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CANADA
MEDICAL JOURNAL.

ORIGINAL COMMUNICATIONS.

Compound Dislocation of the Astragalus. Reduction and recovery with a useful limb. By JAMES A. GRANT, M.D., F.R.C.S., Edinburgh, &c., &c.

J. Moore, aged 35 years, a farmer of robust habit of body, June 24th, 1864, whilst driving a cart to the city his horse took fright, and he was thrown out with violence and dragged for some distance, his foot having caught in the wheel during the fall. He attempted to walk, but was unable, observing that he trod on the outside of the foot, at the same time the suffering was very great. The boot being removed, the following appearances were to be observed. The foot inverted so that the sole looked inwards, tendo-achillis not tense, the astragalus was driven forwards entirely out of its place, where it took a transverse position, and the anterior extremity protruded fully an inch through the integument on the outer side of the foot. On the upper part of the tarsus the skin was stretched tightly over the displaced astragalus. There was no fracture of either the tibia or fibula. There was very little surrounding effusion, so that the outline of the various parts could be well defined. The dislocated bone was thus wrenched from all of its connexions, and thrown transversely across the tarsus. An unsuccessful attempt was made to reduce the dislocation, by extension and pressure. The limb was placed quietly on the bed, and by moderate pressure the bone turned and shot into its place quite unexpectedly. An outside splint was forthwith placed on the leg, and a cold lotion applied over the ankle. An opiate was given at bed time, and the following day he entered the General Protestant Hospital. The cold water cloths were constantly applied until the 8th day after the accident, and then a purulent discharge from the joint having been observed, a linseed poultice was substituted. The discharge continued more or less until the end of August, at which time the wound

closed perfectly. The limb continued in a weak state until March 1865; he was then able to throw aside the sticks, and use the limb with considerable freedom.

From this date the parts gained strength, and at present he walks about as well as ever, and performs the various duties of farm life, the limb having regained perfect motion, the parts surrounding the displaced bone resembling in every respect those of a healthy joint.

"Remarks."—Owing to the extensive relations and connexions of so important a bone as the astragalus, one would scarcely have expected so favourable a termination, more particularly as the bone was severed from its attachments with the os calcis as well as with the tibia and fibula. Le Gros Clark considers that such cases do not admit of reduction, and Gross (in his Surgery, vol. 2 p. 161) says, "I am not aware that the operation of reduction has ever succeeded, except in one case which occurred to Mr. Liston, and in which the accident was attended with fracture of the tibia and fibula, which had probably the effect of rendering the parts more movable?" This case may be considered somewhat unique, and tends to illustrate the great amount of injury which even this joint can sustain, and yet through time and proper rest recover its full power and action. After the accident the inflammation consequent upon so severe an injury, gave rise to considerable effusion around the joint. Just in proportion as the parts returned to a healthy condition, the surrounding induration of tissue lessened. Thus are we able to observe the beautiful operations of nature, by the inflammatory effusion forming no necessary part of the ultimate bond of union, but merely holding the parts in close apposition until such time as union of the original tissues became complete, the temporary splints of nature and art exerting each its part in the progress of the case.

Cases of Blenorrhagia, or Urethritis produced by Leucorrhœa and the Menstrual Discharge. By GEORGE E. FENWICK, M.D., Physician to the Montreal General Hospital, one of the Governors of the College of Physicians and Surgeons, C. E., &c., &c.

The question, does urethritis occasionally follow coitus at the period of menstruation, or during the prevalence of uterine blenorrhagia, has been in dispute for years. My own observations, extending over several years, are conclusive in the affirmative.

The following cases prove to my own satisfaction that such an occurrence can follow in many instances, not invariably so, because we know that leucorrhœa is a most common accompaniment of the pregnant state;

still coitus is constantly occurring during the prevalence of this leucorrhœal discharge, and yet with perfect immunity.

I have no doubt it has fallen to the lot of every practitioner to be the arbiter of a wife's criminality or a husband's guilt, as suspicions the most unfounded, calculated to ruin the peace and happiness of a family, have been time and again submitted to the decision of the physician. I do not wish to assert that a blennorrhœa invariably follows coitus during the menstrual flow, but that it will occur under certain circumstances or certain conditions of the male, wherein a greater aptitude for the reception of the impression seems to exist, or where, from some constitutional disturbance on the part of the female, the secretion, be it menstuous or leucorrhœal, becomes more irritating or acrid. These views are fully borne out by the experience and teaching of some of the first authorities of the day, among whom I may mention Ricord, Diday, Skey, Bumstead, and others.

During my pupilage, I met with two cases of undoubted blennorrhœa produced by having connexion at the menstrual period: one the case of a fellow student, who had connexion with a young person whom he afterwards married. It was remarkable, inasmuch as there could be no doubt of her virginity previous to the act: it was the second time only that she had menstruated; the connexion was fruitful; a marriage shortly after occurred, and they have lived together since.

Case 1.—G—, a gentleman residing in this city, had occasion to visit the neighbouring republic on business during the year 1855. While in one of the principal cities of the Union, he had criminal congress with a female, the wife of a gentleman of known respectability. The parties had been living together as husband and wife for several years, and were so at the time that this occurrence took place. The desire of the seducer was effected after considerable difficulty; and, on his return to his hotel, he noticed his clothes stained, and upon inquiry learnt that she was just recovering from her monthly illness.

The second day after his liason he returned to Canada, and sought the society of his own wife, little dreaming that his sin would be found out. The day following, which was the seventh after he had had the suspicious connection, he noticed a slight tingling in passing urine; this was accompanied by a weepy state of the lips of the urethra; a slight mucopurulent discharge followed. Being an old offender, he sought medical aid immediately, and was told by his surgeon that he had an undoubted clap. He was placed under treatment, and shortly recovered. In the mean time his wife suffered from symptoms of uterine blennorrhœa. She was placed under treatment, and recovered. He, of course, was thoroughly convin-

ced that the woman with whom he had connexion had communicated the disease to him. Months afterwards, having occasion again to visit the States, he found the lady still living with her husband; she declared she had never suffered from whites, and furthermore she had since given birth to a healthy child.

Case 2.—B——, a married man, consulted me on June 10th, 1857; he insisted his wife had given him the bad disease, as he termed it; he was very much depressed in spirits, and bent on a separation. Having known the parties for some years, I felt convinced of his wife's moral rectitude. He certainly had a most acute and decided attack of blenorragia, and suffered intensely both in body and mind. He himself was an exceedingly moral, upright man; he had never suffered from any disease: indeed I doubt very much if he had ever had connexion before he married. I questioned him closely, and with some difficulty elicited the fact of his having had connexion with his wife several days previously, and that he had discovered afterwards unmistakable evidence that she was unwell; still his mind was not relieved by my assuring him of the possibility of the disease occurring under such circumstances. He would not be convinced, but insisted on his wife undergoing an inspection; this was done, but no disease was discoverable. At the end of three weeks he recovered perfectly, without an untoward symptom.

Case 3.—McD——, a farmer of strict moral habits, consulted me in July, 1858, for a most decided blenorragia: his wife is somewhat elderly and of most exemplary conduct. There is little doubt of the truthfulness of the following account. Three weeks previous he had sexual congress with his wife, and at the time the menstrual flow had hardly ceased. Since that period he had slept in a separate bed, in his wife's room; it being the haying season, he was obliged to rise early and work hard, as he had a heavy crop, and very little help. He attributed the attack to the heavy work he had gone through, and I did not undeceive him; the disease yielded to injections, cleanliness and rest.

Case 4.—A gentleman consulted me July 30th, 1859. He stated that the day previous he had exerted himself rolling a barrel of flour up an incline; his foot slipped, and the barrel rolled back, striking him forcibly on the abdomen. This occasioned much pain at the time, chiefly referable to the region of the loins; the pain subsided in the course of a few hours. The following day he suffered from intense scalding and heat in passing urine, the lips of the urethra were red and inflamed, and there flowed a thick muco-purulent discharge. Upon inquiry he admitted having had connexion a few nights previous with his wife, and that in the morning he found his clothes much stained. Upon informing her of the

circumstance, she at first denied it, but upon more careful inspection, found it was so. She fancied herself in the family way, not having seen a change since she had weaned her last child, since which a period of four months had elapsed. The case was placed under treatment, and a speedy recovery resulted.

Case 5.—Joseph M., a French Canadian, consulted me in August, 1859. He had intense scalding on passing urine; there was considerable discharge, the lips of the urethra were of a dusky red, and looked as though they had been touched with lunar caustic. The edges were everted, and a slight superficial slough existed on either lip. He declared he had never had connexion with any person but his own wife; that he had several days before, while she was unwell. He ridiculed the idea of its proceeding from such a cause, as he had done so on several occasions before with immunity. He was put under treatment; a cold water poultice, with lint and oil silk, was applied, and he was ordered to drink freely of flax seed tea. At the end of a week he was quite well.

For the following case I am indebted to my confrère, Dr. F. W. Campbell :

George J——n, a somewhat respectable-looking man, presented himself at the Montreal Dispensary on the 20th June, complaining of a profuse discharge from the urethra, accompanied by a good deal of scalding on making water. States that he has been married about seven weeks, and that since then has not had connection with any one but his wife. On enquiry I ascertained that on the fourth week after marriage the menstrual discharge came on his wife, and lasted for several days and during that time he had frequent intercourse with her. Almost immediately after, the discharge made its appearance. The patient was ordered a weak injection of sulphate of alum, and in a few days he was cured.

I have selected these cases from others in my note book all bearing on the same point. Other causes there are which have undoubtedly occasioned an inflammation of the urethra with all the concomitants of such a condition in any portion of the mucous lining of the body, in other regions. Such causes, as enumerated by authors, are blows, the passage of instruments, urethral calculi, violent exercise, especially horse exercise if long continued, and in hot weather, which is very apt to be followed by a blennorrhagic discharge.

Druitt mentions a case of long continued irritation of the urino genital organs, attended with a discharge following a ride of several miles on horseback without a saddle. Certain articles of diet have been said to occasion a running, such as the continued use of salt meat, cayenne

pepper, ginger; the continual use of beer, and some persons are incapable of using asparagus in consequence of a similar result. Cantharides is well known to occasion strangury attended with bloody urine, and sometimes a copious muco-purulent discharge. A case in point I met with some years since in the person of a young man, who had a violent attack of inflammation of the brain, of which he died. A blister had been ordered to be applied along the spinal column; this was done: but by error was left on for some thirty-six hours. Several days before death the urine was bloody, and there existed an abundant urethral discharge. During the persistence of certain diseases, such as of gout and articular rheumatism, a copious urethral discharge has been noticed, and vaginitis has been observed to accompany or follow the eruption of scarlet fever. There can be no doubt, therefore, that, although rare, blenorragia does occasionally occur independent of any specific poison, and that its existence is not alone sufficient evidence of moral delinquency on the part of either the male or female.

Montreal, 13th October, 1865.

HOSPITAL REPORTS.

Case of Diffuse Cancer of the Peritoneum. Reported by Messrs. WILLIAM McCARTY and JOHN BELL, M.A.

HISTORY.—Mary Drew, unmarried, aet. thirty-three, servant, and a native of Ireland, was admitted into the Montreal General Hospital, February 14th, 1865, under care of Dr. Craik. Her parents generally enjoyed good health. Her father died at fifty of "liver complaint;" mother still lives. One of her sisters died at forty of dropsy.

She says that about the first of November last, she felt a pain in her right side in the region of the liver, which lasted until a short time ago. After this she began to grow weak. About Christmas she observed a tumour ("lump") in the left iliac region which caused no pain. For a year before the cessation of her catamenia, which occurred about the 14th of January, 1865, she suffered from an almost continual leucorrhœal discharge.

SYMPTOMS ON ADMISSION.—On admission a large tumour could be felt occupying the left iliac region and projecting across towards the right side but gradually diminishing in size, and terminating a little to the right of the pubes. To the touch it was hard and unyielding, and was evidently closely adherent to the surrounding parts. Its upper

border was sharply defined and perfectly smooth, resembling, in feel the lower border of an enlarged liver. There was evidence also of some serous effusion into the peritoneum above the tumour, though not to such an extent as to produce any serious distention. She complained of great constipation, and a constant desire to void urine without the power of doing so, the obstruction in both cases being apparently caused by the pressure of the tumour upon the rectum and bladder. On examining per vaginum, a dense hard mass was found at the left side of the pelvis tilting the os uteri upwards, and to the same side, and rendering it difficult to distinguish the different parts from one another. The uterine sound was introduced with some difficulty, and passed into the organ to the usual distance. The catheter was also passed into the bladder not without difficulty, the tumour pressing upon the posterior part of the pubes, and consequently upon the bladder and urethra. The general health was not much impaired, nor did she complain of severe pain, the constipation and difficulty in voiding urine being the principal symptoms.

