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CANADA

MEDICAL & SURGICAL JOURNAL

JANUARY, 1878.

Original Communications.

HYDROMETRA WITH ABSENCE OF THE VAGINA.

Atresia of the External Os; Surgical Operation; Recovery.

By W. BAYARD, M.D. &c., St. JOHN N. B.

In August, 1876, I was called to visit Miss H., aged 22 years, intelligent, well-formed and apparently healthy. I found her in bed labouring under retention of urine and suffering with severe paroxysmal pains like those of labor. The abdomen was enlarged equal in size to what it should be in about the fourth month of gestation.

I had not received a history of her case, and when proceeding to draw off the urine, I found the external genital organs deficient. The clitoris and meatus urinarius alone existed; there was a line where the labia should have been—nothing more—and the part was well covered with hair. The pains continued notwithstanding the relief of the bladder, and only yielded to the hypodermic injection of morphia.

She informed me that "every month" for about a year previous to my visit she had been subject to pain, more or less severe, which lasted between three and four days, during which time the breasts were swollen and tender and the bladder irritable;—that each succeeding month the pain increased in severity;—that she did not observe any enlargement of the figure until about six months before I saw her, and that except

at this "monthly period" she felt no inconvenience of any kind.

Concluding that I had to deal with a case of hydrometra or hæmatometra, I explained the nature of the case to her mother and the necessity for immediate relief, which could only be obtained by a surgical operation. After a good deal of persuasion she consented that the operation should be performed, but on condition that "no man but myself should be present at it." Accordingly I was compelled to make assistants of her mother and aunt.

The bowels having been relieved by an enema, the patient was placed in the position for the operation of lithotomy, the aunt gave her ether, her mother held the catheter in the urethra, while, with the index finger of the left hand in the rectum, I made a transverse incision two inches long midway between the anus and urethra, through the integuments and cellular tissue, and with the handle of the knife and the fingers I carefully tore open a passage, making the wound exactly $2\frac{1}{2}$ inches deep before I came to the tumour. At the base of the wound there existed a slightly elevated circular ridge which I considered was the sealed os uteri, and through it I passed a large sized trocar, when out poured a fluid nearly as thick as molasses but darker in colour, and, as is usual in such cases, without offensive odour. For the purpose of ascertaining the extent of dilatation of the womb, I introduced through the canula the longest probe I had—eleven inches—without being able to reach the fundus of that organ.

In order to secure the passage of the fluid from the uterus *slowly* I introduced a soft rubber catheter through the canula, which was then removed; when she was carefully placed in bed with strict directions not to allow pressure upon the abdomen. The ether did not produce sickness, but she complained of pain for which an anodyne was given. She passed a good night, during which time upwards of two quarts of fluid flowed from the womb. On the second day it ceased passing, when, fearing decomposition of any that might have remained, warm water was carefully injected through the catheter and repeated each day until it passed away without colour.

The catheter was removed on the fifth day and the artificial os was kept dilated with carbolized sponge-tents.

The external wound was dilated from day to day with the fingers, until the sixteenth day, when, finding contraction commencing, I moulded a gutta-percha plug of such a size and shape as to fit accurately the wound. It had a flange on its outer end to prevent pressure upon the os uteri which continued sensitive. This was worn until the wound healed, daily lubricating it with carbolized oil.

On the twenty-fourth day after the operation the plug was removed, and on the twenty-sixth day she menstruated, continuing to do so with regularity since that period.

About six weeks ago I examined the uterus with the sound and found its length normal, its neck much shortened and its fundus movable but not to its proper extent. The artificial vagina,—if it may be so named—admits the finger with ease, but it has become shortened to the depth of a little over an inch, and the neck of the womb is firmly attached to the base of the vagina.

CASE OF ACUTE TETANUS FOLLOWING A WOUND IN THE FOOT.

Treated by Chloral Hydrate.—Recovery.

By ARCHIBALD LAWSON M.D., M. R. C. S. Eng., Professor of Surgery Halifax School of Medicine.

The following case of tetanus is, I think interesting:—

Geo. Smith, aged 10, a fisherman's son of Sambro, on August 2nd. whilst barefoot, accidentally ran against a scythe, causing a wound of left instep implicating the extensor tendons, also one nearly severing the little toe of the same foot. He was brought to Halifax and the wound dressed, he then returned. On August 9th I saw him for the first time; wound of instep granulating healthily, a small piece of bone protruding from wound of little toe which was removed. Sweating profusely, trismus and opisthotonos well marked, with frequent spasms.

difficulty of deglutition and respiration, pulse 144, temp. 103°, pain through body, risus sardonius marked. Gave gr. xvi. hydrate chloral immediately and gr. viii. to be given every hour with mustard to whole length of spine, wound dressed with carbolic acid and oil (1-20). Remained all night and administered the chloral myself, with as much milk as he could suck through the teeth and on account of the great difficulty in swallowing it required much patience to give either. The boy soon slept and was awakened during the night to take chloral and milk. Spasms were much less frequent after the chloral.

Aug. 11th. Worse again, boy refusing chloral, also milk, temp. 101½ pulse 130 and weak, sweating profusely, frequent spasms, no relief of trismus or opisthotonos,—remained three hours giving gr. viii, chloral every hour. Gave also during this time half pint of milk. Left him much relieved.

Aug. 14 Not any worse, pulse 116, temp. 99°, but few spasms, trismus very slightly relieved, spine still stiff but limbs can be bent up on abdomen if care is used. Grains viii chloral every hour, takes but very little milk, bowels relieved by enema, passed quantities of flatus.

Aug. 17th. Was doing well since last visit but the boy refusing chloral the spasms returned to some extent. Gave gr. xvi of chloral with marked relief and ordered gr. viii of chloral every two hours with as much milk as possible. Boy very weak.

Aug. 20th. Boy better, pulse 98, temp 99°, spasms few and slight, trismus somewhat relaxed, bowels moved by injection, still fights against medicine and nourishment.

Aug. 23. Decidedly improving, pulse 88, temp. 99°, jaws still more relaxed, scarcely any spasms except when moved and even then slight, wounds nearly healed. Gave chloral gr. vii every four hours which was continued for a week longer and then given only at night. From this time continued to improve and on September 7th. the boy's father reports that his jaws are looser than ever.

This case is interesting in that it is a recovery from a very acute case, which is rare, that no drug except chloral was administered, no stimulants, and nothing but milk and very little of that for a fortnight.

CASE OF PERFORATION OF THE COLON.

DEATH: AUTOPSY.

Reported by Dr. E. B. C. HANINGTON, Resident Physician.
(St. John, N. B., General Public Hospital.)

P. McS., aged 42, a ship-carpenter, was admitted into the General Public Hospital on August 15th. 1877, complaining of an intense colicky pain in the lower part of the abdomen.

HISTORY PRIOR TO ADMISSION.

He has always been temperate in all things and rarely indulged in alcoholic beverages. Has been remarkably healthy and has never had any kind of fever, nor any peritoneal nor intestinal trouble. His bowels have acted regularly as a rule. His history of the present trouble is as follows:—On the morning of the 14th he ate his breakfast of which neither meat nor fish formed a part, had his bowels opened and then went to work at his trade, feeling perfectly well. At noon he took dinner, the meat part of which consisted of a mutton stew, and at one o'clock returned to his work. At 5 P.M. a sudden, sharp, "clawing" pain "doubled him up," and he at once stopped working and went home. Hot fomentations were applied all night but gave no relief, and when morning came he walked to the hospital and was at once admitted.

CONDITION ON ADMISSION 9 A.M.

He is a stout, well-made, muscular man, a good sample of his class. Face is indicative of extreme anguish, extremities cool, abdominal muscles tense and abdomen tympanitic. No hernia; pulse 90 and small. He has an intense desire to have his bowels opened, feeling that all his sufferings would end with an evacuation. There is neither heat nor tenderness on the

abdominal surface. He has vomited once while being put in bed.

A hot fomentation was ordered to be applied to the abdomen and the following draught administered; R. Ol. Ricini. ʒss , Tr. Opii. ʒss , Aqua Ment. Pip. ʒi .

This was vomited up almost directly and was followed by frequent emesis of a greenish coloured fluid with a bitter taste and sour odour. He passed his urine easily and it was normal in appearance. The vomiting continuing brandy and ice were administered, and a sinapism applied to the epigastrium.

At noon an enema was ordered of the following; R. Ol. Terebinthin. ʒii , Ol. Ricini ʒii , Aqua O.i, but it was returned unaccompanied by fæces in ten minutes. The vomiting has increased and the extremities are becoming cold. Pulse 120 and small; sufferings intense. Hot fomentations were kept applied on his abdomen and he was rolled in hot blankets and surrounded by heated bottles. The following was ordered to be taken every three hours; R. Liq. Morph. *m.x*, Pot. Bromid. gr. xv, Muc. Acac. ʒi . Ice and brandy to be continued.

6. P. M. Appears better and has a more cheerful countenance. Pulse 100 and fuller, but he has still the same intense desire to have his bowels opened. No tenderness over the abdomen but the tympanites has increased.

8.30 P. M. Pulse failed and became very thready and quick. The vomiting has increased in frequency but has no fæcal character. He is perfectly sensible but nearly distracted with the agony of pain in his abdomen. Bismuth trisnit gr. x was given followed with pieces of ice and brandy every few minutes.

10.30 P.M. The former enema was repeated with the addition of Tr. Opii. ʒii . This remained up and gave almost immediate relief of the most prominent symptom. He was seen at this time by the visiting physician, Dr. Hamilton, who ordered a continuance of the mixture and abundant warmth.

Aug. 16th., 1 A.M. Complains less of pain; pulse barely perceptible; vomiting has ceased. There are marked signs of collapse. The enema has not returned. He is perfectly conscious but is sinking fast. He died at 2.15 A. M.

AUTOPSY 14 HOURS AFTER DEATH.

