Platz and such-like alpine sanitaria. As there is now an excellent hotel, with every comfort, there is no difficulty as regards accommodation. A proposition has actually been made by some members of this Association that our meeting next year should take place at the Banff Springs, an idea which has much to commend it, but will need to be carefully considered. The Nominating Committee will, as usual, take this matter up and report upon it to the general meeting.

It is often asked, What becomes of all the medical graduates?

Let any of you pass through that enormous extent of fertile country traversed by our transcontinental railroad and observe the villages and towns springing up like magic from one end of it to the other—let him take note of the solid settlement of large areas even away from the beaten track of the railway—let him step off at any station and, more likely than not, he will meet some young *confrère* who is quietly located there and is growing up with the healthy growth of the town or the country-district. The important mines in various parts, the advancing railways, the great ranching posts, require the services of still more medical men, and in connection with some of these are to be found positions of trust and value unsurpassed in the Dominion. In this way can be accounted for a large number of the graduates from the Eastern schools, and it is pleasant to find good opportunities thus opening out for Canadian doctors in their own country.

It is my melancholy duty to have to refer to some distinguished members of our Association who have been called away from amongst us during the past year. Of these, two were from the roll of our former Presidents, viz., Dr. Marsden of Quebec, and Dr. Botsford of St. John, N.B., both original founders, regular attendants, and well worthy of the high honor bestowed upon them. Dr. Marsden was a man of strong individuality and remarkable tenacity of purpose. Taking a lively interest in the affairs of this Association, his opinion and assistance was much valued on account of his long experience and intimate acquaintance with all matters pertaining to the medical profession. His outspoken expressions, and his example of unswerving loyalty to the best interests of the profession, made him a prominent figure at many meetings. An old man of keen intellect and without garrulity, full of anecdotes concerning a now fast-fading generation, Dr. Marsden will long be missed by those who had the good fortune to be intimate with him. Everyone will remember the massive form and fine head of our late friend, Dr. Le Baron Botsford. One of our founders, and imbued with a lively faith in the possibilities for good of this Association, he was always one of the genuine workers, and was eager to assist

in all good works. His greatest delight was to participate in discussion destined to promote correct views about, and legislation upon, public health and state medicine. A very noble, whole-souled gentleman, whose best thoughts and much of whose time were devoted to the good of his fellow-man. Dr. Henry Howard, that kindly and gentle physician—retiring, thoughtful, and given to abstruse metaphysicial enquiries, the best years of whose life were given to the study of mental disease and to the care of the mentally-afflicted. He it was who had the manliness to condemn flagrant abuses in some of our public institutions, and, at the risk of his official position, to call upon a timid government to correct them. For this alone, if for nothing else, his country owes his memory a debt of gratitude. Amongst others, I may mention Dr. Richard Zimmerman, for some time an official of the Association and one of its warmest friends; Dr. John H. McCollom, Dr. W. N. Woodill, and Dr. Brouse, worthy gentlemen all, who worthily served their generation, each in his separate sphere, and reflected credit upon the high calling of the physician.

You have, gentlemen, many and important subjects to engage your attention. I trust that this Ottawa meeting, this coming-of-age meeting, may long be remembered as one at which some good scientific work was done, and something accomplished towards forwarding the general interests of the profession, promoting its dignity, and elevating it in the estimation of the public.

In closing, I should like to say that it is always a great pleasure at these meetings to receive some of our *confrères* from across the line. As members of a sister Association, we give them a hearty welcome, and are glad to have them participate in all our proceedings. Without prejudice to the political leanings of any one, I am sure I express the views of all when I say that in international visiting and in scientific discussion, all we desire is the most absolute "unrestricted reciprocity," and I am equally certain, from what I know of their hospitable character, that our American cousins are correspondingly pleased when we "retaliate" by joining the meetings of the American Association.

MYXŒDEMA—AN ANOMALOUS CASE.*

By John Campbell, M.D., Seaforth, Ont.

Mrs. P. M., aged 66 years, is the mother of a family and a native of England. Fifteen years ago she was attacked with diarrhœa, which proved to be chronic. She had an average of ten stools in the twenty-four hours. These occurred generally from 5 to 10 A.M., and were usually clay-colored. Tried quite a number of doctors and numerous remedies, without any benefit, until about fifteen months ago, when it was got under control. About that time a new symptom began to show itself, which has gone on increasing until the present time. She began to feel hungry every two hours, and unless she got food she felt very weak and tremulous. About six months ago the stools became more solid, but there were still six in the twenty-four hours, and these were of a light clay color. About this time also she noticed the following symptoms, which have gradually become more marked as time passed: (1) She was swollen all over the body, but especially about the face. (2) The mouth was dry, the speech husky, and the taste sometimes sweet, at other times bitter. (3) She felt an inability to pronounce the words properly—they ran into one another. (4) When there was no food in the stomach there was a gurgling noise, heard or felt by the patient herself. (5) She had hungry spells every two hours, when profuse perspiration would suddenly break out; when she took nourishment the sweating would as suddenly disappear. (6) She felt weak and tired, and there was an awkwardness in all her movements. (7) If she did not get food when the hungry feeling and sense of weakness came on, she would tremble, and would be unable to sit up in bed. (8) She sleeps soundly, but awakens every two hours; if she sleeps longer than that time, she awakens hungry and weak, and with the trembling mentioned, all of which disappear shortly after taking a glass of milk, beef tea, raw eggs, or any nourishment either in the liquid or solid form. She observed that liquid food in combination with a stimulant, as milk and brandy, answered particularly well.

* Read by title at the recent meeting of the Canadian Medical Association.

(9) She has difficulty in standing, and has to be supported while dressing. She cannot balance herself on one foot, and is slow in altering her position. (10) Some eight months ago she noticed that her teeth began to decay, and since then five teeth have broken to pieces or dropped out. (11) The patient also noticed a peculiar dryness and crispness of the hair, which is now well marked. (12) Patient frequently complained of a chilly sensation. She had pain about the heart, but it has latterly passed away. (13) Patient had observed that the skin was shiny and of an ashy color. She did not complain of thirst, nor had she noticed any flushing of the cheeks nor pink streaks over the malar prominences.

All the foregoing symptoms were observed by the patient herself, who is an educated and intelligent woman.

Examination.—Examined the patient on the 22nd of June last, on the 3rd of July, on the 12th July, and on the 9th of August, as well as upon several other occasions, and found the symptoms as follows: Found patient in bed, with a normal pulse and temperature. She had a swollen appearance, and was anæmic. The skin had a waxy hue, and was evidently thickened over the whole body. The face had a cheerful aspect. She answered the questions put to her with slight hesitation, but said that she could not collect her thoughts as well as she used to do. Said she took a good deal longer in writing a letter on account of the slowness with which the ideas came. When asked about the length of time she had been sick, she paused about a minute to think what time of the year we were in, then answered the question. She could see and hear well enough. The swelling was resilient. There was slight pitting on pressure on the feet at first visit, but this afterwards passed away. Both upper and lower eyelids were alike swollen, as also were both lips. The hungry spell came on during one of the examinations, and a profuse perspiration broke out. We observed no swelling of the lower triangle of the neck. Paræsthesia was well marked. Could find no evidence whatever of a thyroid gland. The tongue had marks of the teeth upon it, and was flabby and unhealthy in appearance, and evidently somewhat enlarged. The nails

were long and coarse, and we were told that they grew fast. The muscles of the abdomen were large and flabby, which, with the thickened skin, made it difficult for us to examine the liver and other internal organs in a satisfactory manner. The liver, however, seemed to be diminished in size. The stomach appeared to be tender to the touch, but how much of this tenderness was due to the hyperæsthesia of the skin we could not determine. The tendo-patellar reflex was exaggerated. She passes the usual quantity of urine, which we tested several times with the following result: June 21st—Urine slightly acid, dark color; specific gravity 1030; no albumen. July 9th—Reaction slightly acid, color light; specific gravity 1030; no albumen; no sugar. The patient's hands were swollen and the fingers spade-like. The temperature on both sides of the body was identical.

I have not been able to find out any hereditary or other cause for the disease. At my last visit, on Aug. 28th, found Mrs. M. much weaker, though the swelling had very much diminished, and the thickened skin could be easily pinched up. The hungry spells recurred regularly every hour, day and night, consequently she has to be fed twenty-four times in the day. If one hour was omitted, the patient suffered severely from the weakness, trembling and sweating. The pulse was much weaker. The diarrhœa was by no means troublesome. She complained of the slowness of thought; her memory also was much impaired. She had no pain. Hearing was impaired since last examination. She could not stand now. The tongue was somewhat coated, and the patient had been troubled with vomiting, which for the time had ceased. She was low-spirited. The disease is evidently making steady, but slow progress.

Treatment.—The patient has been on tonic treatment for more than a year, taking such medicines as iron, arsenic, and sometimes strychnine. On July 21st she was put upon jaborandi in addition, taking forty drops of the fluid extract three times a day. Since that time the swelling has diminished considerably, as already indicated, the girth of the body being over six inches less than it was. The dryness of the mouth has pretty much passed away under the influence of the drug. To the sweating

and salivation caused by the jaborandi is to be attributed the diminution in the size of the body. The skin is no longer firm, tense, and waxy as it was, but soft and pliable. It, however, retains the feeling of hypertrophy when pinched up. The weakness is more pronounced, as we have seen, and the interval between the hungry spells is shortened. Our case is somewhat anomalous as regards the ravenous appetite, which we have not found described by any author we have consulted. There can be no difference of opinion as to the termination of the case.

SOME REMARKS ON PENETRATING WOUNDS OF THE EYEBALL.

By Frank Buller, M.D.,
Professor of Ophthalmology, McGill University.

(*Paper read before the Canadian Medical Association, at Ottawa, September*, 1888.)

Accidental penetrating wounds of the eyeball are liable to prove disastrous in three principal ways:

(1) From the immediate destructive character of the injury.

(2) From the consecutive inflammatory reaction.

(3) From extension of the latter to the other eye.

With the first of these factors the ophthalmic surgeon has nothing to do, but with the second and third his responsibility may be grave in the extreme. Notwithstanding the well-known rules of procedure in the management of injuries to the eye, none but the expert can justly appreciate the difficulties and dangers that now and then require to be faced. For my own part, many years' experience have impressed me more and more with one important fact; that is, the paramount importance of immediate attention to this class of injuries. I have no statistics to offer, but I am quite sure the lack of prompt and suitable treatment is the chief element in the disastrous results so often seen to follow comparatively unimportant injuries.

I do not propose to take up the whole subject of traumatic lesions of the eye, but will confine my remarks to penetrating wounds in what is known as the ciliary region—that is, a zone of the eyeball bounded in front by the cornea and behind by the posterior extremities of the ciliary processes. The breadth of this

zone is about five or six millimetres. It has been called the dangerous region, from the belief that wounds of this part were particularly liable to be followed by sympathetic ophthalmia. With certain reservations the designation may be accepted, inasmuch as the vast majority of sympathetic ophthalmias are associated with cyclitic trouble in the exciting eye. On the other hand, it is undoubtedly true that wounds in this region are often not followed by any serious consequences, even when left to the *vis medicatrix natura*. I have seen extensive ruptures of the eyeball from excessive violence in this region recover with fairly good vision, without any surgical interference whatever. Such a favorable result, however, can only be regarded as exceptional. On the other hand, comparatively trivial injuries in this locality are not infrequently followed by loss of vision in one or both eyes. If the injury has involved the lens to the extent of causing traumatic cataract, there is always considerable risk of disastrous complications. Under these circumstances, a more or less protracted irido-cyclitis, with all its attendant dangers, may be unavoidable.

Clean cut wounds, either with or without traumatic cataract, are, as a rule, much more amenable to treatment than are lacerations or injuries inflicted with blunt objects which tear and bruise the part injured; here, in addition to the unfavorable nature of the wound itself, the whole eyeball is more likely to have suffered greater violence, besides which, septic or irritating substances are more likely to lodge in the wound or inside the eyeball when the penetrating wound has been effected in this way. This observation affords a natural indication in the management of all wounds in the ciliary region.

Whenever such a wound, whether clean cut or lacerated, is allowed to heal with any portion of the uveal structures entangled in the scleral aperture, there is a serious risk of consecutive irido-cyclitis and of sympathetic ophthalmia. It is for this reason that immediate attention, if possible, within a few hours after the injury, is almost indispensable to success. Every ophthalmic surgeon of any considerable experience has seen many cases of sympathetic ophthalmia which could have been prevented by proper attention to the original lesion.

I believe all authorities on injuries of the eye agree in advising the restoration or removal of a prolapsed iris when this structure is found entangled in the wound; any prolapse of the ciliary body, they say, should be cut off. As far as it goes, this advice is sound enough, though too often in practice sadly neglected; but in regard to entanglement of portions of the ciliary body, the recommendation is, in my opinion, much too vague. I hold that the edges of the wound should be completely freed of uvea throughout its extent; this can often only be accomplished by separating the edges of the wound, and with fine scissors and forceps clearing away all the uvea from its inner surface so that the bare and clean sclerotic can be brought into accurate coaptation with one or more fine sutures. This is a procedure I have repeatedly carried out, and always with the most satisfactory results, but to be effectual, it should be done early, within twenty-four hours of the injury. The usual antiseptic precautions are, of course, observed prior to and during the operation, and, indeed, for two or three days after. The wound by this time will have healed, and the continued use of antiseptics is then hardly necessary.

In stitching the sclerotic, I sometimes pass the needle through its whole thickness, but it answers just as well to go less deeply; in any case, a fine and exceedingly sharp needle should be used. The so-called Hagadorn's needle is the best. The silk sutures may be of the finest. I always use No. 1 for this purpose. After the operation of cleaning and uniting the scleral wound in this way there is apt to be a pretty sharp inflammatory reaction; but this can be controlled by iced compresses soaked in a weak solution of perchloride and changed frequently. This treatment should be commenced as soon after the operation as the eye begins to become painful, and should be continued until all reaction has ceased: three or four days will usually suffice. Atropine instillations and the internal use of antipyrin are accessory measures of some value.

Some ten years ago I reported a case of complete recovery after an extensive wound involving cornea, iris, sclerotic and ciliary body. Figure 1 represents the position and extent of

the wound inflicted by the bursting of a soda-water bottle. There was a clean cut through the inner edge of the cornea, thence upwards and backwards through the ciliary region. There was

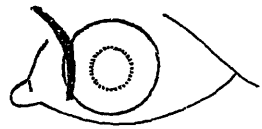

FIGURE 1.

no injury of the lens, but some vitreous had escaped, and both iris and corresponding portion of the ciliary body were prolapsed and engaged in the wound. These being thoroughly cleared away, two stitches were inserted, one at the sclero-corneal juncture, the other about four millimetres further back. These secured good coaptation of the scleral edges. A perfect recovery ensued, and the eye maintained a normal appearance, with the exception of the large iridectomy inwards. Vision being nearly perfect when an acquired myopic astigmatism was corrected with a suitable concave cylinder glass.

