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CANADA

MEDICAL & SURGICAL JOURNAL

JULY, 1880.

Original Communications.

A CASE OF FIBROID DISEASE OF THE HEART.
WITH OBSERVATIONS UPON THE GENERAL PATHOLOGY OF FIBROSIS.

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Professor Theory and Practice of Medicine, McGill University.

[A Paper read before the Medico-Chirurgical Society of Montreal.]

GENTLEMEN,—As this Society combines the features of a clinical and pathological, as well as of a medico-chirurgical and obstetrical society, it may not be out of place to bring before its members the clinical and pathological facts of a case of Fibroid Transformation of the Heart which not long ago has been under my care. Although not a very rare affection, it is a comparatively infrequent one, so that private practitioners have not many opportunities of seeing an example of the disease, which, moreover, is usually, as it was in this very instance, mistaken for fatty degeneration of the heart.

Mr. H. H. W., aged 60, of sedentary habits for the last 15 years, but previously a very active merchant and politician, consulted me first on the 11th September, 1874, respecting an attack he had had for the first time a night or two before. About bedtime he was suddenly seized with urgent dyspnoea, threatening suffocation, as it appeared to him; an incessant cough followed promptly, and in 15 or 20 minutes he expectorated large quantities of very frothy white mucus, and the orthopnoea disappeared.

His complexion was rather waxy-looking, features anxious, and his general appearance suggested failing health.

On enquiry, I learned that over 30 years before he had had a cough, attended with other symptoms of such import, that his physician had ordered a sea voyage, which he took, and returned in a few months quite recovered; that with that exception he had never had any serious illness, and, especially, had not had rheumatic fever; that about 8 years ago, after walking half-a-mile up a slight incline to the St. Anne's station, he experienced for the first time great dyspnoea, with distress at the precordia, and from that time felt it necessary to take his time in walking, so that he occasionally missed the train, although he had arranged his breakfast hour so as to secure sufficient time for his morning walk to the station. Upon another occasion, two years later, when walking up Beaver Hall Hill, he was obliged to stop for some time from dyspnoea and precordial distress. His then medical attendant advised him to avoid going up hills and fast walking, advice which he has since then observed.

On careful examination of the heart at the time of his first visit, I found the impulse and sounds feeble, and a faint systolic murmur confined to the region of the left apex; made a record of "weak heart," and prescribed treatment in accordance with that view. The sudden attacks of dyspnoea above described recurred several times during '75 and '76, and he had on two or three occasions attacks of what seemed to be mild bronchitis. His breathing continued to be somewhat short in walking, and he used a lift in going to the upper rooms of the building in which his office was.

Re-examined in October, '75; the signs of "weak heart" were observed. In March, '76, the nitrite of amy^l was prescribed to relieve short attacks of dyspnoea and cardiac distress; and quinine, with nux vomica, were given. In May, '76, he consulted me for a cough which had recently supervened, and took with benefit the hypophosphite of soda, ammonia and lactucarium. He had been free from the sudden attacks of orthopnoea for a considerable time, but not in other respects as he had been, and I regarded him as the subject of fatty degeneration of the heart.

He returned to the city from his summer residence (in Lachine) on the 17th September, '76, and sent for me on the 18th. His condition was then as follows: Marked œdema of both legs to knees; none of scrotum; moderate ascites; physical signs of effusion in the lower half of the right pleura; not a sign of any in the left; cardiac impulse feeble, apex beat just within line of nipple at 6th rib; superficial cardiac dulness somewhat increased to left; cardiac sounds feeble, and *free* from murmur. Complexion very waxy and sallow; pulse very compressible, of medium volume, and at times intermitting; one or two beats in the minute omitted. He says that his ankles have been swelling for several weeks past, that his breathing has been gradually becoming more difficult, and he has been inclined to sleep chiefly upon the right side. He has not had a sudden attack of pain in it, or any illness suggestive of pleurisy. Urine rather scanty, very high colored, and depositing purplish-pink lithates abundantly; contains moderate amount of albumen. The diagnosis then made was "right hydro-thorax, ascites and anasarca, probably due to weak, fatty heart; no valvular lesion present."

The treatment employed consisted of digitalis, in combination with saline diuretics, and these agents were varied from time to time. The most important vegetable and saline remedies of the class all being tried in their turn, without any marked effect on the urine. Occasional hydrogogues (elaterium, resin of scammony and the acid tartrate of potash, the compound powder of jalap, etc.) were given as the anasarca and pleuritic effusion increased. A generous diet, perchloride of iron and quinine, belladonna and quinine were also employed perseveringly from time to time. Under these measures the ascites remained stationary, but the anasarca and hydrothorax increased, the line of dulness reaching the 2nd rib, and with the assistance of Dr. Campbell (who had on a previous occasion, in consultation with me, confirmed the above diagnosis), I removed from the right pleura, with the aspirator, 3 pints of transparent citron-colored serum. We thought it prudent, mainly on account of the weak heart, not to exceed that amount at the first tapping. A good deal of pain set in that night in the right back, in the neighbor-

hood of the puncture, attended with a feeling of great constriction across the chest, and for three days he did not feel at all as comfortable as he had felt before the operation.

The reduction of the pleuritic effusion was not followed by an increased secretion of urine, although his thirst was very much augmented, nor by any improvement in the color of the skin, which had been somewhat icteroid for several weeks.

Although the jugular veins were habitually distended, and visibly pulsated, and filled up from below when compressed by the finger, at no time could a tricuspid murmur be heard; nor was the slight murmur formerly heard in the "mitral area" perceptible after he came under observation with the dropsy. His pulse generally ranged about 90, although towards the close it reached 108 and 118. Its volume continued fair, and its rhythm was but occasionally disturbed by an intermission or two in a minute.

On the 26th the fluid in right pleura again was on a level with the second rib; no effusion could be detected in the left chest; the œdema in the back and lower extremities was very considerable, and a couple of acupunctures in either ankle were made, and flannel rollers applied. The fluid escaped in moderate quantities; he soon became unusually drowsy and much weaker; his mind wandered, and he died exhausted three days afterwards. No redness of the skin at the site of puncture had supervened.

Dr. Osler conducted the autopsy. Considerable œdema of thighs and legs remaining. Subicteroid color of surface.

Thorax.—Drew off about 7 or 8 pints citron-colored transparent serum from right pleural cavity through a trocar. Right pleura is deeply injected, and some shreds and flakes of recent lymph are found at the posterior and inferior regions, as well as two or three broad bands of recent false membrane dividing the pleural cavity into loculi. No fluid in left pleura. A very old adhesion at base of left lung. Left lung presents very slight puckering and fibroid thickening of pleura at extreme apex. The right apex is exempt. A peculiarity of right upper lobe is that it is *bifid* vertically, the smaller lobe being posterior and

external to the larger. Whole right lung except about the upper fourth is carnified. Pericardium contains 2 or 3 ozs. transparent citron-colored serum; substance is unusually thick and resisting. All heart's cavities distended with blood, as well as the great veins. White patch on *front of left ventricle towards the apex*. Some white coagula closely adherent to lining of right appendix auriculæ. Rest of blood in auricle and right ventricle black and coagulated. Colorless clot in pulmonary artery. Tricuspid orifice very large— $5\frac{1}{2}$ inches in circumference. Tricuspid and pulmonary segments normal. Coagula in some of the pulmonary veins and left auricle. Besides large soft black clots in left ventricle, a layer of yellow stratified fibrin about $\frac{3}{4}$ inch thick adheres to lining of left ventricle and covers about the inferior two-thirds of its anterior wall, whence it extends somewhat over the septum. On section, about the internal half of the wall of the ventricle at the site of the adhering fibrin, has lost its muscular appearance and color, and is anæmic, of pale grey hue, and tough, crunching under the knife. The outer half of the wall appears to be normal, and the whole thickness of the ventricle above this grey area is of healthy appearance. The columnæ carneæ at their basic attachments appear whitish, firm and fibroid on section. The entire thickness of the septum ventriculorum is on section greyish white, firm and tough—fibroid looking. Mitral valve healthy. Aortic segments thickened at their base, and a narrow calcareous ring at the insertion of one of them. Their free margins normal and the valve competent. Aorta from heart to iliacs studded with atheromatous patches.

Abdomen.—About two pints transparent serum without flocculi in peritoneum. Spleen very firm, cuts crisply and with considerable resistance. Liver has very few irregularities on its surface, is tough and firm—very congested and nutmegged. No calculi in gall bladder. Both kidneys of normal size, thick, firm, coarse on section, and congested venously; their capsules above average thickness, but peel off without tearing cortex. Intestines appear healthy.

Brain not examined.

Dr. Osler kindly examined the diseased heart muscle. Microscopical examination of the portion involving the septum near the apex showed it to be made up of ordinary connective tissue fibres, arranged in wavy bundles, with very few corpuscles or fibre cells. In the greater part of the area no trace of muscle substance is found, but at the margins the new growth is seen penetrating between the muscle fibres, some of which are completely cut off and isolated. The endocardium over the spot is thickened. Many of the muscle fibres in contiguous parts presented brown granules and fatty molecules.

There are several points of interest in this case, upon some of which I will offer a few remarks.

The opinion formed of the nature of the case when it first came under my observation was weakness of the heart—probably from fatty degeneration—an opinion based upon the following combination of clinical facts:—Weak impulse and sounds of the heart, without evidences of decided dilatation of the ventricles; occurrence for the first time eight years previously of symptoms like those of angina while walking up a slight incline, and ever after a sense of dyspnoea when walking; recurrence of similar symptoms of angina two years after the first seizure, and under like circumstances; sudden attacks of severe orthopnoea, terminating in expectoration of frothy mucus, yet not due to spasmodic asthma, nor to marked valvular or aortic disease, nor to dilatation of the heart; and a peculiarly sallow complexion and anxious and sad expression of countenance. It is true there was a faint systolic murmur in the mitral area, but the other accompaniments and sequences of valvular disease of at least eight years' standing (which there must have been to account for the features of the case) were wanting, and there was no history of an attack of acute rheumatism. The probability, then, was largely in favor of the existence of fatty degeneration of the heart, for the symptoms and signs which obtained are amongst the most reliable and constant of those met with in that affection. However, I am of opinion that the diagnosis of fatty degeneration of the heart just named cannot itself be pronounced with the scientific certi-

tude that affections of the valves and the more common alterations of the walls of the heart may be. The diagnosis must very often be one of probability rather than of certainty. The case under review proved to be one of fibroid disease, an affection which can seldom, if ever, be diagnosticated from the former alteration, and indeed is very apt to be discovered only after death. It has no constant group of symptoms or signs.