Rigor mortis strongly marked ; abdomen tense, enlarged and tympanitic, and slightly discoloured at the lower part.

On section of the abdomen a most sickening odour arose from the opening and the ascending and transverse colon appeared distended with gas and very prominent. The ascending and transverse meso colon are dark coloured with congested blood. The peritoneal cavity contains Fxii of fluid evidently consisting of the enema last given.

Thoracic Cavity.—Lungs normal and crepitant throughout. There are no signs of disease about the heart ; the right side is filled with dark clots, the left is empty. Liver and gall-bladder healthy, the latter is full and the gall duct pervious. Rectum empty and sphincter ani closed. Commencing at the lower end of the colon and extending upwards for 39 inches the gut is of a crimson-black colour externally, highly congested, and presenting on the free margin of the upper part of the sigmoid flexure a slit or tear, with narrow, thin, yet well-marked red, everted edges. This opening is $\frac{2}{3}$ of an inch in length and is directed transversely across the intestine. It appears as if cut with a sharp instrument. A lumbricoides is partly through this opening, about one-half hanging outside the gut, while on the mesentery near the perforation is a triangular piece of bone smooth and clean as if boiled.

This bone is $\frac{1}{4}$ of an inch wide at the base ; the sides are $\frac{3}{4}$ long and the apex is a thin point. The gut when slit up is coated with a black greasy slime and has a most repulsive odour. In the cæcum is a soft mass of fæces ; the ileum is empty.

(The preparation of intestine showing perforation &c., is preserved in the hospital museum)

CASE OF PASSAGE OF HAIRS IN THE URINE.

BY JAMES A. SEWELL, M.D., L.R.C.S., EDIN

DEAN OF THE MEDICAL FACULTY, LAVAL UNIVERSITY, QUEBEC.

In the number of your JOURNAL for October, 1873, I published a case of the passage of hairs, apparently from the bladder, giving rise to considerable bladder irritation. This

occurred in a child of nearly four years of age, an inmate of the Female Orphan Asylum of this city. After each discharge of urine there was found in the chamber a number of hairs varying from one to seven inches in length, and on examination under the microscope each hair showed a well-defined bulb and all the characteristics of ordinary hair. These hairs occasionally were fine, and light in color, but at other times they were coarse and of a darker hue. The number varied—sometimes there would be only six or eight, but occasionally as many as twenty hairs were passed at a time. Sometimes she would draw from her mouth several hairs, varying in color, and being from eight to ten inches in length. In order to satisfy myself as to the presence of these hairs in the water, I on one occasion caused a chamber to be well washed and dried, and then required the child to make water in my presence. The result was the same, namely, several hairs at the bottom of the vessel.

About a fortnight ago my little patient took ill, had several convulsions, and died in ten days. Up to this time no opinion could be formed as to whence the hairs came from. Yesterday, however, I made a *post-mortem* examination, assisted by Drs. Lemieux and Parke, by which the mystery, so far as the hairs in the urine was concerned, was fully solved. Unfortunately, circumstances over which we had no control prevented us from prosecuting the dissection with a view to discover the source of those hairs which were drawn from the mouth.

Autopsy.—Body much emaciated and unusually blanched. On making an incision and exposing the viscera of the chest and abdomen, these were all found particularly dry, there being not even a *moisture* on any of the organs. The stomach, intestines, liver, lungs, spleen, &c., were quite healthy. On removing the bladder and uterus, with its appendages, the former was opened and found quite normal. The uterus was very small, very soft and very flabby. On slitting up the vagina and the uterus to its fundus, we found the os highly inflamed, patulous and the lips everted; the neck of the organ and part of the body were also in a high state of inflammation, the fundus being healthy as well as the ovaries. In the body of the organ we found two hairs, each half an inch in length.

The stomach was healthy and contained no hairs. I should have remarked that the matron had noticed that during her last illness, the child had passed but comparatively few hairs. The fact, however, of these hairs being discovered, in the uterus, together with the inflamed state of that organ, proves, I think, satisfactorily that the others found in the water during the last six years or more, came from the same source. Those from the mouth, as well their source, must, so far as this case is concerned, remain a mystery.

Quebec, Dec. 23, 1877.

(We are at a loss to understand whence the hairs mentioned in the above unique case could have come from unless they had been intentionally introduced. Children, even of a very tender age, have before now acquired the habit and have practised masturbation. Several well authenticated cases are on record, and we naturally conclude that it is possible that this was a case in point. There are several facts connected with this case which give this impression. In the first place the hairs apparently passed in the urine were not always of the same colour or quality. Sometimes they were light in colour, and fine in quality, but occasionally they were dark and coarse. Again take the fact that the child simultaneously drew from her mouth several hairs somewhat identical in character to those passed in the urine, as though the child had used her mouth as a store-house in which to secrete the hairs which were subsequently utilized for other purposes. The bladder was found healthy, and contained no hairs, but the uterus was small, soft and flabby, the os uteri and body of the uterus highly inflamed, the os patulous and lips everted—a most unusual condition in a child of eight years. Then, again, take the cause or manner of her death—from convulsions. This points to a degree of nervous irritation and excitement that would very likely follow on a continuance of the pernicious practice above referred to. There were found two hairs in the body of the uterus, but whether they had any attachment, or were lying free, is not recorded. If the source of the hairs was any portion of the lining of any of the passages, from the presence of dermal tissue, it would have been apparent.—ED.)

Hospital Reports.

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

Large incised wound of the Eye-ball involving the ciliary region. — Recovery with good vision. — Reported by F. BULLER, M.D., Oculist and Aurist to the Montreal General Hospital.

On the 30th of June last M. McN., æt. 20, bar-tender, was struck in the face with a fragment of glass from the neck of a soda-water bottle which exploded in his hands whilst he was extracting the cork with a pointed instrument which bar-tenders too often employ for this purpose.

About an hour after the occurrence of the injury he was brought to my consulting room by one of his confreres. I found a superficial wound in the left cheek, about $\frac{3}{4}$ of an inch in length, extending obliquely, upwards and inwards nearly to the edge of the lower lid, another through the whole thickness of the upper lid, near its inner extremity, and a deep cut about $\frac{3}{4}$ of an inch in length at the upper and inner angle of the orbit; these three wounds were evidently all made by the same projectile which in its upward course, had also cut through as much of the eye-ball as came within its reach. Traced from below the wound of the eye-ball extended from about two lines below the cornea, near the vertical meridian, obliquely through the inner margin of the cornea and again through the sclerotic along the horizontal meridian to the extent of more than two lines. The wound in the eye-ball was thus over half an inch in length. The aqueous humour had all escaped and there was a large prolapse of iris. In addition to the prolapse of iris a dark mass projected between the lips of the wound. This I judged from its position and appearance to be a portion of the ciliary body. All bleeding had ceased and the parts were easily inspected, vision was only roughly tested, but the patient could count fingers held a short distance in front of the eye.

No vitreous had escaped. This could only be explained by

the oblique direction of the wound. It would seem that the piece of glass had cut through the ciliary ligament and separated a portion of the ciliary body from the sclerotic ; this was the dark mass that projected through the inner part of the wound. Owing to the proverbially dangerous character of wounds through the ciliary region, it became a question of primary importance how the eye could be saved without incurring the risk of sympathetic ophthalmia, obviously it would not have been safe to leave the protruded parts as they were, and the size of the wound precluded the possibility of restoring them to, and retaining them in, their normal position ; it was therefore deemed advisable to cut away the protruding portions, both of iris and ciliary body. With this object in view, the patient was brought profoundly under the influence of sulphuric ether, and with the assistance of Dr. Donald Baynes, and Mr. McDonald, (medical student), I proceeded to operate.

The prolapsed iris was removed in the ordinary way with a pair of fine forceps and scissors.

I then seized the protruding portion of the ciliary body, and cut away as much of it as could be reached, this was of course, followed by a large escape of vitreous, which was also cut off level with the wound. Only a few drops of blood were lost, but as more than a third part of the vitreous humour was lost, the eyeball became quite flaccid. Two fine silk sutures passed from within outwards, through the whole thickness of the sclerotic sufficed to bring the edges of the wound into good apposition throughout its whole extent. The skin wounds were then united by fine sutures, and as they subsequently healed by first intention require no further mention. A light compressive bandage was applied to the eye and the patient sent home in a cab as soon as he was sufficiently recovered from the anæsthetic.

At 10 p. m. the same day I found the eye slightly painful, and moderately injected, but of normal shape, and the anterior chamber restored.

Ordered atropine instillations every six hours, and cold compresses instead of the compressive bandage.

The following day the patient was removed to the Montreal

General Hospital, the eye looking well; the same treatment continued. Bowels to be kept relaxed by compound senna mixture. Milk diet and light extras ordered.

The same treatment continued till July 7th. The wound is now closed excepting at the inner extremity where there is a small protrusion of vitreous. Eye less irritable, but waters when exposed to the light, and occasionally feels painful at night.

To continue using the solution of atropia but omit the cold applications, and keep the eye closed with a compressive bandage. Patient permitted to be up during the day.

July 13th.—The little bead of vitreous has disappeared, the wound is apparently firmly united in its whole length, and the eye feels quite comfortable.

July 17th.—Removed the two stitches in the sclerotic to-day. They might have been taken away some days earlier but did not appear to be creating any disturbance and were therefore allowed to remain longer than was really necessary.

July 23rd.—The eye is almost free from injection, but flushes and waters a little when exposed to strong light. The ophthalmoscope reveals nothing abnormal, but there is iii⁺ of myopia, when this is corrected vision = $\frac{2}{3}$. The wound in the sclerotic has left a narrow dusky, reddish-blue scar, and the inner margin of the cornea is somewhat turbid.

The anterior chamber is shallow, and the removal of the portion of iris as stated above has left a large coloboma artificialis, with a slight adhesion between the upper cut edge of the iris and the lens capsule.

July 27th.—Discharged from the hospital with permission to resume his employment, but to protect the eye from light by wearing a small shade.