Two other cases of quite recent occurrence are also good illustrations of the same class of injury. Figure 2 is that of an

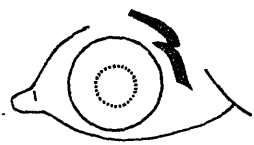

FIGURE 2.

eye which I treated a few weeks ago for a long wound across the upper and outer part of the ciliary region, likewise a bottle accident. There was a long jagged wound through the upper eyelid, and a similar wound in the sclerotic, more than half an inch in length. Much of the vitreous had escaped. The anterior chamber was filled with blood, and the eye had a collapsed appearance. Owing to the lateness of the hour repair of the wound was delayed until the following day. One stitch sufficed to unite the scleral edges sufficiently closely. For about a week there was pretty severe reaction, which finally yielded to the antiphlogistic measures already mentioned, and at the end of

two weeks the eye presented a normal appearance, with the exception of a little congestion at the seat of injury. Only a narrow blue line marking the course of the wound. Vision improving rapidly as the blood in the vitreous chamber becomes absorbed.

Figure 3 is that of an eye penetrated by a sharp-pointed

FIGURE 3.

fragment of glass two weeks ago. There was a clean-cut triangular wound in the ciliary region, much vitreous had escaped, and a great deal of blood was effused in the eye, so that there was only quantative perception of light. Iris and lens were strongly retracted. The patient was destitute of self-control, and an anæsthetic had to be administered in order to repair the wound as already described. One stitch at the apex of the triangle sufficed to bring the clean scleral edges into perfect coaptation. The reaction was quite severe for two days, but the constant application of iced compresses allayed all undue inflammatory symptoms in three or four days. Now the external appearance of the eye is perfectly normal. There is no trace of irritation, and the vision is improving so much that fingers can be counted with the wounded eye at two feet distance.

Quite small, clean cut wounds in the anterior part of the eye are only likely to be serious when complicated with traumatic cataract, if at, or very close to the corneal margin, there may be an entanglement of iris, which must be dealt with on the principles already quoted, either replacement or removal; when situated further back, such small wounds are best managed by non-interference.

Lacerated and punctured wounds inflicted by large or blunt-pointed objects should be treated on the same principles as incised wounds, and an endeavor made to coapt clean scleral surfaces. To accomplish this, a certain amount of trimming of the

scleral wound may be necessary, even at the expense sometimes of enlarging the aperture somewhat; but when every possible precaution has been taken with this class of wounds, most of them will go wrong in one of two ways—either an acute suppurative panophthalmitis will speedily extinguish the flickering ray of hope, or an equally unfortunate termination will occur through the slower but more insidious and dangerous ravages of a chronic iridocyclitis, leaving a shrunken and sensitive eyeball, with a choice between sympathetic ophthalmia or some preventive operation which at best may leave a maimed and sightless eyeball.

A CASE OF PENETRATING WOUND OF THE ABDOMEN, WITH PROTRUSION OF THE OMENTUM.

By Francis J. Shepherd, M.D.,
Surgeon to the Montreal General Hospital.

The following case is of interest, as showing how a penetrating wound of the abdomen, with no wound of the intestines, may proceed to a favorable termination, without either local or general reaction:—

George H., aged 11, a small-sized but healthy-looking boy, was admitted into the General Hospital, July 6th, 1888, suffering from a penetrating wound of the abdomen. The boy states that some hours previously, while attending to his duties in a file factory, he accidentally fell forward on some files which were standing upright in a shallow vessel half filled with lime-water. He says the sharp end of one of the files penetrated his abdomen to a distance of four inches, being prevented from going further by the side of the vessel in which it was standing. On recovering himself, he found the file sticking into his abdomen. He withdrew it slowly, and following the file came what he thought was bowel, which had become attached to the roughened surface of the file. A local practitioner was called and endeavored ineffectually to reduce the parts protruded. The ambulance was then sent for and brought him to hospital. On his arrival at the hospital I was called, and found the boy in very good con-

dition, but suffering acutely from pain at the seat of injury. The house surgeon had applied a towel soaked in 1–40 of carbolic acid to the part, and removing this, a small, irregular wound was seen in the median line, two inches below the umbilicus, from which protruded a portion of omentum the size of a walnut. This was of a dark color and much congested. The boy was placed under chloroform, and after washing the protruded omentum thoroughly with 1–1000 of bichloride, an attempt was made to reduce it, but without effect. The wound was enlarged and it was seen that its direction was upwards under the skin to the umbilicus, where it penetrated the abdominal wall. An incision some two inches long was now made through the wall of the abdomen and the omentum returned; the presenting bowel was examined, but as there was no evidence of wound of the intestine the parts were closed with three silk sutures which penetrated the whole thickness of the abdominal wall. The boy had considerable vomiting after the chloroform, but next day was feeling very well and hungry. He was ordered to have nothing by the mouth for two days except pieces of ice to quench his thirst, but I found afterwards that a patient in the next bed had been secretly sharing his milk with the boy from the morning following the operation. There was no elevation of temperature, and with the exception of a little tympanites on the third day, the patient felt no ill results from his accident. The wound healed by first intention, and at the end of the sixth day the stitches were removed. The boy was up and about at the end of a week, and was discharged from hospital perfectly well in a fortnight. He was seen quite recently and was perfectly well. His bowels, which were constipated for some days after the operation, were moved by small and frequent doses (every two hours) of Epsom salts; this relieved the tympanites in a very short time. The direction of the file was very oblique, and it did not penetrate the abdomen until it had passed upwards under the skin for two inches; this will account for the escape of the intestines. The file was a perfectly clean and new one.

Retrospect Department.

QUARTERLY RETROSPECT OF OBSTETRICS.

PREPARED BY J. C. CAMERON, M.D.,
Professor of Obstetrics, McGill University; Physician-Accoucheur to the Montreal Maternity, &c.

Cæsarian Section compared with Induction of Premature Labor, Version, and Craniotomy.—Professor Leopold and his assistants, Drs. Korn, Löhmann and Präger, have recently published* the statistics of the Dresden clinic for the past four years and reviewed their experience of the various methods of treatment in contraction of the pelvis. Dr. Korn relates 45 cases in which premature labor was induced, with the following results:

In 35, the mothers recovered without fever.
" 9, the temperature rose for two to three days.
" 1, death occurred from sepsis.

Korn thinks that labor should be induced between the thirty-second and thirty-sixth week in cases of

Simple flat pelvis with a conjugate up to $2\frac{3}{4}$ in. (7 cm.)
Generally contracted, - - - - - 3 in. (7.6 cm.)

Craniotomy was performed 71 times, and Präger says that when done with strict antiseptic precautions, it is less dangerous than Cæsarian section, and gives far better results.

Leopold analyses his 23 cases of Cæsarian section performed during the past four years. He admits that the operation is essentially a laparotomy, and always a serious matter even for an experienced surgeon. He recommends early resort to craniotomy, if all the conditions necessary for a safe Cæsarian section operation are not present.

The results in Dresden may be tabulated as follows:

	MATERNAL MORTALITY.	FŒTAL MORTALITY.
Induced labor, - - - -	2.2 per cent.	33.3 per cent.
Turning and Extraction,	4.8 "	41 "
Craniotomy, - - - -	2.8 "	100 "
Cæsarian section, - - -	8.6 "	13 "

* Der Kaiserschnitt und seine Stellung zur Künstlichen Frühgeburt, Wendung, und Perforation bei engem Becken.

Septicæmia was the cause of maternal death after

Induced labor in - - - - - - -	2.2	per cent.
Turning followed by perforation, -	0.0	"
Perforation, - - - - - - - -	0.0	"
Cæsarian section, - - - - - -	4.3	"

Wyder of Berlin (*Archiv f. Gyn.*, Band xxxii, Hft. 1) makes a similar comparison from a review of 9,000 cases of labor at the Charité and 6,000 at the Policlinic. His investigations show the relative mortality of the different operations in Berlin to be—

Cæsarian section, - - - - - - - - - - -	17.9	per cent.
Craniotomy, in moderate contraction of the pelvis,	8.4	"
" in extreme " (5.5–7 cm.)	0.0	"
Induced labor, in moderate " of the pelvis,	5.3	"
" " in extreme " "	0.0	"

The mortality of Sänger's operation is, according to Wyder,

2.13 times as great as craniotomy.
3.37 " " " induced labor.
7.1 " " " " in highly contracted pelves.

In formulating rules for practice, he holds that Cæsarian section is indicated in cases of extreme contraction of the pelvis if the patient is far advanced in pregnancy, but that in the early months the induction of premature labor is to be preferred. In pelves with a conjugate of $2\frac{1}{2}$–$2\frac{3}{4}$ in. (6.4–7 cm.), Cæsarian section and craniotomy are direct rivals, the former offering a smaller fœtal mortality at the expense of greatly increased maternal risk.

Ahlfeld publishes the statistics of the Marburg obstetrical clinic for the past year (*Deutsche Med. Woch.*) The expectant plan of treatment seems to be in vogue at Marburg. Notwithstanding one case of spondylolisthesis, three of marked rickety pelvis, and a number of the simple flat pelvis, the operations were very few. In the total 308 cases, forceps were used only three times, podalic version three times, cephalic version three times, combined podalic version twice, Cæsarian section once. In the treatment of the placenta the expectant plan was employed. After the birth of the child, the patient was allowed

to lie quiet for an hour and a half, the bladder was then emptied and the placenta got away. In 39 cases it came spontaneously, in 260 a little gentle pressure from above sufficed to expel it, and in only three cases was Credé's manipulation required. Ahlfeld says that post-partum hemorrhage has been almost entirely abolished since Credé's method has been discontinued as a routine practice; but then it must be remembered that Ahlfeld is the bitter and uncompromising opponent of Credé.

A New Antiseptic.—Mr. Robson of Leeds (*Brit. Med. Jour.*) proposes the silico-fluoride of soda as a substitute for corrosive sublimate in surgical and obstetrical practice. At the Manchester meeting of the British Association in 1887, Mr. Thomson, F.R.S., called attention to the remarkable antiseptic properties of the neutral fluorides of sodium, potassium and ammonium, and their fluo-silicates. He found that a saturated solution of fluo-silicate of soda (containing .61 per cent.) had greater antiseptic power for animal tissue than a sublimate solution of 1×500. The great objections to the use of corrosive sublimate in surgical and obstetrical practice are that it roughens and cracks the hands, corrodes steel instruments, and is liable to be absorbed and produce toxic effects. Robson has used with marked success solutions of the silico-fluoride of soda (20 grs. to pint) for general surgical work, for vaginal douching, and as a uterine douche after curetting. For washing out the peritoneal cavity after laparotomy, he thinks 10 grs. to the pint quite sufficient. The following are his conclusions:

1. The powder is unsuitable for application to raw surfaces, being very irritating and even caustic.

2. A solution of one grain to the ounce of water is strong enough for ordinary purposes, unirritating to the hands or patient, and an efficient antiseptic. A solution of 10–20 grains to the pint may be safely used to syringe out closed cavities, even where the fluid does not all return. It acts on the glaze of porcelain after long use, and corrodes steel instruments, but does not affect sponges. Its action upon steel is much diminished by adding a little sod. bicarb. to the solution. It is an efficient deodoriser of the hands, and is specially useful when there is

reason to fear absorption. A comfortable and efficient antiseptic poultice may be made by soaking absorbent cotton in a solution (10 grs. to pint), wringing it out and applying it covered with gutta-percha tissue. To deodorise the hands, a saturated solution may be required. It is known commercially as *salufer*, and is put up in tablets (40 grs. each). I have used this preparation for some months, and am quite satisfied with it, the only discomfort being that it discolors the nails.

Puerperal Ischuria.—At the second congress of the German Gynæcological Society held at Halle in May last, Schatz of Rostoch read a paper upon this subject (*Cent. f. Gyn.*, Bd. xii, S. 394). Retention of urine during the first few days of the puerperal period is quite a common occurrence. Several times passing a catheter is all that is usually required, and the patient generally regains control in a couple of days, but not always. As cystitis is very apt to follow the use of the catheter, Schatz disapproves of repeated catheterisings, and recommends dilatation of the urethra instead. One dilatation is usually sufficient. He has practised this treatment for ten years, and has had remarkable success with it. Battlehner (Carlsruhe) uses a 10 per cent. solution of cocaine in these cases. Skutsch (Jena) believes that the trouble arises from pregnant women not learning to pass urine in the dorsal position, and suggests that before labor they should be taught to urinate in that position. He supports his theory by a reference to 42 consecutive cases; 29 of these had learned before labor to urinate in the dorsal position, and after labor 21 urinated spontaneously, 7 had to be catheterized the first day, and 1 the second day. Of the 13 who had not learned, 5 urinated spontaneously, and 8 had to be catheterised, 6 the first day, 1 for five days, and 1 for two weeks.

Remarkable Fecundity—Quadruplets, Quintuplets, Sextuplets, and Septuplets.—The *British Medical Journal* quotes from the *Bund* of May 10 the case of a Swiss woman, aged 38, living near Lugano, who was delivered of six living children, all of whom died a few hours after their birth. It was her second pregnancy, and from the outset she had suffered severely from weakness in the legs and vomiting, and by the fourth month her

abdomen was almost as large as if at full term. On the morning of the 115th day of her pregnancy, while doing some light outdoor work, a considerable hemorrhage occurred, and labor was completed in six or seven hours. There was only one placenta. The fœtal heads were relatively large, the eyes covered with the pupillary membrane, and the genital organs perfectly differentiated. The specimen is preserved in the museum of the obstetrical school at Milan. The Castagnola district is remarkable for multiple births, the proportion of twins being 1 in 45 instead of 1 in 89 (Schrœder), and of triplets 1 in 228 instead of 1 in 7910.

This case immediately called forth a rival story in the *Berner Volkszeitung*, which is claimed to be reliable. A woman of Fullenbach was delivered of seven living children, and as the nearest church was seven miles away, the children had to be carried thither to be christened. On the way, one of them was accidentally lost, whereupon the distracted father made a vow that if the lost child was found alive he would erect a chapel to the Virgin Mary on the self-same spot. The child was found unharmed on the left bank of the Aar, near the Aarburg bridge, and there the chapel stands to the present day.

From France comes the report of another rival case. A woman named Aumont, residing at St. Julie de Varaville, gave birth to five children, three on the 4th and two on the 5th of June last. There were four boys and one girl, and they lived for several days. Madame Aumont bore eleven children in four confinements; the first time one daughter, the second time two daughters, the third time three sons, the fourth time four sons and one daughter.

Portsmouth, England, furnishes another case. Mrs. Norman, the wife of a painter, recently gave birth to four children, three boys and one girl, of whom only the girl survives. Like the Swiss and French mothers, she shows a marked tendency to multiple birth, having previously borne twins and triplets. Unfortunately, in none of these cases has an examination been made to determine the condition of the uterus.

