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Original Communications.

Extirpation of a Fibro-cystic Tumor of the Uterus, with the latter and its appendages, performed on the 12th of June, 1874. By E. H. TRENHOLME, M.D., B.C.L., Professor of Midwifery and Diseases of Women and Children, University of Bishop's College; Attending Physician to the Women's Hospital of Montreal, &c., &c.

Read before the Medico-Chirurgical Society of Montreal.

Miss Isabella Buchanan, aged 33 years, born in Brantford, Ontario, was examined by me for the first time, in October, 1873, presenting a healthy appearance, of medium height and dark complexion, but somewhat spare in flesh.

On special examination, a large globular tumor occupied the abdominal cavity. The abdominal walls very thin, and the skin over the tumor marked by numerous silver lines due to extreme distention; a dark line extends down the middle, and the superficial veins dilated; areolar of both nipples dark and well marked. The tumor is firm, appears non-adherent, as it can be freely moved in all directions.

Percussion elicits a dull note, and a small collection of fluid detected at upper part. Auscultatory sounds nil. Tenderness on pressure at the sides. Measurements are as follows:—

Girth at umbilicus, 41 inches; ensiform cartilage to umbilicus, 9 inches; from latter to symphysis, 11 inches; from right ant. sup. spinous process to umbilicus, $10\frac{1}{2}$ inches; from left ditto to ditto, $9\frac{1}{2}$ inches. External organs of generation normal. Vagina greatly elongated and pointing to left side. Uterus cannot be brought into view with the speculum, and also beyond reach of finger, except when standing with the left leg somewhat elevated. The uterus and right ovary can be felt on the left side of abdomen, over the tumor, before and during menstruation; left ovary not felt. Rectum and anus normal. The menses began when fourteen years old, and have always been regular, but painful, till the appearance of the tumor, since which time they have been free from pain. During the menstrual flow cannot lie on the left side; at other times can rest equally on either side. Urinary organs in good order. The bladder is expanded upwards above the pubes, and when the urine does not flow freely it is readily expelled by pressure of the hand. Digestion and appetite good; bowels regular, but for some months has been troubled with flatulence. With the exception of an occasional attack of palpitation of the heart there is no derangement or disease in the other organs.

Nervous system is in good order.

Respiratory system.—Has a slight cough and shortness of breath when troubled with flatulence, but not at other times.

Circulatory.—Says she "is liable to palpitation of the heart, as is her sister also;" but, at the present time, its impulse is slightly feeble, but otherwise regular and normal.

HISTORY.

Is of healthy parentage on the side of both father and mother; all her relatives are in good health.

The present ill health began in September, 1870, at which time she had an attack of what her physician called "gravel and inflammation of the bladder." After recovery from this sickness, she felt a growth in the left groin, which gradually increased in size. In 1871 the tumor grew rapidly and extended toward the right side. During the year had a slight leucorrhœal discharge, but, otherwise, suffered no inconvenience.

In February, 1872, had an attack of menorrhagia, which recurred again in May of the same year, and three or four times since; the last of which was in July, 1873.

PROGRESSIVE SYMPTOMS.

Patient continued in good health from July, 1873, to the end of January, 1874, when an offensive vaginal discharge made its appearance, which gradually increased in quantity till the last week of the following month (February), when she had what she called a congestive chill, that lasted for about half an hour. A high fever, for three hours, was then followed by profuse perspiration that lasted nearly half a day. After this had a severe headache that lasted a week. The patient's flesh and strength now rapidly failed. Night sweats set in; the vaginal discharge has continued, and is of a highly offensive odor. The menstrual flow is always preceded and accompanied by abdominal distention and intense pain. There are also continuous nausea, a foetid exhalation from the skin, and a foetid breath.

Diagnosis.—That the tumor is fibro-cystic, involving the body of the uterus toward the left side; that the ovaries are intact; and that a communication exists between the cavity of the uterus and a suppurating cyst of the tumor.

Prognosis.—From the decided failure in flesh and strength, since seen last fall, the presence of a suppurating cyst, the increasing agony and distention of the abdomen during every monthly period, the incipient urinary disorder, and the depression of

spirits, it judged that the present state of things could not last more than two or three months before death would supervene. When seen during last fall, I refused to operate so long as she could enjoy life, and as she had reached the limit of that period I now, at her earnest solicitation, concluded to remove the tumor, together with the uterus and its appendages. The condition of the urine indicated the administration of carbonate of lithia (effervescing) for some days before operating.

OPERATION.

Reported by Mr. John T. Davis, medical student.

On the 12th of June, 1874:—

The patient having been laid on the table, Drs. Gardner and Perrigo administered first chloroform and then ether. Anesthesia was quickly produced; the patient passing very rapidly into a tranquil sleep. The pulse and respiration were at this time pretty fair.

At 12.15 p.m., assisted by Drs. Hingston and Kennedy—and in the presence of several other physicians—the operator commenced by making an exploratory incision in the mesial line to the extent of about six inches—the upper end of the incision reaching to within one inch of the umbilicus. The subjacent tissues were then carefully divided on a director, but their very tense condition, and the consequent difficulty in picking up each layer, occupied a good deal of time. The sheath of the rectus was opened close to the linea alba, and afterwards the posterior layer and subjacent fascia. The abdominal parietics were found to be exceedingly attenuated. A small portion of the peritoneum was divided and a director placed beneath, until the cavity was opened the whole length of the previous incisions. It was found that the peritoneum was extensively adherent to the whole surface of tumor. During this part of the operation many small bleeding points appeared, but were perfectly controlled by the unsparing use of Peans' forceps. The adhesions on the anterior surface being now all separated, Wells' trocar was introduced at a point where there seemed to be indistinct fluctuation, but no fluid obtained. It was then found necessary to extend the incision $2\frac{1}{2}$ inches above the umbilicus, and downward to within 2 inches of the pubis, in all making an incision of about 13 inches in length. The divided abdominal walls having been relieved of their pressure, were pressed outward and below the level of the tumor, hugging closely to the surface, by which means the tumour forced to protrude from the ab-

dominal cavity. The adhesions on its posterior surface were found to be numerous.

The tumor was then firmly grasped by the operator, and elevated from below upwards and forwards—adhesions were separated, and the uterine ligaments divided by the actual cautery. Whenever it became necessary to ligate vessels that were divided during the operation, fine flaxen carbolized ligatures were employed, and the ends cut off near the knot. About forty such ligatures were used and left in the cavity of the abdomen. The separation of all adhesions, among which was an attachment of the bowels about ten inches in extent, being accomplished, the tumor was elevated, and the vessels by which it had been nourished—passing from behind forwards to the posterior surface of the uterus just about the junction of the fundus with the cervix uteri, and on the left side—were secured; and strong carbolized linen ligatures applied and cut short, and the vessels divided. A triangular piece of peritoneum, three inches long and two broad (at the wide end) was torn from its connections—by the weight of the tumor—and removed. The tumor was then drawn upwards and backwards to bring into view the cervix uteri, which was found much elongated. The position of the ostium externum was next ascertained by external palpation. The vagina was observed to be much elongated likewise. A bougie about three-fourths of an inch in diameter was then introduced into the vagina, so as to elevate the pedicle, which was now transfixed with a long curved needle armed with a strong hempen ligature. The two halves were then securely ligated, and the wire écraseur applied about one-third of an inch above the ligatures. A few revolutions of the handle of that instrument sufficed for the constriction of the pedicle, which was then divided just above the constricted portion, and the tumor thus extirpated in two hours and fifteen minutes from first incision. The parts in the neighborhood of the wound were now carefully sponged, and the abdominal cavity cleared of clots of blood and other foreign matter—carbolized sponges being constantly used. Considerable oozing, deep down in the right inguinal region, soon became apparent. It was ascertained to be arterial, and the bleeding vessel was secured and ligated—the ends of the ligature being cut off short near the knot, in this as in every other instance of ligation. The edges of the wound were brought together and closed by eight deep sutures of strong carbolized linen, and superficially by the same number of horsehair sutures. The pedicle was transfixed by two

steel pins across the abdomen, the one in the centre and the other in the upper edge of the pedicle embracing the incision on each side; the écraseur was left as an additional security to prevent removal of the pedicle from between the edges of the wound. The cut surface of the pedicle was then smeared over with carbolic acid and perchloride of iron. The wound was covered with two layers of carbolized lint and secured by broad straps of adhesive plaster, passed from side to side. Cotton wool was placed over the abdomen and secured by a flannel bandage about ten inches wide. The patient's pulse at this time, as well as about half an hour previously, had become very shabby, alternately flagging and reviving. Brandy was administered about every ten minutes, until the pulse grew stronger and fuller. She was not removed from the table until reaction had commenced, when she was put to bed—the bed-linen having been previously well-warmed—and hot brick applied to her feet. She was then warmly covered with blankets. The temperature of the room had been made sufficiently warm and comfortable by a fire which was kindled for the purpose of heating the cautery irons.

AFTER TREATMENT AND PROGRESS.

After being comfortably placed in bed, a quarter grain dose of morph. mur. was administered, against my judgment, at the urgent advice of some medical friends. Slept for a few moments at a time up to 4 p.m., when vomiting supervened, for which tincture of aconite was administered every hour with good effect.

At 10 p.m. drew off $\bar{\zeta}$ ij of urine, and as the skin was acting well and temperature and pulse high, omitted aconite, and gave brandy and veratrum viridi. Vomited but once since four o'clock.

13th, (2nd day,) 1 a.m.—Slept quietly for the last three-quarters of an hour; wind in bowels beginning to cause trouble; slight nausea and belching of wind. 4 a.m.—The medicine causes nausea and is omitted; removed $\bar{\zeta}$ ij healthy urine. Has slept more than half the time since 1 o'clock. At 5 a.m. vomited, and at 6 a.m. nausea continues; skin acting freely. 7 a.m.—Took some milk and water; removed $\bar{\zeta}$ ij urine. 11 a.m.—Vomited bilious fluid with injesta. Gave tr. caprici. 5 p.m.—Has slept well during the greater part of the afternoon; skin acts well; feels easy. As pulse was a little hard, and fearing peritonitis, gave the verat. oviride once more, but was obliged to discontinue it as it caused nausea and emicis. About $\bar{\zeta}$ iv of urine was removed

at 3 p.m., and $\bar{\zeta}$ v at 7 p.m. 9 p.m.—Passed flatus per anum; attempts at emecis occurred at the same time, also at 10 p.m., when more gas escaped; after which she had what she called a "refreshing sleep," for about twenty minutes. 11 p.m.—Skin cool and moist; tongue slightly furred. Drew off $\bar{\zeta}$ ij urine, after which she slept well for one hour.

14th, (3rd day).—From 1 to 3 had a quiet, comfortable time; skin moist and cool; drew off $\bar{\zeta}$ vj. of clear, normal-looking urine, with a slight ammoniacal odor. 7 a.m.—Has been troubled a good deal with abdominal distention from difficulty in passing wind, which has not escaped for some hours. Is troubled with nausea, and vomited once. Gave aconite (Flemmings') $\frac{1}{4}$ drop, which gave some relief, but induced great diaphoresis. At 7.30, flatus escaped easily and freely. 9 a.m.—Nausea and a short spasm of pain in bowels, with a chill, and followed by emicis and perspiration. 10 a.m.—Skin cool; flatus escaped freely several times, followed by a natural stool. Dressed the wound, which is united by first intention, and changed her to the far side of the bed. 11.30.—Passed urine naturally, without trouble; there is still slight nausea. Vomited again at noon, after which felt easy. Tongue a little coated. 1 p.m.—Took beef tea with relish, for the first time; before this had taken ice and water only. At 4 o'clock and again at 7 o'clock, passed urine naturally, and slept a good part of the afternoon quietly and well. At 10 p.m., her temperature was normal and pulse 100; skin cool and moist; passed urine and flatus easily. From this time till 3 p.m., 15th June, (4th day), she slept well the greater part of the time, the pulse gradually going down till it touched 86, and the temperature remaining normal. Changed her bed at 1 p.m., when she passed urine as usual. After this complained of phlegm in throat and a tendency to cough, which greatly distresses on account of the pins passed through the pedicle hurting the abdomen. 8 p.m., skin moist but rather hot, thinks the heat of the day makes her feel so warm. Is very free from pain; takes beef tea well; flatus passes free.