One great English authority, Walshe, speaking of cirrhosis of the walls of the ventricles, states that "it is not revealed by either symptoms or signs, unless it have proceeded to such lengths as to have induced aneurismal pouching," etc. (*Disease of the Heart*, 4th edition, p. 359.) Friedreich says that in extensive fibroid degeneration of the left ventricle "we have most frequently observed phenomena explicable by an insufficiency of contractile power in the heart"; and further on remarks that "it is easy to see that these phenomena do not in any manner permit it to be concluded with probability that a chronic myocarditis (*i.e.*, fibroid degeneration) exists," etc.

To quote another recent authority. Prof. Schrötter observes: "It would only be possible to diagnosticate chronic myocarditis when we could with certainty exclude all other diseases of the heart which cause the same or similar symptoms, and especially fatty degeneration; this we could scarcely succeed in doing." (*Ziemssen's Cycloped. Pract. Med.*, Vol. VI., p. 242.) It will probably be admitted that I have cited sufficient authority to prove the difficulty, if not impossibility, of recognizing fibroid degeneration of the heart during life, and two of our latest English authors, Balfour and Hayden, might be adduced on the same side.

Fibroid degeneration of the heart occurs as a localized and as a general alteration of the heart.

(a) The localized form obtains most frequently in the papillary muscles of the left ventricle, usually along with chronic disease of the mitral valve, and this is the only form that has frequently come under my own observation.

(b) It is more rarely found affecting circumscribed portions of the walls of the left ventricle, and manifests a singular and ill

understood preference for the *anterior* wall in the neighborhood of the apex and the adjoining septum, as in the case now under consideration. It may be, as some morbid anatomists suppose, that in both these varieties the process begins in the *endocardium* lining the valves in one case, and the ventricular walls in the other, or in the pericardium, whence it extends to the musculature of the heart and its connective tissue. But not unfrequently the reverse appears to be true, viz., that the disease begins in the myocardium and thence extends to the endo- or the pericardium.

(c) As regards the frequency with which the respective sides of the heart suffer, authorities differ—Wilks maintaining that, combined with hypertrophy, it is far more common in the right than in the left ventricle, while Friedreich, Green and others allege that it is more frequent in the left, and that when present in the right, the same change, but in more marked degree, also exists in the left heart and septum. When the degeneration co-exists with chronic pericarditis, it is said by some to thus implicate both sides of the heart.

(d) A still more rare form of localized fibroid transformation presents itself as an annular induration of the upper part of the *conus arteriæ pulmonalis*, which produces a real cardiac stenosis. This form, very rare in adults, is more frequently met with in early foetal life.

II. The *generalized* fibroid transformation, in which all the walls of the heart are the seat of excessive development of fibroid tissue, was described by Sir Wm. Jenner as occurring together with hypertrophy of the musculature of the heart, when the substance of the organ is the seat of gradually developed, long continued and intermitting congestion—conditions so frequently present in chronic valvular disease. (*Med. Chir. Trans.*, vol. XVIII., 1860, p. 199 *et seq.*) This form has not met with universal acceptance, however, although I think I may say that we are familiar with it here.

The *nature* of the morbid process which determines fibroid transformation of the heart is an unsettled question. The prevailing opinion, however, is that it is a *chronic* myocarditis, origi-

nating in an endo- or a peri-carditis, which extends to the myocardium, and many, especially German and French writers, describe the affection under the title Chronic Myocarditis.

Until pathologists can agree as to what constitutes inflammation, and can point out a reliable means of distinguishing the local changes essential to chronic inflammation from other nutritional proceedings such as the reparative process, hypertrophy, the development of some tumors, etc., it will be difficult to decide whether fibroid transformation is (1st) truly an inflammatory process, or (2nd) a primary hypertrophy of the connective tissue, or (3rd) a secondary and more degenerate modification of nutrition in which, while the secreting structure of glands (liver or kidney for example) or the contractile substance of muscle, wastes and perishes, the connective tissue of the wasting organs, receiving more than its normal proportion of nutriment, experiences a hyper-nutrition. Probably all three views are correct, but they require renewed study and investigation.

Permit me to offer some observations in illustration of the three several modes of fibrosis, or fibroid disease, that I just indicated, but in the reverse order.

1st, *Fibrosis secondary to degeneration of secreting or contractile tissue.*

In some examples of cirrhosis of the *liver*, atrophy of the secreting substance is a very early alteration, and Beale has taught that such atrophy is the primary change, the increased development of fibrous tissue a secondary and very insignificant alteration; and Johnson holds very similar views respecting the origin of the contracted *kidney*.

Another example of this variety of fibroid transformation occurs in muscles the contractility of which has been impaired by some form of paralysis. As the muscular elements disappear a fibrous tissue replaces them. Dr. Beale, indeed, appears to regard the process as one of degeneration, analogous to fatty degeneration. He says:—"The contractile material of the muscles has degenerated into fibrous tissue." (*Med. T. & Gaz.*, vol. I., p. 295, 1869.) And if recent investigations justify the statement that the epithelial cells of the

liver (Hamilton) and kidney (Saundby), and even of the mamma (Creighton), may proliferate and be converted into connective tissue, that is a strong analogical argument in favor of the transformation of muscle cells into connective tissue.

May not some cases of localized fibroid degeneration of the heart depend upon some disturbance in the innervation of the organ equivalent to that productive of paralysis in voluntary muscles? Such disturbance leading to trophic changes in which the sarcous elements are replaced by, if not transformed into, fibrous tissue? Why should not powerful mental emotion or violent muscular effort now and then damage the nervous ganglia of the heart as they do the cerebral ganglia?

In support of the idea that local disturbances of innervation may bring about local hyper-growth of tissue, I would cite the opinion of that acute observer, Dr. T. Addis Emmet, that uterine fibrous tumours are common in female celibates, because they have no "outlet for the nervous force which is being constantly directed to their wombs." (Emmet's Principles and Practice of Gynæcology, 2nd Ed., p. 84.)

Other instances of local fibroid disease of the heart may originate in a local atrophy of muscular fibre induced by a patch of pseudo-membrane, the product of a bygone pericarditis; hyper-growth of the connective tissue following closely upon degeneration of the contractile sarcous elements.

Finally in this connection, as Beale's researches show that the quantity of connective tissue in muscles bears some proportion to age, so that in old age much of the muscular tissue is replaced by fibrous material, it is highly probable that the heart, in common with other organs and other muscles, often suffers in its nutrition, so that its sarcous elements waste more or less, and are replaced by connective tissue as a contingency of advanced life.

2nd. *Primary Fibrosis from Hypertrophy.*

I have suggested that so called fibroid degeneration may sometimes be a primary or at least concurrent hypertrophy of connective tissue, constituting the first great step in the morbid process.

In pseudo-muscular hypertrophic paralysis, hyperplasia of

the connective tissue of the muscle is a very early change, and if not antecedent to, is at least concurrent with, more or less hypertrophy of the muscles.

Such appears to be the correct view, especially of the fibroid transformations that occur as consequences of passive congestion resulting from valvular diseases, and are met with in the heart itself, in the kidneys, liver and other organs. And under this heading belongs the diffused "fibroid transformation" of the heart already mentioned. The morbid process appears to be neither atrophic nor inflammatory, but a real hypertrophy. And "areolar hyperplasia" of the uterus probably often results from similar congestion of that organ, a consequence, it may be, of various degrees of displacement or flexion of the organ itself, or of valvular disease. My friend Dr. Gaillard Thomas has in this connection long ago advocated the distinction that ought to be drawn between chronic inflammation and interstitial hyperplasia.

The *large fibroid kidney* (Klebs' "Cyanotic Induration") affords an excellent example of primary hypertrophy of the connective tissue of an organ. Take the same process in the heart, it occurs independently of inflammation, and as a consequence of slowly developed and long continued congestion of the kidney. But some of the ablest modern authorities, Grainger Stewart, Liebermeister, and quite recently the lamented Bartels, have referred the *chronic contracted* or *red granular kidney* to primary *hypertrophy* of the connective tissue of the organ, which, as a general rule, has *not been preceded by inflammation*.

The very latest investigations of Saundby and of Greenfield (*Lancet*, 27th Mar., '80, p. 490) go to prove that the initial step in the production of this form of fibroid kidney is the formation of connective tissue by proliferation of the epithelium covering the glomeruli (Greenfield), or of that lining the tubules and the glomeruli, and covering the vessels (Saundby). This view of the origin of granular kidney, in my opinion, favors the theory that the process is rather simply hyperplasia than inflammatory; but be that as it may, it is another example of primary overgrowth of connective tissue in an organ.

An interesting variety of this primary hyperplasia of the connective tissue of organs is afforded now and then in Rickets. Dr Dickinson has found that the enlargement of the spleen and liver, occasionally observed in that constitutional affection, is largely due to an hypertrophy of the fibroid tissue of these viscera.

The "simple" form of "grey degeneration" so frequently observed in the posterior columns of the spinal cord affords an excellent example of hypertrophy of the connective tissue of an organ independently of inflammation, although it is not yet settled whether the atrophy of the nerve fibres precedes or follows the overgrowth of the neuroglia. Rindfleisch, however, sustains the latter view.

One of the most important varieties of primary hypertrophy of connective tissue is that in late years specially studied by Sir Wm. Gull and Dr. Sutton, and called by them arterio-capillary fibrosis. They have endeavored to establish the existence after middle life of a cachexia which manifests itself in a tendency to hypertrophy of connective tissue, which first involves the arterioles of the entire vascular system, and may then develop fibroid changes in one or more of the other organs, kidney, liver, brain, cord, stomach, heart, etc.

It is true that some of the ablest pathologists do not believe in the fibroid diathesis, but all admit that an excessive growth of fibroid tissue frequently occurs in the outer tissues of the smaller arteries after middle life, as had been previously pointed out by Charcot and Bouchard under the name of Sclerous Arteritis.

I know of no sufficient reason, however, for regarding the process as inflammatory; and if Mohammed is correct in referring the fibroid thickening of the arterioles to increased arterial tension, then why not recognize in the increased growth of the connective tissue of the over-worked vessels simply a physiological process analogous to that which causes muscle to grow when exercised. Why suppose inflammation necessary or even favorable to the process? It appears to be highly probable that some cases of local fibrosis of the heart and other organs begins in this hypertrophy of the sheaths of the blood vessels,

and extends thence to the connective tissue between and around the muscular fibres, and ultimately causes their atrophy. (See Rindfleisch's Path. Hist., p. 129.)

3rd. *Fibrosis of Inflammatory origin.*

But, thirdly, the new fibroid tissue is no doubt sometimes of inflammatory origin.