Sept. 13th.—The condition of the eye has remained perfectly satisfactory since his discharge, but he thinks it has become more short-sighted. This is actually the case, for a concave glass nine inches focus is now required to bring vision up to $\frac{2}{3}$. Can read fine print (*Jøeger No. 1*) from 10" to 4", showing that the power of adjustment has not materially suffered, as might have been expected after destruction of a part of the suspensory

ligament of the lens, which necessarily occurred when the exposed portion of the uveal tract was removed. The pupil responds readily to light. By focal illumination, a distinct white ridge may be seen projecting inwards towards the margin of the lens, from the locality originally occupied by ciliary processes which were cut away.

Dec. 20th.—A careful examination of the eye, which, beyond the artificial pupil and a narrow dark line in the sclerotic at the seat of injury, presents nothing abnormal to the ordinary observer, now shows a compound myopic astigmatism, which may be so far corrected by — 11 sph. \bigcirc — 24 cyl., that vision is improved from $\frac{15}{200}$ to $\frac{30}{20}$.

The white ridge in the ciliary region has a somewhat flocculent appearance, and is more distinct than at the last examination; it reaches in fact to the inner margin of the lens, and presents a correspondingly curved outline. A few dark specks are visible by mirror illumination in the inner and anterior portion of the vitreous, these whisk about rapidly when the eye moves, showing an abnormally fluid condition of the same. The myopia and astigmatism are easily verified by the ophthalmoscope. Both retina and optic nerve appear perfectly healthy.

Remarks.—That the human eye is capable of sustaining very severe injury without destroying its functions as an organ of vision, is a matter of every-day experience; there are, however, some points in the above case of more than ordinary interest. In the first place, so extensive an injury in the ciliary region would, *à priori*, render the prognosis unfavourable on account of the tendency to sympathetic inflammation of the other eye after wounds in this part of the eyeball. This tendency is generally acknowledged to be due to the irritation of those filaments of the ciliary nerves which happen to become involved in the cicatrix after healing has taken place. In the present instance, this danger was probably obviated by the complete removal of the parts carrying such nervous filaments as were likely to cause subsequent mischief in this way. The principle here inculcated may, perhaps, be susceptible of a more extensive application than might at first sight be imagined, inasmuch

as it would not be difficult to enlarge a comparatively small wound in the ciliary region sufficiently to permit of a similar operation being done, and, where the age and constitution of the patient were such as to render healing by first intention a likely event, such an enlargement of the wound would probably not prove injurious.

That a very large loss of vitreous does not by any means always entail serious consequences, is a fact already sufficiently well known. A subsequent increase in the intra-ocular tension, owing to an undue secretion of fluid to replace the lost vitreous, had not up to the time of the last observation been manifested, for the myopia, which undoubtedly became developed after the injury, can be explained, in part at least, by the alteration in the position, and possibly also in the shape of the lens; this view will also account for the astigmatism which certainly did not exist when vision was first tested after recovery had taken place. It seems only reasonable to suppose that the ciliary muscle no longer acts on all parts of the lens alike, and that this structure has gradually undergone a change in shape, and hence the astigmatism—for had the latter been due to alteration in the shape of the cornea, we might expect to find it diminish with time, just as does the astigmatism which follows certain operations for the removal of cataract.

Two cases of Colotomy in the left loin, performed for relief in Cancer of the rectum.—By G. E. FENWICK, M. D. From a report by the late J. D. CLINE, B.A., M.D.

CASE I.—The first of these two cases was admitted into the Montreal General Hospital on the 7th January, 1876. It is of special interest, inasmuch as it occurred in a child of 12 years, a most unusual age at which to meet with disease of this nature. The little girl was remarkably developed for her age, more resembling a girl of 15 or 16 years.

From the appearance of the growth it was at first taken for syphilitic condylomata, as it more resembled that condition than

epithelioma, and from the circumstances of her precocity it was regarded as more likely to be syphilitic than cancerous. It was very extensive and presented a broad flat raised surface, extending up the bowel as far as the finger could reach, with here and there intervals of healthy mucous membrane. There was no history of syphilis, nor had there ever been intercourse, judging from the appearance of the genitals, nevertheless, it was deemed advisable to place the patient on constitutional treatment—this was done, and the case carefully watched.

PREVIOUS HISTORY.—Her mother says that she has had a soreness and irritation about the anus since infancy, but she never complained of any actual pain until about six months ago, when she noticed pain and uneasiness which was increased whenever she went to stool. This was experienced at the anus and extended up the bowel; this continued after each act of defecation and lasted for several hours. A distinct lump or growth, was observed chiefly confined to the left side, and it gradually engaged the entire sphincter to such a degree that she lost the power to retain the fæces, so that her clothes were constantly soiled with fæcal matter as well as with a foetid discharge which came from the ulcerated surface. When admitted into the hospital her general condition was remarkably good. She was pale but tolerably well nourished, with, however, an expression of anxiety in her face. This probably proceeded from the anticipation of some operative measure being necessary for her relief. The little girl was placed on tonics and also was given the sixteenth of a grain of bichloride of mercury, thrice daily. This was followed up carefully and continued for some time until the specific effect of the mercury began to show itself, but without any benefit whatever; locally, the parts were kept clean and the surface of the sore at first touched with strong nitric acid, and subsequently an ointment of the protoiodide of mercury, grs. v to the ʒi was applied. At the end of five or six weeks constitutional treatment the growth was larger and more protuberant; it was extending round the anus so that two-thirds of the circumference of the gut was engaged in the mass. The discharge was constant and ichorous mixed with blood, and the

little girl was in a most lamentable condition. The diseased bowel bled readily on irritation. The mercurials were stopped and the tonics, with good diet, were persevered with. She improved in general appearance and health but the local malady steadily increased. Under these circumstances it was deemed advisable to recommend the operation of Colotomy with a view of ameliorating her condition. This was determined on because of the steady advance of the disease, it was believed that, eventually the rectum would become completely obstructed, and furthermore, the constant passage of faecal matter over the diseased mass produced great distress.

The friends having consented to the proposal, a consultation of the Medical Staff of the Hospital was summoned, and the operation decided upon. Dr. Fenwick determined to open the colon in the left loin. In performing the operation, he followed the plan formerly adopted by him and which is recommended by Bryant and other Surgical authorities. Before commencing the operation, by accurate measurement, he found the point midway between the anterior and posterior superior spines of the ilium. This was marked. He then drew a perpendicular line upwards towards the lower rib and one inch behind this point. The patient was placed on her right side with a pillow under the loin, and chloroform was administered. The operation was then commenced by an incision of about four inches in length obliquely downwards and inwards midway between the crest of the ilium and the last rib, and bisecting the perpendicular line at about its centre. This incision cut through the skin, fascia and aponeurosis of the external oblique, exposing the fibres of the internal oblique muscle. This was next divided on a director and the fascia lumborum came into view; this was likewise divided, when the fat in front of the kidney became apparent. On displacing this the colon was sought, and with some difficulty found; this was due to its flaccid and empty condition. To facilitate finding the colon the bowel was distended with air, and on carefully opening the fascia transversalis, the bowel protruded and was transfixed with two curved needles, and attached to the edges of the skin in

the usual way. The peritoneum was not injured, and the little girl recovered without a bad symptom. Her temperature never rose above 101°, which it registered the first few nights after the operation. As the wound healed the edges became somewhat inverted, so that bougies were ordered to be introduced into the bowel to dilate the opening. The mass of disease in the rectum increased in size, so that before her discharge from the hospital, which was at the end of six or eight weeks, the fæces passed entirely through the artificial opening.

Case of Cancer of the Rectum, almost complete obstruction of the bowel.—Colotomy. — Recovery. — By DR. FENWICK.—
Reported by JAMES BELL, M.D. Assistant House Surgeon,
Montreal General Hospital.

M. L., æt. 62, was admitted on the 7th November, 1877, suffering from cancer of the rectum. There is no history in his family of cancer, tubercle, or nervous diseases. All his relatives have been strong, robust people, and long-lived. The patient himself has always enjoyed good health, led a very active life, and at one time drank freely. Had an attack of inflammation of the bowels in 1844. About 12 years ago suffered from external piles, these were treated by the application of strong caustics, probably nitric acid, and with some relief. About twelve or fourteen months ago had an attack of internal piles. This gave him much uneasiness, and towards the end of June last he noticed much pain in the rectum of a lancinating character which was augmented on going to stool. It was at this time he noticed some difficulty in passing a stool. This difficulty of defecation increased, and latterly he found that he could alone relieve the bowel by using injections, the pain was such that he was obliged to take morphia to procure ease, and also suppositories of morphia were occasionally made use of.

On examination there was a large cancerous mass, within the sphincter, projecting from the left side, and completely filling the gut, the finger could not be passed except with difficulty, and this gave him much pain.

As there was every likelihood of the bowel becoming com-

pletely obstructed, and as the man's present condition was favorable the operation of colotomy was recommended for the purpose of affording relief. The operation was performed on the 8th of November, in the usual way, opening the bowel in the left loin.

There was great difficulty in finding the bowel in consequence, it was believed, of the extension of the disease to the sigmoid flexure, binding it down in its position. This was shown from the inability to draw the bowel out of the wound and bring it on a level with the surface, so that when it was attached to the skin there was a considerable strain on the ligatures, and they soon gave way, not, however, before free attachments had formed to the tissues in the vicinity. This gave rise to a certain amount of cellulitis, which was readily relieved by free drainage. The patient made a good recovery from the effects of the operation. There never was a bad symptom throughout. The temperature on the morning after the operation registered 99, at which it steadily remained for the first four days, after which it became normal in the morning, with a slight elevation at night; his pulse was never over 96, but more frequently it was in the neighbourhood of 76. Unfortunately, a bed-sore formed over the sacrum; this retarded the progress of the case, but before he was discharged from the hospital the bed-sore was healing and he had greatly improved in strength.