The tumour was considered to be cancerous.

PROGRESS OF THE CASE. *March 29th.*—Up to this time, the patient has continued in nearly the same condition as at date of admission, with the exception of the gradual increase of the tumour.

April 8th.—During the past week she has become much worse, and is now in a very low condition.

April 25th.—Since last note the patient has rallied, and now feels better than she has for many weeks.

June, 1st.—The patient during the past month has experienced an increasing difficulty in defecation, so that daily enemata have been required, and at the same time the desire for frequent micturition grows more urgent.

June 20th. The whole appearance of the patient is now indicative of great suffering. She is very much emaciated; countenance pale and sallow, with eyebrows drawn up.

Respiration sixteen per minute; expiration longer than inspiration, with a well marked rest between them, owing to the pressure of the abdominal tumour. Right side of chest resonant to the lower border of the fourth rib; left side resonant to the fourth rib. Pulse 105 per minute. Impulse of the heart diffuse, but felt most forcibly between the third and fourth ribs, and two inches to the left of the middle of the sternum. Heart sounds natural. The abdomen is very much distended with the tumour and serum, presenting the form of a hemisphere. The length of the abdominal wall, from crest of pubes to the ensiform cartil-

age, which is curved outwards, is eighteen inches. While the patient was in the sitting posture the following measurements were made :

Circumference at crest of ilium.....	44 inches.
“ three inches higher.....	42 “
“ the lower border of 3rd. rib.	32 “

In the middle line of the abdomen the well marked ridged edge of the tumour can be felt four inches above the edge of the os pubis, thence rising less rapidly on the left side than on the right where it becomes indefinable. The superficial veins of the abdomen particularly, but of the other parts of the body are very prominent, being distended with blood. The lower extremities and cellular tissue of the lower part of the abdomen very œdematous.

June 23rd.—Pulse 100. She now takes an opiate draught every night. Is compelled to micturate almost every hour, owing no doubt to the pressure of the tumour and fluid collected in the peritoneal cavity. Urine remarkably clear and limpid, and of the usual quantity notwithstanding her frequent calls to micturate. On examination *per vaginam* the wall of the upper portion of the vaginal canal and parts in its vicinity feel cartilaginous, or rather, as if moulded in plaster of Paris.

June 27th.—Pulse as before. Says she is becoming weaker. Suffers from continual thirst; tongue dry and red. Can lie only on her back with her head and shoulders well bolstered up.

June 30th.—Breathing more oppressed. She is compelled to assume the sitting posture in order to get any rest. Does not suffer from any well marked pain.

July 12th.—Pulse 106. Scarcely any change unless it be that she appears weaker and apparently worn out.

July 13th.—Died this morning.

SECTIO CADAVERIS.—The contrast between the thin emaciated chest and upper extremities, and the tumid white lower extremities is very striking. From these latter, on punctures being made, large quantities of clear serum trickled away. On opening the abdomen it was found to contain two and half gallons of clear amber coloured fluid. After this was removed, a very profuse deposit of cancerous matter presented itself. The small nodules, which were numerous, and the external parts of the growth were soft and white; the deeper parts were of a darker colour, tough and of a fibrous appearance, no doubt from the pressure causing an elongation of the cells into fibres. The hard edge of the tumour, before referred to, was formed by a growth of this abnormal tissue on the abdominal wall, bounded by the line already described. The omen-

tum was adherent at the sides to the abdominal wall, and at the lower border was fused into the general mass of cancer growth and intestines. All the fat was absorbed from the omentum, so that it appeared like a net spread over the intestines, at the intersections of whose threads were formed little pear-like knots of white pliable matter. The peritoneum of the sides of the abdominal cavity and of surface of the diaphragm was thickened and studded with white prominent nodules of the same material. More of the liver was adherent than normal, and between the two adhering surfaces there was interposed a thick layer of the cancer growth. A layer of this substance glued together the two larger hepatic lobes. Patches of it of various sizes were also found scattered over the surface of the liver, which weighed two pounds and thirteen ounces. Gall bladder distended with greenish black bile. Several cysts containing from $\frac{5}{8}$ ij to 3vj of clear yellowish fluid were to be seen on inspection, and of these one of the larger was situated near the neck of the gall bladder and another in the right iliac fossa. Many more were found on cutting into the mass. On the left side of the posterior wall of the abdominal cavity the peritoneum contained nodules of this abnormal tissue.

The intestines were agglomerated into a solid mass with this growth which fills the false pelvis and raises up against the abdominal wall. It is almost impossible to separate the intestines from the cancerous mass, and on section of it they resemble the open mouths of the hepatic veins. It is difficult to recognise the different structures filling the true pelvis, from the effect of pressure and the abnormal tissue. The walls of the vagina are mottled by the deposition of black pigment. Cavity of uterus small with walls thickened and of a fibrous appearance. What seemed to be one of the ovaries enlarged, was situated between the uterus and the bladder, and contained an encysted fibrous tumour of the size of a hen's egg. Kidneys and spleen normal in appearance, except that the latter weighed only $2\frac{1}{4}$ ounces.

The contents of the thorax presented no striking pathological conditions. The right lung weighed twenty-six ounces; the left but twelve. The posterior parts of both were consolidated from hypostatic congestion. Heart small, weighing six ounces; left side flabby, right thick and firm. The superficial veins of it prominent, and the subserous cellular tissue of the left side œdematous.

The dura mater is very tough and adherent.

MICROSCOPIC EXAMINATION.—A section of the tumour shewed the characteristic multiform and multinuclear cells. The fluid of the cysts contained numerous granule cells floating through it.

REMARKS.—The cause of all the signs and symptoms presented during

life was discovered at the *post mortem* examination in this cancerous growth, which was thought to have commenced in some of the pelvic organs on the left side, probably the left ovary, and to have extended to the adjoining organs, gradually incorporating them into its own structure. It covered the iliac veins and pressed on them so as to prevent the return of the blood from the lower extremities, hence their œdema. The obstruction it offered to the vascular system of the intestines and peritoneum caused the effusion of serum into the abdominal cavity. The impermeability of the deep veins, on account of the encroachments of the cancer growth caused the blood to return to the heart by the superficial veins, hence their constant distention. It encased the intestines, particularly the lower parts, so as to impede the discharge of their function. It encroached on and finally bound down the bladder, so as to require its frequent evacuation. The presence of the tumour and such a large quantity of water forced up the diaphragm, thus compressing the lungs and causing the painful difficulty of respiration and the displacement of the heart already alluded to.

REVIEWS AND NOTICES OF BOOKS.

The Endoscope, as an aid to the Diagnosis and Treatment of Disease.
By FRANCIS RICHARD CRUISE, Bachelor of Arts and Doctor of Medicine in the University of Dublin, one of the Medical Officers of the Mater Misericordæ Hospital. Dublin: Fannin & Co.

This pamphlet, of about 45 pages, contains an able article, which was first published in the *Dublin Quarterly Journal* for May, 1865. Since then it has been revised, and is now issued with additions. In opening his paper, Dr. Cruise alludes to the characteristic of modern medicine, viz., *the direct exploration of organs*, for the elucidation of their physiology and pathology. We have more than once stated our conviction that to this division is owing much of the progress which medicine has made within the past half century. The laryngoscope has done wonders in diseases of the throat, and laid the profession under a deep debt of obligation to Czermack and those who, after him, have worked steadily and perseveringly to illustrate the pathological conditions of throat affections as seen by this instrument. And now the endoscope, an apparatus by which the urethra, bladder, rectum, and other portions of the body inaccessible to the naked eye can be viewed, is attracting the attention of leading Irish surgeons. According to the manual before us,

there is some dispute as to who was the originator of the instrument in question; but there seems no doubt, from his own statement, that our author has for many years had the idea in his mind that it would be possible to view hidden cavities. He tried the instrument invented by Desormeaux, but the light being insufficient, he gave up; but lately after much thought and experimenting he obtained as much light as he required. He says: "Since then I have used the endoscope constantly, and have neglected no opportunity of extending my knowledge of it. Early in March last I showed it to Dr. Fleming of the Richmond Hospital, and demonstrated to him and Prof. R. W. Smith an organic structure of the urethra; and by its aid the urethra can be seen and minutely examined from its orifice to the neck of the bladder, each single species of disease ocularly demonstrated, and if need be, subjected to precise local treatment."

Before entering upon a minute description (illustrated) of the various portions of the endoscope used by him, Dr. Cruise, in the following general terms describes the instrument:

"In the first place, there is a tube or speculum, which is introduced into the cavity to be examined; and at one extremity of this a mirror of polished silver, perforated in the centre, is placed at an angle of 45° . The function of the mirror is to reflect the light, which is placed laterally into the tube, so as to illuminate it to the end. As the calibre of the tube is very small, a most brilliant light is required, and, in order to obtain the best effects, it should be made to converge slightly upon the mirror. This convergence is attained by interposing between the light and mirror a plano-convex lens of suitable focal length. The light being sufficient, the lens properly adjusted, the mirror bright and correctly placed with respect to the tube, it becomes a matter of facility for the eye of the observer, looking through the perforation in the mirror, to see clearly to the bottom of the speculum.....The brightest illuminations which can be obtained by any means is that given off by the *thin edge of the flat flame* of an ordinary petroleum lamp. Moreover, the steadiness and intensity of the light are manifestly increased by using an extra tall chimney; by enclosing the lamp in a lantern so constructed that atmospheric air *enters* from below only, thus causing an even draught; and by dissolving camphor in the petroleum, in the proportion of ten grains or more to each fluid ounce. The camphor increases the quantity of carbon in the petroleum, while the arrangements directed to procure a good draught secure its complete combustion."

Though of great use in many hidden cavities, our author thinks that in diseases of the urethra, it will prove most beneficial. "By its aid,

diseases of this part, otherwise merely subjects of conjecture and empiricism, are rendered clear as to diagnosis, and as satisfactory as to treatment as affections of the eye or any external portion of the body, patent to view." To illustrate this assertion of Dr. Cruise, we copy the following case of chronic granular urethritis :

"J. N., a gentleman aged twenty-four years, of strumous and delicate constitution, contracted blennorrhagia fifteen months ago. When almost entirely well of it he caught a second infection some months later. Now the disease showed itself obstinate, and, despite a vast amount of treatment, he retained a chronic discharge, with some scalding, some uneasiness in the perineum, and latterly he was annoyed by slight dysuria, and by a swelled and tender testicle. About the close of last February he placed himself under my charge. I at once carefully examined the urethra with the endoscope, from the neck of the bladder to the orifice. The condition of parts which I discovered was as follows:—The prostatic portion of the urethra was injected and slightly inflamed; the membranous portion was quite healthy; the bulbous portion was *ulcerated and granular*, exquisitely tender, and bleeding on the most gentle touch.....Having made a precise and satisfactory diagnosis, I proceeded, with the help of the endoscope, to cauterize the granular ulceration, commencing from before, and passing backwards. The case rapidly got well, and after six cauterizations, extending over a period of five weeks, the granulations were removed, and the endoscope catheter could be passed into the bladder without causing the slightest pain. The discharge and perineal uneasiness also disappeared, and the swelling of the testicle,—which I attribute to engorgement of the prostatic portion of the urethra, caused by the slight obstruction in micturition,—having yielded to strapping, has not shown the least tendency to return. Of the utility of the endoscope in this case I shall only remark that, in the first place, it enabled me to make a precise diagnosis at once, and subsequently greatly facilitated treatment. I do not know how I could have cured this case without its aid, because strong caustic solutions were required to conquer the granular ulceration of the bulbar region, and I could not have used injections of adequate potency without seriously damaging the anterior part of the canal, which was sound."

Its utility in diseases of the female urethra is illustrated by the following interesting case :

"The case is that of Miss H., a young female, who, for the past two years, has suffered atrocious pain during and after passing water. The urine is healthy, and nothing can be detected, by an ordinary examination of the parts, to explain the distressing symptoms. Latterly her

general health has given way to a certain extent from the excess and continuity of the pain. Having in vain undergone an endless variety of treatment, she lately placed herself under Dr. Smith's care, and by his request I saw her. An endoscopic examination, which was made with difficulty, owing to the nervousness of the patient, and the pain which it produced, revealed a morbid condition of the urethra, near the neck of the bladder. In this situation the passage, for about half an inch in length, was highly vascular, granular, and of the colour of a mulberry. The special treatment which naturally suggested itself, and was determined upon by Dr. Smith and myself, was thorough cauterization of the diseased part with nitrate of silver. On the 31st of March I performed this operation, with the assistance of the endoscope; it caused sharp pain, which lasted for some hours. However, the patient told me to-day (April 4th) that since the cauterization she had obtained more relief from suffering than she has known since the commencement of her disease. Encouraged by this success I repeated the application, and hope, at some future time, with Dr. Smith's permission, to record the termination of the case."