Such is doubtless the nature of the tracts of fibroid tissue met with in tubercle in the lungs for example; so a peribronchitis appears now and then to extend to the interstitial pulmonary tissue and originate a fibroid induration of the parenchyma, and it is highly probable, and is generally held, that an endo- or a pericarditis may sometimes extend to the intermuscular connective tissue of the heart and induce an active proliferation and increased development thereof.

In addition to those more or less extensive productions of fibrous tissue so familiar as a sequence of *inflammation* of the serous membranes, may also be mentioned the scleroderma of adults, the spurious cheloid which occasionally succeeds burns, small-pox, etc., the masses of cicatrix-like tissue resulting from syphilitic disease of the liver, lungs, skin and other organs.

Amongst the most important examples of localized development of fibrous tissue under the inflammatory nusus is that afforded by syphilitic arteritis—a process which is not only responsible for many instances of inflammation, of thrombosis, and of softening of the great nerve centres, but, according to Mr. Welch, assistant professor of pathology at Netley (*Med Chir. Trans.*, Vol. LIX., p. 73), for 50 to 66 per cent. of the aortic aneurisms occurring in the British army. It has, in my opinion, been satisfactorily proven that syphilis is a cause of fibroid disease of the heart, as advocated by Wilks, Moxon, and others, but Hilton Fagge has shown that it is at most a very unusual cause (*Path. Trans.*, Vol. XXXV., p. 95 *et seq.*) It did not exist in my patient.

One of the most interesting examples of development of connective tissue in an organ by inflammation, and the last that I will adduce, is afforded by scarlatinal nephritis, in which it is now known that an interstitial growth of embryonic tissue takes place in the parenchyma of the kidneys, which may even fibrillate.

Reverting from these observations upon the general pathology of *fibroid* hypertrophy to the special example under consideration, I would call attention to the circumstance that while the area of fibroid degeneration in the wall of the left ventricle corresponded accurately to the region in which the endocardium was opaque and covered by a firmly-adhering layer of fibrin, the degeneration also involved the ventricular septum, although no fibrinous deposits lay upon the endocardial lining of that part. And in a case related by Dr. Bristowe (*Path. Trans.*, Vol. VI.) it is mentioned that the patches of endocardial thickening did not "usually" correspond with the patches of fibroid degeneration. These cases appear to show that if the localized variety of fibroid degeneration of the heart is sometimes a consequence of disease of the endocardium, it may also *begin* in the myocardium itself and extend or not to the endocardium, and that, consequently, even when the alteration in the endocardium corresponds in site with that in the myocardium, we are not therefore to infer that that the endocardial disease caused the myocardial.

It might be urged that the co-existence of extensive atheromatous degeneration in the course of the aorta, which is generally regarded as a consequence of chronic endo-arteritis, renders it probable that the fibroid degeneration of the heart was an *effect* of a chronic endocarditis, and such is not an improbable view. But it must not be overlooked that a general tendency to hyperplasia of the connective tissue of organs also existed, witness the firmness and toughness of the spleen, liver and kidneys, as well as of portions of the musculature of the heart, spoken of in the record of the autopsy. And it can hardly be affirmed that it has been proved that the changes in the arterial system which result in atheroma are truly inflammatory, and not simply degenerative.

The co-existence in this case of fibroid changes in many organs appears to point to some general cause, as systemic congestion from tricuspid incompetency (which did not exist) or as the "arterio-capillary" fibrosis of Gull and Sutton. If the former had been the cause of the fibroid transformation of the cardiac muscle, one would have expected it to have been dif-

fused throughout the heart and not localized. On the other hand, it would be begging the question to assume that the cardiac change was part of an arterio-capillary fibrosis, a manifestation of the so-called "fibroid diathesis," as the smaller arteries and arterioles were not examined. However, it must be very rarely, even in that diathesis, that cardiac fibrosis is accompanied, as in this instance, by fibroid induration of the liver, spleen and kidneys—for Hilton Fagge "could find hardly a single example" of such co-existence in any of his own cases of cardiac fibrosis or among those recorded in the Transactions of the Pathological Society up to 1874.

My own view is that the cardiac alterations long preceded those observed in the liver, spleen and kidneys, and that the latter originated in systemic congestion produced by the cardiac disease, especially the tricuspid incompetence.

In looking over some of the records of the past on this topic, I met with a case related by Dr. Whipham which resembles in many respects the case under discussion. (*Lancet*, vol. 1., 1873, p. 25.) In that, an old blood clot adhered to the endocardial lining of the wall of the left ventricle and septum, the endocardium was thickened and the muscular tissue in a state of fibroid degeneration. The author attributes the lesion of the endocardium and of the wall of the heart to the irritation caused by the adhering blood clot, and claims to have first pointed out such a mode of causation of alterations in the heart's substance. In my opinion, the correct explanation of Dr. Whipham's case, as well as of my own, is that a diseased condition of the endocardium preceded and induced a deposition of the fibrin of the blood upon the arterial part. Such a view appears to be more in accordance with known pathological laws than that which supposes the precipitation of fibrin upon a healthy endocardial surface.

There are some interesting features also in the clinical history of the case under review, but I have occupied more than sufficient of the Society's time, and will only mention (1) the suddenness with which the first signs of failing heart-power set in; (2) the disappearance of a systolic murmur of organic

origin, and its absence notwithstanding the presence of a thick layer of fibrin on the lining of the left ventricle; (3) the existence of marked tricuspid dilatation without mitral stenosis or incompetence and without emphysema or bronchitis; (4) the difficulty of satisfactorily explaining in this instance the occurrence of the dilatation of the tricuspid orifice; (5) the super-vention of pleuritis after aspiration of the pleural cavity; and lastly (6), the singular character of the sudden attacks suffered by the patient of dyspnoea and cough, followed promptly by copious expectoration of a frothy mucus, and immediate relief.

Hospital Reports.

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

MEDICAL CASES UNDER CARE OF DR. OSLER.

(Continued from page 114.)

CASE X.—*Anomalous Case of Pyæmia.—Suppuration about tissues in left inferior carotid triangle; Pyæmic abscess beneath tensor vaginæ femoris; Pyæmic infarcts in the lungs; Septic Pleurisy.*

REPORTED BY MR. J. B. HARVIE, OF OTTAWA.

James C., aged 33, mechanic, a large, powerfully-built man, admitted June 8th, complaining of pain in the front of the left shoulder and shortness of breath. Family history good; personal history satisfactory. Has been a ship carpenter; is temperate. Present illness began on June 5th with pain about the left shoulder and fever. Had no chill. Swelling came on above and below left clavicle, and there was pain on outer side of right hip.

Condition on admission.—As he lies in bed, chief features noticeable are: Suffusion of face, lips slightly livid; respirations 30 per minute, and are short, the inspiratory act is caught suddenly, and expiration does not follow for a second or two. *Chest* movement is slight. An extensive swelling is seen in the upper part of the left side extending from the root of the neck, obliterating the supra and infra-clavicular spaces, and extending

as far as the shoulder and anterior axillary fold, while below it reaches nearly to the nipple. To the right it is bounded by the mid-sternal line. Just over the 1st rib the swelling is most intense, and the skin here is reddened. It pits on pressure, does not fluctuate or crepitate, and is not very painful to the touch. Shoulder joint not swollen; glands in axilla not enlarged. The left arm and hand is colder than the right, and look a little livid. The veins are also more plainly visible, particularly the cephalic. On *percussion*, clear note, except over region of swelling on left side. On *auscultation*, breathing weak over left infra-clavicular and mammary regions; otherwise appears normal. *Heart's* apex cannot be felt; diminished area of dulness; sounds normal. Nothing special detected in examination of abdominal organs. *Liver* and *spleen* not enlarged. Complains of pain in the right hypochondriac region, and there is both pain and tenderness over right iliac crest. Tongue slightly coated. No vomiting. 10 *p.m.*—Pulse 136, small; respirations 60; temperature, under tongue, 101.5° ; temperature on swelling in left mammary region, 99.1° : on opposite side, 97.8° . Is quite sensible. Has no cough. Pain has continued in situation above noted.

9th.—Passed a bad night, in spite of morphia. General condition same as yesterday. Temperature 98° ; pulse, 132; respirations 46. Swelling in left lower cervical and mammary regions is unchanged. Has been perspiring profusely; no cough. On examination of chest, expansion is deficient on right side, and there is slight dulness in lower mammary region of this side. On auscultation, fine crepitant râles in this region. Behind there is no evident dulness on right side, but a loud friction sound is heard in infra-scapular region. Tactile fremitus not increased. Evening temperature, 100.2° .

10th.—Patient passed a bad night; respiration very hurried, and constant pain in neck and outer part of right ilium. Is much weaker, and face is becoming cyanotic. Pulse almost imperceptible—135 in the minute; respirations 55, and becoming gasping in character; temperature 100° . Râles abundant on right lower mammary region. Was not examined behind.

Urine has been scanty ; total quantity passed while in hospital \bar{x} , is highly colored ; specific gravity 1062 ; no albumen ; no sugar ; chlorides abundant. Death at 12 a.m.

Autopsy, five hours after death.—Body well nourished ; muscles splendidly developed. In making preliminary incision, tissue over sternum infiltrated with serum, and on making a transverse incision into the swelling in left pectoral region, the pectoralis major is infiltrated, and beneath it there is pus in the meshes of the sub-muscular tissue over 1st, 2nd and 3rd ribs and intervening spaces. There is no definite abscess, but the pus appears to infiltrate the intercostal tissues ; and when the thorax was opened, the two layers of the pleura were found adherent in this region, and pus between the layers. On dissection of the neck, the lower part of sterno-mastoid muscle is infiltrated with serum, and when reflected, pus oozes from beneath its clavicular attachment. The clavicle and first rib were then removed, when the structures at this side of the root of the neck are seen to be surrounded with pus, not forming a definite abscess, but infiltrating the intervening connective tissue. It extends as high as the level of the thyroid cartilage, and, below, passes under the clavicle and 1st rib. Externally it passes out along the omo-hyoid, nearly to the scapula. The sheath of the carotid is not affected, but the sub clavian vessels are surrounded. There is no necrosis of the rib, clavicle, or cervical vertebræ. On dissection of the vessels, sub-clavian artery and branches normal ; vein contains a clot, which is continued into the axillary, and is here firmer, somewhat decolorized, but is not firmly adherent. Orifice of thoracic duct normal.

On section of the parts in antero-lateral part of the *right ilium*, an abscess is opened beneath the *tensor vaginæ femoris*, and can be traced down it for five inches. It also infiltrates the upper and anterior part of the *gluteus medius*. The *ilium* is not diseased ; periosteum firmly adherent, and no evidence of necrosis.

In *thorax*, lungs do not collapse. On lower and anterior border of the right, flakes of lymph are seen, and on upper lobe of left the adhesions already noted, and there are old ones over

entire organ. Right is not adherent, and from the pleural cavity 5-6 ozs. of turbid fluid were removed.