16th June, (5th day). 1 a.m.—Has not slept for last twelve hours, and says she is tired. 2 a.m.—Can't sleep for bad dreams; skin hot and dry; pulse rather wiry; gave one drop aconite every hour. 4.30.—Pulse softer; skin cool and moist; tongue moist but furred; no pain; is tired; dreams still trouble. 8 a.m.—Cough begins to give much distress, for which gave ext. nucis vomici (fld.) in 1-20 drop doses every hour or two. 12 m.—Cough easy;

slept well; skin cool and moist. 4 p.m.—Cough troubled a good deal at one o'clock, but since then easy and well; took half a cup chicken broth and a crumb of bread; skin moist; tongue clean. 6 p.m.—Cough troubles still; urine all right; takes broth freely.

17th June, (6th day). 9 a.m.—Had a good night; slept nearly all the time. All going well, except a little pain with last few drops of urine; says she "feels as though she should be out of bed."

18th June, (7th day). 8 a.m.—All going on well; had a good night; pedicle troubles somewhat, and on examination find it nearly separated; there is a little pocket of pus at site of upper needle; all else looks well; urine passes freely, but of a smoky color. Ordered night and morning the eff. carb. lithia water. 9 p.m.—Passed a good afternoon; troubled with bad dreams when asleep this eve; dressed pedicle, very little pus.

19th June, (8th day). 8 a.m.—Slept since ten last night splendidly, and feels all right, "sleep very refreshing;" passed $\frac{3}{4}$ x normal urine; removed two deep sutures.

20th June, (9th day). 11 a.m.—Passed a fair night, but cough and bad dreams troubled her a good deal; urine a little smoky-colored but quite free; had very severe perspiration between 2 and 4 a.m.; every thing on her wet by it, but skin is now normal. There is free suppuration and discharge around pedicle, which is rapidly separating from the healthy tissue below; removed éraseur and left the wire around pedicle in situ. Cough troubles. 10 p.m.—While dressing pedicle it separated, and with the two needles came away. The whole of the neck of the uterus came away and left a deep cavity, partly due to this cause and partly to elevation of abdominal walls. Wound looks well.

21st June, (10th day). 6 p.m.—Slept well all night; tongue clean; urine free and normal; had a good day; wound discharges freely.

22nd June, (11th day). 10 a.m.—Feels well; tongue clean; urine abundant and normal; wound discharges freely, but very deep from retraction of vagina; had purulent discharge "per vaginum." 10 p.m.—Heat of the day has prostrated her a good deal; all going on favorably.

23rd June, (12th day). 10 a.m.—Gave castor oil to open bowels, as she had no passage since evening of third day. 10 p.m.—Bowels acted well, and abdomen not distended much. Removed all adhesive straps, and keep dressing in its place by flannel roller only; removed about $\frac{3}{4}$ j pus, with some shreds of

cellular tissue from around wound; passed a good day and feels well.

24th June, (13th day). 10 a.m.—Had a good night but bowels slightly loose; some slight pain and tenderness over bowels, also tympanitis; wound looks very well and filling up fast with healthy granulations. 10 p.m.—Wind troubles a good deal; slept fairly, but moans and starts occasionally. On dressing wound and removing some shreds of cellular tissue, find a small pocket of pus to the left and above Poupart's ligament communicating with a cavity of the wound.

25th June, (13th day). 9 a.m.—Appetite good; looks well, although slept little last night; tongue clean, urine normal; wound doing well and filling up rapidly; pocket of pus nearly gone. 11 p.m.—Had a good day, but feels feverish and weak on account of trouble with the nurse during the evening; very little pus and a little tenderness on right side of wound.

26th June, (14th day). 9 a.m.—Had a good night, slept nearly all the time; very free escape of pus from wound; the indurated and hyperplastic tissue around pedicle seems to be dissolving away, although a little still remains on the right side. 7 p.m.—Can lie on right side and take tea with comfort.

27th June (16th day), 10 a.m.—Passed a poor night on account of wind in bowels. Gave veratrum viridi again, but it caused emesis. Tongue skin, etc., all well; wound doing well. 10 p.m.—Gave an injection—the confection of senna failed to move the bowels—which opened then twice; changed the bed linen and placed a new hair mattress under her. Gave 5 grs. calomel which moved bowels freely at 11.30, after which she felt quite easy.

28th June, (17th day). 10 a.m.—Doing well; wound nearly filled up; passed a good night and slept well. Bowels open again this a.m.

29th June. 3 p.m.—Doing well. Free discharge of pus. Sat up in bed for a short time.

30th June. 3 p.m.—Slept well on alternate sides. All doing well. Bowels very slightly distended with air.

1st July.—Doing as well as could be desired.

2nd July.—Wound discharges freely, although nearly filled up to a level with abdomen.

Continued doing well up to 6th July, when I discovered a pocket of pus on right side, which, by gentle pressure, freely escaped by the wound.

7th July.—Sat up for a short time; wound discharges freely; all going well.

9th July.—Pocket of pus in right side gone; but there is one formed on left side. Bowels distended with gas, which does not pass off as easily as usual.

12th July.—Pocket on left side disappeared; wound doing well. Got up in an easy chair while bed was being made, and enjoyed the change.

13th July.—Is able to get out of bed, into the chair, alone. All going well.

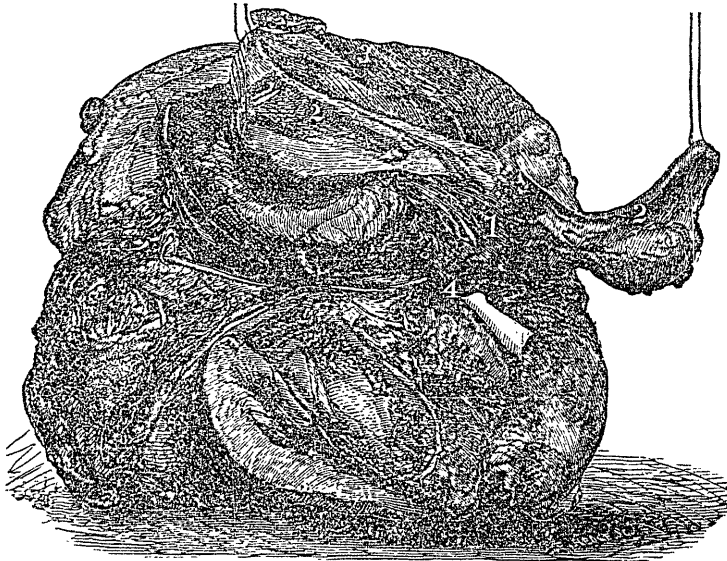
14th July.—All doing well: walked across the room.

17th July, (35th day).—Walked down town as far as Victoria Square; is perfectly well, but feels weak. Is gaining flesh rapidly; weighs 102 lbs., 32 lbs. less than before the operation.

From the above date, till she left for her home in Ontario, she gained half a pound per day in weight, and is quite active on foot.

The tumor weighs 16 lbs., including the uterus and ovaries. It springs from the posterior and left side of the centre of the body of that organ. A No. 10 sound can be passed through a fistulous opening into a cavity situated in the centre and upper part of the anterior aspect of the tumor, which cavity will hold about 35 ozs. When removed this cavity was full of pus. The rest of the growth is of a uniform firm, fleshy character. The accompanying illustration gives a correct view of its contour and peculiarities of formation:

1. Uterus. 2. Ovaries. 3. Round Ligament. 4. Piece of paper which was put into the cervical canal for the purpose of indicating its position, as also the divided portion of the cervix.



The operation, the details of which I have the pleasure of laying before you this evening, is one that has not as yet secured for itself a place among the recognized and legitimate operations of the surgeon.

That this *should have been* the case is not to be wondered at, when one considers its formidable character, and the grave risks to the life of the patient; but that it *can continue* to be thus placed beyond the sphere of warrantable surgery is quite impossible in face of the wonderful success that has of late attended it in the hands of such men as Pean and Keberle. True the risk is, notwithstanding the known perfection of detail in operating, fearfully great, and we would not pen one word that would tend to remove a particle of the heavy weight of res-

ponsibility from the shoulders of him who undertakes it; but, on the other hand, it is no small gratification and pleasure to be a fellow-worker with those who, in dealing with these unfavorable cases, have, by skill and daring, rescued some few of such doomed ones from an early grave.

I trust that the report of this case will not long remain the only successful one on record in Canada, and that where life has become a burden and in imminent danger of an abrupt termination, others may take heart and undertake the operation with hopeful courage, trusting that their efforts may be crowned with a similar success. To avoid repetition I have arranged the temperature and pulse on a form by which the changes can be perceived at a glance.

	Temperature.		Pulse.	
	99.5 M.	101.2 E.	96 M.	124 E.
June 12	99.5	101.2	96	124
13	101.4	99.2	96	128
14	99.2	97.5	100	104
15	97.8	100.8	96	98
16	99.2	101	96	104
17	99.5	101	116	124
18	98.8	101	108	128
19	99.8	100.6	118	120
20	100.1	99.3	112	118
21	99.3	99.8	108	112
22	99.3	99.1	106	108
23	98.8	99.6	104	120
24	98.9	101	104	112
25	99.9	100.2	100	120
26	100.2	101.6	104	124
27	100.8	101.1	112	126
28	100.2	101.5	110	116
29	100.4	101.3	112	124
30	100.7	101.3	112	114
July 1	101.3	101.5	104	114
2	99.8	101	106	108
3	100.2	102.3	106	112
4	99.9	101.8	102	112
5	100.5	102.3	104	108
6	101.8	103.3	100	112
7	100.8	103	110	116
8	102.6	103.4	112	116
9	100.4	101.3	96	112
10	99.5	101.2	96	100
11	99.5	100.3	94	100
12	98.3		96	96

VICTORIA SQUARE,
Montreal, 1874.

Progress of Medical Science.

CLINICAL LECTURE ON FIBROUS ANCHYLOSIS, CHRONIC SYNOVITIS, ETC.

By LEWIS A SAYRE, M.D., Prof. of Orthopædic Surgery in
Bellevue Hospital Medical College New-York City.

Gentlemen: The first case that I bring before you to-day is this girl, who has been suffering for some time from fibrous anchylosis at the hip-joint.

This form of anchylosis in many cases very closely assimilates bony anchylosis. It is important, therefore, that you should be able to distinguish one from the other with great certainty, for the management of the two conditions is conducted upon entirely different plans.

In those cases which most closely assimilate bony anchylosis—for it is in such that differential diagnosis is most difficult—if movements are made at the joint, and any motion whatever is secured during the manipulation necessary to a thorough examination of the case, it will be followed by more or less of pain within twenty-four hours. This is a distinguishing feature of cases of fibrous anchylosis.

For when bony anchylosis is present, no movements at the joint can be made, consequently pain will not be produced at the point of anchylosis.

This rule you will find to be reliable. The subsequent occurrence of pain in and about the joint, even if there be no apparent motion, will justify you in resorting to measures calculated to give to it gradual restoration of motion.

In the case of this little girl, it was exceedingly difficult to determine whether any motion whatever was remaining at the hip-joint, so firmly flexed and adducted was her limb. But the day following the manipulation considerable pain was present, and other evidences of inflammatory action were quite well developed. The limb was placed at perfect rest by placing the child in bed. By the rest in bed and continued application of cold to the inflamed parts by means of icebags, and extension in the line of deformity gradually changed towards the normal. All inflammatory action was subdued within a few days, and then she was placed upon this instrument which had been specially devised to meet the indications in her case. The instrument consists of a pelvic belt, with perineal bands; a long bar with a foot-piece and adjustment for extension; a knee-cap and a movable joint opposite the hip for flexion, extension, and abduction. At the movable joint arrangement is made so that, by means of screws, abduction and rotation of the limb outwards can be effected at the same time. It is, in short, a modification of Taylor's long splint, the modification consisting in the use of screws for obtaining abduction and rotation. It has now been one month since the instrument was applied, and the change which has been produced during that time is very marked. The limb has been abducted to such an extent that it is now nearly parallel with the opposite limb. This can be ascertained only by placing the pelvis in a fixed position. Rotation has been almost perfectly restored, and flexion and extension have been restored to considerable extent. Abduction and adduction are quite free, and the limb is upon the highway to complete recovery.

The case well illustrates what extraordinary results can be obtained in the way of overcoming muscular rigidity by the application of a constant unremitting force. Under circumstances favoring the application of constant unremitting elastic force, equally as favorable results can be obtained by paralyzing muscular power, thus overcoming deformities produced by it.

CASE II. *Chronic Synovitis*.—This patient, as you see, is a man of medium size, exceedingly muscular, and forty years of age.

Some seven or eight years ago, while wrestling, his foot caught against the edge of a board in the floor, which was slightly elevated above the others, and the quadriceps muscle being placed in a condition of powerful tension, luxated the patella upon the right knee inwards, and he fell. While attempting to raise himself, the muscle restored the patella to its proper position. For a few days he was unable to walk, but in a short time recovery, as was supposed, was complete.