In the remarks made at the time of the operation, Dr. Fenwick said that the comfort afforded to patients in this lamentable condition by the operation of colotomy, was attested by all practical surgeons. He believed that in cancer of the rectum, colotomy should be performed at an early date; the pain and misery consequent on each evacuation was very distressing. The patient leads a life of misery; there is constant dread of going to stool owing to the burning pain which is experienced during the passage of the fæces over the ulcerated surface. This has to be relieved by morphia,—and, in the present case, the patient had for some time past taken as much as a grain and a half of morphia three or four times a day. This gives

only temporary relief, and the continued use of such large doses of morphia must interfere with the processes of assimilation and digestion. If, on the contrary, you afford an artificial outlet for the passage of the fæces, you give instant relief, so that the patient is placed in a more comfortable condition, and thereby life is prolonged.

Reviews and Notices of Books.

Contributions to Operative Surgery and Surgical Pathology.—

By J. M. CARNOCHAN, M. D., formerly Professor of Surgery in the New York Medical College, with illustrations drawn from nature. Parts i. and ii.; 4to.; pp. 64. Part iii., pp. 38.—New York, Harper and Brothers, publishers, Franklin Square. 1877 and 1878; Dawson Brothers, St. James street, Montreal.

It appears from the preface that this work was commenced some years ago, and had reached the completion of the fourth number when fire destroyed the establishment of the printer, and plates, drawings and lithographs were lost. This explanation is rendered necessary, because the reader will find, after the dedication of the work to Samuel D. Gross, M. D., &c., of Philadelphia, an epistle, which by the way is without date, addressed by the author to Valentine Mott, M.D., LL.D., and which having been printed during the life-time of that Surgeon, is still retained by the author, from sentiments of great regard for his memory. The author then gives an introductory address on the study of science, which he delivered before his class, when he occupied the Chair of Surgery in the New York Medical College. The subject matter of the work then follows, and we have as a first paper, remarks on the treatment of Elephantiasis Arabum by ligature of the main arterial trunk, the branches of which are distributed to the hypertrophied tissue. This method of treatment has so fre-

quently been practised, and its results are so satisfactory and so well-established, that the efficiency of such a curative method can no longer be doubted.

It is to the author that the Surgical world is indebted for this suggestion, a method which he carried out in practice with success as early as 1852. From that period up to 1858, the author had practised ligation of the main trunk of the artery in four cases with relief in all. The literature of this subject is given in a table of cases, 32 in all, with the following results: There were 16 cures, 12 relapses, 3 deaths, and one case in which amputation had to be practised. In this table, which embraces the records of cases in the practice of other surgeons, we observe an absence of all reference to a case of Elephantiasis of the leg, operated upon by ligation of the femoral artery by Dr. McCallum of this city, and which was the first case operated on after the publication of Dr. Carnochan's paper. The result as far as the elephantiasis goes was quite satisfactory. We have been promised the notes of this interesting case, and hope to publish it in our next. We have reason to believe that the particulars of the case were sent to Dr. Carnochan by Dr. McCallum.

The next paper is on ligation of the trunk of the common femoral artery in relation to secondary hæmorrhage following amputation of the thigh, and also in hæmorrhage from wounds of the plantar arteries and of the anterior and posterior tibials. This fasciculus is illustrated by two lithographs beautifully executed, one representing a case of Elephantiasis Arabum of the thigh. The second represents elephantiasis of the face and neck, in which the author ligatured both common carotid arteries at two operations, six months being allowed to elapse after the first operation. Figure 1 represents the appearance of the patient before operation, and figure 2 her condition eight years after the ligation of both carotids. These plates are highly finished and give an excellent idea of the wretched condition of the patients when they first consulted Dr. Carnochan.

Part III. forms the second fasciculus of these contributions. In this the author describes two cases of successful removal of

the entire lower jaw. In the first case the operation was undertaken for necrosis and caries of the jaw. The operation was performed at one sitting, and the author remarks that previous to the date of this operation, 13th July, 1851, he is not aware that the entire lower jaw had ever been removed with success.

In the second case the operation was completed at two different times. The patient, a woman, suffered from an osteo-fibroid tumour attacking the left side of the inferior maxilla, for which she was operated upon in 1861. The bone being divided opposite the first bicuspid, and disarticulated at the left condyle. A good and rapid recovery followed, but the disease returned, within six months, in the end of the bone at its sawn extremity. In May, 1864, this patient consulted Dr. Carnochan, and at that time he found that the entire body of the bone and the horizontal ramus presented a spherical tumour as large as two fists. This mass Dr. Carnochan subsequently removed, together with the remaining portion of the bone, disarticulating at the right condyle. The patient recovered and the motions of the tongue remained, general and special sensibility was unimpaired, and the voice, deglutition and speech were unaffected.

The next paper consists of general observations on Shock and Collapse and the primary treatment of injuries, with remarks on the time of election for capital operations after extensive lesions. This is a very interesting paper and the author goes fully into the etiology of these injuries, and also into the analysis of special symptoms following shock, physiologically considered. There are two excellently finished plates in this fasciculus, and we must, in justice to the author, commend his perseverance and determination of publishing these observations after the severe loss hinted at in the preface to this work. It is a work of special interest to all practical surgeons, and few there are who take any interest in this department of the healing art, that can afford to be without a copy. It is to be had of Dawson Brothers, St. James Street.

Public Hygiene in America.—Being the Centennial Discourse, delivered before the International Medical Congress, Philadelphia, September, 1876. By HENRY BOWDITCH, M. D., with extracts from correspondence from the various States, together with a digest of American Sanitary Law, by HENRY G. PICKERING, Esq. Svo. pp. 498. Boston: Little, Brown & Company, 1877; Montreal: Dawson Bros., St. James Street.

This work is an elaboration of the Discourse on Public Hygiene, delivered by the author before the International Medical Congress, held in September, 1876, at Philadelphia. In an abridged form, it has already appeared in the transactions of that meeting. We are, however, very much indebted to the author for publishing this valuable treatise in its present shape. The address opens with remarks on the importance of the subject of Public Hygiene, and the author alludes to the fact that, in most countries, people seem to have awakened from their stolid indifference, only within a very few years "Hitherto, little or no attention has been paid to Hygiene, except when under the influence of some frightful epidemic, the panic stricken nations have been aroused from their usual apathy, and have then vainly tried to resist the pest by drugs, by appeals to the gods whose laws they have never studied, or perhaps, by legal enactments." This sad experience has opened a new field for research, and now is seen the endeavour to systematize the study of the causes of disease, with a view to its prevention, by the removal of those causes. This has developed a new department of the science of medicine, which, with the full concurrence and power of the State, the author designates "State Preventive Medicine." Thus is seen "the State," as a student of the causes of disease entering with heart and soul into the controversy, while the practice of medicine and surgery in the resistance of disease, by appropriate drugs, and other means, is left to the schools and to private practitioners.

Tracing the progress of this subject in his own country, the

author divides the past centennial period into three unequal epochs. The first, dating from the political revolution, extends to the year 1832, during which certain systems of medicine, dogmatically asserted, point to a belief in drugs, and the almost supreme power of our art, while the *vis medicatrix nature* was entirely ignored; The second epoch shows a more exact system of scientific observation of facts and their analysis, which led to a degree of scepticism of the value of the art, so haughtily vaunted previously, a disregard for drugs and a profound reverence for nature and her laws. The third and last epoch of our author had its origin in 1869, when the first State Board of Health was established. The author admits, with regret, that this awakening was due more to the exertions of the laity than to the profession, and specially mentions Samuel Shattuck, Esq., of Boston, who, as early as 1850, wrote a report of the Sanitary Commission of Massachusetts, in which he suggested the appointment of a State Board of Health. This, however, was not acted upon until nearly twenty years had come and gone.

Although the author fixes the commencement of the third epoch in his division at the year 1869, we must not suppose that sanitary science was entirely ignored up to this time, as he points to the fact that a National Sanitary Convention was held at Philadelphia in 1857, the following year the meeting took place in Baltimore; in 1859 the Convention met in New York, and again in Boston in 1860, when the war broke out, which put a stop to these proceedings. But more than this, during the war sanitary work was systematically carried on, and many, if not all, the Surgeons employed in the struggle, fully recognised the superior advantages of the prevention of disease over the cure of it. So that, although the commencement of the third epoch is dated by our author in 1869, when the first State Board of Health was constituted, yet that date was not the dawn of sanitation in the American Union. The author shows how wide-spread is the public interest in the questions of hygiene, but this state of public feeling is not confined to the United States of America, but is very general the world

over. Sanitary laws are more thoughtfully studied and sanitary measures are gradually being introduced into all the States and Territories of the Union, although, as our author remarks, there are some "not as yet sufficiently enlightened to appreciate the duties devolving upon them, to be careful of the health of their people." The author then gives the results of twenty specific questions which he addressed in the form of a circular to 263 medical men besides 21 other persons residing in 48 different states and territories, each having a separate government of its own. This circular was sent in every instance to representative men, and he received answers from 179 correspondents, their replies, in many instances were full in detail, but the large majority of them were meagre. The questions cover the ground of matters of interests in a sanitary point of view, but the answers lamentably display a lack of interest in these matters which are of such importance to the welfare of the people generally.

This proves the vital necessity of a different system to be adopted. Sanitary questions are of such importance to the entire country that they should be dealt with by the Federal power and not by the different States. Nor does it appear to us that any good will accrue by leaving this matter in the hands of the State governments. They should, in our opinion, supplement the action of the Central government, but sanitary laws of each State, to be effectual and beneficial, should emanate from the Central government, and be the same in New York as in Louisiana, in Maine and Florida, always permitting of certain special enactments to suit the different conditions of locality. Take, for instance, the question of registration of births, marriages and deaths. If a uniform system prevailed throughout the country, then indeed could valuable and reliable statistics be compiled. This question has earnestly engaged our attention in relation to our own Dominion, and we hold that it is a subject to be dealt with by the central government and not to be left to the local legislatures. It is not a municipal matter, but one on which hinges the very essence of all sanitary inquiry.