Heart—Blood in chambers partly clotted; looks natural, not tarry in appearance. Substance and valves normal.

Lungs—Left is crepitant, except in certain spots to be described. On section, much blood and serum escapes. At apex there is a firm, somewhat wedge-shaped infarct, size of a walnut, greyish-red on section, and on pleural surface presents a greyish-yellow exudation, surrounded by ecchymoses. At anterior border of this lobe are two others a little smaller, and at the lower and lateral part two more, wedge-shaped, surface greyish, substance softening. At extreme base of lower lobe there is collapse. *Right lung*—Pleura over lower and back—reaching to apex—covered by a thick layer of yellowish lymph, which extends between the lobes. When stripped off, pleura much injected. The apex, middle lobe and anterior border of the organ are crepitant; the remainder is dark-colored and airless—collapsed. There is a small infarct at the apex, and a large one at lateral border of lower lobe; in the latter, pus has begun to form beneath the pleura, and the injection is very intense about it.

Spleen not enlarged, moderately soft; no infarctions.

Kidneys look healthy; no infarctions. Bladder and prostate, normal.

Nothing of note detected in careful dissection of *gastro-intestinal canal*. No piles.

Liver normal. Aorta and venous trunks slit open—healthy. No diseased vertebræ.

Brain presents nothing unusual. No ear disease.

No disease of left shoulder joint. Nothing special in examination of the blood.

Remarks.—Among many points of interest in connection with this case, the following may be noted:—

1st, The difficulty of deciding upon the starting place of the disease. In the absence of a spot of acute necrosis of bone or other recognized cause of pyæmia, I am inclined to regard the inflammation in the cervical region as the origin of the trouble. It was of the nature of a diffuse suppurative inflammation of the

intermuscular connective tissue, similar, probably to what occurs sometimes in the upper cervical region, where it is known as *Angina Ludovici*. The pain was felt first in this part, and the suppuration is here more extensive than elsewhere.

2nd, The difficulty in making a diagnosis. The appearance and condition of the man on admission, the rapid breathing, quick pulse and flushed face, suggested pneumonia, but there had been no chill, no cough, and the temperature the morning after admission was normal. Then, the reddened, inflammatory swelling in pectoral and cervical regions, the acute pain in right ilium, rendered it additionally probable that this was not the cause, even when, on the second day in Hospital, the dulness in lower mammary region, the crepitant râles, and, behind, the distinct friction murmur, clearly showed that there was pulmonary disease. The rapid course of the affection (five days), as well as certain features of the case, suggested septic poisoning, but it was impossible to fix upon any source of infection.

Correspondence.

To the Editor of THE CANADA MEDICAL & SURGICAL JOURNAL.

SIR,—There appears in the last number of the *Canada Medical and Surgical Journal*, under the heading "A Legal Question," what purports to be a report of my evidence in a recent action. Permit me to observe that the report in question is incorrect in every particular.

Your obedt. servt.,

W. F. HINGSTON.

37 UNION AVENUE, May 25, 1880.

[We regret that the above reached us too late to be inserted in our June issue. In explanation, we can but say that the source from which the report was obtained seemed quite reliable. Moreover, the judgment rendered was avowedly given upon the strength of this testimony, and, therefore, there was *primâ facie* evidence of the correctness of the general tenor of the report, though absolute verbal accuracy was impossible.—ED.]

Reviews and Notices of Books.

The Principles and Practice of Gynecology.—By THOS. ADDIS EMMETT, M.D., Surgeon to the Woman's Hospital of the State of New York, &c. Second edition, thoroughly revised. With 133 illustrations. Philadelphia: Henry C. Lea.

The call for a second edition of this standard work within a few months from its first appearance is, indeed, "flattering to the author, as an evidence that his labors have proved acceptable." The study of Gynecology has been making advances with great rapidity of late years, and American surgeons have much reason to be proud of the share which they have had in bringing about this desirable result. Amongst the foremost of these stands the author of this work. By his able writings, his persistent enforcement of what he recognized as a sound principle, his successful clinical teachings, and his expert operations showing what can be done by practised hands, Emmet has raised himself into the universal esteem and high respect of his *confrères* far and wide. It needs no words from us to commend to all our readers this embodiment of the experience and observations of the eminent New York gynecologist. It is a complete, systematic treatise upon all the diseases which properly belong to this branch of medicine. Every chapter is enriched by cases drawn from the vast field in which the author has worked for so many years. Some, however, will perhaps be found of more than usual interest owing to the comparative novelty of the subjects treated of. Especially is this the case with reference to the article upon laceration of the cervix. As is well known, it is Dr. Emmett who has particularly drawn attention to the frequency with which this accident is met with, and to the importance of remedying the evil when causing, as it often does, a train of distressing symptoms. Of this trouble our author says: "Its importance cannot be exaggerated, since at least one half of the ailments among those who have borne children are to be attributed to lacerations of the cervix." Trachelorrhaphy is becoming the fashionable operation in the States, and it is not at all

improbable that it may be overdone, for it is certainly not always needed when the neck of the womb is torn—this exaggerated stage, however, probably all novel operative procedures are obliged to pass through. The chapter following this is upon elongated cervix, on which subject Dr. Emmett gives no uncertain sound, denying its existence, and consequently, of course, objecting entirely to the operation of ablation or amputation.

To the specialist this work is simply indispensable, and at the same time our general practitioners will find here a complete fund of information on all points concerning the uterine derangements of their female patients.

A Treatise on Foreign Bodies in Surgical Practice.—By ALFRED POULET, M.D., Adjutant Surgeon-Major, Inspector of the School of Medicine at Val-de-Grace. In two volumes. New York: Wm. Wood & Co.

We have already acknowledged the receipt of four volumes of the new series of Wood's Library of Standard Medical Authors. The success achieved by the original issue of last year has encouraged the enterprising publishers to continue furnishing other treatises upon the same plan. The typographical work, paper, illustrations and binding are all decidedly superior to those of the first series. They form handsome library books, bound in strong green cloth covers, with gilt lettering. One is apt to wonder how it is possible to give so much for so little money.

Although there are several good works upon foreign bodies in certain special situations, such as the ear, the gullet, &c., yet there can hardly be said to be a single thorough treatise which deals with the subject of foreign bodies in the various canals and cavities of the human body. This, then, is the ground traversed by Dr. Poulet in the work before us. These cases are often quite of an emergent nature, requiring instant action. How necessary, then, that all possible information should be possessed by every practitioner in order that the action taken may be guided by sound principles. "Take a student," says the author, "who has passed through all the medical grades, and is on the eve of entering on civil or military service: place him in the

presence of even the simplest cases of foreign bodies—a small stone or a pea in the ear, a metallic splinter in the cornea, or a catheter broken in the urethra—and the anxiety and embarrassment which he manifests will show how insufficient is his surgical knowledge on this point.”

Vol. I. contains chapters upon foreign bodies in the pharynx, esophagus, stomach, intestines, and in the rectum. Vol. II. upon those occurring in the air-passages, the genito-urinary organs, the ear, the nasal fossæ, and, lastly, in the glandular canals.

The plan on which the chapters are constructed appears well calculated to bring out the salient points of each subject both as regards pathology and treatment. They are ably written, and abound with illustrative cases drawn from many sources, which serve to explain the various phases and peculiarities which may be met with in these important cases. A large number of plates are introduced to illustrate anatomical and pathological points, and to show more clearly the different forms of instruments used in the management of foreign bodies in France. It is a most excellent, practical treatise, and contains a great deal of information not to be found elsewhere. The cases themselves are of great value for purposes of reference, for hardly a case can be imagined to which something similar at any rate could not be found in Dr. Poulet's work.

A Handbook of Physical Diagnosis, comprising the Throat, Thorax and Abdomen.—By DR. PAUL GUTTMANN, Privat Dozent in Medicine, University of Berlin. Translated from the third German edition. By ALEX. NAPIER, M.D., Fel. Fac. Phys. and Surg., Glasgow. With a colored plate and 89 wood engravings. New York: Wm. Wood & Co.

This is an excellent and very complete exposition of the different methods of carrying out the physical diagnosis of derangements of various internal organs. The arrangement and contents of the various chapters is necessarily very similar to those of many of its congeners, the work of English and American authors. It is more complete than many text-books bearing the same title, and the discussions on the mode of production of various physi-

cal conditions are scientific and often exhaustive. The chapters on the urine are useful, and the title-page is faced by a very good representation of Vogel's chromatic scale for estimating the depth of color in various specimens of urine. It forms a good number of the Wood's Library series, as representing the German teaching on the important subject of physical diagnosis.

The Essentials of Anatomy, designed as a text-book for students and as a book of easy reference for the practitioner.—By WILLIAM DARLING, M.D., F.R.C.S., Professor of Anatomy in the Medical Department of the New York University, and AMBROSE L. RAMSEY, A.M., M.D., Adjunct Professor of Anatomy in the Medical Department of the New York University. New York: G. P. Putnam's Sons.

The design of the authors in preparing this work has been to furnish a compilation of everything which it is absolutely essential for the student to know of general human anatomy. Much, therefore, has been purposely omitted which is found in most of the standard text-books. It is entirely without illustrations, as it is supposed that every one possesses these, which may be used along with the text as here presented. But a considerable number of diagrams are figured, which have been constructed with a view of aiding memory in retaining facts and associations which are otherwise apt, after a time, to evade one's grasp. The descriptions of parts are clear and very concise. The impression we have formed of the book, as a whole, is that, in many ways, it might considerably assist the student preparing for his examination—especially the *written* examinations in anatomy held at nearly all our schools,—but we cannot think that this way of learning anatomy is to be recommended. By a careful study of such condensed outlines of the various regions and structures, aided by the corresponding diagrams, a theoretical acquaintance with the nomenclature can be obtained; but place a student who has thus tried to master his lesson before a fresh dissection, and he will soon find himself at sea. Again, take some of the illustrations, that of the circulation, for instance, and a good many will say that they are more complicated than that which they are

intended to simplify. In conclusion, we think the "Essentials of Anatomy" will be appreciated by candidates for examination, to assist them in formulating many a *memoria technica*, but beyond this, to the advanced student and the general practitioner, we do not think its usefulness will be at all considerable.

The Student's Manual of Venereal Diseases: being the University Lectures delivered at Charity Hospital, B.I., during the Winter Session of 1879-80.—By F. R. STURGIS, M.D., Clinical Lecturer on Venereal Diseases in the medical department of the University of the City of New York, &c. 8vo., pp. 196. New York: G. P. Putnam's Sons.