About two years after the occurrence of this accident chronic inflammatory action was set up on the

opposite knee, and soon affected both knees; they gradually increased in size, and now, as you see, they are immense. One measures eighteen, and the other seventeen and a half, inches in circumference, and the calves of the legs are very much diminished in size.

For the last two years this condition has remained about stationary. The effusion is now so abundant that the patella of each knee is lifted from its articulation, and, as pressure is made upon it, it can be made to strike the bones below with an audible *click*.

By transmitted light a lake of fluid can be seen below the ligamentum patellæ, with a large collection of semi gelatinous material at its upper surface, presenting a very beautiful pathological appearance. These knees have received an almost endless variety of external applications, and his general system has received a great amount of medication, but all have failed to produce any change, and we now find them as they have remained for a numbers of years.

The effusion in this case has become so great as to preclude all possibility of its removal by absorption, simply because the excessive tension that has been made upon the absorbents has paralyzed their action in such a manner that absorption cannot take place.

The condition is analogous to that occasionally seen in ascites, when the pressure is so great from accumulated fluid that the absorbents will not respond to the influence of internal remedies. In that case, the removal of only a small portion of the fluid will in many cases reduce the tension sufficient to permit the subsequent removal of the remainder by the renewed action of the absorbents. This case, however, has been of so long standing that it is not probable that the removal of a portion of the fluid would be of any benefit, even though followed by the most constant and powerful compression.

In most cases, particularly in the sub-acute and earlier chronic stages, decided benefit can be obtained by pressure applied to the joints. This can be conveniently and effectually done by means of compressed sponge. Cover the joint which is the seat of the synovitis with compressed sponge, and retain it in position by means of a roller bandage. The sponge is then wet with warm water, which causes it to gradually expand and thus produce an equal amount of pressure over all the parts covered; and it can be kept up long as may be desirable. The sponge can be applied one or twice a day, according to the necessities in the case. Changing it every twenty-four hours is usually sufficient.

The question now arises, What is the best thing that can be done for the relief of the present condition of this case?

A free incision will permit the fluid to escape, but the risk of exciting an uncontrollable inflammatory action would hardly warrant such a procedure.

What I propose to do in this case is to remove the fluid by means of the *aspirator*. This also, is not altogether a safe operation, for inflammatory

action may follow its performance; but, under the circumstances, it is the best operation that can be resorted to. In such a case as this, a certain amount of risk must be taken, no matter what operative interference may be adopted.

In all probability, simple aspiration will fail to give any permanent relief, for the reason that the case has been of so long duration. It is also altogether probable that the synovial membrane has become changed in its anatomical structure to such an extent, that permanent benefit will only follow the adoption of some more active measure.

There is a chance, however, that the simple operation of aspiration, followed by elastic pressure, such as obtained by the use of compressed sponge and a roller bandage, may accomplish a cure.

If simple aspiration does not succeed, the fluid will then be removed by means of the ordinary trocar; and when removed, the cavity will be injected with Lugol's solution of iodine. The principal of treatment is precisely the same as that which governs us in the treatment of the tunica vaginalis in cases of hydrocele; namely, to excite a new action in the old and changed membrane, by means of an irritating agent; and for this purpose the solution of iodine indicated is much the safest agent to be employed.

In either case the patient will be placed in bed immediately after the operation, the knees will be firmly bandaged, locked in a perfectly immovable apparatus, elevated above the level of the body, and perfect rest maintained. In addition, icebags will be constantly employed if necessary. The object is to retain the inflammatory action *just within* the point of danger. In this manner we may reasonably expect to bring about complete recovery.

CASE III. *Cancer of Lower Lip*.—These growths, seen not infrequently upon the lower lip, are usually regarded as cancerous in nature. Some of them are not. Some of them bear so close a resemblance to the ordinary epithelioma of the lip, that they cannot be distinguished from each other by the naked eye. They are usually the result of constant and long-continued irritation.

Fortunately there is one plan of treatment best adapted to them all. Remove them with the knife, and that makes an end of them.

There are some steps in the operation which are necessary to be observed if you would make a nice operation, and one which will prove satisfactory to your patient. The ordinary operation is to remove the diseased mass, by making a V-shaped incision, large enough to embrace the whole of it.

Serious hemorrhage can be avoided, during the operation by having an assistant make pressure upon the facial arteries as they pass over the ramus of the lower jaw. The wound can be closed by means of sutures, or pins with the figure-of-8 suture. I commonly employ the pins. These are to be passed through the lips of the wound, and then its edges are brought together in such a manner as to avoid leaving any notch in the free margin of the lip. The attachments of the cheek may be loosened with the

knife if necessary, in order to give more opportunity for perfect adjustment. Two pins are usually sufficient. After the pins have been adjusted and the sutures twisted about them, do not neglect to place a piece of adhesive plaster beneath the point of the pins to prevent irritation and excoriation. Next, long narrow strips of adhesive plaster are to be adjusted in a manner to give support to the pins in holding the lips of the wound in coaptation. These strips, passing above and below each pin, should be carried far back upon the sides of the face and neck. Carefully adjust the edges of the wound a second time, as the plaster is carried over them. The pins are to be removed within 48 hours at most after the operation. To do this without disturbing the wound, seize the pin at the head with a pair of pincers, and carefully turn it round once or twice before making the least traction. With this precaution the pins can be withdrawn without disturbing the threads or plasters, which together with the crust, are left remaining, and should not be removed for some time. Unless the pins are removed before ulceration and suppuration have been established about them, scars will be left at the points of insertion and exit; but with this precaution scar can be avoided.

CASE IV. Ingrowing Toe-nail.—Here, gentlemen, is a case which belongs to the every-day practice in surgery. It is important, therefore, that you should understand how to manage successfully such little cases. Almost any one can cut off a limb, but it is not every professed surgeon even who successfully manages these painful cases of ingrowing toe-nail. It is quite fashionable, especially in cities, to recommend these people to go to some *specialist*, who "knows all about corns, toe-nails, etc.;" and one of these cases is scarcely ever met here but what has been more or less treated by that class of men. Narrow-soled shoes and boots are the great prolific sources of this difficulty. A great many people imagine—and we are sorry to be obliged to say that the greater proportion of this class is made up of ladies—that a narrow foot and high instep are elements of beauty. The result, however, of these efforts to distort the foot is the toe-nails cut their way into the tissues, and the tissues becomes hypertrophied. The appearance very commonly presented is a large mass of fungous granulations rising up from the side of the nail, as you can see very well illustrated in this case.

The toe cannot be cured until this redundancy of flesh is gotten rid of. Sometimes it becomes necessary to employ the knife in the removal of this superfluous growth. Nitric acid is a very good application, and nitrate of silver is another.

Immense relief can be afforded by applying a few threads of cotton beneath the cutting-edge of the nail, in such a manner as to protect the excessively tender tissues from irritation produced by being crowded in contact with it. When the cotton is properly applied, pressure upon the ball of the toe will give no pain. The proper instrument with which to apply it is a narrow thin knife-blade with-

out cutting-edge. With this instrument draw a few threads of cotton down between the nail and the mass of granulations, and so on until they are carried beneath the cutting-edge of the nail. This operation will give some pain during its performance, but the relief which will be afforded by it will be most marked. After the application of the cotton, pencil the fungous granulations over freely with nitrate of silver, or with whatever may be used for the purpose of destroying them. Repeat the application as often as the destroyed tissues separate, until the exuberant growth is all destroyed.

CASE V. Fracture of the Forearm, Phlegmonous Erysipelas, and Inflammation of Wrist-joint. The next case I present to you, gentlemen, is one of considerable interest. This man first suffered from a fracture of the forearm. Phlegmonous erysipelas attacked the limb a short time after the accident; and you will here notice the many openings which have been made for the free escape of pus, numbering, as the house-surgeon says, thirteen. The wrist-joint has also become involved in the inflammatory process. The case was one set down for amputation, but I resolved to make an effort to save the limb.

The difficulty involving the wrist-joint was the chief obstacle to be overcome. The thing desired was to place the joint perfectly at rest, and at the same time remove all pressure from the articular surfaces. How was this to be done? Take a piece of sole-leather, long enough to reach from the digital extremity of the palm of the hand to near the flexure of the elbow, and wide enough to half or two-thirds surround the arm. Dip it in cold water, and make it thoroughly flexible. Cover it with a piece of adhesive plaster, plaster side out, long enough to go completely around it lengthwise, and lock. Now, having covered each opening with a piece of oakum, apply the leather-lined plaster to the palm of the hand, mould it, and secure it with a roller bandage as far as the wrist. Having arrived at that point, grasp the hand already covered, while an assistant grasps the arm near the elbow; then making extension and counter extension, until the patient tells you that all pain is relieved, bring the remainder of the leather-lined plaster against the forearm, and secure it with a continuation of the bandage. In this manner all pressure is removed from the articular surfaces, pain is relieved, and an apparatus is afforded which retains everything at perfect rest. It is almost impossible to devise any means for meeting the indications in this case which is simpler than this. The leather is much better adapted to such uses than a board, for the reason that it can be more perfectly moulded to all the inequalities of the limb. The plaster lining holds it securely in position, in such a manner as to prevent slipping. Since the application of this splint the œdematous condition of the limb has passed away, and the question of amputation is no longer present for consideration.

—*Medical Record.*

ON NÉLATON'S METHOD OF RESUSITATION
FROM CHLOROFORM NARCOSIS.

By J. MARION SIMS, M. D.,

*Surgeon to the Woman's Hospital of the State of New York,
etc.*

Dr. Charles James Campbell, the distinguished accoucheur of Paris, has recently written two papers on anaesthesia in obstetrics, in which he ably sustains the views long taught by Nélaton, that death from chloroform is due to syncope or cerebral anæmia. And amongst other strong arguments to prove his position, he gave a graphic description of a case of chloroform narcosis, which occurred in my practice in Paris, where M. Nélaton, by his method, unquestionably saved the life of the patient. She was young, beautiful, and accomplished, and belonged to one of the oldest and best families in France. Married at twenty, she gave birth to her first child a year afterwards. The head was enormous (hydrocephalic), impacted in the pelvis nearly 24 hours, and the delivery of a dead child was ultimately accomplished with instruments. Dr. Bouchacour of Lyons was called in consultation, and applied the forceps. In a week afterward, the urine began to dribble away, and in a fortnight an immense slough was thrown off. The case, surgically considered, was one of the most interesting I ever saw, and the operation was one of the most difficult I ever performed on any one in her station in life. The base of the bladder was destroyed and the fundus fell through the fistulous opening; it was therefore inverted, and protruded between the labia majora as a herniary mass of the size of an apricot, its external covering being the internal or lining membrane of the bladder, which was of a deep vermilion red colour. The vaginal portion of the cervix uteri and the posterior cul-de-sac were destroyed; and by the reparative process, the cervix and the posterior wall of the vagina were blended into one common cicatricial mass, which was firm, inelastic, and immovable. The case appeared desperate, and M. Nélaton had pronounced it incurable. A preparatory operation was necessary, viz., to open the cervix uteri, by dissecting it from the posterior wall of the vagina, and thus to reconstitute the canal of the vagina up to the canal of the cervix; and by a subsequent operation, to draw forward the flap thus formed, secure it to the neck of the bladder anteriorly, and thereby close the fistula. The first, or preparatory operation, was performed at the country house of the family near Dijon, on November 3rd, 1861, Dr. Dugast of Dijon assisting, and giving chloroform. The second, or operation for the radical cure, was performed on the 19th of the month at St. Germain, about an hour's distance from Paris by rail. M. Nélaton, Dr. Campbell, Dr. Beylard, Dr. Johnston, and Mr., now Dr., Alan Herbert, were present. I seldom give an anæsthetic in private practice for operation on the walls of the vagina, as the pain is generally not sufficient to call for it. But in this case as the slightest touch was unbearable, an anæsthetic was indispensable. Dr. Campbell was selected by the family, as well as by M. Nélaton and myself, to administer the chloroform, especially as he was in the

daily habit of giving it in his large obstetrical practice, and we all had entire confidence in his caution, skill, and judgment. The patient was soon anæsthetised. The operation was begun at 10 A. M., and I thought it would require about an hour to finish it.