In the Appendices I, II and III, will be found the Circular which was addressed to the various correspondents and the answers, or rather extracts from correspondents' letters. Appendix IV. consists of a digest of American Sanitary Laws, passed by the several States and Territories from their admission into the Federal Union to the present time. This has been prepared, at the request of the author, by H. G. Pickering, Esq., Counsellor-at-Law.

This treatise is a valuable and important addition to the literature of the subject, and, as a work of reference, will be freely consulted, as there is to be found in its pages matter which will be vainly sought for elsewhere. It is a strong protest against apathy and neglect, and gives an unvarnished account of the State of Sanitary Affairs in the American Union. It is to be had of Dawson Brothers, St. James street.

Hospitals—their history, organization and construction.—

Boylston Prize-essay of Harvard University for 1876. By W. GILL WYLIE, M. D. "An ounce of Prevention is worth a pound of Cure." 8vo. pp. 240. New York: D. Appleton and Company, 549 and 551 Broadway, 1877.

This is the Boylston Prize-essay of Harvard University for the year 1867. The work consists of eleven chapters, beginning with the origin and development of Hospitals, and continues on in the second chapter to the consideration of the relations between hospitals and pauperism. Tracing the history of the origin of Hospitals, the author gives some interesting details, proving that hospitals are not an outgrowth of the introduction of Christianity. It may be believed that the Phœnicians, Greeks and Egyptians possessed or constructed hospitals for the relief of the sick and distressed. The ancient Egyptians had regular medical officers paid by the state, and according to M. Chabas, there existed a College of Physicians amongst them in the eleventh century before the Christian era. These officers were paid out of the public purse and the law regulated the nature and extent of their services.

The divine art, as it was termed, was regarded as a gift of the gods, and was apparently alone practised by the priests; for on the walls of the temples of Egypt and Greece were seen suspended tablets describing the cures that were effected by the priests, together with recipes and invocations to certain of the gods for certain ailments. From these tablets can be traced a strange mixture of rational medical treatment, and the employment of charms and incantations. Here also can be traced the dawn of scepticism in the efficacy of charms and prayers, leading to the waning power of the priest, and increasing faith and dependence in the skill of the physician.

In Egypt the science of medicine attained a high degree of perfection; there were specialists amongst them, each practising his own branch. In the medical papyrus at Berlin can be found a treatise on inflammation. This is a copy of a more ancient record, and dates back almost to the time of Moses. The Egyptians boasted of Oculists and Dentists. Mummies have been found at Thebes with their teeth plugged with gold, and there are to be found papyri devoted to diseases of the eye; and also to mental diseases. It is very doubtful whether the temples were not in verity a species of hospital and we have evidence of it in Sacred Writ that in the time of the blessed Saviour the sick were brought unto him in the temple and synagogues, and he healed them. That hospitals existed in India several centuries before Christ is evidenced by inscriptions cut on the rocks which still remain, and also by an edict promulgated by King Asoka in the fourth century B.C., commanding the establishment of hospitals throughout his dominions.

On this continent there is evidence that hospitals existed amongst the Mexicans and Aztecs, which points forcibly to the Phœnician origin of those people. The hospitals established by the Mexicans were for the care and nurture of wounded soldiers.

Public dispensaries existed at Athens several centuries before the Christian era. The sick poor resorted to those dispensaries to be treated by the slave doctors, who received

their pay from the State; and the poet Crates, about the fifth century B.C., speaks of a hospital which was, it is supposed, situated in the Piræus. We must believe that the establishment of hospitals has not been confined to any one age, nor have they originated in any one nation, but are the natural result of that repugnance to witness suffering, and that tender compassion found in the hearts of most men, and which induced the Samaritan to bind up the wounds of the Jew, to set him on his own beast, to take him to an inn, and pay the good man of the house for his care and sustenance.

In Ireland, according to the annals of Clonmacnoise, a plague broke out among the people of Parthalon. These congregated on a plain at or near the mouth of the Liffey, and there some nine thousand men and women died of the plague in one week. These people had come there to be treated and cared for, also to sun themselves. This occurred, according to the annals of the Four Masters, about A.M. 2900. But there is further evidence of the use of a house near the palace of Emania which was erected 300 years B.C., during the time of the heroes of the Crimson Branch, an establishment similar to the Asclepia of Grecian history. This house was called Broinhberg, or "house of sorrow," and was in verity a hospital in which sick and wounded soldiers were cared for.

In discussing the relations of hospitals to pauperism, the author points to the danger of giving relief where it is not actually needed, thereby creating a sense of dependence where none should exist—leading to improvidence; and he remarks: "When a king was the State, he could give to the poor, and receive love and loyalty in return; but now, the people, the voters, the paupers themselves, are a large part of the State, and paupers take their alms from the State as a *right*." We can only remark that such a condition of affairs ought not to exist,—nor do we believe even in the author's own country, where universal suffrage is found, that it does exist.

In Chapter III. the author passes on to the subject of Organization and Management. In this chapter he touches upon the value to the physician or surgeon of hospital appointments;

he also pays a high tribute to the humanizing influence of women attendants. Although he admits that men can perform all the offices of supervising, house-keeping, nursing, &c., yet he remarks that "an institution so governed will be wanting in one of the most desirable and essential particulars, namely, that gentle and refining moral influence which is seldom found outside of the house kept in order by a woman."

In Chapter IV. the author discusses the subject of the Construction of Civil Hospitals,—and, in point of location, he prefers to see such institutions in spacious grounds, beyond the limits of a city, though he fully recognises the many objections offered to such a location, specially in large cities. With regard to the construction of buildings, he concludes that "for the treatment of all classes of patients, it is desirable to have every ward in a separate one-storied pavilion." The author next considers the number of beds in each ward consistent with economy for nursing, and also gives the cubic air space which should be allowed to each patient.—"About eighteen hundred cubic feet of air space with a surface area of 124 square feet has been adopted as the space required," this is for medical wards, and for surgical wards, the allowance should be, according to our author, 2160 cubic feet and 3600 or double the cubic area in wards for dangerous cases.

Chapter V. is on warming and ventilation, and many practical hints are to be gathered from this chapter. There is a chapter on pay patients and also one on isolated huts to be used in certain important operations, as in cases where Ovariotomy is undertaken. There is a chapter on the improvement of hospitals now in use, and the last chapter gives a general view of the various plans of hospital buildings at present in use. This little book is well worth perusal. It contains a large amount of interesting and instructive material and should be in the hands of all persons interested in the erection and construction as well as the management of these institutions. It can be had of Dawson Brothers, St. James street.

Extracts from British and Foreign Journals.

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

Cases of Antiseptic Surgery.—Mr. Lister dressed a case in which he operated five days previously for the removal of a large tumour of the thyroid gland. A large portion of the tumour passed backwards between the trachea and œsophagus, and had to be removed by scooping it out from its capsule. It being found impossible to arrest the hemorrhage by ordinary means, the cavity was stuffed with boracic lint previously steeped in carbolic lotion. Mr. Lister stated that two days after the operation, the wound became putrid, with some feverishness and constitutional disturbance; and he explained this as being probably due to the boracic lint with which the wound had been stuffed. From former experiments, he has proved that boracic acid is not fatal to all forms of organisms; and it appears possible that, in preparing the lint, some septic particles may have become entangled in the boracic crystals, and, not being destroyed by them, had thus escaped the action of the carbolic acid. The wound is, therefore, no longer dressed under the spray, but simple boracic lint dressing is used.

In another case, of incision of the thyroid, the operation was performed three weeks ago. Here an unilateral tumour had been removed, which also passed between the trachea and œsophagus. There has been no suppurative or inflammatory disturbance; the wound is now healed, and the patient is going about the ward.

A New Operation for Fracture of the Patella.—In a case of transverse fracture of the patella, Mr. Lister cut down on the fragments, opening the knee-joint, cleansed the surfaces of the fragments, and, having established an independent drain of horsehair for the knee-joint, drilled the two portions of the patella and tied the fragments together with silver wire, and then closed the wound, which was also drained with horsehair.

This operation was performed six weeks ago ; the wound, as exposed to-day, was seen to be completely healed. the ends of the silver wire projecting through the scar. The highest temperature that had occurred was 100° Fahr. on the morning after the operation. There has been no disturbance, constitutional or local, and both the wounds healed in about a fortnight.

The limb will be kept at rest for another fortnight, when, if union has taken place, the wires will be withdrawn.

Removal of Tumour from the Larynx.—The patient was admitted suffering from a tumour of the size of a hazel-nut, apparently attached to the anterior part of the vocal cords.

A fortnight ago, Mr. Lister operated, dividing the cricoid cartilage and upper three rings of the trachea, and was thus enabled to see clearly the vocal cords from below, and found that they were both affected from end to end. After putting a tightly fitting tube into the trachea, to arrest hemorrhage and enable the patient to breathe, he divided the thyroid cartilage in the median line, and clipped away the vocal cords, both true and false.

The wound is now for the most part healed, except at its lowest part, where a small communication with the trachea still exists ; when this opening was closed, the man was able to cough and speak with a distinct but gruff voice.—*British Medical Journal, December 15th.*

Malposition of Testis.—By A. W. Stocks, M.R.C.S. Eng., Salford.—This interesting case is brought forward rather on account of its rarity than for its being of any great or special practical value. The subject of the peculiarity is a young man aged 24, a policeman, the father of three children. He always fancied that he had only one testicle, and it was only some months ago, when he received an injury to the abdomen in the execution of his duty, and became troubled with symptoms of hernia, that the true nature of his condition was discovered.