This is a small and handy volume for the use of Hospital students. It contains in concise form chapters upon almost all the important features and forms of venereal disease. By excluding points which are even yet matter for discussion, and confining himself to that which has been satisfactorily established, the author has succeeded in presenting the entire subject condensed into very small space. After examination of this book, we can say that its teachings appear to be thoroughly sound and in accordance with the most advanced views upon the nature and behaviour of this important—because so common, and often so dangerous—disease. All students are expected to have a fair knowledge of the natural history of syphilis, and to acquire this we know of no safer or better guide than the manual before us of Dr. Sturgis.

A Practical Handbook of Medical Chemistry applied to Clinical research and the detection of poisons: partly based on "Bowman's Medical Chemistry."—By WM. H. GREENE, M.D., Demonstrator of Chemistry in the medical department of the University of Pennsylvania; editor of *Wurz's Elements of Modern Chemistry*, &c. 8vo., pp. 310. Philadelphia: Henry C. Lea's Son & Co.

This is a handbook for practitioners and for students who have already some knowledge of the more elementary parts of the science of chemistry. The first part is devoted to a brief de-

scription of the proximate principles which take part in normal and pathological vital action, and the properties by which they may be separated from their associate compounds and identified. In the second part, the composition of the more important liquids and solids of the body is considered, together with the processes by which they may be analyzed, both for the estimation of their normal constituents and for the detection of compounds whose presence must be regarded as pathological. The third portion of the book treats of the detection of the more ordinary poisons. This is not intended to be exhaustive, but rather to furnish the practitioner with the means of determining, in suspected cases, either the importance of a subsequent analysis by an expert chemist, or that suspicions of poisoning have been groundless. The plan of the work is thus rather different from most others: it is free from all redundant matter, giving only what is essential and practical, and can be recommended as a very useful book both for study and for reference.

A Text-Book of Physiology.—By M. FOSTER, A.M., M.D., F.R.S., Prælector in Physiology and Fellow of Trinity College, Cambridge. From the third and revised English edition, with notes and additions. By EDWD. T. REICHERT, M.D., Demonstrator of Experimental Therapeutics, University of Pennsylvania. With 259 illustrations. Philadelphia: Henry C. Lea's Son & Co.

It is but a few months since we took occasion to express a high opinion of the value and usefulness of Dr. Foster's Handbook of Physiology. It will therefore be quite unnecessary to repeat here the remarks made at that time. The above is the American reprint of the last English edition, and contains the whole of the letter-press and all the numerous illustrations which are found in the original. It is thoroughly well gotten up in a handy, compact form, and with excellent typographical execution. It can be most confidently recommended as one of the best manuals extant.

Books and Pamphlets Received.

Pathogenetic Outlines of Homœopathic Drugs. By Dr. Med. Carl Heinicke, of Leipzig. Translated from the German by Emil Tietze, M.D., of Philadelphia. New York: Boericke & Tafel.

The Practitioner's Reference Book. By Richard J. Dunglison, A.M., M.D. Second edition. Philadelphia: Lindsay & Blakiston.

Photographic Illustrations of Skin Diseases. By Geo. H. Fox, A.M., M.D. Nos. XI. and XII. New York: E. B. Treat.

The Surgery, Surgical Pathology, and Surgical Anatomy of the Female Pelvic Organs, in a series of plates taken from Nature, with commentaries, notes and cases. By Henry Savage, M.D., Lond., F.R.C.S.E., &c. Third edition; revised and greatly extended. New York: Wm. Wood & Co.

Lessons in Gynecology. By Wm. Goodell, A.M., M.D., Professor of Clinical Gynecology in the University of Pennsylvania. With 92 illustrations. Philadelphia: D. G. Brinton.

Transactions of the American Gynecological Society. Vol. IV. For the year 1879. Boston: Houghton, Mifflin & Co.

REPRINTS.

Coccygodynia. By Edward W. Jenks, M.D., LL.D., Chicago.—*Treatment of Puerperal Septicæmia by Intra-Uterine Injections.* By Edward W. Jenks, M.D., LL.D., Chicago.—*Further contributions to the Study of Fractures of the Inferior Extremity of the Radius.* By L. S. Pilcher, M.D., Brooklyn, N.Y.—*Contributions to Gynecology (Fibro-Sarcomatous Tumor of the Uterus, Cancer of the Rectum).* By John Byrne, M.D., M.R.C.S.E. New York: G. P. Putnam's Sons.—*Kolpo-Cystotomy by Electro-cautery.* By John Byrne, M.D., M.R.C.S.E. New York.—*The Population Question at the Medical Society of London.* By Charles R. Drysdale, M.D. London: G. Standring.—*The Abuses of Medical Charities.* By M. P. Hatfield, A.M., M.D., and Boswell Park, A.M., M.D. Chicago: Knight & Leonard.—*Division of the Sphincter Ani Muscles as a Therapeutic Measure.* By Charles B. Kelsey, M.D. New York: D. Appleton & Co.

Proceedings of Societies.

MEDICO-CHIRURGICAL SOCIETY OF MONTREAL.

The regular meeting of the Society was held May 27th, 1880, in the Society's Rooms, 14 Phillips' Square.

Before beginning the regular order of business, the President (Dr. R. P. Howard) congratulated the Society on the event of meeting for the first time in their own rooms. This indicated

decidedly a step in advance, and showed with what a feeling of affection the Society was regarded by members of the profession. Occupying as we do a large city, and being also a centre for teaching, we stand in a peculiar relationship towards the public. The standard is as high in this as in any other city of this continent, and in every city where there are a band of workers, the results are shown in the actual work, not only among those who hold hospital appointments, but also among the profession as a whole. During the past three years there has been a growing interest in the meetings. Its members enjoy unusual advantages, for, in addition to the medical and surgical matter presented, there is at nearly every meeting a number of pathological specimens, some of these possessing unusual interest, and exhibited by one who makes this instructive department a special study. In the future, if work is persevered in, less attempted, and more time given to that which is done, the work done here will be of the greatest interest to Canada at least. The President, in conclusion, expressed the thanks of the Society to the committee who had superintended the furnishing of the Rooms; also to Dr. Fenwick for the generous gift to the Society of a large portion of his reference library.

Dr. Fenwick said, in donating these books to the Society, he did so on the understanding that they should be under the care of trustees, and provision would be made in his will that, in the event of the Medico-Chirurgical Society ceasing to exist as a Society, these books should then become the property of McGill University. He also requested the Society to insist on keeping these books in the library, and on no account allow any book to be taken away from the Rooms.

On motion of Dr. Hingston, seconded by Dr. F. W. Campbell, a vote of thanks to Dr. Fenwick was passed by the Society.

Dr. Osler exhibited a specimen of sacculate aneurism of the arch of aorta, which had become completely obliterated by dense layers of firm decolourized fibrin. It sprang from the upper and back part of the arch just beyond the innominate, and was about the size of a large orange. The carotid and subclavian

of the left side were obliterated. The left vagus and recurrent laryngeal were involved in the wall.

Dr. Ross said this patient had been under his care in the Montreal General Hospital. He was first seen by him some four years ago; he had then a hoarse voice, pain about the chest, localized dulness, and deep-seated obscure pulsation; there was no dyspnoea, was great pain about the left shoulder and in the chest, and signs of plugging in the left subclavian. He was first treated on the principle of entire rest in bed, and hypodermic injections of morphia; later on he took iodide of potass. for a considerable time last winter. When he came under observation again, Dr. Ross concluded that the tumour had consolidated, which on death proved true. This is one of the several cases tending to prove the fact that the tumour can diminish under the use of iodide of potass.

Dr. F. W. Campbell then read a paper on a case of Progressive Motor Paralysis.

In the discussion following, Dr. Ross said that this case reminded him of certain letters which appear in *The Lancet* under the head of "Wanted a Diagnosis." The symptoms would appear to arise from trouble in the spinal cord, and no symptoms seem to demonstrate any cerebral disturbance, and from the character of the spinal symptoms, would indicate ascending spinal paralysis.

Dr. Osler said he did not see how the lesion was in the corpus striatum. If the old view was correct, there must have been a lesion in the corpora striata, as the paralysis was on both sides. He was inclined to believe that the case was one of ascending paralysis, involving the cord.

The President remarked that when he saw the patient in consultation with Dr. Campbell he had expressed the opinion the lesion not only involved the cord, but reached the base of the brain. The lad had been, years before, subject to attacks of *migraine*, attended with hemiopia, and had been obliged to give up reading exciting books owing to the mental disturbance they created. Amongst the earliest symptoms of the paralytic affection were difficulty of deglutition and of articulation and loss of

taste, and these suggested an affection of the bulb. Subsequently, when reflecting upon the case, he concluded that it was probably an example of that rare affection, Landry's Paralysis, or, at least, a variety of "paralysie generale spinale subaigue," the Acute Polio-Myelitis of the Germans. He still felt unable to decide between the two forms just mentioned, but inclined to the view that it was a case of Landry's paralysis. His chief reasons were the progressive character of the symptoms, the absence of early and marked wasting of the muscles, the absence of fever, and of early impairment of electric excitability. Indeed, the electro-excitability of the upper limbs and thighs continued throughout; that of the legs only was impaired. Of course, if Dejernie were correct in saying that the disease is always fatal, my view is unsound, as the patient recovered, and Landry and others admit many recoveries. It is not always an "acute ascending paralysis," as it has been called. Erb states that it may be a *descending* one, as it was in this case. As to the *nature* of Landry's paralysis, Dejernie found in his two cases a lesion of the anterior nerve roots, but none of the cord; but he infers that some alteration of that acute centre, not appreciable by present methods, must obtain. As to the cause of the disease in this youth, Dr. Ross' suggestion of syphilis is important. Urethral chancre is often regarded as gleet. Syphilis may affect the motor cells of the cord and the motor nerves.

Dr. Hingston read a paper on "Certain Anæsthetics," with special reference to the latest advocated, viz., Bromide of Ethyl. Chloroform and ether have been used respectively in Europe and America. Till the past few years chloroform was used entirely in the Montreal Hospitals. Ether, for the past three years, has taken the place of chloroform in the Montreal General Hospital. No deaths have occurred in the Hotel Dieu from the use of chloroform. In administering chloroform he never paid any attention to the pulse, but always watched the respirations closely. Some few years ago Spencer Wells advised the employment of bichloride of methylene. Dr. Hingston's experience with it showed no advantage over chloroform, possessing, as it does, also the disadvantage of being more expensive. Lately he had

used the bromide of ethyl, and was very favorably impressed with its excellence as an anæsthetic, possessing some advantages over those we now use. Anæsthesia can be produced quickly, and the return to consciousness is in a few moments after the towel is removed, besides the great advantage of causing no vomiting. Dr. Hingston then instanced a number of cases in which he had used it. Care should be exercised in selecting the kind used. Some specimens are not good, and one fatal result is recorded by Marion Sims, supposed to be from the inferiority of the specimen used. That manufactured by Wyeth is an excellent and reliable article.