Many years ago I imbibed the convictions of my countrymen against chloroform in general surgery, and have always used ether in preference, never feeling the least dread of danger from it under any circumstances. It is otherwise with chloroform, and in this particular case I felt the greatest anxiety, frequently stopping during the operation to ask Dr. Campbell if all was going on well with the patient. At the end of forty minutes the sutures (twelve or thirteen) were all placed, and ready to be secured, and I was secretly congratulating myself that the operation would be finished in a few minutes more, when all at once I discovered an unusual bluish livid appearance of the vagina, as if the blood were stagnant, and I called Dr. Johnston's attention to it. As this lividity seemed to increase, I felt rather uneasy about it, and I asked Dr. Campbell if all was right with the pulse. He replied, "All right, go on." Scarcely were these words uttered, when he suddenly cried out, "Stop! stop! No pulse, no breathing"; and looking to M. Nélaton, he said, "Tête en bas, n'est-ce pas?" Nélaton replied, "Certainly; there is nothing else to do." Immediately the body was inverted, the head hanging down, while the heels were raised high in the air by Dr. Johnston the legs resting, one on each his shoulders. Dr. Campbell supported the thorax. Mr. Herbert was sent to an adjoining room for a spoon, with the handle of which the jaws were held open, and I handed M. Nélaton a tenaculum, which he hooked into the tongue, and gave in charge to Mr. Herbert; while to Dr. Beylard was assigned the duty of making efforts at artificial respiration, by pressure alternately on the thorax and abdomen. M. Nélaton ordered, and overlooked every movement, while I stood aloof and watched the proceedings with, of course, the most intense anxiety. They held the patient in this inverted position for a long time, before there was any manifestation of returning life. Dr. Campbell in his report, says it was fifteen minutes, and that it seemed an age. My notes of the case, written a few hours afterwards, make it twenty minutes. Be this as it may, the time was so long that I thought it useless to make any further efforts, and I said, "Gentlemen, she is certainly dead, and you might as well let her alone." But the great and good Nélaton never lost hope, and by his quiet, cool brave manner, he seemed to infuse his spirit into his aids. At last there was a feeble inspiration, and after a long time another, and by and bye another; and then the breathing became pretty regular, and Dr. Campbell said, "The pulse returns, thank God; she will soon be all right again." Dr. Beylard, who always sees the cheerful side of every thing in life, was disposed to laugh at the fear I manifested for the safety of our patient. I must confess that never before or since have I felt such a grave responsibility. When the pulse and respiration were well re-established, M. Nélaton ordered the patient to be laid on the table. This was done

gently. But what was our horror, when, at the moment the body was placed horizontally, the pulse and breathing instantly ceased. Quick as thought, the body was again inverted, the head downwards and the feet over Dr. Johnston's shoulders, and the same manoeuvres as before were put in execution. Dr. Campbell thinks it did not take such a long time to re-establish the action of the lungs and heart as in the first instance. It may have lucked a few seconds of the time; but it seemed to me to be quite as long. For the same tedious, painful, protracted, and anxious efforts were made as before; and she seemed, if possible more dead than before; but, thanks to the brave men who had her in charge, feeble signs of returning life eventually made their appearance. Respiration was at first irregular and at long intervals; soon it became more regular, and the pulse could then be counted; but it was very feeble, and would intermit. I began again to be hopeful, and even dared to think that at last there was an end of this dreadful suspense, when they laid her horizontally on the table again, saying, "She is all right this time." To witness two such painful scenes of danger to a young and valuable life, and to experience such agony of anxiety, produce a tension of heart and mind and soul that can not be imagined. What, then, must have been our dismay, our feeling of despair when, incredible as it may seem, the moment the body was laid in the horizontal position again, the respiration ceased a third time, the pulse was gone, and she looked the perfect picture of death? Then I gave up all as lost; for I thought that the blood was so poisoned, so charged with chloroform, that it was no longer able to sustain life. But Nélaton, and Campbell, and Johnston, and Beylard, and Herbert, by a consentaneous effort, quickly inverted the body a third time, thus throwing all the blood possible to the brain and again they began their efforts at artificial respiration. It seemed to me that she would never breathe again; but at last there was a spasmodic gasp, and, after a long while, there was another effort at inspiration; and, after another long interval, there was a third; they were "far between;" then we watched, and waited, and wondered if there would ever be a fourth; at length it came, and more profoundly, and there was a long yawn, and the respiration became tolerably regular. Soon Dr. Beylard says, "I feel the pulse again, but it is very weak." Nélaton, after some moments, ejaculates, "The colour of the tongue and lips is more natural." Campbell says, "the vomiting is favourable: see, she moves her hands; she is pushing against me." But I was by no means sure that these movements were not merely signs of the last death-struggle: and so I expressed myself. Presently, Dr. Johnston said, "see here, doctor; see how she kicks; she is coming round again;" and very soon they all said, "She is safe at last." I replied, "For heaven's sake, keep her safe; I beg you not to put her on the table again till she is conscious." This was the first and only suggestion I made during all these anxious moments, and it was acted upon; for she was held in the vertical position till she, in a manner, recovered semi-consciousness,

opened her eyes, looked wildly around, and asked what was the matter. She was then, and not till then, laid on the table, and all present felt quite as solemn and as thankful as I did; and we all in turn grasped Nélaton's hand, and thanked him for having saved the life of this lovely woman.

In a few minutes more, the operation was finished, but, of course, without chloroform. The sutures were quickly assorted and separately twisted, and the patient put to bed; and, on the eighth day thereafter, I had the happiness to remove the sutures in the presence of M. Nélaton; and to show him the success of the operation.

I have detailed the circumstances of this interesting case at great length, because I believe it goes as far to establish a principle of treatment as any one case ever did, or possibly can.

If the recovery had been complete and perfect with the first effort at reversing the body, there might have been a doubt whether the vertical position was really the cause of resuscitation; but, when the horizontal position was again and again followed by a cessation of all evidence of life, and when life was again and again re-established by a position that favored only the gravitation of the blood (poisoned as it was) to the brain, the inference is very clear that death in such cases is due to syncope or cerebral anæmia. Exhaust the brain of blood in any way, and death follows speedily. Fill it with blood again, and life returns.

I have another case to relate, which goes far to establish the principle of treatment in chloroform narcosis, so forcibly illustrated by the case at St. Germain.

In January 1873, I amputated the cervix uteri at the Woman's Hospital, drew the vagina tissue over the stump, and secured it by silver sutures. The junior house-surgeon gave the anæsthetic. When the operation was nearly finished, he cried out, "The patient has stopped breathing," and immediately added, "She has no pulse." As before stated, I always use ether as an anæsthetic, and could not realise the fact that my patient was in any danger whatever till I was told that they were giving her a mixture of chloroform and ether (one part to four), which some of the surgeons had been using a few days previously. On examining the patient, I found her, as it were, dead; there was not the slightest muscular rigidity; the arms and head fell by their own gravity in any way they directed; the neck was as limber as if it were a mere band of soft linen stretching from the head to the trunk; there was not the least sign of breathing or of the pulse; she was, to all intents and purpose, dead; and I believe she would certainly have remained so if she had been left alone; and I doubt very much whether she could possibly have been resuscitated by any other method than that of Nélaton.

I quickly inverted the body, and had it held thus; and then I shook the thorax, agitating the head laterally, so as to add an impetus to the movement of the blood, which, with the body in this vertical position, would naturally gravitate toward the brain; the jaws

were held asunder, and the tongue hooked with a tenaculum, and pulled forward. In a few minutes the breathing was re-established, and then the pulse returned; and soon the patient was placed again on the table in the lateral semiprone position in which all my operations on the uterus are performed; and the operation was finished, but without any more of the anæsthetic.

These two cases comprise my personal experience with Nélaton's method in chloroform narcosis.

As the facts now laid before you fully explain themselves, it is unnecessary for me to indulge in any lengthened remarks on the subject. In my own country, the accoucheurs often use chloroform, and the surgeons mostly use ether. I believe there has not as yet been a single death from chloroform given during labour; while deaths from it in general surgery occur constantly, and for unimportant operations. There must be a reason for this. I believe that it can be explained only on the theory that death from chloroform is, as a rule, due to syncope or to cerebral anæmia. Now, we know that in active labour there can be no cerebral anæmia, for every pain throws the blood violently to the head, producing fulness and congestion of the blood-vessels, thereby counteracting the tendency of the chloroform to produce a contrary condition. It may be said that the recumbent position has some influence in determining the safety of chloroform in labour; and so it has, but it gives no immunity under other circumstances. Chloroform, given intermittently as in labour, is thought to be less dangerous; but patients in labour are often kept for hours under its influence with safety, and occasionally it is necessary to produce complete and profound narcosis in some obstetrical operations; and yet, I believe, I can safely reiterate what I have already said, that no woman has as yet died in labour from the effects of this anæsthetic. In puerperal convulsion, where the brain is believed to be overcharged with blood—and that, too, when the blood is known to be poisoned with urea—we formerly bled the patient, and we do so now sometimes; but our chief remedy is chloroform, which acts by arresting spasmodic movement, and by producing that very state of cerebral anæmia so necessary to a successful result. Whether puerperal convulsions are less frequent in labours under chloroform than in those without it, I do not know.

I believe that obstetricians may take a lesson from Nélaton's method of resuscitation, by adopting it in cases of threatened death from *post partum* hæmorrhage. Let us not be satisfied with simply placing the head low; but let us, in addition to the means usually adopted, invert the body, and throw what little blood there is left in it wholly to the brain. I have never seen a death from uterine hæmorrhage; but from recollections of the few alarming cases I have witnessed, I now feel sure that recovery might have been hastened if I had known and adopted Nélaton's method of inversion.

Whether death from chloroform is due to cerebral anæmia or not, it is at least safe to adopt Nélaton's method in all cases of supposed or threatened danger; but I think the safest plan is to relinquish the use

of chloroform altogether except in obstetrics. The frequent cases of death from the use of chloroform in surgical operations that have occurred amongst us, even of late, should warn us to give up this dangerous agent, if we can find another that is as efficient, and, at the same time, free from danger. Ether fulfils the indications to a remarkable degree; but, while it is safe, it is unfortunately unpleasant to the physician and bystanders, as well as to the patient. He who will give us an anæsthetic as pleasant to take as chloroform and as safe as ether, will confer the greatest boon upon science and humanity.

COLLES' FRACTURE OF THE RADIUS.

By Daniel La Ferte, M.D., Demonstrator of Anatomy and Lecturer on Orthopædic Surgery in Detroit Medical College.

I wish to offer a few remarks on Colles' fracture, in order to direct the attention of the profession to some points which are even at the present day often overlooked. On account of this neglect there is often left a permanent deformity in the limb, and both surgeon and patient have every reason to be dissatisfied with the result of the treatment.

Dr. Moore, of Rochester, N.Y., deserves great credit for the light which he has thrown on the pathology of this injury. That gentlemen found in his dissections that in a large proportion of these cases the styloid process of the ulna is dislocated underneath the posterior annular ligament. Where this is the case we cannot expect to obtain anything like a good result without first reducing the dislocation. In spite of his teaching, and in the face of the good results which have followed his plan of treatment, many practitioners yet adhere to the teachings of the past, and dress this fracture by simply carrying the hand forcibly to the radial side, and applying a pistol-shaped splint. The effect of this procedure, as will be apparent to all, is to thrust the ligament still farther underneath the process, and consequently aggravate the difficulty. Having liberated the imprisoned ulna, there can be no advantage in applying a pistol splint. The adherents to this mode of treatment claim that the pressure exerted over the lower end of the radius by the extensor ossis metacarpi pollicis and extensor primi internodii pollicis muscles, as well as the traction of the external lateral ligament of the wrist, will raise the upper end of the lower fragment from its bed, and thereby secure proper adaptation of the fragments. I do not believe that the amount of pain produced by the degree of force requisite to secure that end could be endured for any length of time; much less could it be borne three, four or six weeks, or until union had taken place. I doubt very much if the lower fragment is raised to any appreciable extent by this procedure. Moreover, should the fracture be a comminuted one, then certainly the pressure of the muscles over the lower end of the bone cannot exert their influence over every fragment.

What shall we do with the projection of the head of the ulna? My opinion is that we should proceed

according to Moore's method in these cases, which has for its object the reduction of the dislocated ulna. We have all heard of this method, but there are many who are not familiar with its details. The following are the different steps of the operation: Place the hand midway between pronation and supination; take a firm hold of the wrist with one hand, and with the other seize the hand, make extension and counter extension, draw the hand forcibly to the radial size, then backwards and to the ulnar side, bring it in a straight position with the forearm, then forcibly flex it on the latter; lastly, bring it back to a straight position with the forearm. Apply a solid pad over the head of the ulna, and secure it in its place by means of a strip of adhesive plaster two inches in width, and long enough to encircle the wrist two or three times. The arm is then put in a sling, which constitutes the dressing. For greater safety, there can be no objection, in my opinion, to applying well padded straight splints in addition to the above dressing.