The left testicle, which is fully developed, occupies the whole of the normal scrotum, the raphè being placed exactly in the

middle line of the testicle, as if it were the natural condition that it (the scrotum) should be occupied by a single testicle only, whereas the raphè usually occupies a position midway between the two testicles. The right testicle, which is only partially developed, occupies (as is shown in the photographs which I have the honour to pass around) a pouch or additional scrotum, separate and distinct from the scrotum proper, situated between the scrotum and the right thigh, and lies upon the descending ramus of the right pubis. The right spermatic cord leaves the abdomen by the usual route through the external abdominal ring, and can be traced down to the abortive gland. A hernia, at the time of the injury above referred to, was protruded from the abdomen and followed the course of the misplaced spermatic cord. This is completely relieved by the application of a truss.

Four cases of irregularity in the progress of the testicle have lately come under my observation.

In the *first*, no testicle ever descended into the scrotum of a youth, aged 19, who died of a large lympho-sarcomatous tumour in the abdomen. Both testicles, which were only partially developed, were found after death resting on the brim of the true pelvis near the bifurcation of the common iliac artery. In this case both inguinal canals were pervious throughout the whole course.

In the *second* and *third* cases, the testicles, one on the right and one on the left side, were retained within the abdomen, and in both instances a hernia had descended through the patent canal.

The *fourth* case is the one before us.

It would appear, from a consideration of these abnormalities, that the changes which occur during the development of the body have a distinct relation to, and a mutual dependence upon, each other, even where there seems to be little, if any, connection, vascular or otherwise, in the parts implicated in those processes. Thus, in the second and third instances mentioned, the closure of the inguinal canals seems to have been interfered with by the non-transmission of the testes through them.

In the present case, the remarkable irregularity in the course which the testis took in its endeavour to reach its proper destination seems to have depended upon the arrest in the development of the testis itself, and, in the other instances, the patency of both inguinal canals does not seem to have a more rational explanation than that it depended upon the non-descent of the testicles into the scrotum, and their retention in the abdomen was influenced by the non-development of the glands themselves. —*British Medical Journal*.

Paracentesis.—Importance of Preserving a Vacuum in the Pleural Cavity.—ROBERT J. LEE, M. D., F. R. C. P., in the *British Medical Journal* of Dec. 8, remarks on this subject.—There is one important principle on which, it will be allowed, the successful treatment of empyema and hydrothorax depends in those cases which have required the insertion of the drainage-tube, or where any other plan for preserving an opening into the pleural cavity has been adopted. If we consider the effect of making an opening by which air is admitted into the pleural cavity, we perceive that the expansion of the lung is more or less diminished so long as this opening remains patent. We also perceive that, if the opening be of such dimensions that the air which passes into the pleural cavity is greater in volume than that which passes into the lung in inspiration, there is practically no expansion of the lung and its functions are destroyed. It is evident that, in order to obtain perfect expansion of the healthy lung, there must be no communication between the pleural cavity and the external atmosphere, for the effect produced even by a small opening is very considerable. If we wished to ascertain with accuracy the extent to which the expansion of the lung would be diminished by inserting a tube into the pleural cavity, we should have to consider two important points, in addition to those which would enter into the question if the pleural cavities were independent of one another, and the minute air-tubes were non-elastic. By admitting air into one pleural cavity, we disturb the equilibrium which exists between them when both are closed. We also

liberate the force which the tissue of the lung possesses, in virtue of its elastic character, on the side from which atmospheric pressure is removed.

Supposing that the tube which is inserted be very small, in comparison with the aperture of the glottis, the elasticity of the lung will produce such diminution in its volume as to admit a certain quantity of air into the pleural cavity, which must remain, unaffected by the movements of respiration. The resistance offered by a very small tube would be such as to produce but little effect, compared with that which would be produced by a tube of such diameter as that usually employed in cases of paracentesis of the thorax.

When we observe that the tube used for laryngotomy is of sufficient diameter to admit the air necessary for ordinary respiration, it is evident that the drainage-tube will allow such an amount of air to pass through it as almost, if not quite, to annul the forces exerted on the lung by the various muscles of respiration. These considerations enable us to perceive how important it must be to bring the force of atmospheric pressure to bear upon the lung, when it has been compressed by pleural fluid; and we discover the objections which present themselves to the method of treatment of empyema by the insertion of the drainage-tube. We also perceive what may be urged against the method of treatment with the aspirator, the most important of which is the too brief duration of the force exerted upon the pulmonary tissue. We see what advantages belong to both methods of treatment, and some plan, combining a permanent opening for the escape of fluid with the power exerted by the aspirator, suggests itself as reasonable and consistent, and for such a plan I propose the term "continuous aspiration."

The apparatus constructed for this purpose consists of two parts, one of which is attached to the thorax, so as to cover the orifice of the drainage-tube; the second being connected with the first, and used for the purposes of exhaustion. The former may be made of Ivory or India-rubber, in the form of a small hemispherical cup, with a broad grooved margin or phlange to obtain adhesion. The second part is a double-valved ball of

caoutchouc, of considerable thickness and elasticity, by which the cup may be exhausted and fluid removed.

The amount of atmospheric pressure which may be brought to bear upon the condensed lung will depend upon the expansile power of the exhauster. In the earlier experiments which were made, one of the self-acting elastic cups used for cupping was employed. Subsequently, an exhausting syringe was attached to it; and finally, the arrangement constructed by Mr. Banks for Messrs. Maw, Son, and Thompson.

A suggestion of my friend Mr. Napier, to employ the respiratory movements of the lowest part of the thorax as an exhausting power, I hope, will prove successful. In the apparatus which is exhibited by Messrs. Maw & Co., the ball-exhauster is intended to be worked by hand-pressure.

It is almost unnecessary to point out that the pathological condition of the lung must determine the amount of pressure which may be exerted. Practically it will be found that the exhaustion of the pleural cavity may be carried much further than would be supposed possible without producing any sense of tension or discomfort, and, provided that the surface of the thorax is unaffected by the pressure of the cup, the apparatus can be worn without difficulty or constraint.

There are other uses to which this apparatus may be applied, in conjunction with the single drainage-tube: such as large abscesses of the abdomen, etc. I have omitted any reference to the various pathological conditions which are met with in empyema, and have avoided any depreciatory remarks on the ordinary surgical treatment of the disease. A careful consideration of several *post mortem* examinations, and the satisfactory results obtained in the cases of children in which I have used this method of treatment, leads me to introduce it at a meeting of the Association when the subject of paracentesis is to be especially discussed.

Aneurism of the Aorta, Innominate, Subclavian and Carotid Arteries treated by Double Distal Ligature.—

On the 13th of November the members of the Royal Medical and Chirurgical Society were much interested in a paper read by Mr. Barwell upon a case of aortic and innominate aneurism successfully treated by ligature of the subclavian and carotid arteries. The patient, who was shown to the society, was a man, *æt.* 45, and was admitted into Charing Cross Hospital, under the care of Dr. Pollock, July 24, 1877, with a large aneurism at the right root of the neck. He had been engaged in very laborious work at a foundry. Family history good, and no history of syphilis. In November he was seized with vomiting and purging after a drinking bout, followed by rheumatoid pains, which continued in right arm. The swelling first appeared in March, 1877, with weakness and occasional numbness of the right arm. The tumour was oval just above the right clavicle, extended from beneath the inner margin of the left nearly to the outer margin of the right sterno-mastoid, and upward to the lower margin of the thyroid cartilage. It projected considerably, and its strong pulsation was characteristically expansive. There was dulness from the inner third of the clavicle over the first intercostal and second rib, and this mingled with the cardiac dulness. Pulsation was felt on this space: the heart was displaced to the left and a little downwards; and the veins of the right side of the neck and chest, and of the arm, were greatly distended. No bruit at the heart or over the tumour, and no difference between radial pulses. Dr. Pollock treated the case with rest, low diet, digitalis, and ice-bags to the tumour, but the aneurism increased. On deligation being proposed the patient left the hospital, but returned on the 13th of August and wished to have it performed. By this time the tumour had increased so much as to measure horizontally over limits of pulsation four and a half inches by compass and six by tape; and it extended above the middle of the thyroid cartilage, measuring in that direction over three inches. The breathing and circulation were much embarrassed, and there was a slight

cough. On the 14th, the operation was performed, first on the carotid. A very large superior thyroid, simulating prolongation of the sac upwards, necessitated great caution, and there was only room enough to pass a ligature round the common carotid between the aneurism and the bifurcation. The subclavian artery was then reached, and a ligature was passed round it. In disengaging the catgut, a vein above the brachial plexus was ruptured, and the filling up of the wound with blood made its ligation difficult and doubtful. Without waiting, therefore, to verify the isolation of the artery, Mr. Barwell knotted the catgut loosely, stuffed the wound firmly with antiseptic gauze, and had the patient carried to bed, the radial pulse still beating. The next day the gauze was removed, the loose ligature (which was found to include a nerve of the plexus) was left in its place, and a fresh one passed and tied. Both these operations were performed antiseptically. Low (milk) diet was ordered.—15th. Breathing and circulation much relieved; temperature normal.—23rd. Cervical tumour harder and smaller, and thoracic pulsation barely perceptible.—25th. Ordered a dry diet.—28th. Patient suffers from thirst; pulse 102; temperature irregular, radial pulsation disappeared; tumour little larger.—Sept. 3rd. More nutritious diet, with one pint of beer daily.—5th. Temperature and pulse high and irregular; tumour harder and not so large as on last measurement. On the 8th, 9th, and 10th the size of the tumour gradually diminished. On the 9th, temperature 96° , and afterwards continued normal.—Oct. 21st. Patient has gone on well since the tumour began to rapidly diminish, and now a firm solid tumour, about the size of a cob-nut, lies behind the sternoclavicular joint, with pulsations continued from the aorta. No thoracic pulsation, and the whole aneurism is consolidated. Mr. Barwell remarked that the aneurism doubtless involved the aorta innominate subclavian, and carotid, and was not far from bursting. The operation gave immediate relief, and evidently the system of diet had contributed to the successful result. The whole of the subclavian is obliterated, and no radial pulse remains. That aneurism of the innominate artery may be