Extrauterine Gestation treated by Abdominal Section.—Dr.

Hermann reports a case (*Brit. Med. Journal*) which is remarkable in several particulars. The patient, aged 26, had menstruated regularly since her fifteenth year, was married at eighteen, and bore two children, the labors being easy and rapid. No miscarriages. From December, 1885, to March, 1886, she was in hospital for a pelvic swelling to the left and behind the uterus, which was either a dilated tube, pelvic hæmatocele, or ruptured extrauterine pregnancy. This pelvic swelling remained stationary for a month, then gradually became smaller, harder, and less convex, and menstruation returned, having been absent for eleven weeks altogether. She enjoyed good health and menstruated regularly till October, 1887, from which time she saw nothing till 25th December, when a copious flow appeared. About that time she began to feel pain in micturating, and during January there was pain in the back and lower portion of the abdomen on the right side, so severe as to confine her to bed. Her appetite failed and she often felt faint. When admitted to hospital on 9th February she was able to walk to and from the examination couch. The abdomen was tender on pressure, and a round swelling was found rising out of the pelvis and extending almost up to the umbilicus. Per vaginam, the cervix was found pushed upwards, with a large rounded swelling behind it, feeling like a retroverted gravid uterus. The sound passed 3½ inches in the normal direction. A distinct uterine souffle was heard over the abdominal swelling. The next morning she was suddenly seized with violent abdominal pain, collapse, and the usual signs of internal hemorrhage. Preparations were made for abdominal section, and 2½ hours after the first symptoms Dr. Hermann extracted a four months fœtus which was lying free in the abdominal cavity. After the clots were all cleared out, the placenta, which was mainly attached to the right tube, was removed along with the ovary. The abdomen was washed and drained, and the patient made a good recovery, leaving hospital on 30th March. The points of note in this case are—(1) The lateness of the rupture, at the fourth instead of the third month, as is usually the case. (2) The presence of the uterine souffle, which is so rare as to be claimed by some

as diagnostic of uterine pregnancy. (3) The operation was done during primary collapse from the first hemorrhage instead of waiting for reaction. (4) The apparent succession of extra-uterine pregnancy, first in the left tube and then in the right.

Multiple Hydatid Cysts.—Pinard reports a case (*Annales de Gyn.*) of multiple hydatid cysts springing from the liver, involving the whole abdominal cavity, extending down into the pelvis, and displacing upwards the pregnant uterus. The waters came away early and the head presented, but could not enter the brim on account of the tumor. The nature of the tumor was not evident; it did not fluctuate, but felt like a fibrous tumor somewhat softened by pregnancy, the patient having been ten days in labor. An exploratory puncture was made into the tumor with a large trochar, and three pints of liquid drawn off; half an hour afterwards a living child was born, but the mother died on the fourth day. At the autopsy, the cysts springing from the liver were found to have attached themselves to the abdominal wall, intestine and omentum, and to have dipped down into the posterior cul-de-sac and pushed in between the folds of the broad ligament. The cyst attached to the liver was as large as a fœtal head, those adherent to the bowel and abdominal wall were about the size of an orange. The case is of great interest, for it is very rare to find hydatid cysts causing dystocia.

Treatment of Congenital Weakness in the New-born.—Budin (*La Semaine Médicale*) gives an interesting description of Tarnier's method of treatment by the incubator and forcible feeding. His first *couveuse* (incubator) was constructed in 1880, and has been in constant use since November 1881. A smaller and more convenient model was adopted in 1883. By means of an automatic regulator a constant temperature of 85°–98°F. (30° to 37°C.) is maintained, and the air is renewed so thoroughly that it does not become heavy or confined. The younger and feebler the child the more heat it requires. It is swathed in cotton wool, because beneath the wool the temperature is about two to three degrees higher than that of the surrounding air, and if by any accident the temperature of the *couveuse* be allowed to fall, the ill effect upon the child would be minimised. Every

hour or two the lid is raised and the child taken out and fed, care being taken not to expose it to the air of the room any longer than necessary. The artificial incubation is kept up usually for one or two weeks, exceptionally for thirty or forty days. As long as it suffers from congenital debility, it generally remains voluntarily in the incubator and sleeps almost continuously, but as it gets stronger it begins to cry when put back into the box, and ceases when taken out. Before it is permanently removed from the incubator, the precaution is taken to lower the temperature gradually to that of the room in which the child is to be. Infants born at full time, but suffering from cyanosis, œdema, etc., are put in for twenty-four hours, and then they do very well. In 1877–80, before the *couveuse*, 181 children died in the Maternité from scleroma; from 1882–5, with the *couveuse*, there were only nine deaths from this cause.

Some infants are so weak that they cannot nurse or cannot even swallow milk put into their mouths with a spoon. Since 1884 Tarnier has practised methodical artificial feeding (gavage). The same kind of tube that is used for an adult, only smaller, is passed into the stomach and milk allowed to flow in; when sufficient has been administered the tube is withdrawn rapidly to prevent regurgitation. The amount and number of feedings depend upon the age and strength of the child; when very feeble about one-fourth to one-third of an ounce is given every hour. Breast-milk is preferred, and failing that, asses' milk. When the child gets a little stronger gavage is alternated with nursing (mixed gavage); gavage should be continued two or three times daily, even if the child is able to nurse well, if the nutrition does not keep up without it. Many interesting and important physiological questions crop up in this connection. What is the proper temperature for a six month's child? What is the condition of the digestive tract and of the lungs between the sixth and seventh month? At what time is the pulmonary apparatus able to allow breathing sufficient for æration of the blood? What is the capacity of the stomach at that period? What is the structure of its walls and glands? What is the development of the salivary glands?

The results of treatment by the couveuse and gavage have been remarkable; before 1881 no six months children were saved, but with the new treatment they have managed to save at the Maternité—

Of six months children,	30	per cent.	instead of	0.0.	
" seven "	"	63.6	"	"	39.
" eight "	"	85.7	"		
" eight and a half,		95.	"		

Such results as these have an important bearing upon the Cæsarian section controversy. In Germany the tendency now is to perform Cæsarian section even in very moderate contraction of the pelvis; in France, the tendency is to avoid Cæsarian section by provoking premature labor. Tarnier's method has really pushed back the date of viability from the seventh to the sixth month, and has thereby greatly enlarged the domain of induced labor and contracted that of Cæsarian section. Budin predicts that with further improvements in Tarnier's method, the induction of premature labor will eventually triumph over Cæsarian section in all cases but those of extreme pelvic contraction.

REPORT ON THE PRACTICE OF MEDICINE.

By R. L. MacDonnell, M.D.,
Professor of Hygiene, McGill University; Physician to Montreal General Hospital.

Uræmia.*

Uræmia may be defined as the altered condition of health caused by the accumulation within the body of poisonous principles which ought to be eliminated by the kidneys. The symptoms of this altered condition are various in themselves and variously combined. Thus after apparently similar degrees of suppression or diminution of urine, some patients have only violent and persistent vomiting, the brain remaining clear; others have this with diarrhœa superadded, and others, again, become comotose. Convulsions, delirium, asthmatic attacks come and go in seemingly capricious fashion. Traube first attempted to comprehend within one general theory all these

* The Bradshawe Lecture on Uræmia, delivered before the Royal College of Physicians, August, 1888, by William Carter, M.D., B.Sc., LL.B., Lond., F.R.C.P., Lond.

differences. The nervous symptoms are due to cerebral anæmia, and never occurred without preceding cardiac hypertrophy and blood dilution. "Heightened blood pressure caused cerebral œdema, which in its turn caused cerebral anæmia, and as this affected one or other portion of the brain, there would be a preponderance of either coma or convulsions, these last being limited if the anæmia was limited, general if it were general." On this theory could be explained the transitory character of the phenomena. But the theory is too exclusive. Uræmia can be present without any hypertrophy of the left ventricle, and those who had seen this occur rejected Traube's theory. The question as to whether the blood in uræmia is or is not watery has never been determined. Dr. Carter examined the brain in two cases of uræmia. In the first case, one of scarlatinal nephritis, "twenty grammes, partly of white and partly of gray matter, were taken from the middle lobe, carefully dried for forty-eight hours at 82°C. over sulphuric acid, then pulverized and dried again in a similar manner until weight was no longer lost." The proportions of water to solids were almost exactly those of normal brain substance. The brain in the second case was examined in an exactly similar manner to that just mentioned, "when the proportion of solid matter was found to be decidedly greater than in the normal organ, the percentages being 74.55 liquid and 25.45 solid."

Œdema of the brain, therefore, cannot be said to be the cause of uræmia in all cases. Traube's theory ought to be considered in the light of certain experimental facts when the modification of it adopted by Jaccoud and some eminent physicians in our own country will seem far from unreasonable. These experiments, carried out by Raymond and M. G. E. Bernard, consisted in the deprivation of a cerebral hemisphere of vaso-motor supply by incision, in the rabbit, of one of the inferior cervical ganglia. The resulting convulsions were unilateral, affecting the half of the body opposite the operation. Yet the only difference observable between the hemispheres *post-mortem* was that one of them appeared to be affected with very slight œdema. Whether it was the scarcely noticeable œdema caused by this dilatation, as

M. Raymond thinks, that determined the unilateral convulsions or the larger amount of poison which the dilated vessels allowed to act on one side of the brain, yet the facts remain that the convulsions were unilateral, and that they were on the side opposite to the hemisphere whose vessels must have been dilated. It is not improbable that vascular spasms in the brain may occur in Bright's diseases since we know that they occur in other parts where the pallor produced is plainly visible.

The lecturer then deals with two important points in connection with uræmia. The first is as to the supposed utility of dropsy to the Brightic and the danger of precipitating uræmic convulsions, etc., by any rapid reabsorption of the presumedly toxic dropsical fluid. Dr. Carter quotes Bartel's case, where a violent storm of nervous symptoms broke over a patient whose dropsy was rapidly disappearing, as he lay streaming with perspiration in a blanket pack after half an hour's immersion in a bath at 102.5°F. The explanation that this result was due to reabsorption is open to much doubt, for the following reasons, namely, that the rapid absorption of such fluids often takes place without inconvenience ; that convulsions not infrequently come on during the very height of the supposed conservative dropsy, and that (if the patient is not jaundiced or very feverish) the fluids themselves, when examined, appear to be simple, both as regards their organic and inorganic contents. As the rapid relief of dropsy is often a matter of some moment, it will be unfortunate if a doubt is cast upon the propriety of promoting it by all legitimate means. A case similar to that of Bartel's is related, but Dr. Carter adopts a different explanation. The nervous symptoms were due less to the reabsorption of poisonous fluids than to the induction by the heat of the bath in one already half way towards uræmia, of great arterial tension and excitement (a condition of cerebral vessels comparable to that on one side of the brain of Raymond's and Bernard's rabbits), and increased bodily temperature. Since that time Dr. Carter has made it a point of practice to have both the pulse and temperature carefully watched, and if either rises much or headache occurs before perspiration is induced, to have the bath at once

withdrawn and the surface of the skin sponged with tepid water or vinegar and water before it is re-employed.

As regards the second point, Dr. Carter relates an instructive case. He was requested to see a boy of 10 who, on the twenty-first day of scarlatina, and while very dropsical, had suddenly become convulsed. Three other children of the family had died with convulsions in the third week. There was extreme anæmia and œdema. The hot-air bath was used, followed by a purgative and diaphoretics. The sweating was profuse. By degrees the œdema and the convulsions disappeared and eventually complete recovery ensued. "If dropsy were so conservative, and the absorption of dropsical fluid so poisonous as it is sometimes said to be, the fates of those children ought to have been reversed."

As to the composition of the effused fluids, it is altogether unproved and not a little improbable that they are poisonous. The amount of urea and salts is relatively small, even when the vomited matters have been rich in the former substance.

Next, the lecturer directs attention, as a fact influencing if not causing some of the symptoms of uræmia, to the progressively diminished alkalinity, if not towards the end, the actual acidity of the blood, which occurs in some cases.

The facts put in evidence are such as follow: Subcutaneous effusions, effusions into serous cavities, and purulent secretions are, under ordinary circumstances, alkaline or neutral. In Bright's disease, on the other hand, they are frequently strongly acid. In one of the cases mentioned, thin pus collected from large superficial bullæ in a patient uræmic from post-scarlatinal nephritis was always found to be "very acid." Fluid from the chest in the same case was "decidedly acid." In two other cases, serum from the pleural cavity was found to be acid. In one case where death took place very rapidly from uræmia in a young diabetic who had been ill only three weeks, this acidity extended to the blood itself.

The experimental methods of investigating uræmia have, so far, done no more than show us the causes of the difficulties which have hitherto prevented the proper understanding of the

pathogeny of this complex affection. One of the best contributors was that of MM. Feltz and Ritter. The conclusion was that the only really toxic constituents in the urines of health were the potassium salts. Among the organic constituents urea was found to be least harmful. But urea, though harmless by itself, under the influence of ferments, however, it is easily and often decomposed within the bladder, and more easily still in the laboratory, one of the products being carbonate of ammonia. On this fact was based the theory that uræmia depended on decomposition of urea within the blood and the consequent impregnation of that fluid with the poison thus necessarily formed.

"The probability is that uræmia has many causes, this one among them; and that every theory that has been advanced may have some measure of truth and some applicability to particular cases."

The relations, if any, between putrefactive changes and the chemical reactions of living tissues have yet to be clearly established. In the process of decomposition of muscular tissue (Gauthier and Etard) a stage is reached where, coincidently with the dissolution of the muscle structure proper, ammonia is evolved and fixed, and volatile alkaloids of various kinds are formed. Whether these chemical facts have any bearing on clinical facts time will show. Dr. Carter cites a very remarkable fatal case of uræmia in a patient of 52, in whom the symptoms were obscure, death occurring suddenly by collapse. The exhalations of the body of this patient appeared to be of a poisonous nature, bearing out the opinion that a chemical poison was at work.

The results of the experimental researches of Bouchard are quoted. The sources of toxicity of the urine are fourfold, namely: (1) Aliments, and more especially their potassium compounds; (2) the absorbed products of intestinal putrefactions; (3) secretions, such as the bile, saliva, etc.; and (4) tissue degenerations. By careful injection into the veins of different animals, Bouchard established such facts as the following—namely, that the urine secreted during the night differs

from that of the day, not only in degree, but in nature of its toxicity, the former being mainly convulsive in its action, the latter coma producing; that of one part of the day differs from that of another; that the night urine, though specifically heavier, is less poisonous than that of the day; that hard work in the open air markedly diminishes the toxicity, while a mere passing indisposition, indicated by no more serious symptoms than a transient feeling of weariness, markedly increases it; that within the limits of ordinary health, it varies with the degree of cerebral activity, the presence or absence of constipation, and innumerable other circumstances until lately thought to be of little importance; that the several constituents are not only different from, but to some extent antagonistic to, each other.