In diseases of the bladder, we believe the endoscope promises to work wonders, though our author's experience on this head is limited to two examinations, one on the living subject and the other on the dead body. The first was a case of hematuria, under Professor Macnamara, at the Meath Hospital, Dublin, who believed the disease due to a diseased condition of the vesical mucous membrane. The case was a difficult one on account of the rapidity with which blood exuded, rendering turbid the injected tepid water. Nevertheless, Dr. Cruise was able to illustrate to his own and Professor Macnamara's satisfaction the interior of the bladder. The condition of the membrane was highly inflamed, and in points ulcerated. Every gradation of colour, from pale rose to deep purple, and almost black, could be seen, and easily distinguished from the healthy. The examination on the dead body is thus described by our author:

"I have not chanced to meet with a case of stone since I have succeeded in making the endoscope practically available, therefore I have no positive results to show. However, my friend and colleague, Dr. Robert McDonnell, submitted my instrument to a test upon the dead body, which I think may fairly be considered an "*experimentum crucis*," and, in illustration of its capacity, I record the trial, for the veracity of which Dr. McDonnell is as responsible as I am myself:—He first prepared a subject by opening the bladder and introducing into it three substances of a nature the most unlikely to be thought of, and

respecting which I was in total ignorance. He then brought me to the body, and challenged me to tell with my endoscope what the articles in the bladder were. In a few minutes I was able to do so, and to demonstrate them to him. The articles were—a brass screw with a milled head, a short Minié bullet, and a mass of plaster of Paris.”

We give great credit to Dr. Cruise for his valuable communication, and fully believe that owing to his able exertions a new era is about to dawn upon a class of affections, the difficulty of properly treating which is fully understood by every practitioner, under whose notice a large number of them have been brought. Empiricism must now give way to rational treatment, and many sufferers will yet bless the day that the endoscope was invented.

PERISCOPIC DEPARTMENT.

Medicine.

THE LOCALISATION OF SPEECH.

M. Velpeau has for the moment rather puzzled M. Bouillaud, who has again been ventilating, in the Academy of Medicine, his favourite theory of the localisation of speech in the anterior lobes of the brain. M. Bouillaud has, it appears, offered a prize to any one who can produce a case of lesion of the anterior lobes unaccompanied with affection of the speech. To this prize M. Velpeau says he thinks to lay claim. “No one,” replied Bouillaud, “is more worthy of it.”

“What I fear is,” rejoins Velpeau, “that your prize will be like Delpech’s. Delpech asserted that it was impossible to cure fracture of the neck of the femur without deformity, and offered 2000 *francs* to any one who could show him such a case. To all the cases, however, which were sent to him, he took exception; but, having at last become convinced of the fact, he announced in the journals that he had at length himself met with such a case, and had, therefore, adjudged the prize to himself!”

M. Bouillaud replied to the spiritual Velpeau, that he was not a Gascon,* though he lived near Gascony; and that he should certainly with pleasure give the prize when gained. The prize was small, it is true; but, if he had been in M. Velpeau’s position, he would have made it ten times greater.

* Gascons are notorious jokers!

“As for the amount of the prize,” replies Velpeau, “that signifies nothing; if I gain it, I shall give it to the Medical Benevolent Fund. My case is this:—In 1844, a most talkative *perruquier* entered La Charité for incontinence of urine. He was remarkable for his incessant loquacity, his jokes, and his cynicism. He died at the end of seventeen days, but never ceased talking. The day of his death he spoke, and answered properly all questions. This was nothing to suggest any disease of the brain. The brain was examined incidentally; and the anterior lobes were absent. They were in fact, both of them replaced by a tumour as large as a hen’s egg, of a scirrhus nature. What says M. Bouillaud to this case?”

“If M. Velpeau will present me a similar case,” was the reply, “I will give him the prize.”

“Oh,” says M. Velpeau, “the case is perfectly authentic, and on record. There is no need of a second case.”

M. Delpech then joins in, and declares that he himself had made the autopsy; that he had presented the specimen to the Anatomical Society, and that the case was unanswerable. Says M. Bouillaud:

“I declare the fact impossible, and that the *interne* who made the autopsy witnessed a miracle! You may call me mad, if you please; but I will never believe that an injury of the two anterior lobes of the brain can exist without any disturbance of the speech or of the intelligence.”

M. Velpeau: “I think M. Bouillaud is going beyond the limits of scientific discussion. It is a matter of indifference to me where the regulation of speech resides. I have no wish to upset M. Bouillaud’s theories. But, after all, we must confess that we know very little about the functions of the brain; and it seems rash at present to localise a faculty in any particular part. As for a second case, I certainly shall not attempt to find one; it belongs to the future; and the demand reminds me of the amusing reply of the embalmer Gannal. He assured us that his process would preserve for two thousand years; and, when we told him he was joking, he replied ‘Well, you will see!’”

M. Bouillaud then asked the Academy to appoint a committee to decide whether the prize was gained; but M. Velpeau, having told his tale, declined to have anything to do with it.—*Brit. Med. Jour.*

USE OF VERATRUM VIRIDE IN CONVULSIVE DISEASES.

By A. GREIGER, M.D., of Dayton, Ohio.

After an experience of nearly ten years, by the profession, in the use of the “*Veratrum Viride*,” its use in febrile and inflammatory diseases

is not so satisfactory as it was fondly hoped it would prove to be, when first introduced. Still it holds the first rank as an agent in controlling the action of the heart and arteries. But there is a class of diseases over which it exerts an influence which I regard as invaluable, and in which its curative properties may not have received that degree of attention; from the profession, that they are deserving of.

I allude to "Convulsive Diseases," depending upon undue excitement of the brain or nervous centres; such as puerperal convulsions, hysteria, mania-a-potu, convulsions of children, etc., etc.

I have used it in my practice for several years past, (and also others to whom I have recommended its use,) in the various convulsive diseases with the most satisfactory results; generally in a short time controlling the convulsive action, and restoring the patient to quiet and sleep.

The first case of puerperal convulsions in which I was induced to try its effects, was the patient of a brother practitioner, Dr. O. Crook, of this city. He had been called to his patient in the morning, a fine healthy-looking young woman, in her first confinement. He had bled her freely, before my arrival, which was at 9 o'clock, a. m. The convulsions were frequent and powerful, the os uteri but slightly dilated, no chance to deliver, and no prospect that the opportunity would offer for several hours I advised the administration of the veratrum viride. Four drops of the fluid extract were given, and repeated every two hours. The convulsions were partially controlled by the use of chloroform, administered immediately upon the approach of the symptoms of returning convulsions, until the influence of the veratrum was manifest. At 2 p. m., the patient was quiet; the convulsive action having gradually grown more feeble, and the pulse reduced to about 60 per minute. The labour progressed favourably until 6 p. m., when she was delivered of her child. The veratrum was continued in doses sufficient to control the action of the heart, until sensibility returned, which was some forty-eight hours after her delivery; after which time she had a good recovery.

I have since used it in two other cases with like success, and know of no remedy to compare with it in cases of this kind. I have also used it in hysteria; invariably controlling the spasms as soon as the patient was brought fully under its influence. Also in the convulsions of children; given in doses suited to the age of the child, it has always proved highly satisfactory, arresting, in a short time, the spasmodic action.

In all of the above diseases, we have increased action of the heart and arteries, with morbid excitement of the brain and nervous system, and whether it is the action of the veratrum as an arterial sedative, that produces its curative effects, or whether it does not also exercise directly a

sedative influence over the brain and nervous centres, is a matter for further investigation.

But in delirium tremens, I think it is destined to take the place of all other remedies, so prompt and satisfactory are its effects, and more particularly in those patients that are furious and uncontrollable.

Dr. Crook was induced to use it in a case of mania-a-potu, soon after seeing its effects in the case of puerperal convulsions above alluded to. The patient was a robust liquor-seller, and himself a good customer. He had had previous attacks, which had been exceedingly hard to control. In this case, when the doctor was called, he found the patient out in the yard, and it required the efforts of three men to prevent him running away. He was brought in, and four drops of the fluid extract of the veratrum administered and ordered to be repeated every two hours; opium and other remedies having been previously administered, without effect. In a few hours, its effects were apparent; nausea and vomiting succeeded, and the patient reclined quietly in bed, and the following day, after a good night's repose, was about again. Another case, that of a sturdy blacksmith who had imbibed too freely, and who was so unruly that it became necessary to bind him, and tie him fast in the bed: after taking two doses of the veratrum, he went to sleep, and awoke the following morning to inquire of his attendants, "What they meant by tying him up in that style?" they being afraid to unloose him during the night. When informed what had been the matter, he coolly assisted in unbinding himself, and went to his shop as usual. Other cases might be related.

I have used it in one case of chorea. It was the first attack in a young girl of fifteen, and seemed to have come on without much previous warning. The muscles of the left side were principally affected by the convulsive action, and the patient was very much distressed. Not more than six drops of the fluid extract were given, until she became quiet, and the next day she seemed as well as usual. Emmenagogues were then given, and there has been no return of the chorea since.

I would say to any member of the profession whose attention may not have been called to the use of the veratrum viride in the cases above cited, *try it*. The result will be satisfactory.

A REPORT OF A RECENT CASE OF HYDROPHOBIA.

Several cases of hydrophobia have recently happened in the metropolis. We are indebted to Mr. Henry Summerhayes for the following, which has been lately under treatment at St. Thomas's Hospital. The commencement of the attack with priapism is remarkable; nothing of impor-

tance, and no fact likely to throw light upon this strange malady, was made out apparently from the post-mortem examination. Of the post-mortem appearances, fluidity, or imperfect coagulation of the blood, probably owing to some morbid change, together with a congested condition of the brain, spinal cord, and meninges, seem to be the most constant:—

H. R., aged 42, was admitted at 10.45 on May 23rd last, and the following history was obtained of him:—About six weeks previously he had burnt his face and both arms slightly with hot iron. Afterwards a little pet dog with which he was in the habit of playing had often licked his face and hands, as he had been used to do before. Later this dog had begun to snap at people generally, and had on that account been drowned. A second dog, a stranger, is remembered by a son of the patient to have seized the leg of his father's trowsers, some six weeks before about the time of the burns; the son does not suppose that his father was bitten, as he said nothing of it at the time. Nothing remarkable, or that excited the attention of the man and his relatives, occurred until Friday, May 19th, when being at work he was troubled much with priapism; in the night he was kept awake by priapism, and aching pain in the penis and testicles. It was the same on Saturday. On Sunday he is said to have become somewhat intoxicated early in the day; accordingly he went to bed early. During the night he complained very much of priapism and pain. He had no discharge at all from the urethra.

Monday, 22nd—He rose at 6 a. m., drank some hot tea and went to bed again; he ate nothing. At 1 p. m., he consulted a medical practitioner, who ordered him some salts. At 6 p. m. he returned to bed, and suffered much during the night from priapism.

Tuesday, 22nd.—At 5 a. m. he drank about an ounce and a-half of water, which he soon vomited; his wife made him some tea, but he could not drink it. At 11 a. m. he got up; was very bad tempered, and so unreasonably so that his wife thought him scarcely in his right mind. He was sweating very much all the day. At 8 p. m. he was ordered to St. Thomas's Hospital by his medical attendants, and was admitted at 10.45 p.m.

On admission he was perfectly sensible, and answered questions readily. What struck one most forcibly on looking at him was the great difficulty he seemed to have in getting his breath; he would fling his head back and open his mouth wide, and gasp hard. At the same time he would point with his fingers to his throat, as if to signify that the cause of his distress lay there. The muscles of the fore part of his neck were seen to be rigid and contracted. The difficulty of breathing was not uninterrupted; there were short intervals of comparative ease and quiet,

when his respiration was attended with long-drawn sighing rather than with gasping. Quite suddenly a new paroxysm would end the brief remission of distress. He was bathed in a cold clammy sweat; his tongue was covered with a brownish fur; his pulse was weak, 112; his pupils were dilated. He was given some water to drink, but as soon as the cup approached his mouth a paroxysm seized him and he dashed the cup away. The mention of water induced a paroxysm. 11 p.m.—An enema, consisting of beef tea ξ v., brandy ξ j., tinct. opii 3 i., was administered to him.