Dr. Buller said he had given anæsthetics very frequently. Till 1874 the anæsthetic used at the Royal Ophthalmic Hospital, Moorfield's, London, was the bichloride of methylene. Dr. Buller had given this anæsthetic 3,000 times, and then a case resulted fatally. At that time the substitution of ether was under discussion, and the fatal case occurring decided the matter in favor of ether. Joy Jefferies' plan of administering ether was to exclude air entirely. Dr. Buller had used the bromide of ethyl in one case, on an old lady of 70, for extraction of a cataract, and was favorably impressed with it. The patient retained a good fresh color; she went rapidly under its influence, and recovered rapidly, and there was no vomiting. If the latter quality will hold good, Dr. Buller will use it in his practice of ophthalmic surgery before all other anæsthetics, as one very serious drawback to the others is the vomiting which sometimes follows, and destroys the good result of an operation.

Dr. Fenwick had used it in one case, which, however, was not a fair case, as the subject was an epileptic; and there was a considerable amount of struggling on his part, just as much as in the use of chloroform.

The President then referred to the fact that we were favored with the presence of the officers of the Société Médicale, who had been invited to participate in the opening of the new Rooms. He then introduced Dr. Mount, the President of the Société Médicale, who congratulated the Medico-Chirurgical Society on

the step taken, and conveyed to its members fraternal greetings from the sister French Society.

The Society then adjourned to another room, where refreshments were provided and partaken of.

Extracts from British and Foreign Journals.

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

Sulphide of Calcium in the Treatment of Buboos.—My attention was first called to the value of the sulphide of calcium in arresting processes of suppuration through an article in *The Lancet* of February 21, 1874, by Sidney Ringer, M.D. Dr. Ringer claimed that, when the product of suppuration in scrofulous sores was thin and ichorous, the administration of small doses of the sulphide of potassium or of calcium promptly changed the purulent fluid to one of a more healthy character, and that the healing of the sore was promoted. He also claimed that the formation of boils and abscesses was prevented by a timely administration of small doses of the sulphides, and that, when suppuration had already occurred in such cases, the suppurative process was quickly arrested through the influence of these remedies. Opportunity for a practical test of these claims soon occurred, and resulted in my own personal conviction of their entire correctness, and I have now for the last five years habitually prescribed the sulphide of calcium in cases of threatened suppuration in phlegmonous swelling from various causes, and, as a rule, with very gratifying results. The manner of its use was practically the same as advised by Dr. Ringer, viz.: 1-12 grain of the sulphide of calcium every two hours, or 1-20 every hour, during the day and up to the time of retiring. Especially have I found small doses of the sulphide of calcium useful in arresting the progress of furuncular swellings and abscesses, and in preventing their occurrence when threatening. On the other hand, I have repeatedly tested the influence of this drug upon the suppurative processes in mucous membranes, as in gonorrhœa, gleet, leucorrhœa, etc., without

being able to discover that it influenced or modified the suppurative process in such cases in the least degree.

Among the cases in my private practice where prompt arrest of suppuration was quickly followed by absorption of pus already formed and resolution of tumor, and apparently from the use of the sulphide of calcium, were several inguinal buboes associated with chancroid. The simple fact that resolution occurred in these cases was (in accordance with the popular teaching) accepted as proof that the buboes were of sympathetic and not of chancroidal origin.

Authorities have long taught that once the virus from a chancroid has been carried along a lymphatic vessel and deposited in the adjacent lymphatic gland, inflammation is at once set up in the substance of the gland. This, it is claimed, goes steadily on in spite of all and any treatment until an abscess is formed. This must, sooner or later, through advance of the suppurative agency or by surgical interference, result in an open ulcer, the pus of which will possess the same vicious character as the chancroid from which it was derived. This variety of bubo is known as the virulent or chancroidal bubo. The suppuration of such buboes has been considered *inevitable*, and all buboes not pursuing this course have been set down as not of true chancroidal, but of simple or sympathetic origin. Inflammatory lymphatic enlargements associated with chancroid are very naturally dreaded as most likely to prove by results to be of chancroidal origin, and usually, after a few feeble attempts at treatment with a view to their resolution, glands affected are encouraged to suppurate, and prompt incision and evacuation of pus are advised as soon as the slightest true fluctuation is recognized. If suppuration is indeed inevitable, undoubtedly it is wise to encourage it, to evacuate the virulent product at the earliest moment, and thus afford access for efficient treatment for the destruction of this new-formed chancroid. For this reason I had been an earnest advocate for early incision into suppurating buboes associated with chancroid. My experience in the few cases above alluded to, however, made me incline to the belief that a thorough and extended trial of the calcium sulphide in cases of inflammatory

buboes associated with chancreoid might give such results as to make its use imperative in every such case.

In order to gain further light on this important matter, a systematic use of the calcium sulphide was made, in my service at Charity Hospital, in 18 consecutive cases of inflammatory bubo occurring with, or as the immediate sequel of, well-pronounced chancreoid. All the facts considered of importance were noted by myself and under my direction by Dr. Johnson, my House Surgeon, and are truly confirmatory.

Thus it will be seen that, out of 18 cases of inflammatory bubo presenting the rational evidences of chancreoid origin, and treated systematically by the use of small doses of the sulphide of calcium, resolution occurred in 15, and that in only three cases was incision ultimately required.

If we apply to these cases the usual rule that chancreoid buboes always eventuate in chancreoid abscesses, always suppurate and require evacuation by natural means or surgical procedure, then we must hold that only three out of fifteen cases of inflammatory buboes associated with chancreoid were the result of transference of the suppurative process from the chancreoid to the adjacent lymphatic gland. It is just possible, however, that the influence of the sulphide of calcium may, in arresting suppuration, extend to the true chancreoid bubo. The apparent successful use of this drug in the series of cases herewith presented at least suggests and invites a trial of its efficacy in all instances of threatened glandular suppuration, whether associated with chancreoid or of purely sympathetic origin.—*Fessenden N Otis, M.D., in New York Medical Record.*

Etiology of Surgical Scarlatina.—Goodhart and Howse contribute two papers of much interest on this subject to "Guy's Hospital Reports." The first paper contains details of twenty-five cases of surgical scarlatina (besides some of measles, etc.), all that occurred from 1869 to 1878, while the second details four cases occurring within a month, the last three within eight days. Both writers were originally non-believers in the scarlatinal nature of these rashes, but looked upon

them as one of the primary manifestations of septicæmia ; but after observing the probable infections, the sources of which are frequently most carefully traced, the symptoms, such as the rash, the fever, the sore throat, the desquamation, and the albuminuria, and the infection of others with distinct non-surgical scarlatina as a sequel, they have been convinced that it is true scarlatina. Both of the papers support Paget's previously expressed explanation, that either the condition induced by an operation gives a peculiar liability to the reception of the poison, or else, that having received it already, had the patient not been in ill health he might have resisted it longer or entirely. But they have given a much wider significance to this explanation, and make it apply to any local inflammation, especially if attended with suppuration ; for one-third of Goodhart's cases had suffered no operation at all. Of the twenty-nine cases, seventeen were dressed antiseptically. Goodhart draws the conclusion that the contagion obtained its hold on them, not through the wound, but in the ordinary way ; for if the antiseptic dressing has banished (as it has) from their wards septicæmia, pyæmia, and erysipelas, the poison of scarlatina would probably also have been prevented access by the wound. Howse would add to this that had antiseptics not been used, the high temperature induced by the fever would have favored decomposition in the wound, and so the whole train of septicæmic symptoms would have followed the rash, which is so often its initial step ; but that this decomposition was prevented by the antiseptic system.—*Guy's Hosp. Reports*, vol. xxiv., 1879 ; *Am. Jour. Med. Sci.*, Oct., 1879.

The Summer Diarrhœa of Adults.—By H. R. Bigelow, M.D., of Washington, D.C.—With the approach of warm weather the physician will not unwisely occupy himself with the consideration of a class of cases which cover a wide domain of symptomatology, and in which an intellectual therapeutical discrimination is absolutely necessary. The professional practice in cities during the summer months is largely confined to the treatment of diarrhœas, so that it may not be amiss to dwell somewhat at length upon a general analysis of the disease, in its

varying forms, and to point out the indications of remedial interference. It is my purpose to deal only with essential and reflex diarrhoeas, so that the questions of dysentery, cholera, etc., need not cumber the present discussion.

Etiology.—A man of adult years complains to us of a diarrhoea and its concomitant symptoms. What shall we give him? Naturally, the first question demanding solution is, upon what condition does the diarrhoea depend? What has caused it? A diarrhoea results from increased peristaltic action of the intestines, or from excessive secretion, or from the two combined. The exciting causes of these phenomena, in relation to the subject in hand, and which will apply to the majority of ordinary cases, are—1. Intestinal irritation by improper or unripe food and fruit, impure water and constipation. 2. Changes of temperature, bad air, anti-hygienic conditions, fatigue and malarial influences. 3. Obstruction of the portal circulation. 4. Excessive mental excitement. There are, of course, *vicarious* diarrhoeas, the diarrhoeas of typhoid fever, of phthisis, cancer, Hodgkin's disease, etc., but these are intercurrent phenomena, the local manifestations of constitutional disturbance, and are to be met in the general treatment of the primary lesion. In general summer practice it will be found that nearly all of the cases that come to us for treatment will depend upon some one of the foregoing exciting causes. It is essential that the diagnosis should be an accurate one, to insure successful treatment.

Diagnosis.—The history of the case will first arrest attention. The social condition of the patient and his hygienic surroundings. The duration of the disease. The nature of ingesta. The length of time between the last meal and the first symptoms of the attack. The nature of the last meal. The character of the discharges. The co-existence of nausea. The presence of headache, increased upon movement of the head. The condition of the tongue. The daily occupation of the patient. His condition in reference to insomnia. The distinction between the various forms may be confirmed from the symptomatology.

Symptoms.—1. Unripe or improper food; impure water; constipation, acting as intestinal irritants. When an adult has

eaten unripe fruit, or vegetables not perfectly fresh, the symptoms of colic, with or without diarrhœa, soon manifest themselves. There is flushing of the face; more or less activity of the perspiratory glands; a binding, gnawing pain along the greater curvature of the stomach, with nausea, often amounting to emesis. The pain may be very intense, but is neither increased nor diminished by pressure. The diarrhœa which follows may be profuse, liquid and henteric, if the ingesta are forced along the canal by the peristaltic action. Should any undigested matter remain, the discharge is scant and unsatisfying, while tormina and tenesmus are prominent. This form of summer complaint yields readily to appropriate treatment, leaving no ill effects. When the diarrhœa is due to constipation we shall usually have the history to guide us. The general symptoms are small, feculent discharges, usually liquid, the accumulated fæces acting as a foreign body and setting up an irritation; or small, round, hard masses may also be discharged. Hard, indurated swellings may often be made out along the course of the colon. There is a general sense of malaise.