cured by double distal ligature has not yet been proved, as out of the six operations that have been performed two were soon fatal, and two were fatal in a few weeks. Dr. Silver testified to the great improvement effected by the operations. He was, however, doubtful, whether the carotid was implicated or not. Judging from the *post-mortem* appearance of a case that came under his own observation some years ago, he thought that the chief part of the swelling was dilatation of the innominate. Nor did he think a complete cure had as yet been effected, although probably the little pulsation and swelling which remained would disappear in time. Mr. John Wood congratulated Mr. Barwell on the successful issue of his case, and confirmed his statement with regard to the advantage of a non-liquid diet in such cases. He, like Dr. Silver, was not quite sure the aneurism was completely cured. With regard to the use of the catgut ligature, he thought that under the circumstances the ordinary ligature would have done as well. Dr. Barclay also spoke in favour of the dry diet, but said that unfortunately it was not every patient who would submit to the treatment. Dr. Douglas Powell agreed with Dr. Barclay as to the temperament of the patient being a main element in curing those cases by rest and diet. He asked Mr. Barwell whether any sphygmographic tracings had been taken; and whether the aneurism caused any pressure symptoms. Mr. Barwell, in reply, said that as the patient had previously undergone medical treatment without much relief, he did not think that anything short of surgical interference would have saved the man's life. The height to which the tumour extended in the neck pointed, in his opinion, to the carotid being involved. The swelling that remained was no larger than might be expected from the complete coagulation of the aneurismal contents; and the great diminution in its size could only be accounted for on the view of its complete consolidation. Of course, rupture might hereafter take place from further extension of the aneurism, as in Mr. Heath's case (which was aortic only), and in which four years elapsed between the date of operation and death. No nervous symptoms of any account followed the ope-

ration. No sphygmographic tracings were taken. The rapidity with which the wound healed, and the secondary hæmorrhage were strong points in favour of the catgut ligature.—*The Doctor.*

A Clinical Lecture on Colotomy. —

Delivered in University College Hospital, London.—By CHRISTOPHER HEATH, F.R.C.S., Holme Professor of Clinical Surgery. GENTLEMEN.—During the last year, you have seen in the wards several cases of disease of the rectum, in more than one of which I have performed colotomy. We again have a similar case, on which I intend to operate on Wednesday; and, therefore, I thought this a suitable opportunity for making some remarks on the operation.

Many of you, no doubt, will remember the case of the man M., who was in the hospital towards the end of last year. He was a man fifty-eight years of age, of blanched cachectic appearance, who had suffered severely for some time from cancerous ulceration of the rectum; and, shortly before he was admitted, fæces had found their way into the bladder. On admission, we found him suffering "great pain, with fæces in the bladder and blocking up the urethra; and, if this state of affairs had been allowed to continue, no doubt the fæces would have formed the nucleus of a vesical calculus. The patient was admitted on December 27th, and on the 29th colotomy was performed in the left lumbar region. Immediately afterwards, the fæces ceased to pass into the bladder, and were all passed by the opening in the loin. The patient convalesced slowly, but fairly, and left the hospital in the following February. When first the operation was performed, he was troubled for a time by urine finding its way into the rectum. He was, therefore, placed on a Hooper's bed, so that the urine might gravitate into an utensil beneath. On calling at his lodging to day, on my way to the hospital, I found that lately the urine had begun to escape by the artificial anus; and, when I passed my finger into the rectum, I found it more obstructed than on the last examination. It is probable that the cancerous mass there has

increased and blocked the anus, so that the urine regurgitates through the rectum, and so out at the wound; in fact, the rectum and bladder in this case are one common cloaca. By diverting the fæces from the rectum, we relieved the man of the suffering caused by the obstruction, which, at his time of life, would soon have proved fatal. At best, he cannot live many months; but he will at all events, end his days in peace.

The woman now upstairs was admitted last week, with nearly complete obstruction of the great bowel. She is extremely emaciated, having nearly starved herself to death; the pain she suffers from the obstruction being so great that for some time past she has taken next to no food. This is not a case of cancer, but of constriction due to ulceration, probably syphilitic. She is married, and her history is that, ten years ago, she began to be troubled with habitual constipation and pain at defæcation. She noticed that her stools were very small in calibre, and was told she had stricture. There is no family history of cancer. She has had two children since the stricture existed. She has had no miscarriage. Thus, you see, the history is obscure, but at all events not cancerous, and there is no reason why her life should not be prolonged in comfort by the operation.

Of other cases of colotomy you have seen, one was that of a woman who was operated on last year, and who had a great mass projecting in her rectum, evidently cancerous. The only thing remarkable about this case was its unfortunate termination soon after the operation, which was on July the 5th. On the following day, symptoms of peritonitis set in and the patient died on the 8th. The operation was easily performed, and there was no unusual pulling about of the intestine. No *post mortem* examination was held, but I am certain that the peritoneum was uninjured in the operation.

Putting together the different cases in which I have undertaken the operation, I find that, out of twenty-two cases, eight proved fatal and the rest lived variable lengths of time, the operation not being the immediate cause of death. This is a good average, considering that the nature of the cases were so bad especially those of obstructiona. The other cases were for

ordinary cancer without obstruction, and for communication between bladder and rectum. One case was that of a lady with pelvic abscess after a confinement. The abscess seemed to have opened up a communication between the bladder and rectum, so that fæces entered the bladder, blocking the urethra, and rendering the patient's life miserable. I performed colotomy in the left loin in 1872, and she is now quite well. She has little inconvenience, passing her motions by the opening in her side, and no one about her having the slightest idea that anything is wrong.

The bulk of the operations are performed for cancer, with more or less obstruction. If there be no present obstruction, then you do it for the impending obstruction or for the painful ulceration. Nothing is more painful than this ulceration of the rectum. The patient lives a life of agony, continually suffering from a hot, burning pain. Morphia may be given, but it affords no permanent relief; and the patient dies, either out of health from constant use of the drug, or from exhaustion. If you divert the fæces from passing through the rectum, you at once relieve the patient's suffering, and undoubtedly prolong life, one of my cancer cases living two years and nine months after the operation.

Of syphilitic ulceration of the rectum, Mrs. K., whom you may have seen in the ward occasionally, affords a good example. In her case, the syphilitic ulceration is not primary, for that form is rarely met with, but tertiary; and tertiary ulceration of the rectum is much more common in women than in men, in the proportion of five or six to one. In them the disease seems to bear some relation to the vagina, as if the poison infiltrated through its wall into the rectum. First, there is painful ulceration, and, after that is well, it is followed by inveterate stricture of the bowel. Thus Mrs. K. had ulceration, with more or less stricture; and everything had been done, but nothing would cure the ulceration. I therefore performed colotomy, and it was followed immediately by great relief. But her's is a peculiar case, part of the fæcal matter still passing by the anus. Being anxious to know if this really were the case, I took her

into the ward for a few days, to be closely watched by the nurses, and they confirmed her statement, It is difficult at first sight to understand how this occurs, the two openings being so completely apart; but I have noticed the same thing in one or two cancerous cases, and this is, in fact, the only drawback to the operation, and fortunately it is by no means constant.

The cases of stricture are the most formidable when the disease gives rise to complete obstruction. Now, obstruction may be acute or chronic. Acute is caused by some twist or band in the small intestine; but it is in chronic obstruction that colotomy is called for, because it is most frequently due to cancer of the sigmoid flexure. It is important, when called in to a case of this kind, to diagnose the state of affairs at once and the great thing is to ascertain if there has been a gradual, increasing difficulty of defæcation. That is sometimes not easily made out, especially in women; but, if you question closely, you will generally find that there really has been gradually increasing difficulty. Do not think that fæces "like tobacco-pipe" are absolutely necessary evidence of the state of the bowel. A very frequent condition is that of constant diarrhœa, in which small lumpy motions, with more or less liquid, are passed; therefore, the calibre of the motion affords no certain indication of stricture. From what I have said, you will have perceived that, in cases of chronic obstruction, the disease is most likely to be situated about the rectum; and it is often possible for you to feel it on examination with the finger and in females you have the advantage of examining by the vagina. I find that, by using the fore and middle fingers, I can reach higher up the bowel than with the fore-finger alone, for then the middle finger is apt to be in the way. With two fingers, also, you can sometimes draw down the mucous membrane, and so reach a little higher. Still, the evidence thus obtained is often negative. Then the next best method is to pass a tube up into the bowel. A tube such as is attached to a stomach-pump is the most useful; but it is dangerous if not carefully used, for you may do harm by pushing it through a softened part of the bowel. If it be oiled previously, it may

pass up readily enough ; but when the finger is introduced by the side of it, you may find the end of it bent down. Thus, in a case of stricture, although you may apparently succeed in your examination, still you do not pass the obstruction. The the best plan is to introduce the tube filled with warm-water ; then distend the bowel slightly by injecting a little, at the same time pushing the tube a little further. By repeating the manœuvre again and again, you may either reach the obstruction or introduce the tube for its entire length. Generally speaking, you meet with obstruction at the sigmoid flexure, which prevents you going any further. Then, having made your diagnosis, the road is clear. But sometimes, on the other hand, you may push the tube up for its whole length and find no obstruction. Then, if you cannot obtain any evidence of the locality of the obstruction, you may perform the operation on the right side.