The normal relations of the tendon of the extensor carpi ulnaris and head of the ulna being borne in mind, will serve as a guide to the surgeon. When he has succeeded in reducing the dislocation, he will find the head of the ulna lying on the radial side of the tendon, its normal position, whereas when the dislocation exists the tendon lies on the radial side of the head of the bone. In very fleshy individuals it is not always an easy matter to feel the tendon, but in the majority of cases it will serve as a very important landmark. The object of the pad is to keep the head of the bone in its position, which it would otherwise be very difficult to accomplish, on account of more or less laceration of the internal lateral ligament and inter-articular fibro-cartilage.

I had occasion, lately, to try Moore's method in a case of this kind of four week's standing, in a boy twelve years of age. The arm had been dressed in the usual way, by means of a pistol splint. When he came under my observation, the case presented the symptoms of Colles' fracture in a marked degree. Having placed the patient under the influence of an anæsthetic, I broke up the adhesion, reduced and dressed the fracture according to Moore's method, applying in addition straight splints to the forearm. At the expiration of three weeks I removed all the dressing, and found union perfect. The powers of pronation and supination were normal, and motion of the wrist not in the least interfered with. The head of the ulna projects to a very slight extent, when compared with its fellow of the opposite side. I do not assert that such a result can be obtained in all cases; but, considering the time at which reduction was effected in this case, and the favorable condition in which the limb is left, I feel highly encouraged to adopt the same plan of treatment whenever an opportunity shall present itself.—*Detroit Review of Medicine.*

AN EXTRAORDINARY CASE.

The *Irish Hospital Gazette* records an extraordinary case recently brought before the Dublin Patholo-

gical Faculty by Professor R. W. Smith, of Dublin University. The disease under which the woman succumbed whose skeleton he exhibited was one of rare occurrence, and difficult alike to diagnose, treat, or even name. At the time of her death the woman was forty-five years old. Fifteen years previously she had been sent to jail for some offence, which was probably committed while insane, as shortly afterwards she was transferred to a lunatic-asylum. During the first ten years of her residence there nothing remarkable about her was noticed, and she was employed in washing the floors, etc. At the end of this period she ceased to be able to work, and was confined to bed for the remaining five years of her life, gradually becoming more feeble, and dwindling away in stature until she became about one-half the height she was originally. She did not complain of any pain; her limbs became coiled up in every possible shape, and she seemed gradually to disappear from off the face of the earth. She died, possibly, from constitutional disease of the osseous system. He (Professor Smith), however, looked upon the condition of the bones not as a disease, but as a manifestation of an as yet unknown diseased condition. Professor Smith had weighed all the bones individually; the total weight of the skeleton (including the cranium) was two and one-half pounds, which equalled about the fourth part of the weight of a child at birth. The bones were extremely light, soft, fragile, and atrophied in every respect. The number of fractures was prodigious. The ribs were in a hundred fragments. The head of the humerus was bent; the fibulæ were curved; the thigh-bones and pelvis were huddled up together, and the bones of the vertebræ thinned and worn away across the front of their bodies. The lower jaw was atrophied and broken into three fragments; the base of the skull was cribriform all through; and he (Professor Smith) believed that if the woman had lived longer not a vestige of a bone in her body would have been left. As to the nature of this disease he (Professor Smith) believed that it was identical with rickets occurring in the adult; and although that opinion might appear heretical to some, yet he was glad to find that in the last volume of Trousseau's Lectures on Clinical Medicine, that distinguished author had expressed his opinion that osteomalacia and rickets were one and the same disease.

PROLAPSE OF THE UMBILICAL CORD.

Dr. George J. Engelmann sums up a paper, (*The American Journal of Obstetrics*, August, 1874) as follows:—In conclusion, I will sum up in a few words the facts attained and the laws established by the examination of our prolapse cases.

The causes of the prolapse of the umbilical cord have mainly proved to be such circumstances as prevent the complete filling of the pelvic brim, and the close adaptation of the lower segment of the uterus to the presenting part. One of the more important of these circumstances is the shape of the presenting foetal part itself, and we thus find that foot-presen-

tations are most frequently complicated by prolapse, whereas vertex presentations are least threatened.

The foetal appendages are of secondary and minor importance: undue length of the cord, its marginal insertion, or attachment of the placenta low down in the uterus, can never be direct causes of the accident; excess of liquor amnii is alone to be feared.

Some stress is to be laid on obnormity in shape and position of the womb, much more upon twin births. More dangerous than any of these is the contracted pelvis, which I have proved by measurements and numbers to be the main cause of prolapse of the funis, directly and indirectly; a fact hitherto generally accepted, but never as yet clearly established. Another such vague general statement, that the prolapse is by far more frequent among multiparæ than among primiparæ, our cases disprove; they show that primiparæ are, comparatively speaking, almost as frequently afflicted as multiparæ.

The law governing the location of the prolapse is of importance, and here for the first time touched upon: it will, I trust, be verified by the investigation of other observers.

The post-mortem examinations revealed only the lesions due to death from the asphyxia, nothing characteristic for death caused by prolapse of the cord.

The prognosis we can give is somewhat better than generally allowed; most favourable for foot-presentations, after these for shoulder and transverse presentations, while vertex-presentations are more dangerous than any; the case being, under all circumstances, more threatening when occurring in a primipara.

In the treatment of our cases the high importance of the postural method has been developed, more as an adjuvant, however, than as a method in itself of dealing with the prolapse.

Version is comparatively the most successful of all operations, and should be more frequently resorted to when any choice of method is given, as in head-presentations: the application of the forceps and reposition of the cord are less to be relied upon; but, whatever may be the course determined upon, it must be borne in mind that the success of all operations by which we seek the preservation of the child whose life is threatened by compression of the prolapsed cord is in a measure dependent upon the judicious use of chloroform, its application to full surgical anaesthesia.

SUBACUTE OVARITIS.

E. J. TILT, M.D.

(Transactions of the London Obstetrical Society. xv. 1874.)

The difficulty of correctly diagnosing ovaritis arises chiefly from the fact that peritonitis obscures the diagnosis by embedding the pelvic organs in a mass which forms, only too often, a hard pathological puzzle. The symptoms may be divided into those known as catamenial and objective.

Although subacute ovaritis may be met with during the whole period of ovarian activity, it is most likely to occur in young unmarried women,

from fifteen to twenty years of age, particularly in those who are delicate in body, sensitive in mind, and with proclivities to tubercular disease. When met with in women presenting none of these peculiarities, the patients will be found to have suffered all their lives from menstrual irregularities. Women, suffering from this trouble, complain of habitual pelvic and mammary pain, and especially of a marked aggravation of the nervous symptoms of menstruation, the menstrual flow being usually too abundant, or, as occasionally happens, too scanty. The pain of subacute ovaritis is deep seated, persistent, moderate, bearable, extending from the ovarian region to the knee, and sometimes accompanied by numbness, coldness and anaesthesia of the anterior part of the thigh. The pain gives rise to a certain degree of hesitation in the patient's movements, since she has learned to know that a sudden motion will increase it. Firm pressure on the ovarian region increases the pain and the peculiar nausea which not unfrequently accompanies it. The pain somewhat subsides soon after menstruation, only to reappear, however, a few days before the next period. It is not relieved by a free flow of the menses. Menstruation is preceded and accompanied by a marked aggravation of the usual mammary symptoms of that period, the breasts being swollen, painful and hot. Hysterical phenomena may also be present.

A vaginal examination will often throw a great deal of light on the case, even if it does not finally settle the diagnosis. The left hand should forcibly depress the ovarian region, while the two first fingers of the right hand examine, *per vaginam*, both sides of the body of the uterus. A forcible inclination of the cervix uteri to the side on which the disease is supposed to exist, stretches the connections of the fundus uteri and the ovary to such a degree as greatly to increase the pain. Sometimes the ovary descends into Douglass's pouch, where it can be felt as an ovoid body, about two inches long, either more or less fixed by peritonitis, or fleeing from the finger, only, however, to return, as by a kind of ballottement. This body, when seized, will be found to be semi-elastic and peculiarly sensitive to pressure. A combined rectal and vaginal examination will often be found of great service in making out the diagnosis.

As regards treatment, a well appointed hygienic course for menstrual and inter menstrual periods should be advised, combined with a tonic treatment. Six leeches should be applied to the suspected ovarian region, which should subsequently be painted with oleate of mercury for six weeks, after which counter irritants may be used.

In all cases where uterine disease coexists, it should be carefully treated, since it will be found impossible to relieve an ovaritis while a disease of the uterus is allowed to continue unheeded. In these cases, in addition to the above treatment, an injection should be ordered twice a day of acetate of lead. Not unfrequently, in these cases, marriage will be immediately followed by a severe attack of uterine inflammation.—*Med. and Surgical Journal.*

ON THE LEUCORRHEA OF LITTLE GIRLS.

Lecture by M. BOUCHUT, Médecin de l'Hôpital des Enfants Malades, &c.

We have at the present time under observation two cases of leucorrhœa, one in a little girl ten years of age, the other in a child four years of age. As this disease greatly preoccupies the mothers, who, in their ignorance of the things of life, cannot comprehend that organs in process of development, and which are supposed to be dormant and far from physiological activity, can become diseased, I am desirous of telling you what is the nature of this malady, and what is its treatment.

The first case is that of a child ten years of age, who has been ill for three weeks. Without any known cause, without previous disease, the child was taking with itching and abundant whitish discharge, which stained the linen green, as in women affected with blennorrhœgia. The vulva is hot, its folds are impregnated with pus, and the orifice is swollen and dusky wine-red. No follicles or ulceration are seen on the mucous membrane, and lateral or hypogastric pressure does not cause the escape of pus from the vagina. The clitoris is red, swollen, and passes much beyond the labia majora.

As regards antecedents there is no trace of scrofula, but there is eczema of the head, in the hair, and pityriasis on the face. It is to me evident that this child has an herpetic diathesis—an important observation, which suffices to account for the leucorrhœa.

The other child had for several days an indeterminate febrile state, attending which was leucorrhœa followed by *aphthæ* of the vulva, which have ulcerated, and on which phagedenism has created profound invading ulcerations, characterizing a particular form of gangrene of the vulva. This leucorrhœa is a result of defective care and of proper washing, indispensable in all the acute diseases of little girls.

These two cases are essentially different, for the one is a diathetic leucorrhœa, and the other is an inflammatory leucorrhœa due to want of attention. You will find these two orders of causes in many cases of leucorrhœa, but they are not the only ones. We must add to these, attempts on virtue, which are very common, and which, by attrition of the parts, engender an inflammation of the parts followed by leucorrhœa, or by blennorrhagic or syphilitic contamination, determining a veritable blennorrhœgia or syphilis—that is to say, chancre and its consequences. If to these causes you add masturbation, which irritates the mucous membrane of the clitoris and vulva, and then oxyurides of the rectum, which, passing from one part to the other, provoke irritation of the mucous membrane and itchings, you will understand what are the causes of leucorrhœa in little girls.

The most frequent cause is herpetism or herpetic diathesis, scrofulism, and dirtiness, which, in the acute diseases of childhood, is followed by the most sad consequences. In effect, in typhoid fever, septicemic disease, small-pox, virulent disease, one often sees the vulva covered with a muco-purulent discharge of a very irritating nature, and if one does not have the children washed, a vulvar folliculitis

results, followed by ulcerations with red edges and grey pseudo-membranous base, resembling *aphthæ* of the mouth. A little later these ulcerations become phagedenic, increase in every way, causing considerable loss of substance, and destroying the vulva and perineum to the anus. There is extensive molecular gangrene.

In other cases, under the ulcerated follicle a sudden engorgement of the cellular tissue occurs like a hard core, accompanied by tumefaction and redness of the labia majora; then a black eschar appears, which rapidly extends, and forms true gangrene of the vulva. This is escharifant gangrene, which is nearly always followed by death.

These kinds of leucorrhœa are the most grave and least common. The others connected with scrofula or herpetism do not involve like consequences. They remain some weeks or months and then disappear. Their nature is indicated by the scrofulous or herpetic state of the children. The seat of the leucorrhœa of little girls differs absolutely from the seat of leucorrhœa of women and young women. Whilst in the adult leucorrhœa is always vaginal or uterine, in the little girl it is always vulvar. It only occupies the external parts of generation. It is the mucous membrane of the great and lesser lips of the vulvar orifice which is affected. In the two children which you see in my "service" the suppuration comes from the exterior, and the vagina is of no account. I have just shown this to you on the patients, and you have been able to acquire the exact proof of my statement.