24th, 1 a.m.—The paroxysms had not abated; the enema had been retained; the pulse was stronger, 130. He was rational, and complained greatly of thirst. Nurse had watched him dip his fingers in water and struggle in vain to get them to his lips. 1:30 a.m.—A teaspoonful of brandy-and-water was given him, and caused a most violent paroxysm. It was observed that any noise in the ward or the effort to speak brought on paroxysms. 2 a.m.—Enema, tinct opii 3 ii., beef tea Oss. 3 a.m.—There was no change, except that the poor man was considerably weaker. 5 a.m.—The enema was repeated, with the addition of brandy ξ i. 5:30—He seemed to be trying to vomit almost constantly. The paroxysms were more frequent and more severe. 7:20—The enema was again repeated. 10:30 a.m.—He died exhausted.

Autopsy on the 25th inst. at 2.30 p.m.—No wound could be found on the body. The papillæ at the back of the tongue were prominent, and the submaxillary glands appeared somewhat congested; the mucous membrane of the pharynx was congested; the œsophagus appeared healthy, as did the larynx, trachea, and bronchi; the lungs were congested and slightly œdematous. The large veins were full of dark imperfectly coagulated blood. The diaphragm was very flaccid; its muscular tissue appeared healthy under the microscope, but appeared to break up very readily into ultimate fibres and fibrillæ.

INFLUENCE OF CALOMEL UPON DENTITION.

By Dr. JULES CHAMPOUILLON.

Calomel, so precious in the treatment of infantine diseases, gave me, three years ago, a result which I did not seek, but which struck me, on account of the advantages to be derived from its use in cases of difficult dentition. Two months ago a case of the same kind again presented itself, and this time, observer, watchful, and warned, I was able to follow the action of the medicine step by step.

First Observation.—On September 17th, 1862, the wife of a police-

man brings me, at the Hospital of Tlemcen, Algeria, her little daughter, suffering from an abscess in the anterior chamber of the right eye, consequent upon a blow received twelve days previously. The little patient, eleven months old, is of good constitution; she suffers but little from the eye. For the purpose of obtaining the re-absorption of the matter, I prescribe calomel, divided according to Law's system. Forty-eight hours after administering the first dose the abscess has diminished, but the child slobbers, and the submaxillary ganglions are painful and somewhat tumefied, especially on the left. I wish to ascertain the state of the mouth. The mother then informs me that her child on the day of her admission into the hospital only had the lower median incisors, and that subsequently, that very morning, the two upper incisors had appeared. The gums are hot, red, and swollen. I continue the calomel, limiting myself, however, to a packet morning and evening. Two days later (the 22nd) the two lateral lower incisors have pierced the gum; the evening of the same day the left lateral incisor of the upper jaw shows itself in its turn. I then cease the calomel, for which I substitute a little chlorate of potash, notwithstanding the entreaties of the mother, who begs me to continue means "for so easily cutting teeth." The morning of the 23rd the upper left eye tooth has pierced the gum; the abscess of the eye has diminished one half. On the 29th the child quits the hospital, her mother alleging business. Eight days afterwards I again saw the little patient. Her eye was quite in the same state; her gums were still red, but no other tooth had appeared. Thus, in four days, six teeth made eruption.

Notwithstanding the idea of coincidence—which, for the first two teeth, I admit willingly—it seems to me difficult entirely to deprive the calomel of all participation in an evolution so rapid. The irregularity of the eruption, and, above all, its tendency towards one side, strengthens this opinion. Doubtless, the delay in the appearance of the teeth created conditions favourable to the evolution. I know, also, that the salivation ensued with a rapidity not usual with children; but may it not be ascribed to the fractional dose of the remedy? In refusing to continue the calomel, I was not unmindful of the danger there would have been in evolving germs not having as yet attained maturity, even if it could be done. Of course, for a simple delay without accidents I should not advise the use of calomel sufficient to affect the gums; but, in cases of difficult dentition, I should demand of mercurial salt rather than of any other medicine an action which might also produce some benefit in another point of view. Verily, the medication is known. However, I cannot but think that in cases of serious accidents, of dangerous com-

plications owing to difficult dentition, the administration of calomel actively pursued—more actively than is generally done—would produce a swelling and softening of the gums, which, by favouring the dental eruption, would counteract those accidents so rapid in their progress with children.

Second Observation.—On May 17th, 1865, a mother brought me her child, twelve months old, having the right corner clouded by extravasations of recent date. I examine the mouth. Of the two lower median incisors, one is through, the other ready to come through; the rest of the line of sockets does not announce a near evolution; no pain; no submaxillary swelling. The remedy is first administered on the 17th. On the 19th the child has taken twenty packets, containing altogether two grains of calomel. There has been no diarrhœa, but there is salivation. The gums are rather red and softened; not much ganglionic congestion. I cease the treatment on account of the state of the mouth and of the amelioration of the eye. That day the upper median incisors show themselves; then, the morrow (the 20th), the upper lateral incisors; at length on the 22nd, a lower lateral incisor, on which side I did not note. Thus, five teeth have appeared in four days.

Certainly, cases of spontaneous evolution as rapid as those cited are to be found. But it would be, at least, very curious that this rapidity should coincide with the four days' use of calomel, to cease so soon after, although the group cut remained incomplete and not symmetrical.—*Med. Times and Gaz.*

Midwifery.

MONSTROSITY IN A CHILD FOLLOWING A FRIGHT TO THE MOTHER IN THE THIRD MONTH OF PREGNANCY.

(Under the care of Mr. PAGET.)

Whatever be the explanation of the fact, it seems fully proved to be by no means an unfrequent occurrence that women who have, during pregnancy, been subject to some strong mental impression, give birth to children with a deformity or defect which showed a marked likeness to the object that produced that impression. A large number of cases might be collected in support of this. It appears important, however, to notice that in the great majority of instances of this kind which are sufficiently authenticated to deserve attention, the maternal impression was not slight and soon forgotten, but powerful enough to induce a settled conviction of

what the result to the child would be. Dr. Carpenter, in the last edition of his work on "Human Physiology," says:—"No soundly-judging physician of the present day is likely to fall into the popular error of supposing that "marks" upon the infant is to be referred to some *transient*, though strong impression on the imagination of the mother; but there appear to be a sufficient number of facts on record, to prove that *habitual* mental condition on the part of the mother may have influence enough, at any early period of gestation, to produce evident bodily deformity or peculiar tendencies of the mind. The error of the vulgar notion on this subject lies in supposing that a *sudden fright speedily forgotten* may exert such a continual influence on the nutrition of the embryo as to occasion any personal peculiarity." Some very interesting remarks on monstrosity in children, with some remarkable examples of the condition, may be found in Dr. Montgomery's "Signs and Symptoms of Pregnancy." The subjoined case is offered as a contribution to the literature of this obscure and difficult subject.

—A girl, 12 years old, was in Lucas Ward in the month of April last, for the treatment of an attack of lepra. She at once became a nine day's wonder in the hospital, under the name of the "monkey child," for it was found that the left arm and the greater part of the trunk presented a precise resemblance to the like parts of a monkey. The arm was long, thin, and withered looking, the scapula prominent, and the skin deeply stained with dark brown pigment, and covered with an abundant crop of lank tawny hair, some of which was nearly two inches in length—in fact, the likeness of these parts to the corresponding parts of a monkey was so complete that any one, judging by them alone, would almost certainly think she was a champanzee. Her mother stated that when she was three months pregnant with the child she was very much terrified by an organ monkey, which suddenly jumped upon her back as she was passing along the street.

The following remarkable instance was related by Mr. Paget, as he went round the wards, as having taken place under his own observation:—A person when pregnant with her first child chanced to shake hands with a man who, by an accident some years previously, had lost the middle fingers of the right hand, the index and little fingers, from long practice in grasping objects, having afterwards fallen almost into the shape of a lobster's claw. Being a nervous and very sensitive woman, she was startled and distressed when she became aware of the condition of the hand, and for several days she could not dismiss the recollection of it from her mind. When her child was born, it was found that the middle fingers of both hands, and the middle toes of both feet, were, absent. After an

interval of five years, during which she had had four perfectly formed children, and, being now pregnant with a fifth, she again encountered the man, and was again obliged to shake hands. She was so much disturbed by this occurrence, and so impressed with the idea that the child would be deformed, that in the evening she wrote down the event and her conviction regarding the child. When the child was born it was deformed exactly as the first had been.

LACERATION IN A NEW-BORN CHILD.

Mr. R. King Pierce showed to the Obstetrical Society of London April 5, 1865, a foetus, born at full time, and exhibiting at birth two lacerations: one extending through the integuments transversely across the abdomen, about the level of the scrobiculus cordis; a second one across the throat, exposing all the vessels and muscles of the neck. The two lacerations had all the appearance of incised wounds; but the evidence was clear that they had not been produced by an act of violence other than of rapid delivery.—*Lancet*, June 3, 1865.

Materia Medica and Chemistry.

ON THE THERAPEUTICAL PROPERTIES OF HEMLOCK.

By Dr. GARROD.

Hemlock has long been employed in medical practice, but many complaints have been made as to the uncertainty of its operation. In the London Pharmacopœia the leaves are employed, and a tincture, an ointment, and an extract were made from them. But as the activity of hemlock depends upon the presence of a peculiar fluid alkaloid, named *conia*, which readily undergoes decomposition when exposed to the air, the dried leaves must lose their efficacy by keeping, and hence it appeared to the committee who prepared the British Pharmacopœia that the fruit should be substituted for the leaves in the officinal preparations, as the former contains *conia* in a more concentrated state. A juice of the fresh leaves, the *succus conii*, has also been introduced into the British Pharmacopœia, a little spirit being added to the liquid to prevent decomposition. The tincture of the British Pharmacopœia, termed *tinctura fructus conii*, is made in the proportion of two ounces of the fruit to a pint of spirit. Dr. Garrod has lately made a series of clinical experiments with hemlock, the result of which shows that it possesses far less energy than is generally supposed, but the tincture of the British Phar-

macopœia (made with the fruit) is more efficacious than that of the London Pharmacopœia (made with the leaves). Of the latter Dr. Garrod administered doses of from one drachm to half an ounce three times a day in about twenty cases, and latterly he gave a fluid ounce at each dose without producing any discomfort to the patient, who indeed exhibited no symptoms at all from the employment of the drug. The tincture employed was supplied by the most respectable pharmaceutical establishments. The tincture of the British Pharmacopœia, however, is more active; for in the case of the patient who took a fluid ounce of the London tincture for a dose, it was found that when the tincture of the fruit was substituted, five drachms were sufficient to cause the development of some symptoms, but these were only slight. Dr. Garrod considers, therefore, that the new tincture possesses at least twice the strength of the old, but that it is not very potent.

Dr. Garrod doubts very much the efficacy of conium in any form in relieving the pain or altering the diseased action in carcinomatous affections; but he thinks that in large doses it may be advantageously administered in cases of severe spinal disease, both structural and functional. In paraplegia, when there exists a sub-inflammatory state of the spinal cord, as indicated by pain in the back and startings of the limbs, hemlock is of great service; and Dr. Garrod has often seen the incontinence of urine checked by the drug. Conium appears to be beneficial where strychnia is injurious; and Dr. Garrod suspects that in very many cases of paraplegia, even when the ordinary symptoms or irritation of the spinal cord cannot be detected, some lurking action may exist which is aggravated by the employment of strychnia, but is generally soothed by hemlock. Dr. Garrod relates a case in which strychnia had been administered with the effect of aggravating the symptoms, and more especially the incontinence of urine, but in which the employment of hemlock in gradually increasing doses was followed by positive alleviation and eventual convalescence. The dose of the tincture of the British Pharmacopœia may range from half a drachm upwards, according to the nature of the case and the urgency of the symptoms.—*Medical Times*.

Surgery.

LIGATURE OF THE ILIAC ARTERY.

A case of aneurism is described in the *Dublin Medical Press*, having occurred in the city of Dublin Hospital, under the care of Professor

Wm. Hargrave, in which ligation of the left common iliac artery was resorted to. *Per se* the operation was successful, as the artery was entirely and permanently occluded, without the following of secondary hemorrhage. But the patient died from exhaustion, the result of pelvic abscesses and hemorrhage established in the aneurismal sac through collateral circulation.

Without going into a history of the case we give the account of the operation and of the autopsy.