The presence of seven distinct toxic substances was determined, combined together in the most variable proportions under different circumstances, of which two were convulsivant (one of the two being either the coloring matter or contained in it), one (probably urea) diuretic, one narcotic, one sialogogue, one pupil contracting and one temperature reducing.

Urinary poisons may have very different effects, according to the times and circumstances of their formation. The cause of uræmia does not persist, for it may, and does, differ from hour to hour.

The remainder of the lecture is devoted to consideration of the treatment based upon the above-mentioned principles.

Hospital Reports.

MONTREAL GENERAL HOSPITAL.

GYNÆCOLOGICAL CASES UNDER CARE OF DR. ALLOWAY.

CASE I.—*Pelvic Cellulitis ending in high abscess. Operation.*—Aged 29 years, married two years. Was confined on the 11th of April last. Three weeks after confinement she caught cold and experienced chills, high temperature, and a pain in left inguinal region. She was admitted into hospital on the 18th of May, complaining of extreme prostration, frequently recurring chills, rapid heart action, and high temperature remittent in character.

Examination per vaginam elicited very little information. There was some deep-seated induration felt high up in the region of the left broad ligament, with some slight fixity of the parts generally to that side. The bases of the broad ligaments, however, were quite free from exudation. Fluctuation was shortly afterwards discovered in the left iliac region parallel to the inner side of Poupart's ligament.

June 2nd.—An incision was made over the most prominent part of the abscess and one pint of very fœtid pus removed. On examination of the pus cavity it was found that the fluid had pushed its way through the abdominal muscles and passed along upwards and downwards for some distance beneath the adipose layer of covering. The bottom of this cavity was found to be formed in the upper part of the broad ligament. A drainage-tube was inserted and the wound dressed with sublimate jute cushion. *9th.*—Tube withdrawn and cavity packed with iodoform gauze. *28th.*—Gauze dispensed with.

July 5th.—Wound almost closed. *8th.*—Patient discharged well enough to be sent to the Convalescent Home at Murray Bay.

Parametrial inflammation following the puerperal process and ending in abscess formation is not at all uncommon, but in the large majority of such cases, arising as they generally do from a cervical laceration becoming infected from without, the whole base of that infected ligament and the parametral tissue extending around the cervix become very soon one solid mass of exudation, depressing the pelvic floor. This inflammation may extend to the base of the other ligament, and in this way the whole pelvic floor becomes depressed. In these cases, should abscess formation set in, fluctuation can generally be felt first through the vagina or rectum. My hospital case, however, exhibited no such features; there was no pelvic floor induration and suppuration took place at the apex, not the base of the broad ligament. It thence followed the course of least resistance, the shortest path to the external surface. These rare terminations of puerperal pelvic inflammations do not, I think, arise from cervical infection, but probably from infection origi-

nating higher up in the genital tract: as, for instance, the placental site or adjacent endometrium. The poison in such cases would be more likely to miss the connective tissue in the lower base of the broad ligament and infect that in the upper zone of the pelvis. As the exudate suppurates it strips the peritoneum from the sides of the pelvis and abdominal wall. It often perforates the fascia of abdominal muscles and burrows beneath the integument; or it may follow the round ligament and appear at the external inguinal opening.

This is the second case within a short time I have reported where the pus made its way through the abdominal muscles to the surface. Imlach of Liverpool has reported cases in which the pus followed the course of the round ligament through the inguinal canal. This rare termination of abscess of the parametrium must be distinguished from abscess of the perimetrium resulting from suppuration in a diseased ovary. The latter always invades, by extension of inflammation, the Fallopian tubes, intestines, and adjacent structures. Such indurations are not felt by lifting up the pelvic floor except when the bimanual method with considerable force is used; and they have some other features in common with those of the case I have related. The broad distinguishing point, however, lies in the fact that abscess of the parametrium follows parturition, while abscess of the perimetrium occurs in virgins and the sterile.

CASE II.—*Pelvic Cellulitis before Puberty, ending in extensive abscess formation. Operation.*—Was admitted to the hospital May 9th with the following history: She has never menstruated; has been in fair health, although delicate from birth, until March last, when she complained of pain in the lower part of abdomen at times, and began to emaciate and lose health generally. Three weeks before admission to hospital she was suddenly seized with severe colicky pain in the right side of abdomen. This pain continued for about twenty-four hours, after which it moderated, but would again recur at varying intervals. During this period of time she experienced so-called chills and fever; she began to lose her appetite and rapidly to

emaciate. Bowels have been constipated as a rule, but the night following her admission had six stools; the evacuations were of a purely mucoid character, and accompanied with much pain and rectal tenesmus. Temperature on admission, 98.5°F.; pulse 112. Functions of bladder and kidneys normal.

Examination.—A soft, fluctuating, fully distended cystic tumor situated in the centre of abdomen and extending from pubis to umbilicus was observable. Its origin was from the pelvis, had gradually extended upwards, and had throughout occupied the middle line. Patient states that she had not noticed the enlargement until within three weeks past, but the childlike simplicity of the patient rendered this statement rather valueless in the history of its formation. On palpation, the tumor was somewhat tender, especially at the upper limit, near the umbilicus. The contents seemed somewhat easily displaceable from side to side, and its walls were evidently very thin. Percussion note dull throughout area of tumor, and clear note on each side and in flanks. Auscultation nil.

The vaginal examination proved very interesting. The fluid contents of the tumor could be made to fluctuate by external pressure upon the finger in the vagina as low down on the posterior wall as midway between the fornix and the vulva, thus separating the recto-vaginal connective tissue fascia to this extent. The fluid also seemed to extend on either side of the vagina along up the pelvic walls and end in a large oval-shaped tumor rising out of the pelvis into the abdominal cavity. The parts were virginal, though the vaginal walls were soft and distensible. The cervix was high up and seemed crushed against the pubic bone; the os looked backward, and its lips were normal. I passed a sound into the cavity of the uterus, which measured 5 cm., and seemed normal in condition and anteflexed.

The question arose, What was the nature of the fluid in the sac, and where was it anatomically situated? As regards the fluid, it was either gradually effused blood or a large hæmatoma, or pus. As there was not direct evidence in the history of the case to point to blood effusion, it was in all probability a large post-uterine retro-peritoneal pus collection dissecting the peri-

toneum from the pelvic walls and lifting itself in the direction of least resistance—the anterior abdominal wall. The fact of it being so peculiarly palpatable, so low down in the recto-vaginal septum, where the connective tissue is so very loose, and the fluctuation wave passing on either side in the direction of the peritoneal reflection seemed to locate the fluid as being outside the peritoneal cavity. I passed an aspirator needle through the posterior fornix and pus began to flow at once. The needle was withdrawn and a bistoury passed in its track, making a fair sized opening, which was still further enlarged by a uterine dilator. From this opening a pint and a half of very fœtid pus flowed. I curetted the cavity thoroughly, removing large quantities of granulation tissue, and inserted a T-shaped drainage-tube. The little patient improved from this out, her temperature rising occasionally a degree above normal at night. Five weeks after the operation the drainage-tube was removed, but it was found that within the next thirty-six hours the temperature rose up to 104°F. Patient was now placed under ether and the cavity found to contain a large quantity of fœtid pus which had collected since removal of tube. The cavity was again thoroughly curetted with the sharp instrument and the tube reinserted. A few days after this operation the patient was allowed to leave her bed and walk out on the gallery of the hospital. Three weeks was now allowed to elapse, during which time the discharge from the cavity became markedly less every other day. At the end of this period the tube was removed and the cavity found to be only 1¾ inches in depth. It was, however, thought better to again use the curette, which brought away a considerable quantity of granulation tissue; tube again reinserted just to within the cavity.

During the following ten days there had been no discharge, and the tube was finally removed (20th July). The patient remained in the hospital for some days, and no evidence of further collection showing itself, she was sent to her home.

The interesting points in the above case touch principally upon the etiology and treatment. And it is exceedingly difficult to say what the starting point was, in so young a girl, of so

grave a condition. It may have been a small hæmatoma following an abortive attempt at menstruation, giving rise to a localized cellulitis, followed by suppuration in a delicate strumous subject. As regards the treatment, it rested between laparotomy and vaginal puncture. I chose the latter and, I think, the more rational course, as by it the peritoneum was not opened. The curetting of the cavity was somewhat difficult, and required great caution and delicacy of touch. To remove the thick granulation tissue from the walls of the pus cavity and not go through, involving, probably, a fatal issue, required care. Should such an abscess open into the rectum, it becomes a serious calamity, as there is no other safe course open but to obtain drainage by laparotomy, thorough curetting, and allow the bowel opening to close.

ERYSIPELAS.—Speaking of erysipelas, Nussbaum expresses himself thus: "I have had the pleasure recently to obtain a rapid cure in many cases of erysipelas by a very simple method, which does not present any danger nor occasion any pain, which is not the case in injections of phenic acid, which are almost always cruel on account of the suffering. The erysipelatous parts, previously rubbed with a pomade of lanoline and icthyol (equal parts), are enveloped in salicylated cotton. It will be found, the day after this application, that not only has the erysipelas not advanced, but that there has been a notable amelioration in all the morbid symptoms. The roughness, the redness, and the pain have very much diminished—in a word, all the phenomena of irritation have disappeared as if by enchantment, and do not return. It is hardly ever necessary to continue the application for more than three days."—*Algemeine Weiner Medical Zeitung.*

A GENERAL ANTIDOTE FOR POISONS.—According to the *American Journal of Pharmacy*, a general antidote for poisons may be made by mixing equal parts of calcined magnesia, wood charcoal, and hydrated oxide of iron, and is applicable in cases in which the poison is unknown. It should not, of course, supersede the stomach pump or other forms of emesis.

Society Proceedings.

CANADIAN MEDICAL ASSOCIATION.

Twenty-first Annual Meeting, held at Ottawa, Sept. 12th and 13th, 1888.

GENERAL SESSION.

Dr. J. E. Graham, Toronto, President, took the chair at 10 o'clock, and formally opened the twenty-first annual meeting of the Canadian Medical Association. In introducing Dr. George Ross as President elect of the Association, he expressed the great pleasure it afforded him in doing so, and said :—I think we can congratulate ourselves upon the prospect of having a very pleasant and profitable meeting, and upon the fact that we have selected as President for this year a gentleman who is in every way capable of fulfilling the duties of that office. Dr Ross is one of the leaders of the profession in the largest city of the Dominion, and his reputation is not alone confined to that city but to the Dominion at large.

Dr. George Ross, (Montreal) then took the chair.

The Secretary, Dr. James Bell (Montreal), read the minutes of the last meeting of the Association which were approved of.

The following gentlemen having been duly proposed and seconded, were unanimously elected members of the Association: Dr. Allen Baines, Toronto, Ont.; Dr. W. Anson, Ottawa; Dr. M. C. McGannon, Brockville; Dr. Thos. Potter, Ottawa; Dr. W. C. Cousens, do.; Dr. B. F. Hurdman, do.; Dr. S. Wright, do.; Dr. C. J. H. Chipman, do.; Dr. A H. Horsey, do.; Dr. J. W. Shillington, do.; Dr. W. F. Graham, do.; Dr. C. P. Dewar, do.; Dr. W. H. Klock, do.; Dr. T. L. Brown, Melbourne, Que.

The following were selected as members of the nominating committee :—

Drs. F. W. Campbell, T. G. Roddick, Montreal; J. E. Graham, Wm. Canniff, Toronto; Bray, Chatham; Sweetland and Church, Ottawa; Griffin and Mullin, Hamilton; Eccles, London; Fenwick, Kingston; Baird, Pakenham; Smith, Seaforth; the President and Secretary.

The following gentlemen were nominated :—

Chairman of Medical Section.....Dr. Bray, Chatham
" Surgical Section.....Dr. Cameron, Toronto.
" Obstetrical and Gynaecological Section....Dr. Trenholme, Montreal.

Dr. Graham pointed out that, last year, a committee was appointed, the object being to endeavor to further the interests of the Association, and to present a report at this meeting, but that owing to the absence of Dr. Stewart, ex-secretary, in Europe this summer, nothing had been done by that committee. He said that it was felt that this Association was not in such a flourishing condition as it ought to be, and that it did not hold the sympathy of the profession throughout the Dominion; also, that the By-Laws are found to be very deficient. He therefore suggested that another committee be appointed with the view of bringing in a report at the next annual meeting that would be of advantage to the Association.

Dr. Roddick moved, seconded by Dr. Bray, that Dr. Graham, Dr. Ross (President) the President elect, the Secretary and Treasurer, form the committee.—Carried.

Moved by Dr. Girdwood, seconded by Dr. Rodger, that a committee be appointed, consisting of Drs. Wright, Campbell, Sullivan, Bray, Eccles, Milne and himself, to ascertain the feeling of the different Medical Councils of the Dominion, upon what terms reciprocity of registration may be obtained between the different provinces, and the mother country and other colonies.

He stated that on making enquiry in regard to reciprocity of registration with Great Britain, he was informed that before registration could take place, it would be necessary to have an Order-in-Council passed making a new law of reciprocity of registration applicable to Canada. Reciprocity takes place between Great Britain and Australia, and he thought that we might very fairly have reciprocity of registration between Great Britain and this colony. He also remarked upon the want of harmony existing between the Medical Councils of the different provinces in not allowing members to practice in any province in the Dominion.

Drs. Bray, Mullin, Campbell, Sheard and Cousens spoke in discussion.

Motion carried.

The President read his address. (See page 241).

A vote of thanks for his able address was moved by Dr. Workman, seconded by Dr. Campbell, and carried.

Sir James Grant spoke in support of the motion

The meeting adjourned until 2 o'clock.

MEDICAL SECTION.

Dr. Bray, Chatham, in the Chair.

Dr. Sheard, Toronto, was appointed Recording Secretary.

A telegram was received from Dr. Canniff, of Toronto, regretting his inability to be present and therefore his paper on "The duty of the Medical profession under the Public Health Act of Ontario," was omitted, and Dr. T. W. Mills, of Montreal, was called upon to read his paper on "The influence of the nervous system on the nutritive processes." He began his subject by referring to a synopsis of a paper read by him last year on a new basis of improved Cardiac Pathology, which developed the theory that all the nutritive processes were constantly under the influence of the nervous system. He explained metabolism as the molecular life of protoplasm, and regarded the organic action of the nervous system, or nerve with the tissue element, as regulating these processes. He proved that nerves going to bone, on being divided, caused atrophic changes in the bone, a change called by Charcot, Acute Necrobiosis. He also referred to certain affections of the skin following nerves, which he traced to similar nervous lesions. He spoke of the cause of death in animals, after section of the vagi nerves, as being a pneumonia, which was an inflammatory process due to the severance of the nerve connection. In birds, section of nerves in connection with the heart was followed by its fatty degeneration. He discussed the influence of the Trigeminus nerve, also the inhibitory fibres, and sympathetic fibres, due wholly to such interference with nutrition. He referred to the emotions, and their influence on vital processes as being such, and also dwelt upon the training of athletes, stating that over-exertion called into play, and used up, the residual nerve force.