The liquid secreted is acrid, irritating pus, yellowish-white, colouring the linen green, and more or less abundant according to the case. It provokes a disagreeable pruritus, which forces the children to scratch, and which sometimes gives rise to habits of masturbation, which they have not previously had. Again, as the liquid is very irritant, if the children after having touched the vulva with the hands and soiled the fingers, rub their eyes, very grave purulent ophthalmia sometimes results; hence the necessity of putting on gloves or long chemises tied beyond the feet.

After what I have said of the leucorrhœa of little girls, and of its different nature, you will see that the treatment should not always be the same, and that it varies according to the presumed cause of the disease.

In leucorrhœa caused by emigration of oxyurides from the rectum to the vulva, the vulvar orifice should be washed with carbolic lotions, enemata of the same should be given, or of scot, and suppositories of mercurial ointment should be put into the rectum.

In the leucorrhœa of acute diseases lotions of water and aromatic wines may suffice. But if there are follicular ulcerations or phagedena the following ointment should be used:—

Axunge, 30 parts

Coal-tar, 3 "

and night and morning washings with coal-tar sapo-nine.

If instead of phagedenic ulceration there is an

eschar, one should detach it, and dust the wound with powdered camphor.

Now, for the leucorrhœa produced by scrofula and herpetism, we must administer internally cod-liver oil and syrup of arseniate of soda. In these cases we ought to prescribe baths containing carbonate of soda, sulphurous or sublimate baths, lotions of sublimate, of coal-tar saponine, of carbolic acid, and if the disease resists, paintings with solution of nitrate of silver. The leucorrhœa never resists these combined measures, and the combination of internal and external treatment which I have mentioned suffices to triumph over this disease."—*Annales de Gynécologie*, Mai, 1874.

THE STRUCTURE OF THE MUCOUS MEMBRANE OF THE UTERUS AND ITS PERIODICAL CHANGES.

By JOHN WILLIAMS, M.D., Lond., Assistant Obstetric Physician to University College Hospital.

The paper consists of observations made on the uteri of nine women who had died in different stages of the monthly period.

In two of the uteri the menstrual flow had almost ceased, and the mucous membrane was wanting in the bodies of the organs. The muscular fibre-cells were more or less exposed in the cavity, and the meshes formed by their bundles contained glands and groups of round cells.

In one uterus menstruation had ceased three days before death, and the muscular fibres were not exposed in the cavity of the organ, but imposed upon them was a layer of tissue composed of fusiform and round cells. This tissue contained glands. The muscular tissue near the internal orifice was devoid of glands, but nearer the fundus it contained numerous glands.

In one uterus, in which the catamenial flow had ceased probably about a fortnight before death, the layer of superficial tissue was thicker than in the last; and near the internal orifice there was a marked and abrupt distinction between it and the subjacent muscular tissue.

In one uterus the flow had ceased three weeks before death, and the superficial layer was still thicker; and the distinction between it and the subjacent muscular layer was well marked, except at the fundus. The uterine glands were tubular, and arranged in some parts obliquely, in others perpendicularly to the surface. They were lined by columnar ciliated epithelium.

In two uteri menstruation was imminent, but the flow had not begun. In these the mucous membrane of the body of the uterus was fully developed, and had begun to undergo fatty degeneration. There was a marked distinction between it and the muscular tissue throughout the uterine cavity; it was highly congested.

In one uterus the menstrual flow had taken place for one day, and in another for two or three days before death. In these there was extravasation of blood into the mucous membrane, and the latter had in part been disintegrated and removed.

Menstruation appears essentially to consist not in

a congestion or a species of erection, but in growth and rapid decay of the mucous membrane. The menstrual discharge consists chiefly of blood and of the debris of the mucous membrane of the body of the uterus. The source of the hemorrhage is the vessels of the body of the uterus. The mucous membrane having undergone fatty degeneration, blood becomes extravasated into its substance; then the membrane undergoes rapid disintegration, and is entirely carried away with the menstrual discharge. A new mucous membrane is then developed by proliferation of the inner layer of the uterine wall, the muscular tissue producing fusiform cells, and the groups of round cells enclosed in the meshes of the muscular bundles producing the columnar epithelium of the glands.—*Obstetrical Journal*.

LAMBERT H. ORMSBY,

Surgeon to the Hospital, and Demonstrator in the School of Surgery, Royal College of Surgeons in Ireland,

ON CHRONIC RHEUMATIC ARTHRITIS OF HIP-JOINT.

This is a disease that produces at times great deformity in this joint. It has, as is well known, been first accurately described by two Irish surgeons, Mr. Robert Adams, of Dublin, and by the late Professor R. W. Smith; it was formerly called chronic rheumatism of the hip-joint, then *morbus coxæ senilis*; but the first-named seems to be the generally accepted term in the present day to denote this peculiar disease. Mr. Adams says, as to the cause of this chronic disease of the hip joint he believes little is known. We have heard it frequently attributed to the effects of cold and wet, and an acute attack of rheumatic arthritis of the hip-joint produced by cold we can easily conceive may occasionally merge into the chronic affection we wish to describe. We have also reason to think that falls upon the greater trochanter have given rise to the first symptoms of this disease, but in many cases no satisfactory cause can be assigned by the patient for the origin of the affection.

Symptoms.—It generally occurs in those advanced in life, over 50, but may arise sooner—between the ages of 50 and 70, the most common. I have seen it more in men. One hip or both may be effected, also other joints in the body. It commences by the patient complaining of great stiffness in the joint, and about the greater trochanter a dull boring pain is felt, extending down the front of thigh to knee; the stiffness is most felt in the morning; if the patient has walked much in the day the stiffness and pain are severe in the evening; there is a limitation in the range of motion, pain is felt when the patient places full weight on the affected joint, but when the surgeon presses the head of the bone up against the acetabulum no appreciable pain is experienced, the limb is shortened for about two or three inches, which varies in different subjects, but it is more apparent than real, owing to the obliquity of the pelvis, the nates is flat on the affected side, and the muscle appears wasted. When the joint is rotated, crepitus, owing to the grating, can be heard occasionally. A

patient so suffering finds a great difficulty, in fact, in some cases it is impossible, to bend so much as to touch their toes; the attitude of standing and mode of locomotion are quite characteristic—they stand on the sound leg, slightly bent forwards in body, and rather spread the affected limb out, and with a slight bend at the knee, and the mode of locomotion is generally by the aid of two sticks, and is accomplished very slowly and interruptedly, the body slightly bent forward at the hip. The anatomical or pathological appearance in the joint is as follows: The muscles are flabby and atrophied, the capsule is thickened, the synovial fluid is deficient, and if any of the sub-synovial tissue is present, it is very red and vascular, the cartilage of incrustation is removed from the bottom of the acetabulum and head of the bone, exhibiting at times a polished porcelainous appearance, due to friction of the two bones against each other; the cotyloid ligament is frequently ossified; the acetabulum is deeper and larger, and forms a deeper cup than usual, with a level brim round the head of the bone, and narrowed so as to make it difficult to remove the head of the bone when required for examination after death; the Haversian gland is completely removed; the ligamentum teres is either ossified or entirely destroyed; the head of the femur is rounded, or depression, or bony ridges or nodules are seen on its surface; the neck is shortened. Cases of this disease have before now been mistaken for osseous tumour in intracapsular fracture; these little bony deposits may be developed round the acetabulum and capsular ligament. I merely mention this disease on account of the deformity, in order that you might be aware of it and not mistake it for anything else. As regards the treatment it is at its best state but palliative; as yet no remedies are suggested for the purpose of curing it permanently, being a disease of advanced life and one of disorganisation and degeneration of the several tissues constituting the joint.

Medical Press.

SUBCUTANEOUS INJECTIONS OF ERGOTINE FOR THE VARICOSE VEINS OF PREGNANT WOMEN.

At a meeting of the Obstetrical Society of Berlin, in April, 1873, Dr. RUGGE related a case where he had obtained marked results from the use of ergotin. A woman, 36 years of age, who had suffered exceedingly, during a previous pregnancy, from varices, came under his care in the eighth month of pregnancy, suffering from her previous trouble. The veins of the left leg and thigh were enlarged, dilated, and tortuous.

Injections were made subcutaneously with from one to two grains of ergotin, and repeated every few days. The action was very apparent after the first injections, and after the seventh the varices had almost disappeared. The right extremity was not affected.

There was some pain and infiltration following each insertion of the instrument, but no abscess occurred. The ergotin had no influence in provoking labour-pains.—*Med. Record*, April 1, 1874, from *Berlin Klin. Woch.*, 44, 1873.

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MEDICO-CHIRURGICAL SOCIETIES.

Among the many features which the medical profession of the day presents, there is none so peculiar as the tendency to organize and form societies, both local and general.

We are impressed with this fact on perusing the different medical exchanges which are sent us, for in them all do we meet with reports of such societies. Much that is valuable is by such means made public, and facts which otherwise would be lost to the general body, are recorded. Thus thought answers to thought and a spirit of investigation and observation is engendered, so that the tendency to narrow one'sself down to routine duty is removed, broader views being inculcated. This is as it should be, and we deem it the duty of those whose experience and reading fit them for discussing medical questions to take an active part in such meetings, that the younger and rising generation may have an example to follow out the spirit thus shown. Probably not the least benefit derived from such meetings of the profession, is the kindly feeling and fellowship which, fostered by association and the influence thus exerted, does more to control the actions of each individual than all the ethical rules which may be published. The younger practitioner specially feels this, and requires that countenance and support which such combinations offer, and which will sustain him in his early difficulties. From the difference in language, Montreal is, unfortunately, obliged to have two medical societies, and thus a separation is established between the members of the profession, the result being that one section is almost unknown to the other. Our remarks have been induced by the languishing state of the English-speaking society, and we consider it a shame on the part of its members that so little interest is manifest in its behalf.

Of late its meetings have been so poorly at-

tended that the proceedings have often been delayed until a chance comer should enter to complete the quorum, and this even with the small number required to form such quorum, which was reduced on purpose to meet like contingencies. Even this small quorum sometimes cannot be had, for lately the meeting was called with a resulting attendance of the President, Secretary, two gentlemen who were to read papers, and one other member. Surely this is too bad, for elsewhere in country places, where societies exist, their members travel considerable distances to attend the meetings of their society and partake freely in its discussions. Montreal which is supposed to be the head of the Dominion in all matters, hardly furnishes sufficient medical men who maintain an interest in the working of its medical association, and but few of the senior members of the profession ever put in an appearance at its meetings. How many previous associations have existed in Montreal we have not made out, owing to the paucity of reports obtained in the medical periodicals of the past; but we trust that the present association will institute full reports of proceedings, so that the future inquirer into such histories may have extended facts to guide him.

Twenty-five years ago Montreal could boast of two societies, a Medico-Chirurgical and Pathological, and among the names of their officers we find many who are still active and well known among us to-day. We are surprised that they should have suffered the society to lapse, seeing that they have been active in promoting those which have been subsequently formed. In August, 1865, a society was again established with the old title of Medico-chirurgical; Dr. G. W. Campbell being its first President. To combine both sections of the profession, the officers were chosen from the English and French members, and it was permissible to use either language, and many valuable communications were brought before the Society. We notice in the report read at the annual meeting, held on the 15th of January, 1866, that there were 80 physicians practicing in Montreal at that time, about half of whom were members, and the hope was expressed that all would be included by the next annual meeting. At that meeting Dr. Hingston was elected President for the following year, but that year was barren of result; owing, no doubt, mainly to the

difficulties which arose from the use of both languages. The society soon ceased to exist.