Operation, April 29th, 1865. Patient well under the influence of chloroform before and during the operation. An incision was made from the point of the last rib, slightly curving downward to Poupart's ligament, mid-distance between the anterior superior spine of the ilium and symphysis pubis about eight inches long through the superficial fascia; the three broad muscles were next carefully divided from below upward and from angle to angle of the incision. Any hemorrhage was venous with the exception of the internal branch of the circumflex ilii vessel, which was sliced. A ligature was tied on each side of the opening, and the vessel divided. The transversalis fascia was perfectly *cleansed* and *free from any blood*; it was very strong. The smallest possible portion of it was pinched up in the forceps, and found by its transparency to be free of the peritoneum, which was divided on the director on the entire extent of the wound; the peritoneum was freely exposed, and the color seen beneath it. The peritoneum was removed from the iliac fossa to the mesial line of the body with the greatest facility, with more ease than in the dead subject it carried with it firmly adherent, the ureter. The aneurismal sac, occupying the external iliac artery, remained almost in a state of repose, *i. e.*, did not project into the wound, as has occurred in similar operations. It was well defined at the cardiac or proximal end, and corroborated what was ascertained before the operation, of dipping deep into the pelvic cavity, perhaps compressing the external iliac vein, so accounting for the great œdema of the entire of the left limb. The common iliac artery was now exposed and visible to the naked eye; the vein was not equally apparent. The separation between these vessels was easily effected with the finger nail, and a hempen ligature passed under the artery from within outward. In compressing it on the aneurismal needle, all pulsation on the aneurism completely ceased, *it becoming so flat as to have disappeared*. The genitor-crural nerve was embraced by the ligature in the first instance, from *which it was excluded*. The extreme sensitiveness of this nerve was evident from the fact that when very gently touched, to free it from the ligature, the patient was roused to perfect consciousness from a deep anæsthetic sleep. This occurred twice.

The artery was tied about half or three quarters of an inch above its division into the external and internal iliaes.

The patient died July 11th, seventy-third day after the operation.

Post mortem examination, (Drs. Tufnell and Croly.) An incision made from umbilicus to symphysis pubis, and another from same point to ant. super. spinous process of the ilium. Muscles and fascia transversalis next divided; intestines adherent in left iliac fossa, by firm bands of lymph, the result of inflammation. The intestines being drawn up, the fascia iliac was exposed, covering the iliacus internus muscle; ureter was observed crossing the anterior surface of the common iliac artery, just at its bifurcation. The aneurismal tumour which was soft, and fluctuating to the touch, measured five inches by two and a half behind, and to its outer side lay the anterior crural nerve, flattened and expanded. The abdominal aorta was exposed as high as the origin of the inferior mesenteric branch; it presented a normal appearance as regards size; an inch above its bifurcation into the common iliaes, a calcareous deposit about the size of a four penny piece was seen protruding through the coats of the artery; it occupied the right side of the vessel.

The left common iliac artery (that on which the ligature was applied) was much smaller than the corresponding artery of the other side; there was a fibrinous clot in it just below its origin from the aorta—the vessel was severed by the ligature, half an inch above the bifurcation into the internal and external iliaes. On passing a probe through the internal into the common iliac, it was stopped by the adhesion of the vessel at the distal side of the ligature. The same occurred on passing a probe through the aorta into the common iliac. The common iliac vein was closely adherent to its artery, and the external vein was pressed on by its artery. Femoral artery and vein healthy, and of natural size. Iliac fossa unusually dense, and closely bound to the vessels; a large oval lymphatic gland occupied the left side of the common iliac artery, which was seen during the operation of a bluish color. The pelvic cavity was filled with unhealthy pus; the pelvic bones sound and not indented by the tumor. Internal epigastric artery slightly enlarged. A probe passed through it into the aneurismal sac touched a soft fibrinous clot. Walls of sac thin.

The aneurism was egg-shaped, the larger end downward, and a little inward, measuring five inches in length, three and three quarters in depth, and extended from about one inch from the origin of the external iliac artery, *which was enlarged* to within one and a half inches of the profunda covering the external iliac vein for about two inches of its course externally and posteriorly. The tumour, on being laid open for the entire of its extent, contained at its two superior thirds a very soft greyish fibrin-

ous clot, but not distending it; in the inferior third was a soft black blood deposit, scarcely to be considered a coagulum being so friable. The aneurism communicated with the external iliac vein by a well defined oval opening of about one quarter of an inch in diameter, situated a little below the middle of the tumour on its internal and posterior aspect. The epigastric, slightly enlarged, could be traced backward to the same opening, the arterio-venous of the internal posterior opening of the aneurism, and seemed to form prior to its communication with the aneurism, a small cavity, capable of containing a bean, which was filled with fluid blood.

This examination shows the case to have been one of aneurismal varix (or arterio-venous aneurism), in this case being a spontaneous formation (in contradistinction to the traumatic variety), which has been recorded by Bransby, Cooper, Perry, and Prof. Porter, affecting the femoral vessels, being a primitive disease, the result of thinning of their coats. This rare variety was surmised early in February, for combined with a well-marked *bruit de soufflet*, there was also a most remarkable vibratory thrill which was occasionally so loud and strong as to mark the proper aneurismal bruit. This surmise was fully confirmed by the examination, which presented as described a well-marked complication of the direct communication between the vein and artery, and still more complicated by the direct entrance of the epigastric artery into the inferior part of the aneurism.—*Philadelphia Medical and Surgical Reporter*.

PHILEGMONOUS ERYSIPELAS OF THE UPPER EXTREMITY, AND
SUPPURATION OF THE AXILLARY GLANDS FOLLOWING A
PUNCTURE OF THE FOREFINGER; AMPUTATION; RECOVERY.

The amputation of a limb is often unjustly looked upon as an opprobrium to surgery. But when we consider that the end achieved is the preservation of life, and the removal of a limb whose integrity is destroyed, we think the operation deserves to be classed with the happiest results of conservative surgery. In the case about to be related (from notes by Mr. Alderson, house-surgeon) the usefulness of the limb was gone, and the patient would infallibly have sunk had not amputation been resorted to. A point of interest was that the man was a reformed drunkard. Now Virchow states that the drunkard's dyscrasia does not persist if the cause be removed, and the present instance would certainly seem to confirm that statement, for no one could have exhibited greater reparative power after an operation than did this man.

James G——, aged forty-five, a wiry, healthy looking potman, was admitted into West London Hospital Aug. 3d. A fortnight previously,

he came to the out-patients' room with a whitlow of the right forefinger, produced, he said, by a scratch from some rusty metal. He had formerly been a great drinker, but for the last two years had led a very temperate life. A free incision was made into his finger, which was fully twice its natural size. At his next visit he expressed himself as free from pain, and the inflammation in the finger seemed nearly gone. On Aug. 3d he presented himself at the hospital, and said that a few days ago, when the finger was nearly well, it was attacked with inflammation, which rapidly spread. His countenance was very anxious, his tongue furred, and his pulse quick and feeble. It was evident that he was suffering from great constitutional disturbance. The hand was greatly inflamed, and there were red lines extending along the inside of the limb to the axilla, where a mass of enlarged glands could be felt, and any pressure on them caused him much pain. He was at once admitted into the hospital. A poultice was then applied to the finger, and the entire limb wrapped in hot fomentations. He was ordered a mild purge, and to be well supported with beef tea and stimulants.

Aug. 5.—The limb had yesterday become so brawny that the house-surgeon made several incisions into it, so that to day the redness and tenderness are much lessened.

9th.—The size of the arm is much diminished, but the skin looks of a dead leaden colour, and it is evidently extensively undermined. The axillary glands are suppurating. The man has lost flesh, and looks anxious.

16th.—The skin over the dorsum of the hand and all along the outer side of the limb has, sloughed away, so that the extensor tendons are exposed almost as clearly as if they had been dissected out. The man's pulse is weak, and he emaciates from day to day.

19th.—The muscles along the inside of the arm are nearly exposed, the skin hanging in tatters at places. As the man was now in a very precarious condition, Mr. Teevan determined, after consultation with his colleagues, to remove the limb, as the only chance of saving life. Accordingly, the patient was put under the influence of chloroform, and the arm was amputated just below the shoulder-joint, by a long internal flap and a short external one, as the sloughing had extended so much higher on the dorsum of the limb along the inside. A few hours after the operation the man smiled, and said he was very comfortable and quite free from pain.

20th.—Slept very well last night; tongue clean; appetite good.

From this date he made a most rapid recovery, the wound was healed in three weeks, and he left the hospital at the end of the following month, looking strong and well.—*Lancet.*

Strumous Disease of the Shoulder-joint ; Resection ; Good Recovery.—Resection of the shoulder-joint is a comparatively rare operation, although we have placed several cases on record where it has been performed in adults with a very fair share of success, indeed more so than occurs with respect to almost any other articulation. In the child it is still more uncommon, but through the kindness of Mr. W. Travers, the resident medical officer, we are enabled to publish the following successful example in a little girl, aged four years :—

C. B.—, aged four years, of the dark strumous type, was admitted into Charing-Cross Hospital, the children's ward, on Oct. 10th, 1864, with strumous disease of the right shoulder-joint. The mother stated that about two years since the child had been ill with measles, from which she apparently perfectly recovered. Some two months after the attack had subsided it was noticed that she cried if the arm was roughly handled, and at length could not bear the joint to be moved at all. She also moaned a great deal during her sleep. At this time the shoulder did not appear in any way swollen or inflamed. The symptoms continued for twelve months, the pain evidently becoming gradually worse. The child now, too, became pale, thin, and capricious. At the end of the twelvemonth the joint was noticed to be swollen, but not red; the swelling slowly, yet certainly, increased; the pain was more constant. At the expiration of four months from this time, an abscess formed in the axilla, burst, and discharged freely. The child was placed under medical treatment, but without benefit, and, after remaining eight months longer, gaining no relief, she was brought to the hospital by her mother, and admitted as above.

On admission, the shoulder was found swollen, and the structures apparently thickened; movement much impeded, and causing great pain. A sinus still remained in the axilla, from which exuded thin pus. The child look wan and ill; her countenance spoke of constant pain and anxiety. The limb was confined, and kept at perfect rest; and tonics, with good nourishing diet, ordered to be given. Opiates, as far as practicable in so young a subject, were given at night; yet her nights were broken and fitful. This treatment was pursued for upwards of a month; and although the child's general health was very much improved, the disease seemed in no degree stayed, but rather increased. A probe passed along the course of the sinus proved the head of the humerus to be extensively diseased. On Nov. 19th Mr. Canton removed the upper part of the bone, to the extent of about an inch and a half, together with a portion of the glenoid cavity, which was also found to be affected. The horse-shoe-shaped flap was employed. The structures around the joint

were found thickened, and apparently in a state of strumous degeneration. But little blood was lost during the operation, and no vessel needed a ligature. The edges of the wound were adjusted, and kept in position by the aid of sutures. A pad was placed in the axilla, and the arm gently yet firmly bandaged to the body. No bad symptom followed the operation, and the child slept sounder the first night after than she had done for a very long time. In the course of a few days her appetite improved, and the countenance lost its former constant look of pain. At each daily dressing the wound discharged a small quantity of healthy pus, which gradually became less, and has now entirely subsided. At this date (three months after the operation) the wound has quite healed, and a fair amount of motion is obtainable. The child complains of no pain, and her health is greatly improved.—*Lancet*.

ON THE PATHOLOGY OF TETANUS.

By J. LOCKHART CLARKE, F.R.S.

In this communication, the author described the condition of the spinal cord in six cases of tetanus. In every one of these there was not only more or less congestion of the bloodvessels, but there were also definite, and frequently extensive, lesions of structure, such as had never yet been discovered. These lesions consisted of disintegrations of tissue in different stages of progress, from a state of mere softening to that of perfect fluidity, and were accompanied by certain exudations and extensive effusions of blood. They were found chiefly in the grey substance, which, moreover, was in many places strangely altered in shape—unsymmetrical on the opposite sides; or partially fused with the adjacent white column in a common softened mass. Although lesions of this kind existed in one form or other, in every *region* of the cord, they were absent in some places, nor did they ever, together, for long maintain the same shape, size, or appearance, but were constantly and alternately increasing, diminishing, or disappearing, at short but variable intervals.

These lesions in tetanus were precisely similar in character to those which the author had discovered in the spinal cords of many ordinary cases of paralysis; and on comparing the lesions and symptoms of both kind of diseases, he found ground for the support of the following conclusions. 1. The lesions are either not present or are present only in a slight degree, in those cases of tetanus which recover. 2. They are not the effects of the *great functional activity of the cord*, manifested in the violent spasms, but are the effects of a morbid state of the bloodvessels.

3. They are not alone the causes of the tetanic spasms. 4. The tetanic spasms depend on *two separate causes*—firstly, on a *morbidly excitable condition of the grey substance of the cord*, induced by the hyperæmic and morbid state of its blood-vessels, propagated from the injured nerves, and resulting in exudations and disintegrations of tissue; and, secondly, on *irritation* propagated and spread through the morbidly excitable cord from the same source—from the periphery, by the diseased nerves.