Dr. Mills' paper was discussed by Dr. Playter of Ottawa, and Drs. Sheard and Graham, Toronto. Dr. Graham asked Dr. Mills to explain the causes of accelerated heart's action. Dr. Mills promised to do so after he heard Dr. Graham's paper upon "A case of extreme rapidity of the heart's action." Dr. Small, Ottawa, also spoke in reference to the nervous influence on the movements of the Amœba, and Dr. Campbell and others took part in the discussion, to all of which Dr. Mills replied.

Dr. Wright, Ottawa, then explained the absence of any

special Medical Address as he did not clearly understand what the meeting expected of him.

The Section then adjourned to meet at 10.30 a.m. Thursday.

SURGICAL SECTION.

Dr. Clarence Church, Chairman.

Dr. Proudfoot, Montreal, read notes of a case of "Excessive hemorrhage after cataract extraction, into the anterior chamber of the eye." No Anaesthetic was used, and no iridectomy made. Pressure was made over the globe by compress and bandage, which were removed next morning, owing to great pain, and an atropine solution dropped into it. Hemorrhage continuing, pressure was re-applied with boracic acid lotion, and morphia given for the pain, which was very severe. Hemorrhage continuing, on the eleventh day, enucleation was performed, and on dividing the globe, the point from which the hemorrhage came was found to be in the Retina. No reason could be given for the troublesome hemorrhage, excepting that the patient was very plethoric and a drunkard. No discussion followed the reading of this paper and the section adjourned to meet at 10.30 a. m. Thursday.

OBSTETRICAL AND GYNÆCOLOGICAL SECTION.

Dr. Trenholme in the chair.

Dr. Alloway, Montreal, read a paper on "The indications for, and comparative merits of Emmet's and Schroeder's methods of operating upon the Cervix Uteri. This paper gave rise to an interesting discussion upon the subject. Dr. Gardner spoke in favor of Schroeder's operation as compared with Emmet's in cases of extreme hypertrophy of the neck, and inflammation of the mucous membrane. It enables disease to be removed where Emmet's fails on account of the stitches being unable to approximate the edges together after an operation. Dr. Trenholme favored Emmet's operation in all cases, except in very extreme ones of hypertrophy and inflammation accompanied by glandular degeneration of the follicles where Emmet's operation was not available, but thought that in very few cases would this be found necessary, if the tissue was pared away well towards the cervical canal, leaving a narrow border by which tissue could be obtained. Pressure upon the hypertrophied parts afterwards would lead to the formation of the natural cervix. In no case were we warranted in amputating the cervix, if it could be avoided.

The general sense of the meeting was that it was much indebted to Dr. Alloway for bringing the subject up, and that the operation of Schroeder should be resorted to only in extreme cases.

GENERAL SESSION.

THURSDAY, September 13th, 1888.

The meeting opened at 10 o'clock. Dr. Geo. Ross, President in the Chair.

Dr. G. H. Oliver, Delegate to the Association from the Medical Society of the State of New-York, Dr. Wallis Clark of Utica, N. Y., and Dr. Imrie of Detroit, Mich., were introduced by the President, who, on behalf of the Canadian Medical Association, welcomed them.

Dr. Henderson, Kingston, President of the Ontario Medical Society, was invited to a seat upon the platform. He expressed the pleasure it afforded him to be present at this meeting, and said that as the representative of the Ontario Medical Association he felt sure that any friendly sentiments conveyed to that Association through him would be heartily reciprocated. It will always be his duty to promote that unity and concord which should exist between the Ontario Medical Association, the local societies, and this Dominion Association. He referred to the re-formation in Kingston, a short time ago, of the Cataraqui Medical Society, which is now affiliated with the Ontario Medical Association, and which has sent two delegates to this meeting, and hoped that such a society will be formed in Ottawa, and elsewhere, with the view of forming a connecting link between the local society and this Association.

The following gentlemen were elected members of the Association :—

Dr. W. J. BURNS, Caledonia; Dr. WALLACE, Metcalfe; Dr. PRESTON, Carleton Place; Dr. LYNCH, Almonte; Dr. MUNRO, Perth; Dr. SUTHERLAND, Valleyfield, Que.; Dr. BURNS, Almonte; Dr. MILNE, Victoria, B. C.; DR. DAVIS, Chelsea, Que.

The President referred to the great pleasure of seeing present a representative from such a distant province, and upon the suggestion of Dr. Proudfoot, invited Dr. Milne to a seat upon the platform.

The Nominating Committee reported as follows:—

On motion of Dr. Bray, seconded by Dr. Sheard, the Report of

the Nominating Committee was received and considered clause by clause.

Dr. H. P. Wright, Ottawa, was elected President for the ensuing year. Dr. James Bell, Montreal, was re-elected general Secretary.

A letter of resignation from Dr. Sheard was read by the Secretary.

The committee recommend that the resignation of Dr. Sheard as Treasurer be accepted, and that a hearty vote of thanks be passed to him for his services during the past seven years in that capacity.

Dr. Proudfoot, Montreal, moved, seconded by Dr. Trenholme, Montreal, that the thanks of the Association be tendered to Dr. Sheard for the long and valuable services rendered to the Association as Treasurer.—Carried unanimously.

Dr. W. H. B. Atkins, Toronto, was then elected Treasurer.

Dr. Mullin having called attention to the fact that no allowance was made to the Treasurer for travelling expenses, etc., it was

Moved by Dr. Bray, Chatham, seconded by Dr. Burns, that the travelling and other expenses of the Treasurer, Dr. Sheard, for this year, and that of 1887, be defrayed by the Association.—Carried.

The committee recommend that the following be elected Local Vice-Presidents:—

Ontario.....Dr. Chas. Sheard, Toronto.
Quebec.....Dr. F. W. Campbell, Montreal.
New-Brunswick.....Dr. Graham, Bathurst.
Nova Scotia.....Dr. Ed. Farrell, Halifax.
Manitoba .....Dr. Lynch, Winnipeg.
British Columbia.....Dr. J. M. Lefevre, Vancouver.
N. W. Territories.....Dr. Jukes, Regina.
P. E. Island.....Dr. Jenkins, Charlottetown.

And the following Local Secretaries:—

Ontario.....Dr. Griffin, Hamilton.
Quebec.....Dr. A. N. Worthington, Sherbrooke
New Brunswick.....Dr. Kellar, Fredericton.
Nova Scotia.....Dr. Webster, Wolfville.
Manitoba.....Dr. A. H. Ferguson, Winnipeg.
British Columbia.....Dr. Milne, Victoria.
N. W. Territories.....Dr Oliver C. Edwards.
P. E. Island.....Dr. McLaren, Georgetown.

The names submitted by the committee for Local Presidents and Secretaries were carried unanimously.

The committee recommends that the next annual meeting be held at Banff, N. W. T. in the early part of August, 1889

On the suggestion of the Committee that the next annual meeting be held at Banff, a general discussion ensued.

Invitations were extended to the Association to hold its next annual meeting at London, Ont., by Dr. Eccles; at Toronto, Ont., by Drs. Sheard and Graham, and at Victoria, B. C., by Dr. Milne, and a letter received by Dr. Ross from Lucius Tuttle, Passenger Traffic Manager of the Canadian Pacific Railway Company at Montreal, dated September 11th, 1888, was read, stating that if the Association desire to meet at Banff, a trip will be given from Montreal, or from other Stations in Ontario or Quebec on the line of the Canadian Pacific Railway to Banff and return, first class, including a double berth in the sleeping car for each person, meals in the dining cars on the way west of Montreal and back, and four days living at the Banff hotel, for a round sum of $95, and that similarly low rates will be made from other points in Canada, and as far as possible from cities in the United States.

Dr. Walker, Dundas, moved in amendment to the Report of the committee that the Association meet next year at Toronto to receive the President's Address, and then adjourn to meet at Banff for the transaction of other business. Dr. Horsey, Ottawa, seconded the amendment.

Dr. Mullin, Hamilton, moved in amendment to the amendment, seconded by Sir James Grant, that the next meeting of the Association be held at Toronto on such date as may be deemed advisable by the officers of the Association, and that, in addition, an excursion to Banff be organised by them to take place immediately after the meeting.

The amendment to the amendment, and the amendment to the Report of the Committee were lost on division, and the recommendation of the committee carried that the next annual meeting be held at Banff in the early part of August, 1889.

Dr. Bray, Chatham, moved, seconded by Dr. Trenholme, Montreal, that the Executive make satisfactory arrangements with the railway authorities for members to go to the end of the line.—Carried.

Dr. H. P. Wright, Ottawa, thanked the Association for the honor conferred upon him in electing him President for the coming year.

The meeting then adjourned to meet in Sections.

MEDICAL SECTION.

THURSDAY, September 13th, 1888.

MORNING SESSION.

Dr. Bray in the Chair.

Dr. Graham, Toronto, was called upon to read his paper on "A case of extreme rapidity of the heart's action." He reported two cases, one of which was characterised by a rapid beating of the heart, the beats numbering over 140, and being uncountable. His illness lasted three weeks, and the peculiar features in the clinical history were the absence of dyspnœa, the absence of renal changes discoverable on examination of the urine, and any physical signs directly referable to the lungs. The case was treated by rest, regulation of diet and the administration of digitalis, and after a comparatively short treatment, the patient recovered his accustomed health. The second case was more prolonged and peculiar in the fact that continued muscular exertion reduced the heart's beat to normal. This had been discovered by him only after repeated examinations, and during a period of rest, the heart again became accelerated. There was nothing in this case to account for such acceleration.

Dr. Mills explained in extenso the influence of the Cardiac nerves upon the heart's action, dealing mainly with the sympathetic and vagi. He spoke also of embolism in the coronary arteries as a possible cause of such acceleration. He referred to blood pressure, as slowing the heart's action rather than accelerating it. Dr. Sheard discussed the case, and suggested embolism, or toxic matter in the blood as a possible cause for such acceleration, and referred also in commendation to digitalis as a method of treatment, particularly the infusion of digitalis. Dr. Mullin thought it was an important case, and had direct bearing upon the importance of acceleration of the heart as affecting a life insurance risk. He would like to ask Dr. Graham what influence he thought such acceleration of the heart would have in shortening the ordinary duration of life. Dr. Milne, Victoria, also spoke, referring to a case of modified heart's action associated with tetanus, and stating that such cases were evidently due to a close association between the nervous and cardiac action.

The section then adjourned to meet at 2 o'clock.

SURGICAL SECTION.

Thursday, Sept. 13th, 1888.

MORNING SESSION.

Only one paper was read at this session, that by Dr. Fenwick, of Montreal, upon "Retropharyngeal Tumors." The operation is formidable, and its literature rather scanty. Dr. Cheever, of Boston, Mass., appears to have been the first who operated on these tumors. Velpeau operated in 1836 on a large tumor, operating by the mouth, tying the common artery first. The patient died on the seventeenth day. Dr. Fenwick was early convinced that operating from the outside is the correct method. These tumours are usually sarcomatous or cancerous, and in a large majority of cases, recur. Dr. Fenwick then proceeded by diagrams to illustrate Dr. Cheever's method by cutting from without. A long, straight incision is made, beginning on a level with the lower border of the ear, and extending down the neck in the line of the great vessels. If sufficient room is not thus given, he makes a transverse insicion from the straight incision across the jaw. The jaw is not divided, the vessels and nerves are drawn aside, and the tumor enucleated in the usual way. Czerney's operation is modified from Cheever's. He opens the trachea and keeps up respiration in this way during the operation. He divides the jawbone between the second and third molar, and in getting down to the tumor, has to sacrifice the chief nerves and vessels in that region. He then removes the tumor with a hot knife. Dr. Fenwick then described his own operation by a curved incision following tolerably well the line of the angle of the jaw. In two cases, the operation was easy, no vessels or nerves of importance were divided, except the facial nerve in one case. The bleeding in both cases was practically nil.

Dr. Sheard thought that distinction ought to be made between cancerous and sarcomatous tumors. He thought cancerous tumours, which were not neglected, required a more serious operation, and that more room should be given, as they could not be removed solely with the finger without dissection.

The section then adjourned until 2 o'clock p. m.

OBSTETRICAL AND GYNÆCOLOGICAL SECTION.

THURSDAY, Sept. 13th, 1888.

Dr. Smith, Montreal, delivered his paper upon "Some minute but important details in the management of the continuous current in the treatment of Fibroid and other diseases of the Uterus." He insisted upon attention to the antiseptic treatment, and upon performing all the operations with care. The results in his own hands had been very satisfactory. He recommended the Electrode of Dr. Inglemann in preference to Apostoli's clay electrode. The different forms of electrodes and sounds were shown, and that of Martin he favored most, as being the least expensive, and, at the same time, serving the purpose. He referred to the necessity of exact dosage, and the after care of patients where much electricity had been used.

This paper led to a very interesting discussion as to the field for which it was intended to be useful. Dr. Trenholme, Montreal, favored an antiseptic method apart from irrigation, simply advising that the vaginal passage be washed out with soap and water, and a plug of antiseptic cotton left in contact with the cervix, when the sound was removed. Other members took part in the discussion.

The session was then brought to a close.

MEDICAL SECTION.

AFTERNOON SESSION.

Dr. R. P. Howard, Montreal, read an interesting paper on "Ophthalmoplegia Externa," illustrated by diagrams. He spoke of a case of Ophthalmoplegia Externa and Interna, and explained as a cause the close association of the cerebral centres, and the extension of the disease from these. He also mentioned peripheral neuritis as being a cause in some cases. He referred to cases recorded where both Ophthalmoplegia Externa and Interna had been caused by hysteria. He noted also the association of this condition with locomotor ataxia and pseudo-hypertrophic muscular paralysis. He was convinced, however, that Ophthalmoplegia Externa could exist without such association. He also discussed the relation of syphilis to this ocular disease.

Dr. Howard's paper was commended very highly by Dr.

Graham, of Toronto, who spoke as to the very great rarity of such cases.

Dr. Stewart, Montreal, also spoke in reference to it.

The paper of Dr. Campbell, Seaforth, "Myxœdema, with report of a case," was taken as read.

Dr. Playter, Ottawa, read a paper on a few facts relative to Communicable Diseases in man and animals, especially as brought out at the recent Paris Congress and British Medical Asociation, referring particularly to Tuberculosis. His paper was listened to much with attention, and was discussed.

The Medical Section then adjourned.

SURGICAL SECTION.

AFTERNOON SESSION.

Dr. Bell, of Montreal, read a paper on "Exostosis Bursata," in which he gave the notes of a case which he believed to be the only one reported by an English-speaking surgeon. Dr. Shepherd, Montreal, referred to the great rarity of the disease, and drew attention to the explanation which was offered of the existence of floating cartilages in the joints.