Another effort was made to establish a society, and, on the 12th of November, 1870, the present Medico-Chirurgical Society was ushered into existence. It has survived four years, and during that time many valuable papers have been read, and subsequently published in the medical journals. During the first three years the meetings commanded a good attendance, but the past year has shown a falling-off in attendance and great lack of interest until it has reached the result of being unable at times to obtain a quorum. Even at the annual meeting the attendance was smaller than what might be expected and leads to the impression that this society will also be soon numbered with the past. We hope not, however, but trust that each and all will deem it their duty to attend regularly and take part in the proceedings; and that there should be no difficulty in getting papers, it should be the pleasure of each member to carefully prepare one, so as to be ready when his turn comes. Heretofore, the Secretary has had difficulty in inducing members to give papers, and when some of them have been brought before the society, the reader has excused deficiencies on account of the hurried manner in which the paper was prepared. This is not what should be expected; if hurriedly written they do not reflect credit on the reader, nor do they command the attention of his hearers, and thus interest is lost in the society. We trust that a new life and energy will be infused into the Society, and in future its meetings will be characterized by discussions worthy of the position which the city and its physicians occupy in the Dominion and thus set an example to other associations. At the annual meeting, which occurred on the 16th of October last, Dr. Hingston, the retiring President, delivered the usual address, which embraced many of the questions now agitating the scientific and literary world. As this address will be published in our next, we forbear making any remarks upon it. At its conclusion Dr. Hingston received a vote of thanks for his valuable paper, and also for his conduct in the chair during the past year. The following officers were elected for the coming year: President, Dr. Reddy; 1st Vice, Dr. Godfrey; 2nd Vice, Dr. Craik; Secretary-Treasurer Dr. Roddick. Council, Drs. Hingston, Fenwick and Gardner.

HEALTH OF MONTREAL.

The following is an abstract of a report sent us by Dr. Larocque, one of the Health officers of the city.

In September there occurred 577 deaths; of these 464 were children under ten years, and 224 were from zymotic diseases. The mortality in August was 785, of these, 678 being children. Small-pox, scarlatina, and whooping cough had about the same number of victims in September as in August, but typhoid fever has considerably increased in fatality, there having been 22 deaths therefrom in the former month, against 13 in the latter.

Whooping-cough is the infantile disease that seems increasing most, 23 deaths from it having occurred in August and September.

The Health officers desire legislation for the purpose of instituting by-laws for the prevention of disease. The regulation it is desired to enforce comprise such as the following:

That medical men report to the Board of Health all cases of disease coming under their treatment within twenty-four hours thereafter.

That all boardinghouse, hotel or house keeper report cases of contagious disease on their premises to the Board.

The Health officers to visit localities where contagious maladies exist and adopt such precautions as may be required, such as sending patients to hospital when they cannot conveniently be isolated; disinfecting or even burning all that can possibly spread the contagion; and in cases of small-pox, vaccinating or re-vaccinating members of the family, neighbors or attendants on the sick most exposed to the infection.

The Corporation ambulance to be alone employed for transport of the sick, carters or other persons being strictly forbidden to do so.

Bodies of persons deceased of contagious diseases to be disinfected and interred within so many hours after death as may be decided on; simple hearses devoid of trappings or other ornaments that might absorb the contagion only to be used: and the bodies not allowed to enter any church or charnel-house, but be at once buried.

The officers of Health and Sanitary police to have authority to enter into any house or other building, and examine its sanitary condition

from top to bottom, and inquire into the vaccination or non-vaccination of the children.

To facilitate vaccination the city to be divided into four districts, with an office in each, for performance of the operation, and where a register of vaccination will be kept.

Forms to be distributed to the different religious denominations for record of births, and to be collected by the officers once a week; with aid of these it will be possible to have children vaccinated at the legal age and form a statistical compilation of some value.

Death certificates should only be signed by a doctor and brought to the Health Office; when no certificate is given the Board reserve right to hold an investigation to ascertain the cause of death.

The sale of milk must be regulated, as it is at present sold in such an adulterated and diluted form as to be insufficient to nourish children. Adulterated liquors, being the cause of frequent sickness, should be analyzed, and their sale also regulated.

DEATH FROM CHLOROFORM.

One of these deplorable accidents occurred lately in Kingston, the victim being a lady who was having a tooth extracted. The occurrence of like fatal issues is from time to time recorded in the news of the day and most generally from chloroform having been taken during the performance of some minor operation, especially in dental surgery. We have been struck with the fact, and can only account for it by the nature of the operation which generally permits or requires patients to assume a sitting posture. This position favors cerebral anemia—which is the cause of death, so that the first remedy to be tried is change of posture as advised by Nelaton. The patient to be inverted with the feet upwards and head downwards. In a case reported by Dr. Sims, of New York, life was restored by this method after respiration had ceased for fifteen minutes, and other cases are recorded where this plan had succeeded after other plans had failed.

We are informed that the Medical Faculty of the University of Bishop's College have been placed on the list of Medical Schools recognised by the Royal College of Surgeons of England.

REVIEWS.

A Practical Treatise on the Diseases of Women.
By GAILLORD THOMAS, M.D., Prof. of Obstetrics and Diseases of Women and Children in the College of Physicians and Surgeons, N.Y., Surgeon to the New York State Women's Hospital, Hon. Fellow of the Obstetrical Society of London, &c., &c. Fourth Edition, thoroughly revised, with 186 illustrations on wood. Published by Henry C. Lea, Philadelphia: Montreal, Dawson, Bros.

To favorably notice a treatise that has already attained its 4th edition within five years, that has been translated into German, and is now being prepared for the French and Italian press, is a work of supererogation so far as commending it to the profession is concerned, but is nevertheless one of the most pleasing duties that falls to the lot of the reviewer.

The first chapter is devoted to a most instructive and able summary of gynecological history, wherein we learn that many of the most useful of recent discoveries are but the reproductions of past ages that have been long lost to science. Notably is this the case with reference to the uterine sound and vaginal speculum.

The second chapter is occupied with most valuable information upon the important subject of the etiology of uterine disease. Improperities in dress, and want of care during menstruation and after parturition, are treated with well merited condemnation as fruitful sources of disease.

Chapter iii., on the diagnosis of diseases of the genital organs, is a succinct summary of all the known modes of investigation together with clear instructions as to their use in order to attain satisfactory results.

Chapter iv., on diseases of the vulva, gives a complete description of the diseases of this part, without reference to specific diseases common to it and other parts of the body.

Chapter v. is devoted to rupture of the perineum, and not only details the various modes of procedure, but illustrates the subject with original drawings that cannot fail to impress a clear conception of the appropriate treatment upon the mind.

Chapters vi. and vii. are devoted to diseases of the vagina.

Chapter viii.—On atresia vaginæ. We note with pleasure that, among the various methods

of evacuating retained menstrual blood, the aspirator is strongly recommended as a preliminary procedure, to the operation, necessary to render the outlet potent per via naturalis. This course very materially lessens the danger to the life of the patient.

Chapter x. gives an exhaustive catalogue of urinary, fecal and simple vaginal fistulæ; among the latter we notice a rare form, not mentioned by other writers, viz., vesico-uterovaginal fistula. The whole subject is handled with skill, and the various instruments required to perform the operation, together with the operation itself, are illustrated by drawings, some of which are original.

Chapter xii. is occupied with general considerations upon uterine pathology and treatment. The causes of failure in therapeutics are treated at length, and deserve the careful attention of all who occupy themselves with this branch of the profession.

Chapter xiii. deals with acute endometritis and its complications. The authors deem acute parenchymatous *metritis*, as a primary affection, to be of rare occurrence, and that it should occupy a subordinate place in pathology. This view is supported by very able argument, and will doubtless carry conviction of its truthfulness to those who take the trouble to thoroughly investigate the subject.

Chapter xiv., on chronic cervical endometritis gives a complete exposition of the predisposing and exciting causes of this most common and important form of uterine disease. In the treatment the author gives a number of original wood cut illustrations of the various instruments recommended. One point of no small moment in the application of liquid caustics is overlooked, viz., directions for protecting the adjacent structures from injury; which can easily be accomplished by flooding the neck up to the cervical canal with a neutralizing solution.

We are glad to see that Dr. Thomas does not favour the use of nitrate of silver, as it is not so powerful an agent as the fuming nitric acid. This is quite true, but he might have gone a step further and reprobated its use on the ground of its favoring obliteration of the cervical canal; a result that is not unfrequently obtained by means of this agent.

The use of the curette is spoken of, and its value in the treatment of obstinate cases of

inflammation of the mucus glands of the cervical canal is worthy of trial by those who know what it is to deal with these difficult cases.

Chapter xv. treats of chronic corporeal endometrites, and leaves nothing to be desired with regard to the etiology or treatment. The question of intra-uterine medication is dealt with in a masterly manner. Intra-uterine scarification is touched upon and commended, although the author has had no experience in that form of treatment.

Chapter xvi.—On areolar hyperplasia of the uterus, or the so called perenchymatous metritis. Here the author roams with freedom on new territory, not that the condition had not been noticed by others, but that it was left for him to recognize its true pathology and place the subject in its true light. The doctrine enunciated as to the non-inflammatory character of this disease and which ascribes it to the hypergenesis of the uterine tissues, if not generally accepted by the profession, will not long remain unrecognized by those who give the subject their serious consideration. The chapter is replete with everything referring to the subject.

Chapter xvii. deals with granular and cystic degeneration of the cervix uteri. The granular condition is discussed at great length. The treatment recommended leaves nothing to be desired, and commends itself to the judgment as rational and scientific.

Chapter xix. and xx., are occupied with displacement and descent, of the uterus and exhibit the usual thoroughness of the author.

Chapters xxi. to xxv., inclusive, thoroughly exhaust all that can be said on the pathology and treatment of the various forms of uterine versions and flexions. The subject is largely illustrated both as regards the various forms of displacements, by original and instructive drawings. The value of pessaries is insisted upon in suitable cases, while their improper use and the evils they may cause are strongly spoken of and warned against.

Chapter xxvi., on inversion of the uterus, its pathology, diagnosis and treatment, is one of the most valuable chapters in the book. Remarkable success has followed persevering and well directed attempts at reduction even after 5, 10, and 17 days effort.

The author earnestly deprecates excision

except as "dernier resort," which from the foregoing remarks means much more than the expression generally conveys to the mind.

Chapters xxvii. to xxxi. are occupied with periuterine cellulites, pelvic peritonitis, pelvic abscess and pelvic hematocele, and are of great value.

Chapters xxxi. to xxxiv., upon uterine fibroids and polypi, are very full and complete; although the conclusions of the author with regard to gastrotomy for removal of the uterus in cases of fibro-cystic and fibroid diseases connected with it, are hardly in accordance with what one would expect from the success that has of late attended the operation. Surely the advice "that if it (the tumor) be completely amalgamated with the uterus, or so bound to neighbouring parts that removal proves difficult, the operation may be abandoned" is more than a doubtful commendation and quite unwarranted by the recent success that has attended that operation.

Chapters xxxv. and xxxvi. are occupied with uterine cancer and moles, and, while complete, present nothing new upon the subject.

Chapter xxxvii. deals very thoroughly with uterine and ovarian dysmenorrhœa. The subject is illustrated by numerous drawings of the latest and most approved instruments employed in the treatment of the disease.

Chapter xxxviii. on menorrhagia, and metrorrhagia is very full and satisfactory to the reader. The causes are grouped under four heads, which place the whole matter clearly before the mind.

Chapters xl. and xli. briefly touch upon leucorrhœa and sterility, and might have (for all practical purposes) been omitted; inasmuch as all that is connected with these subjects are fully treated of in other parts of the work.

Chapter xlii., treats of amputation of the neck, and, as a result of some experience, the author strongly recommends the use of the galvanic cautery where available.

The remaining chapters, with the exception of a short notice of chlorosis, are occupied with diseases of the ovaries and ovariectomy. The author gives a very able summary of the whole subject, and leaves no point of value unnoticed.

In conclusion we can cordially commend this work to the profession as the very best extant upon diseases of women. There is a fulness of research, and richness of original matter, pre-

sented in a pleasing, vigorous style, that is most refreshing to meet with.

The illustrations are clear and distinct, and the workmanship, as to both printing and binding, is admirably executed, and does credit to the well known publishers.

The Complete Hand-book of Obstetric Surgery, or short rules of practice in every emergency, from the simplest to the most formidable operations connected with the science of Obstetrics, with numerous illustrations. By CHARLES CLAY, M.D., late senior Surgeon and Lecturer on Midwifery, St. Mary's Hospital, Manchester, Fellow of the Obstetrical Society of London, Hon. member of the Louisville Obstetrical Society, late President of the Medical Society, Manchester, &c. Third Edition: Lindsay & Blackiston, Philadelphia, 1874. Montreal; Dawson Bros. Price \$2.25.

The modest title of "complete handbook" suggests much complacency and self-satisfaction as to the perfection of the work on the part of its author.

We are free to commend it as embodying very many valuable rules of practice, but find that like other human productions it cannot be called "complete." A thorough exhaustive of the whole subject treated of, could not be expected in a small work of some 300 pages. There may be some compensating advantage in small hand-books, that can be carried round in the pocket for reference, but we believe that critical seasons present no opportunity for consulting your pocket companion.

In the little book before us we notice what may well be called some grave omissions and a few small errors: when speaking of tying the cord, the author says nothing about the advantage of allowing a few drops of blood to escape when a child is still-born and there is capillary congestion. Such a procedure favors the establishment of respiration and often saves the child's life.