2. Excessive fatigue occasions an ephemeral diarrhœa which has no especial history other than its exciting cause. In those cases wherein the flux is the result of anti-hygienic conditions, we will be apt to have more or less constitutional disturbance. The face will be pale and pinched, eyes sunken, with general emaciation. There is constant diarrhœa, painless and crapulous. Pulsë quick and shallow.

3. Obstruction of the portal circulation. The "bilious diarrhœa," of common parlance. What physician will not recognize the vertigo, the headache that comes and goes and is increased by physical activity, the bad taste in the mouth and coated tongue, the drowsiness and languor, and the foul odor of the discharges. The ideal disease of the laity.

4. Excessive mental excitement. This is the most severe and often the most obscure form of the disease. It will not yield to the usual astringents, and is accompanied by many distressing symptoms. We have a history of mental strain, at a time when the heat of the summer has been most intense.

There is irregular action of the heart, with palpitation. Insomnia. Excessive nervous irritability, with photophobia. There is pronounced mal-assimilation, with gastric irritability. Each active cerebral effort is followed by intestinal discharge. In few other diseases have we such a typical example of the influence of the mind upon the body. This diarrhoea is essentially reflex, and can be controlled only by treating the nervous system. In general we have to decide whether it is desirable to check the flux, whether we shall give cathartics or purgatives, or nerve tonics, and what combinations best subserve these ends.

Treatment.—In all cases where we have reason to suppose that there is undigested food in the alimentary track, it is a good practice to exhibit at the very commencement a dose of castor oil and opium. This somewhat nauseous admixture may be rendered palatable by combining with it compound tincture of cardamoms, oil of gaultheria, pulverized acacia, white sugar and cinnamon water. Should there be extreme pain or cramp, a spiced hop poultice (hops, cinnamon, cloves, linseed and brandy) over the abdomen gives much relief. While the subcutaneous injection of $\frac{v}{x}$ minims of Magendie's solution will quiet pain and nausea. If the stomach is incapable of retaining the oil, it should be administered as an enema. A persistent diarrhoea should be treated with powders of oxide of zinc, with bicarbonate of potash, or with gallic acid and opium. Where the anæmia is marked, the debility extreme and the diarrhoea malignant, in the sense that some anæmias are said to be malignant, there is no more desirable mixture than the elixir of calisaya bark and aromatic sulphuric acid. If the tendency be to cholera, quinine and ergot, or carbolic acid, should be given with hot brandy punches, with laudanum, or the subcutaneous injection of the hydrate of chloral. The simple, uncomplicated diarrhoea that one meets so often in the summer will usually yield to a little chalk mixture with the tincture of krameria; when more severe we may use a mixture of tincture of opium, spirits of chloroform, alcohol and spirits of camphor. An enema of the sulphate of copper before breakfast is useful in many

cases of great tenesmus. As a general rule, when sent for to attend a case of cramps resulting from unripe fruit, or anything of that nature, I order a castor oil enema at once, with the immediate application of a hot spiced hop poultice over the abdomen. If necessary I add a subcutaneous injection of morphine, and leave the patient with the assurance that he will be well in a few hours, and that nothing more will be necessary. If an adult patient comes to my office complaining of an active diarrhoea, attributable to no other cause than that of heat and over-exertion, I order him a few powders of the oxide of zinc and bicarbonate of potash, to be followed by a mixture of the elixir of calisaya and sulphuric acid. If the diarrhoea be due to constipation we have nothing better than a pill of extract of nux vomica, extract of belladonna, with extract of physostigma. These should be taken regularly, to overcome the habit, which is due probably to a relaxed condition of the muscular coat of the bowel.

In the *Practitioner*, Dr. J. M. Fothergill writes as follows : " Look at the treatment of diarrhoea. How commonly is an astringent mixture, containing an opiate, prescribed, without further reflection? Of course, in a great many cases immediate effects are produced which are gratifying to the patient. Yet in a certain percentage of such cases such a plan is not only not successful, but does harm; in those cases where there is an offending mass in the intestines, setting up a secretion to sweep it away, but where the secretion is set up too low for its removal there is a teasing diarrhoea, a persistent desire to go to stool, with small, ineffective motions, affording no relief. Here the ordinary diarrhoea mixture does harm; and what effect it has is to arrest a spontaneous reflex act, often of a beneficial character. The proper treatment is to administer a dose of castor oil, or better still, a scruple of rhubarb, in powder, by which secretion is set up above the offending mass, and it is swept away; after which diarrhoea ceases. The secondary action of rhubarb in constipating the bowels renders it the agent *par excellence* for the treatment of this form of diarrhoea. The astringent and opium treatment of diarrhoea is

equally or still more out of place in those cases where there is a fecal mass lodged or accumulated in the rectum. Every surgeon who sees much of diseases of the rectum has instructive stories to tell of cases where the patient has consulted a large number of eminent physicians, without avail, for a persisting diarrhœa. The usual mixtures in great variety are prescribed, without effect; at last the persisting tenusmus drives the patient to a rectal surgeon, who, on examination, finds a solid mass in the bowel, around and past the sides of which the thin fecal motion passes. Here diarrhœa is the only possible means by which the bowels can be emptied; and it is fortunate that the astringent mixtures are inoperative to arrest this diarrhœa, else the patient's condition would indeed be a serious one. The mass is removed, and then the diarrhœa spontaneously ceases."—*Phila. Med. & Surg. Reporter*.

Homœopathic Springs for Fever and Ague.—In Westphalia there is a spring which, after flowing for twenty-four hours, entirely ceases for six, then returns with a very loud noise, and in a stream large enough to turn three mills. The well at Torbay ebbs and flows sixteen times in an hour. The Giggleswick well in Yorkshire rises and falls every ten minutes. St. Anthony's well, near Edinburgh, has a similar regular intermittent movement. In Savoy there is a spring which is very uncertain and irregular in its rises and falls; this water has been suggested for the irregular chills of pyæmia, while sea-water, which rises and falls regularly with tides, is said by Dr. Max Greubler to rival natrum muriaticum in the cure of intermittent fevers. He also hints that the other waters may be tried in obstinate cases of fever and ague. The waters from the intermittent geyser springs in Iceland have not yet been suggested by Dr. Greubler for the worst cases, but he points, with pride and pleasure, to the numerous cases of malarial disease which have been cured at the springs, called the *Puits de Vaisse* at Vichy, which have a perfectly regular and curious *intermittent* action, preceded by a subterranean noise, followed by a violent eruption of mud, water and gas, strongly impregnated with the

hydrosulphurous odor, which occurs at intervals more or less regular, six or eight times every twenty-four hours. Dr. G. prides himself very much upon a homœopathic inspiration which led him to give these waters, especially in cases attended with flatulence and more or less violent explosions of gas and scybalæ. In some cases he was obliged to use what he calls the ascending rectal douche, or injections of the water, which is highly impregnated with gas. Thus all the indications were fulfilled—the water, gas and fæces were forced first to ascend, and then to descend; and were finally expelled from the patient's body, to his great relief and comfort.—*N. Y. Med. Record.*

Chian Turpentine in Cancer.—The great subject of talk in medical circles is the discovery, by Mr. Clay, of a remedy for cancer. All the papers, general as well as professional, are full of it. The new cure is nothing more than our old friend, Chian turpentine. Mr. Clay seems to have made his great discovery almost by accident. He went to trying different drugs in cancer till he found one that did good. He offers no physiological or pathological explanation of its action. He gives his facts, and that is all. His reputation is too high for there to be any doubt on the subject, and it is said that some of the London surgeons—for Mr. Clay dates from Birmingham—have data which fully confirm his statements. It is a great discovery, and encourages us to try new remedies in diseases which have hitherto been considered incurable. Clay's formula is:—Chian turpentine, - - - - grs. vj.

Sublimed sulphur, - - - grs. jv.

Mix. Make two pills, to be taken every four hours.

It has been suggested that the pills might not dissolve very readily in the stomach, and the turpentine may be made into a mixture according to the following method: Dissolve an ounce of Chian turpentine in two ounces of pure (anæsthetic) ether. Then take of this solution half an ounce, of solution of tragacanth four ounces, of syrup one ounce, of flowers of sulphur 40 grains, the whole to be made up with water to 16 ounces. Of this one ounce is to be taken three times a day. Patients are found to

take it quite as readily as they do the pills. Since the appearance of Mr. Clay's paper Chian turpentine has gone up considerably in price; a short time ago there was hardly any demand for it, now it is obtained with the greatest difficulty, and we are told that we are not to expect any more for three months—a serious matter for sufferers from cancer. In a few days the Chian turpentine rose from three shillings a pound to sixteen shillings, and then the supply practically ceased. I hear that a large firm in London has some four or five pounds, but they naturally enough do not care to part with it, and keep it for their regular customers. A writer in *The Lancet* says that much of what is now sold as Chian turpentine is a wholly fictitious article, manufactured from black resin, Canada balsam, and the essential oils of fennel and juniper. Perhaps one of the most curious points about the new remedy is that it was mentioned by Paracelsus in his "Chirurgia Magna" as a cure for cancer.—*Therapeutic Gazette*.

Sims' Speculum always at Hand.—

The index and middle fingers of the right hand may be used as a perineal retractor in place of the ordinary Sims' speculum. They may be introduced with the patient in Sims' latero-prone position, the operator standing back of the patient, on the side of the table, in exactly the position of the assistant who holds the speculum in the ordinary way. In this manner the cervix and vagina may be exposed almost as well as by the speculum. This method of exposing the parts may be of great use when a speculum is needed and not accessible, in the application, for instance, of the tampon in sudden cases of hemorrhage, or in consultations at a distance, when, for reasons not anticipated, it becomes necessary to examine the pelvic organs.—*Ex.*

Lacerated Cervix.—O. E. Herrick suggests a modification of Emmet's operation for lacerated cervix. He freshens the edges of the laceration, but instead of applying sutures as Emmet directs, he encircles the neck with a rubber ring or with several of the little rubber loops that are found at the stationers and are used for holding papers together.