Mr. Brooke thought the facts brought forward by the author tended strongly to support the views of Dr. Radcliffe on muscular action. He should say that they pointed to the conclusion that in tetanus the disintegration of the spinal cord must necessarily imply diminished, not exalted functional activity.

Mr. Durham had examined on the plan introduced by Mr. Clarke, the spinal cord of a patient who had died of hydrophobia. He found intense congestion with extravasation in the dorsal region, but congestion only in the lower parts of the cord.

Mr. Gant referred to a *post mortem* examination of a case of tetanus, in which a very large quantity of blood was found in the vertebral canal. To the naked eye the cord did not present any remarkable appearance; it was very elastic.

Dr. Althaus asked the author how many cases of tetanus he had examined, as in some cases in which the cord had been examined no changes had been found.

Dr. Harley thought the Society was deeply indebted to Mr. Lockhart Clarke. They were indebted to him because he had opened a new field. Until Schröder van der Kolk began his investigations, nothing had been done in this way. He (Dr. Harley) thought that with the researches of Clarke a new era in the study of nervous diseases had commenced. We still hear of insanity as a disease of the mind, and as if it were nothing more than mere functional derangement. He thought, however, that such phrases as "functional derangement" were doomed. "Functional derangement" was but an apology for our ignorance; catalytic action was something we do not understand; "vital action" a cloak for our ignorance. He believed that, thanks to Lockhart Clarke, such terms would disappear, and he could but half express his great obligations.

Mr. Lockhart Clarke, in reply, said that the observations described in the paper were made on the spinal cords of six cases of tetanus; and that since the communication of the paper he had examined the cords of three more cases, with precisely similar results. The lesions and alterations of structure, though numerous, were in some places exceedingly small, and appreciable only under glasses of considerable magnifying power.

AMPUTATION AT THE ANKLE BY AN ANTERIOR FLAP.

At a meeting of the Medico-Chirurgical Society of Edinburgh, Dr. P. W. Watson shewed a specimen of comminuted fracture of the tuberosities of the os calcis, produced by direct violence. It was attended with extensive laceration of the soft parts, and required amputation to be performed at the ankle-joint. This, as the soft parts forming the ordinary heel-flap were destroyed, he effected by dissecting up the soft parts from the dorsum of the foot as far forward as the instep, and having completed the disarticulation, and sawn off the ends of the tibia and fibula, this flap was folded down, forming a long anterior flap, exactly as in the amputation in the lower third of the leg, according to Mr. Teale's method. The operation was undertaken as affording a more satisfactory site for division of the bone than the amputation in the lower third of the leg, although the resulting stump in such a case could not be expected to be capable of sustaining the weight of the body as in the method by the heel-flap.

GUNSHOT-WOUND OF THE BLADDER.

Dr. Van Buren of New York relates the case of L. L. J., a merchant, aged 40, of good constitution, who was shot through the bladder during a riot on July 16th, 1863. The accident occurred at 5 p. m.; and, as he had not emptied his bladder since 9 a. m., the organ was distended. Half an hour after the injury, Dr. Van Buren found him pallid and moderately collapsed. He stated that, when struck, he felt as if a football had hit him in the abdomen; and that, on putting his hand to the part, he found himself deluged with urine. There was a wound an inch and a half to the left of the median line, and two inches above the brim of the pelvis. The forefinger could be passed to its full length into the wound, and moved freely in any direction in a cavity behind the abdominal walls, but nothing could be distinguished but coagulated blood. Nothing abnormal could be discovered from the rectum. The bullet (an ounce musket-ball) was found under the skin of the right buttock, about an inch above the ischiatic notch; it was removed through a simple incision, which healed in a week. The abdomen was soft, natural, and not tender; there was slight pain; there was strong and frequent desire to pass urine, but none came through the urethra—a little escaping from time to time through the abdominal wound. It was decided not to introduce an instrument *per urethram*, but to favour the escape of urine through the wound; and to give a fourth of a grain of sulphate of morphia every second hour, with beef-tea, and a moderate amount of ice

and water. The only dressing applied to the wound was a moistened rag. The progress of the case was unattended by any unfavourable symptoms; the morphia was suspended on the eighth day, when half an ounce of castor-oil was given, which produced two copious stools, unaccompanied by pain or blood—the first since the wound was received. On the seventh and eighth days he passed some urine by the urethra; but as it was followed on one occasion by a severe pain in the right thigh, he again emptied the bladder through the wound until the fifteenth day, from which time he voided urine every three or four hours by the natural passage. The wound, which had become coated with urinary salts, now became clean, and on the twenty-second day was quite healed. (*New York Medical Journal*, May, 1865.)

GANGLION OF THE WRIST.

Ganglion of the wrist, also termed hygroma and synovial cyst, is a tumour of varying nature. It may be the result of a hernia or protrusion of a tendinous sheath, or of an articular synovial membrane; it may consist in a closed cavity, or in a cyst entirely unconnected with synovial structures, or a bursa, whether original or created by friction. The tumours situated at the back of the wrist are different in nature from those which occupy the front. Mr. Chassaignac has shown that, when the ganglion is found on the palmar aspect of the wrist, it is not unfrequently formed by an appendage of the articular synovial; whereas, at the back of the hand, MM. Gosselin and Michon's dissections teach us that the tumour consists in small cysts resulting from the enlargement of a bursa, the existence of which was long unsuspected. On the posterior surface of the wrist, the tumour is always situated in the same spot—viz., opposite the insertion of the extensor carpi radialis brevior into the base of the metacarpal bone of the third finger. Near this insertion is placed a bursa analogous to that which exists beneath the tendo-Achillis, and under the influence of local irritation, the cavity acquires unusual size, and forms what is termed hygroma.

Under these circumstances, it is not surprising that crushing the ganglion with thumbs, or a watch seal, is not an infallible cure. After its rupture the bursa forms again, even when methodical pressure has also been used. The same remark applies to puncture, and to subcutaneous laceration. If the contents of the cyst were merely of a serous nature, iodine injections or electricity might, as in hydrocele, effect a cure; but it is generally filled with a thick fluid, often mixed with blood,

and the two powerful methods of treatment alluded to are, therefore, resorted to in vain.

M. Jarjavay had recourse to the plan advocated by Bérard, jun., who, after incision of the skin, dissected the wall of the cyst as far as possible, and removed the tumour, even at the risk of exposing the tendon. In order to avert inflammation and its consequences, the wound was closed by first intention. Gentle pressure was exercised by means of a soft lint padding, secured with adhesive plaster, and a stream of cold water flowing from a reservoir, placed above the bed, was allowed to run permanently over the wrist.

This operation was performed a fortnight since, on a girl aged eighteen. Six days afterwards, although the cold douche was still persevered in, a complete cure was effected.

The same treatment has been applied with equal success by Mr. Jarjavay in twenty-three other cases.—*Journal of Practical Medicine and Surgery.*

ONYCHIA.

Our readers are well acquainted with the various proceedings devised by the ingenuity of surgeons for the relief of the sufferings induced by what has been termed the growth of a nail into the flesh. The method recommended by Mr. Long was recently applied by Mr. Jarjavay with admirable dexterity and results most satisfactory. No preparations are necessary for this operation, nor bandages, nor local anæsthetic measures; it is performed in the simplest manner with a common spatula.

The patient having been placed in a sitting attitude, the surgeon grasped the foot in the left hand, and firmly secured the great toe; and with a spatula, held like a pen between the thumb and the two first fingers, gently raised the skin at the root of the nail; having reached its posterior edge at the bottom of the groove of the follicle, he rapidly inserted the spatula beneath the nail, which he raised and detached in a moment.

In his "Manual of Operative Surgery," M. Malgaigne expresses his disapprobation of the procedure, which he asserts has not succeeded with him: he states that it is of difficult performance, and exquisitely painful to the patient. This may be the case, but we cannot believe that, had Mr. Malgaigne proceeded in the same manner as Mr. Jarjavay, he might not have effected a similar result. The facility with which the nail may thus be removed is accounted for by the fact, that its attachment to the subjacent surface is close in its anterior part only, and pain is, therefore, experienced, but at the conclusion of the operation. It is moreover tran-

sient, and can bear no comparison with that induced by the forcible introduction of scissors beneath the nail in a region copiously supplied with nerves.—*Jour. of Prac. Med. and Surg.*

Mr. Syme's Case of Excision of the Tongue.—A correspondent, an intelligent English student in Edinburgh, states that the woman upon whom Mr. Syme operated about eight or ten days ago, did well until the evening of the 23d, when about 11 o'clock she died. Her death was most sudden and unexpected, Mr. Syme having considered her so far recovered as to request that she should try and leave her bed. It is the fourth case he has had, three of which have proved fatal. On the 24th Mr. Syme operated for axillary aneurism; he first made a small incision above the clavicle so as to admit the finger of an assistant, and thus press the artery against the rib, he then cut into the sac, turned out the clots, and tied the artery above and below the rupture. Mr. Syme is certainly a fearless operator, and a good surgeon.—*Med. Times and Gaz.*, May 27, 1865.

CLINICAL LECTURE ON DIPHTHERIA.

By EDW. HEADLAM GREENHOW, Assist. Physician to the Middlesex Hospital.

GENTLEMEN: I propose to bring before you the subject of Diphtheria, and to take as the basis of my lecture two cases which have recently been in the hospital, and which were characteristic examples of the two principal varieties of this formidable complaint—namely, of that form in which the urgency of the case is due to the local manifestations of the disease, and of that other form in which the danger arises from the general constitutional affection. The former of these is especially characterized by the existence of symptoms of apnoea, and the pressing danger is caused by the more or less complete occlusion of the air-passages by the membraniform exudation from which the disease derives its name of diphtheria. The latter, on the other hand, is characterized by the predominance of symptoms of asthenia caused by the intensity of the general disease, and the danger to be apprehended is the gradual exhaustion of the vital powers. You should, however, fully understand, that although these two forms of diphtheria are so diverse in their more salient characters, and the kinds of danger which attend them, there is yet no doubt of their being, as I have said, only varieties of one and the same disease, for they not only occur constantly during the same epidemic, but very often also in the same household, at or about the same time. I have seen many examples of this, and one, which occurred only a few months ago, was especially striking, on account of the severity of both forms, causing

death rapidly in both cases. I was called to see a young gentleman aged fifteen, who had come home from school, I believe, with the complaint, and was suffering from the most urgent laryngeal symptoms, of which, in fact, he died the same evening, almost immediately after the operation of tracheotomy. Four days afterwards, his sister, aged eight years, was taken ill with diphtheria of the other, the asthenic form, which also ran an unusually rapid course, and proved fatal on the fifth day of her illness, without the supervention of any laryngeal symptoms. Another proof of the identity of the disease in the two different forms is, that although, in many cases, their separate characters are as sharply marked as in my description above, yet other cases occur side by side with them, which partake more or less of the characters of both forms. I say more or less, because, in fact, one of the two classes of symptoms does usually predominate.

Although the two varieties of diphtheria to which I propose directing your attention to-day are the most important, I must remind you that they are by no means the only forms of this disease. In every epidemic there are many cases in which neither are the air-passages involved, nor are there any urgent symptoms of general constitutional affection. Many of these would perhaps at another time be regarded merely as cases of common inflammatory sorethroat; but, occurring as they do at the same time, and frequently in the same household, with characteristic cases of diphtheria, we cannot but refer them to the same category. Several of you saw, the autumn before last, a rather severe case of diphtheria, which came from a house in the vicinity of the hospital in which sorethroat had previously been prevalent. The lad, aged sixteen, was a shoemaker's apprentice, and slept in the same room with three other boys. The family consisted of eight or nine persons, five of whom, including the three fellow-apprentices, had been under my care as out-patients in quick succession during the preceding fortnight, for sorethroat of varying intensity, but unaccompanied by exudation. Lastly, but still forming a part of the same epidemic,—if I may be allowed to apply the term to so limited an outbreak of disease—the lad presented himself, with symptoms of so great prostration, that we were compelled to take him into the hospital. His fauces were coated on both sides with the characteristic false membrane, and although he made a good recovery, his illness was severe. Albumen was found in his urine on the day after his admission, and he only regained health and strength after a prolonged and tedious convalescence. Again, cases characterized, it is true, by more or less diphtheritic exudation in the fauces, but unattended by any urgent symptoms, form a large proportion of every epidemic. Sometimes

it even happens that almost all the cases in particular epidemics are of this mild kind. Such cases usually recover under any rational mode of treatment, and it is the consequent great apparent success in treating them which has sometimes led even honest and worthy practitioners to promulgate as a specific for diphtheria some medicine with which they have treated large numbers of cases; the truth being, that by far the greater proportion of these cases required only common care, and would probably have recovered without any medical treatment at all. But although these mild cases so often do well with any or no particular medicine, I must not dismiss them without a word of caution to you, on the one hand against over-treating them, and, on the other, against neglecting them. I have seen serious mischief ensue from what I must term meddling treatment of such cases, especially when in the form of local applications; and yet even the mildest case requires careful watching, because, either by the invasion of the air-passages, or by the accession of constitutional symptoms, a case which in its first stages appeared of the mildest kind, may subsequently assume a most serious form.