Dr. Shepherd followed with a paper on "Mania following operations." He reported six cases. Dr. Bell, in the discussion which followed, related two cases, in one of which he attributed mania to the use of Iodoform. He asked if there were any cases on record due to Iodoform. Dr. Buller related his experience of one case of mania following the operation on a cataract. Dr. Dickson, of Pembroke, asked Dr. Shepherd, if mania from Iodoform would be apt to occur in the use of the drug when applied to small surfaces. Dr. Shepherd replied that the danger would be greatest when Iodoform was applied to a large surface, as, for instance, to the interior of a large abscess cavity.

Dr. Buller then made a few remarks on "Penetrating Wounds of the Eye Ball." Dr. Proudfoot related a case of a penetrating wound of the eye-ball produced by a pen. He agreed with Dr. Buller as to the urgency of an immediate and prompt treatment, and cleansing the wound. In reply to Dr. Dickson, Dr. Buller advised, for the control of inflammation, the application of cold, to be changed to warm applications, with antiseptic solution of bi-chloride of mercury, one part in 10,000, and one or two doses of 10 or 15 grains of Antipyrin.

Dr. J. Stirling, Montreal, followed with a paper on "Some eye symptoms due to Cerebral Lesions." Dr. Buller said that in cases of fracture of the orbital plate, the blindness may be due to infiltration of blood in the sheath of the nerve, and reported a case which had occurred in his practice of that nature.

Dr. A. Lapthorn Smith's paper on "The treatment of Varicocele and Orchitis by the electrical current of tension" was then read; also a paper by Dr. Smith on a "Case of Resilient Stricture of the Urethra cured by electricity." Dr. Dickson enquired if Dr. Smith had ever used the treatment in neuralgia, sciatica, or enlarged prostrate. Dr. Buller suggested the decomposition of water as an easier method of determining which is the negative pole. Dr. Smith in reply to Dr. Dickson, said that the use of a continuous current would probably prove useful in the enlargement of the Prostate. In reply to Dr. Church, Dr. Smith said that his cases had been under observation for a considerable time and certainly after a lapse of three years might be considered cured. Dr. C. Dickson, Kingston, said that in his large experience in the use of electricity in neuralgia, he had found the negative pole of tension often increase the pain, especially if any neuritis existed.

GENERAL SESSION.

THURSDAY, 6 o'clock p.m.

Dr. Geo. Ross, President, in the chair.

The minutes of the last session were read and approved.

Moved by Dr. Milne, Victoria, B.C., seconded by Dr. Sweetland, Ottawa, that in view of the apparently increasing prevalence of tubercular disease in domestic animals, more especially in cows, it is the opinion of this Association that it is desirable that some legislative action should be taken by the Dominion Government to check the progress of this disease, and we urge that the Government take this matter under their consideration at as early a date as possible. Carried.

Dr. Mullin, seconded by Dr. Smith, that the cordial thanks of this Association be tendered to the members of the profession in Ottawa for the courteous manner in which they have treated the the Association, and its members individually. Carried.

It was moved by Dr. Sheard, seconded by Dr. Pickup, that the thanks of the Association be tendered to the Railway and Steam-

boat Companies for travelling privileges accorded to members of the Association. Carried.

Dr. Fenwick moved, seconded by Dr. Sweetland, that the thanks of the Association be the tendered to the Dominion Government for the use of the Railway Committee Rooms for the purpose of holding the present meeting. Carried.

On motion of Dr. Mullin, Dr. Wright, President-elect, took the chair.

Dr. Sheard, Toronto, in moving a vote of thanks to Dr. Ross, retiring President, said that he was sure that all the members of the Association appreciated the whole-souled manner in which Dr. Ross acted in the position of President of the Association. Much is due to Dr. Ross for the success, the vitality and the perseverance which has characterized, and which has blessed the Dominion Medical Association, and he hoped that he might be long spared to give us his guiding counsel.

Dr. Church, Ottawa, seconded the motion, which was carried unanimously.

Rr. Ross thanked the Association for the vote of thanks tendered him, and said that as regards the Association he had always felt indeed a very keen interest, and had always endeavoured to do his share in supporting its interests. With reference to the coming year, the President's duties, according to our present regulations, only begin with his presidence over the annual meeting of the Association. He might, therefore, be of some service to the Association in assisting in making the next annual meeting a success, and as they had come to a decision as regards the place of meeting, he hoped that members would use every endeavor to be present, and to make the meeting a successful one. Every exertion should be made to attract a large number of our Canadian graduates who are now scattered throughout the North-Western States, and a number of American physicians, to the next annual meeting at Banff.

Dr. Sweetland, Ottawa, was appointed Auditor.

On the motion of Dr. Mullin, Hamilton, the thanks of the Association were tendered to Dr. James Bell, Montreal, for his valuable services as Secretary.

The twenty-first annual meeting of the Canadian Medical Association was then brought to a close.

CONGRESS OF AMERICAN PHYSICIANS AND SURGEONS.

First Triennial Session, held at Washington, Sept. 18, 19 *and* 20.

Dr. Reginald H. Fritz of Boston opened the discussion on *Intestinal Obstruction in its Medical and Surgical Relations.* He confined himself to the diagnosis and medical treatment of acute, internal and mechanical varieties of intestinal obstruction. The only causes recognized were strangulation from adhesions, vitelline remains, peritoneal slits, pockets and rings; intussusception, knots and twists; abnormal contents; strictures and tumors. The evidence presented resulted from the analysis of 295 cases collected from medical literature since 1880. The most constant symptoms of obstruction proved to be pain, vomiting, tympany, and tumor. Stoppage of the bowels was not regarded as the most essential symptom in diagnosis, since frequent, loose stools characterize intussusception and may occur in other varieties of obstruction. Too much attention directed to this symptom leads to erroneous diagnosis, since it is of frequent occurrence in peritonitis, and often results in irrational and injurious treatment. The physician is called upon to decide whether the given case is one of acute obstruction; then, where its seat and what its cause; and, finally, what is to be done. The evidence showed that the diagnosis is to be made by excluding the various causes of peritonitis. Its seat in the large or small intestine is to be determined by injection, under high pressure, when necessary. The variety is, for most practical purposes, an intussusceptum or a twist of the large intestine, and strangulation or gall-stones of the small intestine. The differential diagnosis depends upon the relative frequency of these varieties, the age of the patient, the antecedent and immediate symptoms. The treatment consists in the attempt to relieve intussusception of the large intestine by forced injections, under anæsthesia and with massage, and to treat obstructing gall-stones by opium, possibly with the aid of laxatives and electricity. All the other varieties of acute obstruction require surgical treatment. The latter is also necessary, on or before

the third day, in cases of intussusception not yielding to forced injection, and in gall-stones when the symptoms become urgent.

DR. SENN of Milwaukee said that the operative treatment of intestinal obstruction was in its infancy. Since laparotomy for other indications has become an established and frequently practised procedure, a number of the bolder and more aggressive surgeons have resorted to direct measures for the relief of intestinal obstruction, but, like all serious operations for otherwise incurable and fatal affections, its general application has met with strong opposition, not only by the laity, but also by the profession. The appalling mortality which has attended the operation in the hands of even the most competent surgeons has been quoted in the discussions on this subject in medical societies as a sufficiently strong argument in favor of non-operative interference. In this regard, the history of laparotomy for intestinal obstruction is only a repetition of the history of ovariotomy. The mortality of laparotomy for acute intestinal obstruction will be reduced to that of other intraperitoneal operations, and surgeons will recognize the importance of operating early before the patient's strength has been wasted by the disease, and before the parts involved in the operation have undergone irreparable textural changes. The mortality of abdominal section in the treatment of the different forms of intestinal obstruction will always be great, because the conditions which have caused the obstruction are often an intrinsic source of danger. In others, the removal of the obstruction necessitates an intestinal resection, which in itself is a vastly more serious operation than the removal of an ovarian tumor. Intestinal obstruction, irrespective of its cause, is always followed by a series of consecutive pathological changes which, independently of the partial or complete interruption of the passage of intestinal contents, tend to destroy life. The dilatation of the intestinal tube on the proximal side of the seat of obstruction may give rise to such a degree of abdominal distention as to destroy life from suspension of important functions by mechanical pressure. In acute obstruction, violent peristalsis on the proximal side of the occlusion causes an increased afflux of blood to the portion of bowel the seat of exaggerated physiological function; which, after cessation of peris-

taltic action, remains as an intense venous and capillary engorgement. During the paretic stage the blood-vessels in the intestinal wall have lost their support, hence transudation and exudation readily take place into the paravascular tissues, which, combined with the capillary stasis attending this stage of the inflammatory process, results in gangrene. The intestinal wall, in a state of inflammation, becomes permeable to pathological micro-organisms which are always present in the intestinal canal, and which, after passing through the entire thickness of its walls, enter the peritoneal cavity and induce septic peritonitis—a frequent immediate cause of death. These facts are cogent reasons for adopting surgical measures in all cases of intestinal obstruction due to mechanical causes as soon as a diagnosis can be made. If this were done, the two greatest sources of immediate danger attending and following laparotomy, shock and septic peritonitis, if not entirely avoided, at least would be less likely to occur, and the tissues the seat of operation would be in a favorable condition for direct treatment and repair. An abdominal section in the treatment of intestinal obstruction is always necessarily attended by some shock, and it is therefore of the utmost importance to perform the operation at a time when the organs of circulation and the nervous system are still in a condition to resist successfully the immediate effects of the operation. Death from septic causes can only be avoided by operating at a time when the intestinal canal, at the seat of obstruction and on its proximal side, is still in a condition capable of resisting infection, and of undergoing a satisfactory process of repair, in case it becomes necessary to incise or resect during the operation. The statistics of operation for intestinal obstruction will improve as soon as we shall be able by improved methods of diagnosis to make an early positive diagnosis, and will adopt in the treatment positive surgical measures before the prospects of a recovery have been rendered improbable, if not impossible, by days and weeks of useless, and more than useless, medication. True intestinal obstruction, whatever its cause may be, is as strictly a surgical affection as strangulated hernia, and remediable only by the same kind of surgical treatment. Physicians should recognize this fact, and should call into counsel a surgeon as soon as a

probable diagnosis of intestinal obstruction can be made. To let a patient die of the consequences of a removable cause of obstruction, without an operation, is a reflection upon modern surgery. The difficulties which surround the diagnosis, and the present imperfect technique of the operative procedures in cases of intestinal obstruction, are not only responsible for the heretofore late operations, but also, to a great extent, for the many failures. Ways and means for more accurate diagnosis will have to be devised by more careful clinical observations and by experimental research, while new and improved methods of operation must be devised and their merits safely tested by experiments on animals. Insufflation of hydrogen gas is a valuable means of diagnosis in locating the seat of obstruction before tympanites has set in, and, therefore, best adapted at a time when most needed—during the early stage of intestinal obstruction. If the colon dilates uniformly from the sigmoid flexure to the cæcum, the obstruction must be sought for higher up in the intestinal canal. The passage of gas through the ileo-cæcal valve, rendered incompetent by the distention of the cæcum, is always attended by a characteristic gurgling or blowing sound, which is always heard most distinctly by applying the ear or stethoscope over the ileo-cæcal region. Not infrequently the sounds are so loud and distinct that they can be heard at a distance of several feet. If the gas passes the ileo-cæcal valve under a pressure not in excess of that required to overcome it in a state of health, and if, after inflation, a thorough examination of the ileo-cæcal region by inspection, palpation, and percussion reveals nothing abnormal, the search for the obstruction is continued by inflating the small intestine slowly and making frequent examinations of the abdomen to ascertain the height to which inflation has been made and to study the relative positions of the different abdominal organs. Inflation is also a useful diagnostic resource in locating the obstruction during laparotomy for intestinal obstruction. The intestine below the seat of obstruction is always empty, collapsed and anæmic as compared with the portion above the obstruction. When the obstruction is located high up in the intestinal canal and the tympanites is extensive, the empty portion of the small intestine has by

compression become displaced, and is often not readily found. In such cases the distention of the bowel from below will indicate to the surgeon at once the location and length of the intestine below the seat of obstruction from below upward. The manipulation of the healthy intact portion of the intestinal canal in search for the obstruction is by far a less hazardous procedure than the handling of the distended portion above the obstruction rendered paretic, exceedingly vascular, and much softened by obstruction. In cases in which we suspect the presence of a perforation, inflation with hydrogen gas will demonstrate not only its existence, but also its location. Invagination is rare above the ileo-cæcal valve, and location can be determined by inflation with hydrogen gas, and if resorted to early it may prove the means of effecting the mechanical reduction. In ileo-cæcal and colonic invagination slow and persistent distention of the colon with hydrogen gas, with the patient completely under the influence of chloroform, is the safest and most efficient means of effecting reduction, and should always be resorted to whenever these conditions are recognized or even suspected.

Mr. Durham of London desired to express the extreme pleasure he felt in coming here among his American *confrères*, and at the hospitable reception he had received at their hands. The subject of intestinal obstruction is one in which he had taken the greatest possible interest. It was possible some of those present might have come across a book entitled *Quain's Dictionary of Medicine*, and if they would look over that book they would find that the article on intestinal obstruction was written by him. He takes a deep interest in these cases, inasmuch as the life and health, the comfort and prosperity of the patient depend upon a rightful action on the physician's part. Truly he may say there is no class of cases more dangerous, more serious, more urgently calling for surgical treatment than those cases of intestinal obstruction. He agreed with Dr. Senn in one thing, and that is, that the sooner the physician calls in the surgeon the better it is for the patient. He agreed with Dr. Senn that surgical operation should be performed as soon as the diagnosis is made, but he did not know any class of cases in which the diagnosis is so difficult as in this class of cases. He

went further than Dr. Senn and said that cases do occur, from time to time, in which the surgeon is justified in operating before he had made a diagnosis, in order to enable him to make one. In regard to this question of diagnosis, he said that if his hearers would recall his article in *Quain's Dictionary* they would recollect that he had collected several thousand cases. What we should be guided by is not the statistical probabilities, but the actual indications of the particular case before us. Every case must be studied and judged upon its own merits, and treated according to the indications that present. The chances may be 999 to 1000 in favor of one man and 1 to 1000 in favor of another. In regard to the treatment of intestinal obstruction, he would say the first thing to do is to determine the seat of the obstruction. In cases of acute intestinal obstruction, or where there is reason to believe that the obstruction exists in the small intestine, then he believes the proper course of treatment to pursue is to open the abdomen and search for the cause, and relieve it as best we can. On the other hand, when the indications are that the obstruction is in the large rather than in the small intestine, there is not the same degree of urgency in a very large proportion of cases. Of course, the procedure to be adopted must depend upon the fact as to the seat and the cause of the obstruction, and here he ventured, with the greatest hesitation, to take issue with Dr. Senn on this point. Dr. Senn said that lumbar colotomy is obsolete. As a matter of fact, it is not obsolete. It is an operation that is performed on the other side of the Atlantic day after day, and will never become obsolete if he can help it. He knew of no operation in surgery, except the simple one of tracheotomy, that affords so much relief and prolongs the patient's life as this. He said that if he himself were the subject of cancer of the rectum, he should most certainly have lumbar colotomy performed.