On one occasion lately, I performed the operation on the right side. It was in the case of an old lady with symptoms of obstruction of three weeks' standing. All the tube had entered the bowel, and no guide to the position of the disease had been discovered. As I said before, I performed the operation on the right side, and the patient survived for six weeks, and died mainly, I believe, from a bed sore. In that case, I met with a peculiar condition which I do not think is mentioned in any of the books, and which I have only seen on two occasions ; I mean the presence of gas in the peritoneal cavity. On cutting down upon the bowel, I found the peritoneum considerably distended ; but, there being good sunlight at the time, I was able to avoid opening the cavity, and the gas soon disappeared, and did not influence the patient's recovery in the least. I noticed something similar to this in a case in the hospital in 1874. There, again, the peritoneum was enormously distended, so much so that it was impossible to operate without pricking it, and the case terminated fatally from peritonitis. The explanation of this condition, no doubt, is that the bowel above the obstruction having been distended for some days, a certain amount of gas transudes into the peritoneal cavity. The prac-

tical bearing of it is, that you are liable to mistake the distended peritoneum for distended intestine.

And now as regards the operation itself. It is performed by preference on the left side, or on the right side under exceptional circumstances. The patient is placed on the right side, with a pillow under the loin, in order that the left loin may be thrown into greater prominence. You then measure a point midway between the anterior and posterior superior spines of the ilium, and from that point draw a vertical line upwards to the last rib. This line will give you the position of the bowel. Then make an incision four inches long, somewhat obliquely between the crest of the ilium and the last rib, half of the incision being on each side of the vertical line marked out. There is some difference of opinion as to the precise direction of the incision, some preferring it horizontal, others oblique. I myself prefer it slightly oblique, running parallel to the last rib. In making the incision, you divide the skin, subcutaneous fat, the external oblique and latissimus dorsi muscles, thus exposing the internal oblique. Having divided that for the whole length of the wound, the fascia lumborum comes into view, and you carefully divide it on a director. You have now exposed the loose fat about the kidney and colon in the anterior part of the wound, and the edge of the quadratus lumborum behind. Keeping the edges of the wound open with spatulæ, you displace the fat with the finger and seek for the bowel. In cases of obstruction with distension, you have no trouble in doing this, the bowel presenting at the wound covered only by fascia transversalis. This fascia varies in thickness in different cases, and has sometimes been mistaken for peritoneum. But, if the bowel be empty, you tear through the fascia transversalis carefully with the finger-nail just in front of the quadratus lumborum, and, on introducing the forefinger, you will generally succeed in hooking the intestine. If you do not succeed in doing this, by turning the patient over on to his back the bowel will, in all probability, fall on your finger. Bringing the bowel into the wound, you roll it round and expose the posterior surface which, as you know, is generally uncovered by peri-

toneum, and, when the bowel is distended, this surface is much larger. With a large curved needle, you then pass a stout silk thread through the skin to one side of the ink-mark, across the bowel, and again through the skin at a corresponding point on the other side of the mark, repeating the proceeding at the other end of the incision. Thus the colon is held to the margins of the wound before being opened. A transverse incision is now made into the bowel between the threads, and, the finger being introduced, the two loops can be drawn out, and, on dividing them, you have four threads to fix the bowel to the wound only requiring to be tied. The rest of the incision on each side of the bowel is then closed by ordinary sutures, and the operation is completed. The complications are very small. The greatest difficulty is in reaching the bowel when it is empty, but, with a little experience, this becomes quite easy.

Last week, with Mr. Erichsen, I saw an interesting case of total obstruction in a gentleman who had been treated homœopathically for three weeks. The small intestine was distended to three times its normal size, and there was a clear history of obstruction of the large bowel. We decided on colotomy, and I performed it as usual in the left loin. After I had finished the operation, on putting my finger into the lower opening in the bowel, I found a mass of disease, evidently cancerous, at the upper part of the sigmoid flexure; for I may say that it is not really the sigmoid flexure that is opened in colotomy, but the junction of the transverse with the descending colon; since, on putting your finger into the upper opening, you find that it goes horizontally in front of the kidney. This patient survived the operation seven months.

These being the principal points concerning the operation, you will watch the one on Wednesday with greater interest.—
British Medical Journal.

CANADA

Medical and Surgical Journal.

MONTREAL, JANUARY, 1878.

“L'UNION MEDICALE DU CANADA.”

Our attention has been called to an article in the September number of *L'Union Medicale du Canada*, commenting upon that which appeared in our August number on the subject of the Triennial Meeting at Three Rivers in July last. We regret much that we had not carefully perused that article earlier, as from it we learn for the first time, that our French-Canadian brethren felt aggrieved at the tone of our article, and were disposed to regard it as offensive towards them. Nothing could be further from our thoughts.

We should be very sorry to say one word which could be considered offensive to gentlemen, with a large number of whom we have had the most agreeable professional relationships.

Our condemnation was addressed only to the small number—those who are described by our respected contemporary as “*d'un très petit nombre des nôtres*,” and we offer to our French-Canadian friends our most sincere regrets that our article should have been open to the interpretation which they have put upon it.

Had we been aware of this feeling, the expression of our regrets would have come earlier. Our condemnation of the policy of those who would raise these distinctions of race, applied equally to the English as to the French-speaking members of the profession—for among the former, as among the latter, are some to be found who allow their feelings at times to outrun their judgment.

It has ever been our desire to smooth the troubled waters of national strife, and to make the profession, in fact what it is in

name, a liberal profession, where men of all nationalities and creeds can work harmoniously together for the promotion of the science of medicine. As in the past, so in the future, this will be our object,—and we trust our French-Canadian friends will accept the assurance in the same spirit of sincerity in which it is offered.

LACTIC FERMENTATION, ITS BEARINGS ON PATHOLOGY.

A most interesting paper on the subject of lactic fermentation and its bearings on Pathology, was read before the Pathological Society of London, by Mr. Lister, on Thursday the 18th December ult. This was accompanied by experiments, and an exhibition of apparatus used by Mr. Lister in carrying out his researches. In speaking of bacteriæ, he remarked that it was very probable they did not require any germ, they were in themselves reproductive organisms. In thanking Mr. Lister, the President remarked that it was customary for members, on their admission to sister societies, to deposit with the society some specimen of their art. In joining this society Mr. Lister had given them a specimen of his experimental skill and deep scientific acquirements, which would be deposited in the annals of the Pathological Society of London.

MCGILL MEDICAL SOCIETY.

This association which began its existence on the 23rd of April, 1877, is now in a most prosperous condition. Its membership is extensive, and its meetings have proved useful and interesting to all frequenting them.

The first meeting of the winter session took place on the 13th of October, and since then the following readings and papers have been given.

Oct. 13th, Mr. GURD read a selection entitled "Nature's Gentleman."

Mr. MILLS presented a paper on "The relations of the Medical Practitioner to the Public, and of Medical Students to each other."

Resolutions of sympathy with the family of the late Dr. Cline were passed at this meeting.

Oct. 27th.—Mr. SUTHERLAND gave a selection from Oliver Wendel Holmes.

Dr. RICHARD McDONELL then exhibited an interesting pathological specimen of aneurism of the descending thoracic aorta, causing caries of the bodies of the vertebræ.

Mr. CHISHOLM read a report of a case of Tubercular Nephritis, observed in the Montreal General Hospital.

Nov. 10th.—A reading from "Pickwick" was given by Mr. McLAREN, and the election of officers followed. Dr. Osler was re-elected President by acclamation; Mr. Mills, First Vice-President; Mr. Sutherland, Second Vice-President; Mr. Vineberg, Treasurer; Mr. Mignault, Secretary; Mr. T. Gray, Librarian; Messrs. Guerin, T. L. Brown, and Chisholm, Councillors.

Nov. 24th.—Mr. HENDERSON opened the programme with a selection from Shakespeare.

Dr. OSLER then exhibited the following:—

1. A case of patency of foramen ovale.
2. Aneurism of abdominal aorta.
3. Chronic meningeal tubercle.
4. Specimen of lung in a case of pneumonia.
5. Specimen of lung in a case of empyema.

The same gentleman then favoured the association with a paper on "The influence of position for hearing heart murmurs."

Mr. Mills then followed with a communication upon the powers of articulation displayed by a patient after excision of the tongue.

Dec. 8th.—This evening had been allotted to a debate upon a general subject, so, after a reading from Mr. ROGERS entitled "Edinburgh after Flodden," a discussion took place upon the question, "Whether Science, or Literature or the Fine Arts

have done most towards the advancement of mankind." On the affirmative were Messrs. Mills, Chisholm, and O'Callaghan. Negative—Messrs. Mignault, Guerin, and Henderson.

Dec. 15th.—This was the last meeting before the Christmas holidays, and Mr. R. T. E. McDONALD was the reader of the evening, and gave a selection from "Hurdy Gurdy."

Mr. T. GRAY followed with a paper on "Albuminuria in pregnancy," and with the report of a case of "Glosso-labial pharyngeal paralysis."

Mr. MILLS read a short communication on "The pulse."

The Society then adjourned till the first Saturday after the Christmas holidays.

BOOKS RECEIVED FOR REVIEW.

Hospitals—Their History, Organization and Construction. Boylston Prize Essay. By W. GILL WYLIE, M.D. New York: D. Appleton & Co., 1877.

Contributions to Operative Surgery and Surgical Pathology. Parts 1, 2 and 3. By J. M. CARNOCHAN, M.D. New York: Harper & Brothers, 1877.

Public Hygiene in America. By HENRY J. BOWDITCH, M.D. Boston: Little, Brown & Co., 1877.

Guide to Therapeutics and Materia Medica. By R. FARQUHARSON, M.D., Edinburgh. Philadelphia: H. C. Lea, 1877.

Materia Medica for the Use of Students. By John B. BIDDLE, M.D. Philadelphia: Lindsay & Blakiston, 1878.

A Compend of Diagnosis in Pathological Anatomy, By Dr. JOHANNES ORTH. New York: Hurd & Co., Publishers. Boston: H. O. Houghton & Co., Cambridge, 1878.

The Action of Medicines. By ISAAC OTI, A.M., M.D. Philadelphia: Lindsay & Blakiston, 1878.

The Cure of Rupture, reducible and irreducible by new Methods. By GEORGE HEATON, M.D., Boston: H. O. Houghton, & Co., Cambridge, 1877.