He claims the following advantages from this modification of the operation : 1st, As about all the pain experienced during the operation is from the introduction of the sutures, if these are omitted, an anæsthetic may be dispensed with. 2nd, If the patient is not etherized, it is not absolutely necessary to have professional assistance, and one can operate upon patients that would not listen to such a proposition if strange physicians were to be present. 3rd, The parts are kept in just as close contact, and union takes place just as soon. 4th, There is less danger of inflammation taking place in the parts. 5th, There are no stitches to remove. 6th, In slight cases patients may be operated upon at the office, and even without their knowing that they are undergoing any important operation, as they are not obliged to keep their beds a single day on account of it.—*Med. & Surg. Rep.*

Dressing for Superficial Wounds.—

Dr. Geo. Cowan (in *Louisville News*) speaks highly of a dressing which consists in applying a piece of adhesive plaster to each side of the wound, to which plasters have previously been fastened, so as to oppose each other, a row of ordinary hooks, such as ladies use. The hooks should be about a quarter of an inch apart, and set back a little from the edge, so as not to press upon or irritate the skin. By means of a cord passed around these hooks the wound is *laced* together, and pressure can be regulated as desired.

Eczema Intertrigo of Infants.—Dr. H. B. Hodges, in the *British Medical Journal*, recommends the following after twenty-five years' practice :—

R.—Plumbi Acetatis.....	gr. xxx.
Acid Acetic dilut.....	ʒij.
Glycerinæ.....	ʒiiss.
Aquæ Rosæ, ad.....	ʒviij.

He uses no internal medication. M.

AN EMETIC FOR INFANTS.—Dr. S. W. Smith (*British Med. Journal*) writes: I beg leave to record that half a teaspoonful of glycerine acts as a simple and efficient emetic for infants. Perhaps some of your readers can confirm this by future experience.

CANADA

Medical and Surgical Journal.

MONTREAL, JULY, 1880.

THE HEALTH OF MONTREAL.

We have received the Annual Report of Dr. Larocque, the Health Officer of the City of Montreal, for the past year. It is an important document, and contains a number of suggestions which should command the careful consideration of the Board of Health. Several things are pointed out in which the working of the department has not been satisfactory. These might well be remedied, and from our failures other cities might learn something to their own advantage. The Report gives first a short historical sketch of the various changes that have been made in the composition of the Board of Health from the time that two health officers were first appointed in 1870. The writer is of opinion that increasing attention has been given of late years to this important branch of the public service. In proof of this he says: "We observe that whenever serious interest has been taken in the affairs of the Board of Health, economy has invariably followed. In 1876 the expenses of the Board amounted to \$25,000; in 1877, to \$17,000; in 1878, to \$11,000; and in 1879, to only \$10,450." We can hardly believe that pure *economy* and extra attention of the members has effected such a large saving. We should rather attribute the greatly diminished expenditure to the sweeping reduction in the appropriations which have been made in all the civic departments.

It is satisfactory to find that vaccination is being fairly well looked after by the district officers acting under the Board, and more than this, that there is every reason to believe that the supply of vaccine is well kept up and of excellent quality. The

natural result of this, of course, is that we hear no more of the ulcerated arms, erysipelas, &c., following vaccination, which gave rise to such an outcry from the anti-vaccinators a few years ago.

“ We should have, as in other cities, a collection of the best authors on hygiene, which, together with the reports and other documents that we receive, would form, before long, a small library from which useful information concerning public health could be obtained.” This suggestion is an excellent one. The carrying of it out would cost but very little, and we hope the authorities will act upon it without delay.

There is evidently a conflict of authority between the Health Officer and the Sanitary Inspector. It is, indeed, “ matter for surprise ” that “ the duties of the officers and other employees have never been really defined.” Unsophisticated people would think that this would be the very first thing to do, and we can only wonder how on earth the wheels of the machine move at all when this first element of order is wanting. In our opinion, far too much is allowed to fall directly under the Sanitary Inspector, and far too little under the Health Officer. The latter, we think, should be the head of his department, responsible in all things to the Board of Health. All general instructions should emanate from him, and all reports should pass through him to head-quarters. It is in this way only that a properly organized system can ever be made to work.

It is matter for congratulation that the death-rate of the city has been lower for 1879 than for many years past, if not than ever before. Still, much—very much—remains to be done in reducing this to the standard of other cities which are sanitarily better cared for. This year the figure has been 28.47 per 1,000 of the population, whilst during the ten preceding years it was not less than 30 per 1000. By a comparison of the mortality in eight of the chief cities of Great Britain it is shown that this is higher than any one, except Manchester, which gives 29.1 per 1,000. With our natural advantages, therefore, it is plain that we should never rest until the mortality here is brought within the limits of the less favored and much more crowded European towns. It can be done, and it should be done.

A number of special topics are also discussed, with remarks upon proposed methods of improving upon the work being done: Isolation of persons suffering from contagious diseases—A better Civic Hospital—The better inspection of milk—Drainage—The reports of contagious diseases from medical men—The preparation of a Sanitary Map, &c. The Report concludes with elaborate and detailed tabulated statements of the deaths and diseases in the various quarters of the city through the year. It should be read by everyone interested in sanitary matters and the well-being of our city.

THE TRIENNIAL MEETING of the College of Physicians and Surgeons of the Province of Quebec, for the election of Governors, was held in this city on the 14th inst. After the annual address of the President, voting began and continued until 5 p.m. The ballots were then counted, and the results, as given below, were announced at 9 p.m. There was a large attendance:—

For the City of Montreal—Drs. Howard, Craik, David, Campbell (F. W.), Robillard, Rodger, Lachapelle, Rottot, Trudel, and Hingston.

For the District of Montreal—Drs. Church, Gibson, Ladouceur, Perrault, Prevost, Lafontaine, Laberge, P. E. Mignault, Lanctot.

For the District of St. Francis—Drs. Austin, Worthington, and Larue.

For the City of Quebec—Drs. Belleau, Marsden, St. George, L. Larue, Parke, Rinfret (sen.), Sewell, and Lemieux.

For the District of Quebec—Drs. Marmette, Gingras, Simard, Michaud, Robitaille, Rousseau, and Bonin.

For the District of Three Rivers—Drs. Ross, Gervais, and Desaulniers.

At a subsequent meeting of the Governors, held on the 15th inst., the election of Officers of the College for the ensuing three years took place as follows:—*President*, Dr. R. P. Howard; *1st Vice-President*, Dr. Lemieux; *2nd Vice-President*, Dr. Trudel; *Registrar*, Dr. Larue; *Treasurer*, Dr. E. P. Lachapelle; *Secretaries*—*For the District of Montreal*, Dr. F. W. Campbell; *for the District of Quebec*, Dr. Belleau.

THE NEW ONTARIO COUNCIL.—The following are the names of the members of the newly-elected Council of the College of Physicians and Surgeons of Ontario :—*Territorial Representatives*—Dr. J. L. Bray, Western and St. Clair Division ; Dr. E. G. Edwards, Malahide and Tecumseh ; Dr. R. Douglass, Sauguen and Brock ; Dr. J. A. Williams, Gore and Thames ; Dr. W. McCargow, Erie and Niagara ; Dr. J. D. McDonald, Burlington and Home ; Dr. J. H. Burns, Midland and York ; Dr. W. Allison, King's and Queen's ; Dr. H. C. Burritt, Newcastle and Trent ; Dr. C. A. Irwin, Quinte and Cataraqui : Dr. W. Mostyn, Bathurst and Rideau ; Dr. D. Bergin, St. Lawrence and Eastern. *College and University Representatives*—Dr. J. McCammon, Queen's College ; Dr. W. H. Ellis, Toronto University ; Dr. W. B. Geikie, Trinity Medical College ; Dr. D. Phelan, Regiopolis College (Kingston) ; Dr. E. Spragge, Trinity University ; Hon. Dr. W. H. Brouse, Victoria University ; Dr. J. A. Grant, Ottawa University ; Dr. W. T. Aikins, Toronto School of Medicine ; Dr. M. Lavell, Royal College of Physicians and Surgeons, Kingston. *Homœopathic Representatives*—Dr. C. Logan, Ottawa ; Dr. G. Henderson, Strathroy ; Dr. R. J. P. Mordon, London ; Dr. E. Vernon, Hamilton ; Dr. G. E. Husband, Hamilton.—*Canada Lancet*.

CORONER'S UNCLAIMED BODIES.—We are glad to observe that the Solicitor-General has caused an amendment to be added to the new Coroner's Bill, to the effect that the bodies of paupers unclaimed shall be given over by that officer to the Inspector of Anatomy (where such person exists) for the purpose of dissection. The correction of this omission was urged in the last number of the JOURNAL, and it will doubtless assist in preventing the annually-recurring complaints of body-snatching.

ANOTHER DEATH FROM CHLOROFORM.—A case of death from inhalation of chloroform occurred at the City Hospital, Hamilton, Ont., on the 3rd June last. The unfortunate individual was a woman who had been admitted for the treatment of mammary abscess. The anæsthetic used was a mixture of one part of spirits of turpentine and eight parts of chloroform. The patient

had already, a very short time previously, been anæsthetized for the purpose of incising the breast, and although a similar agent (but containing somewhat more turpentine) was made use of, no bad effects were observed. On this occasion, however, after inhaling for a few minutes only, the quantity first administered, there occurred sudden spasm, pallor, difficulty of breathing, and cessation of pulse. Every effort was instantly made and persisted in by Dr. Kittson, the attending physician, and Dr. Mills, the resident surgeon, to restore animation, but in vain. The *post-mortem* examination failed to reveal any organic lesion, and the following verdict was rendered by the coroner's jury: "That Catharine Donahue came to her death on the 3rd June, 1880, from chloroform administered in the Hamilton City Hospital, and it appears to this jury that the chloroform was administered in a proper manner, and her death could not have been foreseen, and no blame can be attached to any one."

NEW DISPENSARY.—A general dispensary, free to all, has been opened on Wellington street, for the accommodation of the increasing population of Point St. Charles. It has been properly organized, with G. T. Drummond, Esq., as President, and will no doubt command a fair share of public support. The following gentlemen have been nominated as medical officers: *Consulting Physicians*—Drs. Hingston, Craik, and E. H. Trudel. *Attending Staff*—Drs. T. A. Rodger, T. J. Alloway, M. M. Seymour, and J. J. Guerin.

TYPHOID FEVER.—The last number of this *Journal* contained a report of the proceedings of the Medico-Chirurgical Society of Montreal, in which mention is made of a case of Typhoid Fever at the St. Lawrence Hall some months ago. We understand that the above statement is being used to injure the reputation of this Hotel. This is manifestly unfair. The case alluded to occurred in October last. The disease was not shown to have communicated itself to others, and, as far as we know, the establishment has since been perfectly free from fever of any kind. As we became the medium of spreading the report, we willingly take the earliest opportunity of making this explanation. We have no hesitation in saying that the sanitary condition and general healthfulness of the St. Lawrence Hall will compare favorably with that of any other hotel in this city.