Dr. Wm. Ord of London said that he supposed he was called upon as a physician to express the general inadequacy on the part of that branch of the profession to deal with the subject of intestinal obstruction. The fuction of the physician appeared to him, as has been said before, to come in very early in the case. He must admit that the question of diagnosis is a matter

of very great difficulty, where in the case of physiological obstruction there is an absence of indication of local pain or a fever, or anything like a bloody discharge from the bowel. Perhaps he may be thought to be a little cowardly, under such circumstances, if he should be inclined to adopt the views of the first speaker rather than of the second, and claim a little time. Sir William MacCormack would, he thought, bear him out in some of his remarks. In a good many of these cases he has operated with the greatest care, but the operation has been performed too late. But in cases in which things seemed most favorable in regard to time, and in which the operation was done with the greatest care and most perfect surgical completeness, it has been as satisfactory in its results as one might have hoped.

Mr. Thomas Annandale of Edinburgh said that he had two good reasons for not speaking; first, he had arrived but half an hour ago from the steamer, and second, that, unfortunately, he had not, owing to that, been able to hear the papers or much of the discussion. As he had been called upon to speak, he might be permitted to give his opinion in regard to the treatment of intestinal obstruction. Now, in regard to treatment, he thought it was very important to divide these cases into acute and chronic. In regard to the acute cases, it is perfectly right that everything medicine can do should be tried, but should not be tried too long. As soon as it has been tried for forty-eight hours, then the case belongs to the surgeon, and the sooner he opens the abdomen the better. If possible, open the intestine and form an artificial anus. In regard to chronic cases, he thinks one might wait, in fact, until the symptoms have become acute, and then, if the symptoms of a chronic intestinal obstruction become acute, he should operate at once. He had heard his friend, Mr. Durham, speak of lumbar colotomy in cases of cancer of the rectum. He has learned to prefer inguinal colotomy in the left inguinal region, because it is not a serious operation in the matter of risk, if properly done, and is certainly a simple one in a large majority of cases.

Dr. Senn, in closing, said that he could assure Mr. Durham that hydrogen when injected into the intestinal canal never forms an explosive, as the canal naturally contains hydrogen

gas. It has been tried hundreds of times on animals and at the bedside without an explosion. One of the first experiments he made was on himself. In reference to colotomy, he would say that he did not mean to condemn this operation. He advocated its use in several cases, but he did repeat the statement that lumbar colotomy might become obsolete. The operation is done for the purpose of securing to the bowel perfect physiological rest, which cannot be done by a lumbar colotomy.

AMERICAN GYNÆCOLOGICAL ASSOCIATION.

DR. HOWARD A. KELLY read a paper on *Palpation of the Ureters in the Female*. He thought that Carl Pawlik's method was a very valuable means of examining for calcareous masses lodged in the ureters or kidneys. Inflammatory conditions also could be diagnosed. The bladder should be dilated with some bland fluid as a preparation.

During the discussion upon Dr. Kelly's paper, DR. WM. POLK of New York spoke of the ease with which the ureters can, at present, be palpated either per rectum or vaginam, and that it was a method of examination with which every one should make himself familiar.

DR. STANSBURY SUTTON of Pittsburg read a paper on *Pelvic Abscess*. He spoke of two forms—septic and aseptic. When we cannot trace any septic origin, we are inclined to say that the inflammation arises from cold. Warm poultices in treatment did no good, and were only used as a matter of ancient usage. He preferred a blister or ice applications.

DR. GOODELL, in discussion, said he never saw a case of pelvic abscess arise from gonorrhœa; it is almost invariably due to septic infection; occasionally from cold during menstruation. He operated early, and when he had to deal with a rectal opening he inserted a probe into it and cut down upon the probe through the vagina, thus converting the rectal into a vaginal fistula, and the rectal opening closes.

DR. PARRISH of Philadelphia did not use aspiration as a curative method of treatment, only as a means of diagnosis. He thought it was not safe to use so strong a solution of the bichlo-

ride as 1–1000. It was not safe to wait in these cases until a distinct tumor had formed.

Dr. T. Gaillard Thomas of New York spoke of three forms of pelvic abscess: (1) Inflammation of the broad ligaments; (2) of the cellular tissue between the vagina and posterior part of the uterus; and (3) the cellular tissue between the bladder and the uterus. Another form he would add, viz., pyosalpinx. He thought that laparotomy could often be avoided by draining through the vagina. Fluctuation in hard pelvic tumors often cannot be obtained, and still contain pus. Constitutional symptoms should not be waited for. He said there are but two localities through which pus should be let out from the pelvis—the vagina and through the abdominal wall. An abscess pointing towards the rectum should never, if possible, be allowed exit there, it is a calamity. Dr. Thomas cited two cases of death from the escape of fæces and gas into the abscess cavity. Neither should an abscess ever be opened into the bladder; he dissected up the paravesical tissue as he would in extirpation, and got at the abscess in this way. He used a dilator and always drained. Pelvic abscesses are always immoveable, neoplasms moveable; this was a valuable diagnostic difference.

Dr. Gill Wylie (New York) thinks that four out of every five cases occurring within a year or two after delivery were due to salpangitis or ovaritis. He prefers to open the abdomen at once; it is of no use to leave a rotten ovary behind after opening the vagina. Dr. Wylie spoke of one patient having died in New York and one in Chicago from using an aspirator in pelvic abscess.

Dr. Polk believed pelvic abscess to be directly due to tubal disease, the infection being carried by the lymphatics from the uterus.

[It will here be noticed the extraordinary and marked diversity of opinion existing between the foregoing surgeons regarding the cause and treatment of pelvic abscess.]

Dr. Sutton said it was not the stem or the sound that produced pelvic abscess, but the infective matter introduced with either.

DR. REAMY of Cincinnati read a paper on *High Amputation of the Cervix for Cancer.* This was a very interesting and practical paper, and brought out some important facts. At first he used bromine solution following curetting; the strength of the solution was 1 to 13 of alcohol. The thermo-cautery was also used in these cases. Later on he began to use the scissors. He occasionally opened the peritoneal cavity unavoidably, and then caustics could not be used. When the incision took place between the vaginal junction and the internal os the latter remained unimpaired, which was important. It was, however, most important to cut wide in the healthy cellular tissue, as this formed the field for spreading of the disease more than did the cervical tissue proper. Cases treated in this way were those wherein the disease was confined to the vaginal portion and not beyond. The disease must not have involved the supra-vaginal portion. When the disease is so confined, Dr. Reamy said total extirpation should not be performed. Dr. Reamy prefers the wedge-shaped incision for the following reasons: (1) It removes the epithelium; (2) it removes the sub-epithelial tissue; (3) it leaves a flap to be closed in on the stump by sutures; (4) the stump in the vagina presents a more natural appearance than after amputation. Seventy-five to eighty per cent. of cases begin in the squamous epithelium, goes up into the cellular tissue, and may never invade the body at all; therefore he advises to cut wide and remove only the vaginal cervix. Dr. Reamy cited cases now alive and having survived from five to fifteen years after the operation of partial extirpation. He does not believe that cases should be limited to two years without recurrence, and considered as cures.

DR. BAKER of Boston said that Dr. Sims and Dr. Thomas both began to use the scissors at about the same time, but that their work was interfered with by the Woman's Hospital Board adopting a measure which excluded all cancer cases. Dr. Baker then began to do his operation, following Sims' teaching. He separates the parts according to Schroeder's method, and then removes a wedge-shaped piece as high as the fundus. When the wound thus made was closed with sutures, he found that the

disease returned in the stump. He therefore began to use the thermo-cautery and left the wound open. In 1886 he reported ten cases. Six of these were living at end of three to four years; five are living now six to ten years after operation. He stated that he would shortly show by publication that fifty per cent. of cases operated on survived four years after operation. He believes that total extirpation should be limited to those cases where the diseases originated in the body of the uterus, or in which it extended upwards instead of laterally. He cited cases now alive after four years which were treated with the knife, cautery and chloride of zinc (strength ℥v to ℥i).

Dr. Byrne of Brooklyn said that nineteen years ago he read a paper before this Society, in which he restricted his treatment of cancer of the cervix to one method—removal by the galvano-cautery. This method consisted in making a circular incision with the knife around the cervix, near its vaginal junction. Traction is then made on the cervix, and the cautery wire is slipped into this incision and connection with the battery made. He stated that he had never known, out of 130 to 140 cases, the disease to return when the cervix was removed in this manner (*sic*).

During the discussion upon this paper, the extreme rarity of cancer of the cervix in the virgin was acknowledged. Dr. Reamy stated that he had known of only *one* case in his experience.

Dr Vander Walker felt something should be said in favor of escharotics in the treatment of uterine cancer. He thought that when once you removed the cervix by a cutting operation you were powerless should a return of the disease take place. In one case he treated with chemicals, his patient experienced seven relapses, and during all this time she had been kept alive and able to do housework, by curetting followed by chloride of zinc. He therefore thought that chemical cautery should have a place, and be considered in this respect as against amputation with knife or scissors.

Dr. Reamy, in his reply, paid a high tribute to the views of Dr. Vander Walker in the latter's intercession for the use of

caustics, but said that the method he advocated in his paper did not preclude the employment of chemical agents also. Dr. Reamy concluded with a most brilliant peroration in defence of the curability of cancer of the cervix if seen at all early. He regarded Williams of London as a great authority, but regretted much that that author did not recognize the vast and valuable work done by American surgeons in this field.

Dr. E. C. Dudley of Chicago read a paper on *The Technique of Vaginal Hysterectomy*. The principal point the author dwelt upon was the controlling of hemorrhage by pressure forceps instead of by ligatures. After the peritoneum had been reached the opening was enlarged by inserting the forefinger of each hand and spreading them forcibly apart, so ∧, until the broad ligaments were reached. The broad ligaments were also controlled by forceps, so also the ovaries if necessary. If in doubt, forceps can be fixed on the broad ligaments from behind also. He has had as many as twenty pairs of forceps hanging in the vagina at once, and did not find they at all interfered; spoke strongly against inverting the uterus, and said that he has by this method performed the operation in so short a time as twelve minutes. He closes the wound also by forceps, and his reasons for so doing are to prevent prolapse of intestine, and in this way give rise to peritonitis. A great value of the forceps, besides acting as hæmostatics, is that of ensuring good drainage. He wraps the handles in iodoform gauze, and does not use drainage of any other kind, the metal instruments, he contends, being the very best conductors of fluids. The forceps thus placed can be removed in twenty-four hours, but he prefers leaving them on for forty-eight. He does not advise vaginal tampons of any kind, as they interfere with drainage. He simply applies a vulvar dressing, which is frequently changed. He quoted twenty cases with two deaths (10 per cent.) When the tumor is very large he has an idea of doing laparotomy and fixing the forceps on the broad ligaments through the vagina, but guided by the fingers of the other hand passed through the abdominal opening into the pelvic cavity. He concluded by contending strongly in favor of the forceps superseding all other methods of hæmostasis.

Dr. Jas. B. Hunter of New York stated that vaginal extirpation of the uterus with ligatures was the most difficult operation in uterine surgery, and that undoubtedly the employment of forceps would do much to shorten and render more easy the performance of the operation. He said there was as yet a difficulty in this matter, and that was the want of the right kind of forceps. He used those of Richelieu as modified by Polk, and thought them the best as yet made. Spoke of one case requiring thirteen pairs of forceps, which were removed in forty-eight hours. He thinks they secure good drainage. Does not close the wound, wraps forceps with gauze, and uses no drainage tube. Thinks the forceps of whatever model should be very strong; considers thirty minutes sufficient time for the operation.

Dr. Reamy thinks it is impossible to sufficiently compress the broad ligaments with one pair of forceps on each. The blades ought to completely enclose the stump. Dudley's forceps are too small and weak. He does not think vaginal hysterectomy at all a dangerous operation, certainly not more so than ovariotomy.

Dr. Lane of San Francisco (by invitation) said he was the first surgeon in America who had performed vaginal hysterectomy. He had in all operated fourteen times, uses strong cord as ligatures, and never used forceps. Dr. Lane stated that he considered vaginal hysterectomy *the* safest capital operation in surgery. In his fourteen cases he had only one death. He had found the operation more difficult in very fat women, and comparatively easy in very thin women. He spoke of the danger of wounding the rectum, which happened in two of his cases.

Dr. H. Marion Sims of New York read a paper on *The Importance of the Microscope in the Treatment of Sterility in Women.* Dr. Sims' essay was, upon this important subject, a most valuable and interesting one, delivered in a manner full of earnestness and gentle modesty so characteristic of that gentleman, and so pleasant to listen to. The principal features brought out were in regard to cause and treatment. The author laid stress upon the abnormal condition of the secretion of the cervical canal as a cause of sterility, and impressed upon the surgeon the necessity of not discharging his patient as cured until

the secretion had become normal, and thereby not poisonous to the spermatozoa. He also dwelt upon the necessity of removing neoplasms, of correcting displacements, and of operating for lacerations, etc.

Dr. Jas. B. Hunter, during discussion, said that he believed in the necessity for dilatation and incision in such cases.

Dr. Wilson of Baltimore also believed in dilatation and incision.

Dr. Johnston of Danville, Ky., laid stress on one cause left out by Dr. Sims—viz., the infantile uterus of adults caused by injury to the pelvic sympathetic supply, giving rise to a paralysis analagous to a form of infantile paralysis. Menstruation in such cases is irregular, but the physical formation of the woman is good. All parts, in fact, are healthy but the uterus, which lacked power to form a placenta.

Dr. Skene of Brooklyn found abnormal condition of secretion in cases of infantile uterus. The secretion in some cases resembled that of pneumonic sputa. In answer to Dr. Skene, Dr. Johnston said that there was a difference histologically between the infantile uterus and the senile uterus; to wit, the infantile uterus has more epithelial development than the senile, the secretion is therefore different. The senile uterus is simply an organ composed of pure scar tissue, which becomes more and more dense as age creeps on.

Dr. Sims, in reply, said he was fully impressed with the fact that when death after incision occurred, it was invariably when the operation had been done in the office by an unskilled enthusiast, and the patient allowed to go home afterwards. He thought that gentlemen engaged in a large general practice should be careful, and not be tempted into performing in an offhand way a procedure so apparently harmless and simple. They may succeed a few times, but sadness and regret will be sure to follow some dire calamity, which must ever be inevitable under such circumstances.

Dr. Jas. B. Hunter read a paper upon *Pregnancy as a Complication in Pelvic Disease*. In this elaborate paper Dr. Hunter enumerated all of the known pelvic complications of

pregnancy. It was shown that most tumors grew rapidly during pregnancy, and that benign growths of a certain nature were liable to become malignant.