It seems strange that any writer of the present day should recommend the use of glass specula, or single curved forceps, yet such are the views of Dr. Clay, from which the best authors of the day strongly dissent.

With regard to the discovery of the placenta the author has quite overlooked the fact that the cleanliness and comfort of the patient can

be secured by the use of a quart bowl for the reception of the liquor amni and placenta: also, says nothing of the aid that can be given, both to the passage of the head and protection of the perineum, by the now well-known process of enucleation, when the occiput is well under the arch of the pelvis. The fact that the hand pressed over the body of the uterus during the last pain that expels the child generally causes the placenta to descend and occupy the vagina as the child passes into the world, is not mentioned.

In the treatment of post partum hemorrhage it is strange that the author does not so much as refer to the use of the solution of per-chloride of iron, the most efficacious and speedy of all known methods for arresting hæmorrhage where life is in imminent danger.

With regard to irregular contractions of the uterus and irregular labor, while we readily admit the character of such labors may generally be changed to a natural one by an opiate, yet such desired result cannot be secured in other cases where the trouble is due to decidual adhesions around the os, where detachment of the membranes or their rupture alone can accomplish it, as recommended by authors.

Much doubtless can be said to the praise of the little work, but we have thought it right to point out some serious defects that appeared to us in glancing through its pages.

A Manual of Toxicology, including the Consideration of the Nature, Properties, Effects, and Means of Detection of Poisons, more especially in their medico legal Relations. By JOHN J. REESE, M.D., Professor of Medical Jurisprudence and Toxicology in the University of Pennsylvania. Philadelphia; J. B. Lippincott & Co., 1874. Montreal; Dawson Bros.

The author of this book, in his preface, has anticipated the objection that, in view of the many excellent existing treatises on toxicology, in various languages, a new work on the subject was uncalled for. "This objection," he says, "however, might be equally urged against new publications in almost every department of science, there is scarcely one, of which it may not be affirmed, that its literature is abundantly supplied. Yet this does not deter new authors from venturing before the public, prompted,

doubtless, by the desire of offering something of at least a passing value, and of adding, it may be, a fragment to the store of human knowledge." What we have seen and read of this book, in our opinion abundantly justifies its claims to existence, and we have no doubt that, to the student especially, it will prove a useful work. The author has not scrupled, whenever it seemed to him proper, to make use of the recorded experience of other authorities. The pages of the book are enriched from Taylor, Guy, Christisen, Orfila, Tardieu, Caspar, and in the author's own country from Wharton & Still's "Medical Jurisprudence," and Professor Warmley's "Nucro-Chemistry of Poisons," a work which well deserves to be called magnificent, when we consider the profusion and excellence of its illustrations. The first part of the book is devoted to "The Mode of Action of Poisons on the Animal Economy; Circumstances which modify the Action of Poisons; the Post-mortem Inhibition of Poisons; the Evidences of Poisoning; and to Medico-Legal questions connected with Poisoning. A chapter is also devoted to "The Duties and Privileges of Medical Experts." Here our author deploras what has been sneeringly termed by newspapers, the "war of the experts;" that collision and difference of opinion which, from its frequency, the public have come to expect as a matter of course, and, in consequence, to reject all expert testimony as superfluous if not worthless; "a result which, it is to be feared, is not unfrequently reached also by the jury, to the great and manifest disparagement of justice." This unfortunate state of affairs is due to the fact that, in trials for poisoning as well as other medico-legal cases, it is quite usual to find medical men summoned as experts, both by prosecution and defence, who have never made the subject of toxicology a special study, and are, of course, ignorant of the important details of the science; but who, nevertheless, because they are "doctors," and are erroneously supposed to know, will venture to assume this most important function, and will even presume from the witness-box to enlighten the court and jury on one of the most intricate branches of science, and will hazard opinions which may probably determine the momentous issues of life and death."

The remedy suggested is, of course, the only proper one, and it is simply marvellous that it

has not been applied sooner in England and France, as well as in the United States and our own country, where the old objectionable system still prevails. These improvised experts should, of course, be excluded from poison trials, and the responsibility confided to genuine experts, as in Germany, where, in criminal cases, the experts first summoned "are exclusively those whom the State, after proper examination of their competency and skill in such particular inquiries, has duly authorized to act for this purpose; while, in addition, there is organized a tribunal of experts, to which the opinions of expert witnesses can be referred."

Some such remedy as this just mentioned is urgently needed to save medical evidence from the opprobrium from which it too often justly suffers.

These general questions having been disposed of, the author proceeds to the toxicology of particular poisons. He adopts the classification adopted by Taylor, but with some slight modifications. Poisons are divided into two classes, irritants and neuratics, the latter being divided into (a) cerebral, (b) spinal, and (c) cerebro-spinal. The individual poisons are then treated in detail, those which are most frequently employed coming in for a proportionately larger share of attention. The tests for each are given with due attention to detail. This part of the work is thoroughly up to the time.

The author has not, however, entered on the subject of spectrum analyses. The following are his reasons:—"This truly beautiful method of analytical research has developed the most wonderful results, both in chemistry and in other departments of medical science. In point of delicacy, it far transcends the most subtle and refined chemical reactions, and as a corroborative means of evidence, it will doubtless prove of great value to the toxicologist. But, as it deals, so to speak, with infinitesimals, we do not think that it would be safe, in a case of alleged poisoning, to rest the evidence solely upon the spectral demonstration of the supposed toxic agent, to the exclusion of the recognized chemical tests. When an accumulated experience with spectral analysis has rendered the identification of the various poisons absolutely and exclusively certain, we can probably afford to abandon altogether the more tedious and complex methods of chemical research.

In conclusion, we have to say that we confidently believe that this book will prove a valuable addition to the literature of the profession.

Surgical Emergencies together with the Emergencies Attendant on Parturition, and the Treatment of Poisoning. A Manual for the Use of General Practitioners. By WILLIAM PAUL SWAIN, F.R.C.S., Surgeon to the Royal Albert Hospital, Devenport. Philadelphia, Lindsay and Blakiston, 1874. Montreal, Dawson Bros. Price \$2.00.

Though this work cannot be considered anything more than a compilation from the more recent authorities in surgery, yet it is exceedingly valuable in presenting to the busy practitioner in a condensed form a clear and concise statement of the treatment to be adopted in emergencies. An opportunity is afforded to refresh the memory with the necessary conduct of such cases, and thus remove doubts as to the course to be pursued. The 82 illustrations which are scattered throughout the work appear at once to the eye and add to its value, so that altogether we consider it to be one of the most valuable and instructive manuals extant. The experience of the author has enabled him to present to the profession all that is valuable and necessary, and therefore we cordially recommend the work to our fellow practitioners. The chapter on antiseptic treatment is of great value, and is in our opinion of most importance. As the cost of the manual is only two dollars, no practitioner should be without it, especially those engaged in country practice. The size is such as to admit of its being carried in the pocket, and it will often be found to repay the cost when its owner cannot obtain a consultation owing to distance from a confrère.

The Sanitary Journal. Devoted to Public Health. Edited by EDWARD PLAYTER, M.D. Pp. 32. One dollar per annum in advance; single copy, twenty cents; Toronto.

With the exception of a bulletin issued by the Health Officers of Montreal, this is the only Sanitary Journal published in Canada. The

growing importance of the science of hygiene calls for the publication of such works, and, while they are useful to the physician, their perusal is of vital interest to the public, who will thereby gain information as to the best means of preventing disease and prolonging life. We wish it every success, and trust that it will be the means of doing much good.

The Physician's Visiting List for 1875. Lindsay, & Blakiston, Philadelphia.

This work has now been published for the last twenty-four years, and its merits are such that its publication will be demanded for many years to come. In this city it is used by a large majority of medical practitioners, and we would advise those who do not now use it, to give it a trial, and we are assured that they will continue its use. By the concise arrangement of this diary much time is saved in making entries, and from the facilities thus afforded in recording work done, hundreds of dollars can be saved which otherwise would be lost. For prices and sizes send for catalogue of publications.

PERSONAL.

We record elsewhere the death of Dr. J. C. Anderson, who graduated at McGill, in 1865. Dr. Anderson did not enjoy very good health for a long period of time before his demise, and the physical depression thereby produced, combined with an excitable and nervous temperament, led him to be somewhat erratic in his actions. At no time did he appear to settle down steadily in the pursuit of his profession, but from time to time has changed his residence from Montreal to Sorel, and we believe elsewhere. His death occurred in this city and his remains were removed to Sorel for interment.

Dr. James C. Irvine (M.D., McGill, 1866) has returned to Montreal to reside permanently and will shortly resume the practice of his profession, at 111 Fulford street, where his office and residence is situated. After graduation Dr. Irvine entered the service of Montreal Ocean steamship Company as surgeon, remaining about two years in the service of that line, he then exchanged into the Royal Mail Line.

running to the west coast of Africa; after one year's service with the latter, he re-entered that of the M. O. S. Co., remaining one year, and then finally left to again serve in the African Line. He was surgeon of the "Macgregor Laird" steamship when that vessel was wrecked on the rocks in the Bay of Crisco, where she became a total loss. The passengers and crew were landed on Eloby Island in the Bay, and were obliged to remain there nine days, during which time they were attacked by the negro savages, and in the melee which ensued several of the crew were killed, and Dr. Irvine received six slugs in the leg and a stab in the neck which laid him up for some months. On the ninth day they were taken off by a French man-of-war and carried to Fernando Po, being sent from there to England as shipwrecked mariners. While on the African line a petition was received from the British residents of Bonny River, asking him to come there, at which station he stayed two years and was through the severe epidemic of yellow fever which occurred on the coast in 1873. On his departure the residents presented him with a very handsome testimonial and expressions of regret at his leaving. While on the Bonny River, in addition to his other duties, he was physician to King George, receiving a salary of \$800 a year from his sable majesty, and at one time was called to visit a sick king in the Eboe country where a white man had never before been seen or permitted to enter. Dr. Irvine has been attending the hospitals in London during the last six months.

By the time this number will have reached our readers Dr. F. W. Campbell, the editor of this paper, will have returned to Montreal, as it was his intention to sail from Liverpool on the 29th of October. He was detained in Scotland beyond the time expected for his return owing to the death of a relative, and during his stay was laid up with a severe illness which confined him to bed for some time, however, by accounts received lately, he had recovered his usual health, and we expect to see him resume his duties with renewed vigor.

Dr. Francis W. Campbell, editor of the *Record*, returned from Europe by the Allan Mail S.S. *Polynesian*, on the 9th of November, as did also Dr. Elkington, of Brockville.

Dr. Wolfred Nelson removed an enlarged thyroid gland from a young woman living in the western end of the city, on the 24th of October. The left gland alone was implicated in the enlargement, and there was no connection with the right lobe. Very little blood was lost during the operation, and the patient has since done well, the wound being almost completely healed. All the females of her family are affected with goitre. The mother has an enlarged thyroid gland of great size occupying the whole of the anterior portion of the neck. The operation was performed at the request of the patient, as the deformity gave her much annoyance.

Dr. Norman Kerr, a few years ago surgeon on the Allan line, has purchased a practice in St. John's Wood, London.

Dr. Edmond Robillard, of this city, recently paid a short visit to Europe. He returned by the *Sarmatian*, the middle of October.

HEALTH OF MONTREAL.

The health of Montreal is not by any means satisfactory. Small-pox continues its ravages—the eastern section of the city still furnishing the greatest number of victims. Vaccination is being pushed with a certain amount of vigor—and we think that already its use is being demonstrated; for the last couple of weeks (ending November 20) has shown a considerable diminution in the death-rate from this affection. The city authorities have opened a Small-pox Hospital, in an old family residence in the new Mount Royal Park, and it is doing good and effective service. We regret to notice, however, that the authorities of the Montreal General Hospital still receive this disease—believing themselves compelled to do so by a clause in a Provincial Statute. Typhoid fever is also very prevalent, there being several hundred cases in the city—many cases are fortunately of a mild type. We have also heard of several cases of true diphtheria.

BIRTHS.

At Montreal on the 23rd of October, the wife of Dr. J. C. Irvine of a daughter.

DIED.

At Montreal, on Saturday, the 24th of October, Dr. J. C. Anderson, eldest son of Rev. Canon Anderson, Rector of Sorel.

At St. Leboire, on the 24th inst., after a short illness, Dr. J. A. O. Tetreault, in the 49th year of his age. The funeral took place from his late residence, at St. Pie, on Tuesday, the 27th October.