With these preliminary observations, and begging you to bear in mind that I can only bring a small section of my subject, so to speak, before you to-day, I proceed to consider the first of the two grave forms of diphtheria which I have described, as it was exemplified in the more recent of our two hospital cases.

Mary Ann M——, aged eleven years, was admitted into Northumberland ward on the 24th of April, under the care of my colleague, Dr. Thompson. She had been ailing with cold for about a week, and had had sorethroat from the first. Two days before admission she had commenced coughing, and at the same time her voice had become hoarse; but, notwithstanding her indisposition, she had continued able to play about with her companions as usual in the open air until the afternoon of Sunday, April 23rd, when dyspnoea came on more decidedly, the cough and hoarseness increased, and she became so ill that on the following morning her mother procured her admission into the hospital. At the time of admission her breathing was difficult, laboured, and stridulous, and she spoke in a faint, husky voice. Her face was flushed, and the expression of her countenance anxious. Her skin was hot, pulse about 140, respirations about 24 in a minute. Mr. Waymouth, the clinical assistant, under whose observation she first came, states that at the time of her admission there was a small patch of false membrane on the fauces; but when I saw her, two or three hours later, this had disappeared. The case seemed so urgent, that Dr. Thompson requested his colleagues, including myself, to see the patient, for the purpose of

considering the propriety of performing the operation of tracheotomy. I found both tonsils enlarged, somewhat ragged-looking and reddened; the pillars of the fauces were also of a dusky-red colour, and the glands at the angles of the jaw, especially those on the right side, were slightly enlarged. The tongue was moist, and coated with a white fur. The urine was normal in appearance, and contained no albumen. On examining the anterior part of the chest, I found a deficiency of resonance in the left infra-clavicular region, and the respiration on both sides of the chest sibilant, with slight rhonchus in the upper part of the left lung. I was informed that there was dulness on percussion over the greater part of the left side of the thorax posteriorly, but the child was so ill that I did not attempt to verify this fact for myself. Immediately after the consultation tracheotomy was performed by Mr. Moore, and I shall presently state to you what were my own views of the case, and the grounds on which I advocated a decision in favour of operating. From two and a half to three ounces of blood were lost during the operation, and the pulse at once fell to 128, but shortly became exceedingly feeble. The respirations became exceedingly tranquil, and the child fell into a quiet sleep. At eleven P. M. the pulse was 140, the respirations 34; the patient had slept well at intervals, and had partaken freely of the strong beef-tea and brandy ordered for her. On the 25th it was reported that she had passed a good night and had taken abundance of nourishment. She was perfectly calm, her pulse from 130 to 140; but the respirations, though unembarrassed, were very frequent, being nearly fifty in a minute. The breathing was found to be tubular, and the percussion resonance dull over the whole of the left side of the thorax posteriorly; the respiration over the right scapula was also slightly bronchial; the deficiency of resonance and bronchial breathing below the left clavicle remained as before the operation. Throughout the day and night she continued stationary, coughing a good deal, but expectorating freely, until early on the morning of the 28th, when she became restless and began to have difficulty in raising the expectoration. During the day her breathing became more and more embarrassed, and gradually sank, and died at half-past four p. m., about forty-eight hours after the operation.

At the post-mortem examination a shallow, ragged ulcer was found on the surface of each tonsil, but both throat and fauces were free from exudation. A small patch of false membrane was lying loose on the under surface of the epiglottis, and the larynx and also the trachea, for the space of an inch and three-quarters downwards, were almost entirely lined with a tough false membrane, of about the thickness of kid leather, for the most part lying loosely on the mucous surface, but here and

there so firmly attached as to require much force to tear it away. The incision made by the operation had passed directly through this membrane. The larynx, trachea, and bronchi contained a large quantity of thick, tenacious, muco-purulent secretion. The mucous membrane of the larynx and trachea was generally somewhat reddened, and presented distinct patches of a still deeper redness. On tracing the left bronchus downwards from its origin, the smaller tubes were found to be inflamed and filled with thick mucus. The upper lobe of the left lung was collapsed, and the posterior part of the lower lobe was dark coloured and much congested. The right lung was also slightly congested, but otherwise appeared to be normal. The rest of the viscera were healthy.

I have spoken of this case as illustrating one of the forms of diphtheria, because I regard it as having really been a case of that disease, and not one of ordinary croup; and I am led to this conclusion by the fact that sore-throat, although of a mild kind, had preceded the laryngeal symptoms for some days, and still existed at the time of the patient's admission to the hospital. This accords with the ordinary history of diphtheria affecting the air-passages; it commences in the fauces, and usually, after a shorter or longer interval, creeps downwards into the larynx and trachea. The interval between the commencement of the illness and the accession of laryngeal symptoms may indeed be very brief, sometimes not exceeding a few hours, but in my experience it has more frequently been several days, though very rarely protracted beyond a week. One reason why laryngeal diphtheria often appears to commence suddenly is the fact, to which I have already adverted, that the earlier symptoms of cases which ultimately become dangerous are often of the mildest character, and consequently sometimes altogether escape the observation of friends or attendants until the symptoms of actual croup give the alarm. Last autumn I saw, at the request of her medical attendant, a little girl, aged four years, whose indisposition had been so entirely overlooked by her parents, that they had brought her up from the country only a few hours before I saw her, and until the dyspnoea and stridulous breathing suddenly came on, and induced them to send for medical advice, were proposing to take her on to Gloucestershire. Yet not only were the tonsils enlarged, with a patch of exudation, the size of a six-penny-piece, on each, but the fauces were generally injected, and the glands at the angles of the lower jaw swollen; showing beyond doubt that the disease must have been progressing for some days, even if we had not ascertained on inquiry that the child had had a slight sore-throat for nearly a week, which had not, however, prevented her from taking her food, and going about as usual. In fact, in that case, as well as in the case we are con-

sidering, it was evident to me, when first called on for an opinion, that the disease had already reached a stage in which, unless speedily relieved, the patient could not survive many hours, and in which the only possible modes of relief were either by means of the spontaneous expulsion of the false membrane, which I felt assured was choking up the larynx or trachea, or else by means of the artificial admission of air to the lungs through an opening in the trachea. Now and then, though very rarely, I have known cases of this kind recover, when apparently desperate, in consequence of the spontaneous separation and expulsion of a mass of false membrane, bearing a more or less close resemblance in shape to some portion of the air passages. I had some time since in my possession two such portions of false membrane, one of which formed an exact cast of the lower part of the trachea and the first portion of the bronchi, and the other an equally accurate cast of the larynx and upper part of the trachea. Both had been expelled by patients who were apparently almost moribund, and in both places the expulsion was followed by recovery. I also some years ago found in the post-mortem examination of a little girl, whom I had seen once a few hours before death, a deposit of false membrane lining the whole of the larynx, and extending nearly an inch downwards into the trachea. This false membrane formed a complete tubular cast of the parts, but was almost entirely loose, being only attached at a few points to the mucous membrane which it overlaid. Thick and dense in the larynx, it became gradually thinner in the trachea, until it terminated in an extremely thin, soft, and scarcely coherent pellicle. The child had died very suddenly a few hours after I had seen it, and the immediate cause of death appeared to have been the partial detachment of the false membrane lining in the larynx, which had choked the passage, and barred the admission of air. I was much mortified to find after death that possibly the operation of tracheotomy might have saved the child's life, and that the false membrane being loose, might not improbably have been seized with a pair of forceps, and drawn through the wound. I should add, however, that the spontaneous detachment and expulsion of the membraniform exudation, whether entire or in flakes, by no means insures the patient's recovery. The temporary relief is indeed for the most part very remarkable, and encourages the hope that the patient—who, although only a short time before apparently in the last struggle for life, may now be sleeping calmly—is on the high road to perfect convalescence; and in some instances this may really be the case. But such hopes are too often illusory, for the same tendency to repeated renewal of the false membrane, by fresh exudation, which is frequently seen in diphtheritic

affections of the fauces, exists also in the larynx; and, unless the local inflammation itself be upon the wane, it is too frequently found, a few hours after the expulsion of the former cast, that a new one occupies its place, and that the patient is in a worse state than before, being less able to cope with the fresh attacks of dyspnœa, and less likely to have strength to expel the obstruction. In fact, as long as the inflamed mucous membrane continues to pour out the liquid exudation which coagulates into the diphtheritic deposit, so long must the process of formation go on. It is by the persistence of this process that what was at first a mere semi-transparent pellicle on the fauces, becomes in the space of a few hours a dense membrane, and that the latter often increases in thickness from day to day, notwithstanding the waste going on at its free surface. And so therefore I regard it as probable, seeing the great rapidity with which the membrane re-forms upon the fauces when it has been artificially detached, that, unless the inflammatory affection be really on the decline, the process of exudation and coagulation may go on for a time even more rapidly after the expulsion of the false membrane from the larynx than whilst it still covered the deceased surface.

To return, however, to the case of the little hospital patient. I was convinced, as already said, that the only possible chances for her life lay either in the almost immediate expulsion of the false membrane or in the speedy performance of tracheotomy. The former is, as I have explained, an event of rare occurrence, never to be counted on in any particular case, and the issue of which is exceedingly uncertain when it does happen; the latter alternative of operation has very frequently failed in such cases, and seemed especially likely to do so in a case in which the left lung was already partially consolidated, and the bronchial membrane probably inflamed. Nevertheless, considering that the child's suffering was urgent, that its death in a few hours seemed inevitable, unless relief could be given by the operation, and that there were no severe constitutional symptoms to contraindicate tracheotomy, I spoke very decidedly in favour of its being performed. The event proved that in the circumstances the operation was not only justifiable, but right, for it was scarcely over when the child's breathing became comparatively tranquil, and she fell into a quiet sleep almost as soon as laid down in bed; and although it is true that in this case, as in too many others, life was not saved, it was certainly prolonged, the most urgent suffering was permanently relieved, and death came in a gentler and less distressing form than it would otherwise have done.

The immediate causes of death in this case were, doubtless, the collapse of lung and the plunging up of the trachea and primary bronchi

with tenacious mucus, which the child was unable to get rid of by expectoration; for the lung-tissue, although collapsed, was not inflamed, and the bronchitis was scarcely in itself severe enough to have proved dangerous, except as a complication of the graver disease. In fact, however, I regard both the bronchitis and the collapse of lung as having resulted from the laryngeal affection; the former having probably been mainly occasioned by the gravitation downwards of the acrid fluid, from the larynx and trachea, consequent upon the patient's inability to expectorate. The collapse of lung doubtless arose, as it so often does in the bronchitis of children, from the imperfect admission of air into the lungs during inspiration, partly in consequence of the obstruction in the larynx and trachea, partly from the choking up of the bronchial tubes with tenacious mucus. This latter, again, was in a great measure owing to the inability to cough it up, consequent on the want of power to take such a full inspiration as necessarily precedes the act of coughing. This was therefore eminently a case of diphtheria, fatal in consequence of the local manifestations of the disease, and it was in the conviction that these constituted the real danger of the case that I entertained no doubt respecting the propriety of endeavouring to save the patient by tracheotomy.—*Lancet*, June 3, 1865.

ANEURISM OF THE THORACIC AORTO.

Dr. Potain, of the Hospital St. Antoine, gives, in *L'Union Médicale*, an interesting case, in which aneurism of the thoracic aorta was diagnosed by means of the laryngoscope. The patient, on admission, suffered mainly from cough, aphonia, and dyspnoea, and was treated for laryngobronchitis. But as the treatment had no effect, M. Potain, convinced that the mischief lay in the larynx, examined the organ with the laryngoscope; and, to his surprise, found the mucous membrane in a perfectly healthy state. The cause of the aphonia, however, was at once explained by a complete paralysis of the left vocal cord. Hence, it appeared probable that the left recurrent nerve was affected in some part of its course. On further investigation, M. Potain was able to observe deep down in the trachea on its left side a reddish and projecting surface, which prevented the first division of the bronchi from being seen. No pulsation, however, was observed in it. This fact, however, with certain auscultatory signs, led to the diagnosis of aneurism, which was confirmed by autopsy. The recurrent nerve was found closely pressed between the tumour and the trachea; it was flattened and transformed into a kind of ribbon, and could only be recognized by its continuity with the pneumogastric nerve. All the laryngeal muscles supplied by the left recurrent were more or less atrophied.