DR. SKENE of Brooklyn, in discussion, said that utero-gestation had a general good effect on mal-nutrition, especially when accompanied with a flexed uterus of mal-developmental origin. He thought it was an unfortunate thing for women with chronic pelvic inflammation to become pregnant. If, however, a woman with a displacement becomes pregnant and goes to full term, she will likely be much benefitted. He was under the impression that it was a mistake to consider pregnancy beneficial in cases of displaced ovary. He had invariably found that the displaced ovary had again dropped down after parturition, and caused as much trouble as before.

DR. B. MCE. EMMET thought it better to endeavor to cure the pelvic inflammation before pregnancy took place, if possible.

DR. JAMES C. CAMERON of Montreal (by invitation) spoke of cases of fibroids under his observation which had disappeared after parturition; also a case of rupture of the ureter during labor, followed by death from uræmic poisoning, which went to show that after severe attacks of pelvic inflammation all subsequent pregnancies involved danger.

DR. ENGLEMANN of St. Louis read a paper on *A New Method of Electro-therapy and its bearing on Surgical Gynæcology.* The main feature of this paper consisted in the recommendation to *try* electricity before resorting to the knife. Dr. Englemann's views, however, upon this subject were so well known that there was but little discussion entered upon.

T. JOHNSON-ALLOWAY.

Selections.

Acute Tonsillitis.—Dr. Carl Seiler (*Med. and Surg. Reporter*) says: When a patient presents himself at the dispensary, complaining that the throat has been sore for some days, and symptoms of acute tonsillitis are present, the fauces are first thoroughly washed with my antiseptic solution. Then not only the inflamed tonsils, but the adjacent inflamed surfaces, are carefully painted with a solution of nitrate of silver, one drachm to the ounce, and the following gargle prescribed:

℞ Potasii Bromidi - - - ʒiv
Potasii Chloratis - - - ʒi
Tr. Ferri Chlor. - - - f ʒiiss
Ext. Glycyrrhizæ - - ʒi
Aquæ - - - q.s. ad f ʒiv

M. Sig. A teaspoonful in water every two hours; gargle and swallow.

In this formula there is a chemical reaction between the tincture of the chloride of iron and the chlorate of potash, by which free chlorine is liberated, and so acts as a disinfectant. The resulting iron salt is highly astringent, while the bromide, besides its local action, diminishes the reflexes and adds to the patient's comfort. After all, however, it is the argentic nitrate that relieves the suffering. It is worse than useless to apply a weak solution, as it is painful and seems to act as an irritant; while the application of a solution of one drachm to the ounce produces no disagreeable sensation, but is followed by a sense of comfort. After the application, a tenacious film of albuminate of silver forms, adhering closely to the surface (doubtless containing some undecomposed silver nitrate), and thus the astringent and sedative effects of the silver are kept up for some hours. If, after that time, the tonsils be examined, they will appear paler and smaller than when first seen. These applications are made in the dispensary once a day to patients requiring them, care being taken that none of the nitrate of silver solution drops from the cotton swab so as to get into the larynx, where it would produce severe spasm of the glottis. Sometimes a single application will effect

a cure in acute tonsillitis. In no case has it been found necessary to make over three applications, the cure being usually complete on the fourth day. At the end of ten days the tonsils, if chronic hypertrophy exists, may be removed with the tonsillotome or wire snare, or shrunken away by repeated use of the galvano-cautery, and a return of the disease in this way prevented. Unless this is done, the patient who has had one attack of acute tonsillitis will certainly have others.

The Treatment of Flatulent Dyspepsia.—Pepper, in a clinical lecture, stated that flatulence may result from the excessive formation of gas. Under these circumstances, such remedies as sulphurous acid, which is a powerful antiseptic, will be found useful. It may be given alone or combined with small doses of strychnia. He prescribed as follows:

℞ Acidi Sulphurosi, ℥iss vel ℥ij
Strych. Sulph., gr. ss
Tr. Card. Comp., ℥ss
Aquæ ad. - - ℥iv

Sig.—One drachm after meals, in water.

You may resort to a different class of remedies and give creosote. This is a local stimulant to the stomach, and in atonic cases is of service. It is at the same time a powerful antiseptic and antifermentative agent. Creosote is best given one half or one hour after meals, when the process of fermentation is about beginning. At this time the gastric digestion should have passed through the acid stage, and the contents of the stomach should be neutral or alkaline. Given at this time, the creosote may be advantageously combined with an alkali, as sodium bicarbonate.

℞ Creosote, - - gtt. x
Sodii Bicarb., - ℥ij
Pulv. Acaciæ, - q.s.
Aquæ, - - - ℥v

Sig.—Two drachms one hour after meals.

In place of the sodium bicarbonate in the above formula the subnitrate of bismuth may be employed. If it is recognized that there is not only a state of atony with a tendency to fer-

mentation, but that there is also a deficiency of gastric power, pepsin may be given. Pepsin is best taken in acid mixtures, and should be given at the acid stage of the digestion. At the same time, if the administration of the drug is postponed for a short time after meals, it comes at a time when the power of the gastric juice is about exhausted.

℞ Pepsin. fort., - - 3j
Creasot., - - - gtt. x
Bis. Sub. Carb., - 3ijss
M. Et. ft. pulv. No. xxx.

One of these powders, in a small gelatine capsule, can be given one hour after each meal. Again, in this same line of thought, we have agents, like powdered charcoal, which act as absorbents of the gases, and are, at the same time, anti-putrefactive and anti-fermentative in their action. Powdered charcoal, with soda or bismuth, may be given a couple of hours after meals, and in the class of cases of which I have been speaking, may afford a great deal of temporary relief. When charcoal is given, the patient should be informed that it will cause blackening of the stools.—*The Polyclinic.*

Anæsthesia with Chloroform and Oxygen.—Dr. Kreutzmann (*Cent. f. Gyn.*) recommends a mixture of oxygen and chloroform vapors as an anæsthetic in obstetric and surgical practice. The mixture may be made by passing freshly prepared and pure oxygen through chloroform on its way to the inhaler. Neudörfer injects a small quantity of chloroform into a balloon filled with oxygen, administering through a face piece. It is claimed for this method that anæsthesia is at once established after a few deep inspirations without the least excitement, and that there are no disagreeable after-effects, the patient awaking promptly on ceasing the anæsthetic as from a refreshing sleep.

Grafts of Chicken Skin.—G. Martin reports a case (translated from the French for *Physician and Surgeon*) of a child whose entire scalp was burned, and eight months later grafts of the skin of fowls were used with the result of obtaining

a regeneration of skin 7 centimeters by 8 in two months. In speaking of transplantations, he says: "We think that the skin of fowls, and especially of chickens, is to be recommended; it is supple, of fine texture and vascular, stretches well over the surfaces, and adheres without reabsorbing, giving important islands of epidermis which develop and spread, forming new tissue, soft and quite different from ordinary cicatricial tissue. The manual of operation which we employ in our grafts is very simple. The skin should be raised under the wing of young chickens, and should have no cellular tissue attached and no fat; the shreds should be one-half to one centimeter square; sutures are useless, the skin adhering very easily. The wound and the dressing should be rigorously aseptic. Iodoform gauze and light cotton compresses may be used." These are certainly interesting facts for the general practitioner, who often has extensive ulcerated surfaces to treat; and patients often, through ignorance of the amount of pain given in taking the grafts from the arm, decline to submit, whereas the chicken skin can always be readily obtained. We are inclined to think that this effective aid to the healing of extensive denuded surfaces is not resorted to as frequently as it should be. It not only hastens repair, but lessens the amount of cicatricial contraction which follows. Recently several operations have been reported in which the contraction that follows the healing of long-standing trachoma has been effectually overcome by transplanting mucous membrane from the lower lip.—*Digest.*

THE TREATMENT OF BLEEDING FROM THE NOSE.—Wade recommends the expedient of Hutchinson. The hands and feet of the patient are placed in water as hot as can be borne. This will check the most obstinate epistaxis, without any ill consequences.—*Deutsche Med. Wochenschr.*

MUSCULAR RHEUMATISM.—A case of muscular rheumatism presented to the clinic was treated by giving, internally, 20-grain doses of muriate of ammonium three times a day, and externally, a liniment containing: Aquæ ammonii, f ʒj; spirit rosmarini, f ʒiij; liniment saponis, f ʒij. M.—*Digest.*

THE

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THE CONGRESS OF AMERICAN PHYSICIANS AND SURGEONS.

The meeting of the recent Congress of American Physicians and Surgeons at Washington, under the presidency of Dr. Billings, was in all respects a great success. Founded on a purely scientific basis, it is fortunately free from medical politics, the bane of many medical associations. Composed almost entirely of the authors and teachers of the day, its meetings cannot fail to do much for the advancement of our profession. A very noticeable feature was the presence of a considerable nnmber of distinguished English physicians and surgeons. In future numbers we intend referring in detail to a few of the more important papers and discussions.

CANADIAN MEDICAL ASSOCIATION.

We devote considerable space in the present number to the minutes of the twenty-first annual meeting of the Canadian Medical Association, which met in Ottawa under the presidency of Dr. George Ross of Montreal. In point of attendance the meeting was fully up to the average, while in the character of the papers presented we believe that it more than held its own with any previous meeting. Time and again we have referred in these columns to the really deplorable apathy shown by too many members of the profession in not attending these meetings. We have no hesitation whatever in saying that there is not a single member of the medical profession in our whole Dominion who would not have been greatly benefited by an attendance at

the recent meeting. The stimulus that every man receives from coming into personal contact with so many and so varied minds is in itself worth all the time and trouble that it takes to attend these meetings. Probably not more than two per cent. of the profession usually attend. This is far from creditable. It is sincerely to be hoped that the efforts being made to have a good meeting at Banff next year will find a strong sympathy throughout the profession—a sympathy that will, we hope in many cases, take the shape of a resolution to be there. We would direct our readers' special attention to the president's remarks on this place as a climatic resort. It would seem that we have in our own country a place which at no distant date will rival some of the more celebrated European health resorts. Next August, then, every practitioner will have an excellent opportunity of becoming practically acquainted with the merits of Banff as a health resort and at the same time of enjoying a fine holiday trip.

PROVINCIAL MEDICAL BOARD.

The semi-annual meeting of the Provincial Medical Board was held in Quebec on Wednesday, the 26th September, the President, Dr. W. H. Hingston, presiding. After the reading of the minutes of the last meeting, a letter was read from Dr. R. A. Kennedy, one of the representatives of Bishop's College, resigning his seat upon the Board. It was announced that Dr. Perrigo had been selected by this Faculty to replace Dr. Kennedy. The following committee on Credentials was appointed, viz., Drs. Lachapelle, L. Larue, and Perrigo. The President asked for the opinion of the Board upon the application of Miss Mitchell for a license, she having recently graduated at Kingston. The Board decided that she suffered no disability, the word candidate in the law having no qualification as regards sex. The reports from the assessors of the University of Laval at Quebec and Montreal were read and adopted. The President announced that, since last meeting, Prof. Read of Lennoxville had resigned the position of examiner for matriculants, and he had temporarily appointed Mr. Hamilton Petry, M.A., in his

place. This action was confirmed, and Mr. Petry continued as such examiner. The report of the examiners for matriculants was read and adopted. It showed that 43 candidates had been received. A physician from Montreal, claiming to hold a London diploma, asked for a license. He asserted that his diploma had been burnt in a fire at Chicago. It was decided that he must produce a duplicate of such diploma. The applicant then requested the protection of the Board for six months. It was decided not to comply with this request, and to grant no permission to practice until the required document is produced before the President.

Moved by Dr. Grandbois, seconded by Dr. Rousseau, and resolved, "That this Board petition the Legislature to make such regulations as shall require any applicant seeking exemption from the requirements of the law governing the practice of medicine to furnish the opinion of this Board upon the reasons for such application."

Dr. Lachapelle read the report of the committee on Credentials, and the following gentlemen were sworn and received the license of the Province, viz.:

Laval University.—Joseph Francois Thomas Savary, Chambord, lac St. Jean; Pierre Venant Sosthène Lefrancois, Quebec; F. X. Feuilteau, Hereford, County of Compton; Joseph Samuel Poliquin, Lévis; John N. Mount, Montreal; Joseph Ed. Laberge, Ste. Philomène, County of Chateauguay.

Victoria University.—J. T. Adrien Gravel, St. Paul de Chester; Jos. Antoine Langis, Maria, County of Bonaventure; Avila Chrétien Zaugg, Montreal; Prosper O. Lauzon, Montreal; Théop. Alex. Archambault, St. Paul L'Hermite; J. Horace Chartier, Ste. Angèle de Monnoir; Louis Raymond Benoit, Chambly; Félix Laroche and Théodule Lécuyer, Montreal.

McGill University.— A. D. Stewart, Richmond; James R. Clouston, Howick, P.Q.; Robert H. W. Powell, Ottawa; D. Spencer McDougall, Russell, Ontario; A. E. Orr and H. J. Hopkins, Cookshire; Edward P. Williams, Ottawa.

Dublin Apothecary.—J. Alexander McHeay, Watford, Ont.

One graduate was refused because he had not completed the required four years of study.

One candidate was examined before the Board and rejected.

Dr. Lachapelle, the Treasurer, submitted his report from 15th September, 1887, to 15th September, 1888. Receipts were $7,491.32. After paying all expenses, there remained a balance on hand of $3,954.90. Report adopted.

Moved by Dr. Howard, seconded by Dr. Paré, that the secretary write to Mr. Lamirande requesting him for the future to make a report to each semi-annual meeting, giving the names of all unlicensed practitioners against whom complaints have been made.

Mrs. Mary Deway was examined for a license as midwife, and approved.

The meeting then adjourned.

Medical Items.

—The distinguished French chemist, Chevreul, recently attained his 102nd year.

—An International Medical Congress will assemble in Melbourne in January next, under the presidency of Mr. T. N. Fitzgerald.

—Prof. von Esmarch, the director of the surgical clinic at Kiel, spent a few days in this city on his way to attend the congress of American Physicians and Surgeons at Washington.

—The *Illustrated Medical News*, a new weekly, will shortly make its appearance. Each number will contain an original colored plate and numerous woodcuts to illustrate notes, lectures and reports of operations.

—We regret to announce the death of Prof. Rühle of Bonn, one of the most distinguished physicians of Germany. He contributed to *Ziemssen's Cyclopædia* the article on "Pulmonary Consumption." He is to be succeeded by Prof. Schultze, lately of Dorpat and Heidelberg, The latter is known especially by several able contributions to neurological literature.

—Prof. Bartholow recommends the following plan to disguise the disagreeable taste of Epsom salts: Boil for two minutes in an earthen vessel one ounce of sulphate of magnesia and two and a half drachms of roasted coffee in a pint of water.—*Coll. and Clin. Record.*