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CHANGE OF TYPE IN DISEASE.

The question whether the non-employment of general and local bleeding, in the treatment of fevers, and acute diseases generally, as now followed by the majority of practitioners, is due to a change of type in disease, or to a more correct knowledge of the pathological conditions than were possessed by our forefathers, is one which has occasioned not a little discussion. It is now again revived by the address in medicine delivered before the British Medical Association, at its last meeting held in August, by the Regius Professor of Physic, in the University of Dublin, William Stokes, M.D., D.C.L. The very high position occupied by this gentleman, and his vast experience, extending over a period of over forty years, during which time the change of type (if the true cause) occurred, gives to his opinions weight possessed by few living physicians. Dr. Stoker at once strongly asserts his conviction, that disease now is not of the same type as it was thirty years ago, and calls to his assistance Drs. Christison, Watson, Alison, and Graves—the two former being still alive, to give their testimony—the two latter, but recently removed. The address is a very lengthy and able one, and we regret we are only able to give a few extracts, which will, however, give our readers some idea of the stand taken, and the opinions given by its talented author. He says, speaking of the change in the method of practice:

“We can hardly conceive a revolution in practice more complete. Venesection is now, from being the most frequent, the rarest of operations. In place of the loss of blood, we have the exhibition of stimulants; in place of a system of almost starvation, we have the careful use of nutriment.

This change has given rise to the charge against our predecessors and teachers, that they were bad practitioners, ignorant of true pathology, little better than blind followers of traditional error. Not only has their

power of observation been questioned, but their morality and honour have been assailed; for it has been suggested that the doctrine of change of type was an invention to cloak their former errors.

But the thinking man finds it hard to believe that the fathers of British medicine were always in error, and that they were bad observers and mistaken practitioners. They, indeed, have rested upon their labors, but their works remain; and he who reads the writings of Sydenham, of Haygarth and Fothergill, of Heberden and Fordyce, of Gregory, Cullen, Alison, Cheyne, or Graves, must have a very inapprehensive mind, if he fail to discover that they were giants in those days, and that the advocacy of such ideas only indicates a state of mind not consonant with the modesty of science.

The declaration that it has been or can be proved by a more advanced pathology, that bleeding never was the proper remedy for fevers and inflammations, has as yet no scientific ground. It is not yet given to us, notwithstanding all our advance in normal and in morbid anatomy, in the physiology of health or in that of disease, to be able to say, from the most minute examination of the dead organ or structure, what were *all* the conditions which attended it during life, in health or in disease—what were its local vital phenomena, what was its accompanying constitutional state. The words of Goethe, so well rendered by Dr. Anster, convey a deep practical lesson to those who would base medicine on anatomical change:

“ Alas! the spirit is withdrawn—
That which informed the mass is gone.
We scrutinise it when it ceases to be itself,
Finger and feel it, and call this
Experiment analysis.”

But let us ask, Which is the most probable of the two suppositions? First, that our predecessors, including such as I have named, were bad observers, incapable of divining the truth, and blind adopters of an antiquated and mischievous method; or, secondly, that the type of disease has changed, and that in our own time.

When I read the words of Alison—the best man I ever knew—it is with a feeling of wonder how it has happened that men should forget what reverence is due to his memory; whether we look on him personally as a man of science and a teacher, or at his life as an exemplar of a soldier of Christ. It was my fortune to be very closely connected with him during my student days in Edinburgh, and to attend him by day, and more often far into the night, in his visits of mercy to the sick poor of that city, to whom he was for many a year the physician, coun-

seller, and support. This was forty years ago, and at that time he recognized the change. Often he said to me, 'We cannot bleed this man; we must get him wine;' and the wine was got, and given with an open hand, so long as it was required. He used to say, 'I am not anxious to put these poor people into hospital; they will get on better at home, if we are guided by looking at their constitutional even more than their local state.' This, however, has been well put by Dr. Watson, who dates the commencement of the change from that of the first presence of cholera in London in 1863.

Dr. Christison, in his *Memoir on the Changes which have taken place in the Constitution of Fevers and Acute Inflammation, in Edinburgh, during the last Forty-six Years*, says:—

'Looking at the epidemics of fever in Edinburgh from the beginning of the present century, he shows conclusively that, in 1817-20, and in 1826-29, their characters were those of Cullen's synocha and synochus—inflammatory, relapsing, critical. Speaking of the epidemics of 1817-20, he dwells on the hard, incompressible pulse, the ardent heat of the skin, the florid hue of the venous blood, and the impetus with which it escaped almost *per saltum* from the vein, the vivid glow of the surface, and the distracting pain and pulsation of the heart and chest. Similar phenomena occurred in the epidemic of 1826-29; and, in both, bleeding was largely practised with the happiest effects; so that, in the epidemic of 1817-20, the mortality, which was at first one in twenty-two, fell to one in thirty—a result which disposes of the charge of malpractice against the profession. But, in 1834, Dr. Christison found that probably for two years previously a change had been going on:—synocha had disappeared; synochus had lost the vehement reaction of its early stages; typical typhus was much more common; and what did not come up to Cullen's mark of fully formed typhus was what physicians would now commonly call mild typhus, with more of introductory reaction than we observe now, but with less than in the two epidemics of 1817-20, and 1826-29.'

I have given, I hope, a sounder explanation; less flattering, perhaps, to the rising generation of physicians, but surely more honourable to physic itself, more creditable to medical observation and experience, more consonant with the advanced state of medical philosophy. My own convictions on the subject are so strong, that I regard nothing as more likely, than that in the course of time some now present will see the day when a reflux in the constitution of fever will present it again in its sthenic dress, and again make the lancet its remedy. And in that event it is not impossible that, while we are now charged with giving up blood-letting, because it was discovered to have never been the proper method of cure, we will hereafter

be assailed by some new enthusiast in blood-letting, who, in imitation of Dr. Welsh, and regardless of the fate of his doctrines, will accuse us, with equal justice, of having made our late fevers asthenic and typhous by blindly withholding their fittest remedy.

I may now add the results of my own experience in this matter. I remember the period when the change of type took place in Ireland; and am under the impression that it was observed earlier in Ireland than in Scotland, or at least in England. The great epidemic of fever in 1828 was a remarkable one from its compound nature, and seemed to be made up of synocha, synochus, and enteric typhus. But nothing was more remarkable than the vehemence of the inflammatory reaction in many cases; and it is a curious fact that this was sometimes seen at its highest pitch in the relapses, when it was often far more violent and dangerous than in the first attack. Local bleeding was largely employed. In many cases, venesection or arteriotomy had excellent results; so that, although there were abundance of cases with prostration, and others marked by the typhoid condition, the old sthenic character had not disappeared. The amount of wine used at that time in hospital was quite insignificant as compared with its consumption for the last twenty or twenty-five years. In Dublin, at least, this epidemic passed into one of intermitting fever: and it was then I ventured on testing the nature of the practice recommended by Dr. Mackintosh of bleeding in the cold stage. The result of the experiment was against the use of the lancet; but I mention it, as indicating the time when it may be said venesection was abandoned in our wards.

Thus, between 1822 and 1828, the sthenic character of essential and of local disease existed, and the lancet was freely used, often, as I believe, and as I have elsewhere stated, with too great freedom; but I well remember observing the frequent occurrence of the phenomena mentioned by Dr. Christison—the vehement action of the heart, the incompressibility of the pulse, the vivid redness of the venous blood, and the force with which it spouted, almost *per saltum*, from the orifice in the vein. I have myself taken as much as sixty ounces in a case of active congestion of the brain, with hemiplegia, before any impression was made on the arterial excitement: in this case, complete success followed. In rheumatic fever, too, we found the use of the lancet in the early stage of the disease to be productive of great relief. Venesection was seldom used more than once; but its effect was to shorten the duration of the disease, to lower the fever, to lessen the liability to the so-called metastases, and to render the whole case much more amenable to treatment. But I have not bled in rheumatic fever for the last quarter of a century; for the

whole character of the disease has changed. We have not had for many years the bounding pulse, the exaggerated heat and sweating, nor the same liability to acute inflammations of internal parts. The action of the heart is often feeble; and the tonic and supporting plan seems called for from an early period. Another point worthy of remark is, that cardiac and aortic murmurs of the anæmic kind have for many years been much more frequently observed, both during the attack and in the convalescence, demanding the use of iron for their removal. Observations of a similar kind apply to other acute diseases; such, for example, as erysipelas and other affections of the skin. Before 1830, we had, as an ordinary disease, the acute phlegmonoid erysipelas, attended with inflammatory reaction, vivid redness, and great swelling of parts. The practice of free leeching gave great relief; so also did that of incisions. All these characters have, to a great degree, disappeared.

The Pathological Society of Dublin has been now established for twenty-six years, during which time it has held weekly meetings for six months of each year. As one of the Secretaries of that Society, I have had full opportunity of seeing and examining the recent examples of diseased structure brought weekly before the body—amounting to nearly 3000 specimens—the collected products of the various hospitals of the city; and this result is remarkable, that the specimens of acute disease have had a character very different from that commonly met with in Dublin between 1820 and 1830. As a general rule, these specimens all showed appearances indicative of a less degree of pathologic energy. In pneumonia, for example, the redness, firmness, compactness, and defined boundary of the solidified lung was seldom seen; and that state of dryness and vivid scarlet injection, to which I ventured to give the name of the first stage of pneumonia, became very rare. In place of these characters, we had a condition more approaching to splenisation—the affected parts purple, not bright red; friable, not firm; moist, not dry; and the whole looking more like the result of diffuse than of energetic and concentrated inflammation; or we had another form, to which Dr. Corrigan has given the name of blue pneumonia, in which the structure resembled that of a carnified lung which had been steeped in venous blood.

Let us turn now to the serous membranes, and the same story is repeated. The high arterial injection, the dryness of the surface, the free production, close adhesion, and firm structure of the false membranes in acute affections of the arachnoid, pericardium, pleura, and peritoneum, with which we were so familiar before the time in question, ceased in a great measure to make their appearance. The exudations were more or less hæmorrhagic; the effused lymph lying like a pasty covering rather

than a close and firm investment; it was thin, ill defined, and more or less transparent. In many of such cases, during the disease, as the late Dr. Mayne has shown in his memoir on pericarditis, friction-sounds were never presented. Serous or sero-fibrinous effusions tinged with colouring matter replaced the old results of sthenic inflammations, and all tallied exactly with the change in the vital character of the disease.

It has happened to me—and I mention this in evidence that we were not mistaken as to cases peculiar to the sthenic form—that a few instances of disease in its old inflammatory characters have appeared in isolated examples, and at irregular intervals of time; so that we at once recognised their nature, and employed with success the old treatment in all its vigour—employed the lancet, although for many years its use had not been resorted to. This is very important, as showing that there are influences, the nature of which is as yet unknown, that affect the vital character of local disease in an inconstant manner.”

MEDICO CHIRURGICAL SOCIETY OF MONTREAL.

The second regular meeting of this new society was held upon the last Friday in September. There was a fair attendance, the chair being occupied by Dr. Hingston, Vice-President. Several new members were elected, and others proposed for membership. A brief discussion took place upon a very interesting case of Trumatic Tetanus, which lately occurred at the Montreal General Hospital, and which proved fatal. We hope to give the notes of this case in our next. We trust that when the society gets fairly into operation, its proceedings will furnish us with many interesting cases for publication.

At a recent meeting of the Medico-Chirurgical Society of Edinburgh, Dr. Thomas Keith exhibited four ovarion cysts which he had recently removed by ovariectomy. All the operations were simple and easily performed, and were followed by the rapid recovery of the patients. Dr. Keith had performed ovariectomy 31 times, with the result of 22 recoveries and 9 deaths, or 29 per cent. of deaths.

From a return just published it appears that the Chancellor of the Exchequer has received the enormous sum of £55,333 0 6½ for duty on quack medicines. — Previous to the discovery of vaccination, and when the population of Great Britain was only ten millions, the number of deaths annually from small pox was 30,000. Now, with a population of thirty millions, the number of deaths is less than 10,000. — A statue has been erected at Bologne to the memory of the immortal Jenner. It is ten feet high, and stands on a marble pedestal twelve feet high. — Dr. Forbes Winslow, the eminent physician, is in a dangerous state of health.